

Signature page

“Damned if you do, damned if you don’t”: Canadian-born and  
immigrant mothers’ experiences and perceptions of infant  
feeding in contemporary Nova Scotia

By  
Lesley Magee

A Thesis Submitted to  
Saint Mary’s University, Halifax, Nova Scotia  
in Partial Fulfillment of the Requirements for  
the Degree of Master of Arts.

October, 2016 Halifax, Nova Scotia

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Date: October 27, 2016

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**“Damned if you do, damned if you don’t”: Canadian-born and immigrant mothers’ experiences and perceptions of infant feeding in contemporary Nova Scotia**

by Lesley Magee

**Abstract**

Following is an exploratory study of Nova Scotian women’s infant feeding experiences based on data gathered from two focus groups – one with Canadian-born mothers and one with mothers who had migrated to Canada in early adulthood. An intersectional approach grounded in feminist and critical theories is used to explore how immigrant and Canadian-born mothers perceive the influence of socio-cultural factors on decisions around feeding their babies. The purpose of the research is to explore how mothers’ personal experiences provide context for the shared and individualized aspects of mothering, specifically infant feeding, and to demonstrate the value of women’s stories and personal experiences in understanding the nuanced environment in which infant care and feeding practices currently exist. Descriptive analysis of each focus group discussion allows for the contrast and comparison of references to practices, beliefs, and values that emerge.

October 27, 2016

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Without the love, encouragement and support of my family and friends, this endeavour would have been much more difficult and may not have come to a conclusion.

## **Introduction**

Research on infant feeding decisions and practices indicates that socio-cultural factors strongly influence mothers' decisions, resulting in a wide range of feeding practices (Apple, 2014; Brown et al, 2008; Chen, 2010; Dodgeson et al, 2002; Giles, 2011; Guerrero, 1999; Hausman, 2003; Jessri and Farmer, 2013). According to Nancy Mohrbacher, "breastfeeding is a complex social behaviour" (2010, p. 180) and there are often complex factors affecting a mother's decisions on how to feed her baby, including perceptions, attitudes and norms. The work of Bernice Hausman focuses on the social constraints of breastfeeding using an intersectional framework to explore how systemic and structural realities impact parents' infant feeding decisions. Of particular interest to Hausman (2003; 2006; 2007; 2014) is how social constraints interact to impact a mother's ability to feed her infant in the way she intends and desires. According to Daglas and Antoniou, "breastfeeding is often not determined by biological factors, but it is mainly based on the habits, standards and behaviours existing in each society." (2012, p. 353). In their view, acceptance of breastfeeding by individual mothers is dependent on perceptions of the function of breasts, perceptions of the quality of mother's milk, and traditional practices associated with breastfeeding in a community.

An amazingly complex behavior, infant feeding has become a variable and diverse practice taking on many forms, from extended breastfeeding to exclusive formula-feeding to various combinations of human milk and formula and everything else in between. In addition, traditionally-perceived mothers are not the only caregivers of infants represented on the breastfeeding spectrum as one might assume. Also included are grandmothers who re-lactate for their grandchildren, fathers who were once female, non-biological mothers, among others (Giles, 2003). All this to say that there is a wide range

of infant feeding possibilities and practices and this research only touches on a few of a multitude.

Demographic characteristics like socio-economic status; education levels; identification with an ethnic community; marital status; identification with an oppressed racialized community; among others, all have an impact on whether or not a mother breastfeeds exclusively for the recommended six-month period, or for as long as she initially intends to (Hausman, 2014; Labbok et al, 2014; Gionet, 2013; Statistics Canada, 2011). As such, socio-cultural factors must be taken into account by individuals and organizations who provide breastfeeding education and support (Daglas and Antoniou, 2012; Dodgeson et al, 2002; Guerrero et al, 1999; Jessri and Farmer, 2013).

Through this qualitative study grounded in feminist and critical theories, I use an intersectional approach to explore how immigrant and Canadian-born mothers in Nova Scotia perceive the influence socio-cultural factors have or had on decisions around feeding their babies. The purpose of this research is twofold – firstly to explore how mothers’ personal experiences provide context for the shared and individualized aspects of mothering, specifically infant feeding, and secondly to demonstrate the value of women’s stories and personal experiences in understanding the nuanced environment in which infant care and feeding practices currently exist.

The gap in national and provincial breastfeeding rates suggests a disconnect between federal and provincial policy and the options available to Nova Scotian mothers, an idea also put forth by Nathoo and Ostry (2009) in their historical analysis of breastfeeding in Canada. Despite the recommendations, mothers consistently choose (willingly or not) an option not recommended by health practitioners, policy-makers, researchers and other “authorities”. Researchers consistently find that most women try to

breastfeed their babies but cease because of an underlying lack of support in the face of a multitude of challenges and constraints (Chen, 2010; Dodgeson et al, 2010; Hausman, 2014; Jessri and Farmer, 2013; Mohrbacher, 2010). Culturally appropriate support is essential when working in a postmodern, transnational context such as contemporary Nova Scotia. However, it is important to keep in mind that culture is only one aspect that needs to be considered – how does cultural background intersect with other axes like socio-economic class, gender, religion, nationality, ability, etc., in influencing mothers’ breastfeeding decisions? Ultimately, it is through understanding how these attributed social characteristics intersect in the lives of mothers that effective support can be provided. Despite the intrinsic value of mothering work, it is invisible and disparaged at worst and undervalued at best in many postcolonial, post-industrial societies, including Canada (Nathoo & Ostry, 2009; Ostry, 2006; Palmer, 2009).

The National Childbirth Trust (NCT) (2008) cites London Infant Survey 2005 data indicating that most mothers who wean their babies within the first six months wish they could have breastfed for longer. As an organization, they advocate for moving beyond public education by offering the tools, information and support needed by mothers to make informed choices that work in the context of their lived reality. Data from the Nova Scotia Atlee Perinatal Database (2014) points to the same phenomenon, where rates of intention to breastfeed among mothers in Halifax Regional Municipality (HRM) are on par with breastfeeding rates at discharge. It is known that breastfeeding rates drop significantly within the first few weeks (Gionet, 2013), so it can be inferred that there are many mothers (the majority even) who are not meeting their infant feeding goals.



The goal of my thesis is to explore how immigrant and Canadian-born mothers feel socio-cultural factors influence their decisions around feeding their newborns and young children. What is lacking in the research on infant feeding in Nova Scotia for the most part, with exception to Judith Cormier's Masters and PhD research with Mennonite (1998) and Mi'kmaq women (2014) respectively, are first-hand accounts of how social categories like gender, socio-economic status, nationality, race, ethnicity, ability, religion among others, intersect in the lives of new mothers as they decide how to best care for and nourish their infants. After careful consideration, I decided to collect data through two focus groups – one with mothers who came to Canada as immigrants and one with mothers who were born in Canada. I chose to collect data from the two groups of women separately so that women who were not as comfortable in English did not feel intimidated among women who speak English as a first language and were comfortable to express themselves in any way they wanted. Although the immigrant women involved were from diverse ethnic groups and did not share a common language, they had the shared experience of immigrating to Canada, belonging to minority ethnic, religious and/or racial communities and three of four spoke English as an additional language. Helen was the only participant in this group whose first language was English. Focus Group A participants were also familiar with each other from having worked together so felt comfortable sharing their infant feeding experiences with each other. Having data from the two focus groups has allowed me to explore differences and similarities between Canadian-born and immigrant mothers in terms of the constraints they face, their decision-making processes, beliefs, values and the resulting practices.

The objectives of this study are to:

- probe more deeply into the role that socio-cultural factors play in influencing Nova Scotian mothers' infant feeding decisions by analyzing mothers' stories, retelling their personal experiences, and naming their knowledge.
- provide a space where women from diverse backgrounds can voice their experiences, not as anecdotal evidence, but as contributions to a complex narrative on an issue that is a fundamental part of being mothers and women.
- identify ways that policy, programming and outreach can more effectively support all women in Nova Scotia in their infant feeding decisions and help women develop their own definitions of breastfeeding "success".
- explore how feminist theory has intertwined with breastfeeding practice and policy in HRM, Nova Scotia and Canada in recent history.

My interest in breastfeeding as a practice and in providing practical support to breastfeeding mothers has grown from my own experience as a mother. While pregnant, my husband and I found out that our daughter would be born with a moderately serious heart defect requiring surgery soon after birth. Through research, I found out the most important thing I could do for a myriad of physical, biological, emotional, social, and psychological reasons was to breastfeed her, and so my goal became to breastfeed her exclusively for at least six months, as recommended by the World Health Organization (WHO) and various federal bodies. At the time my exposure to breastfeeding was very limited, having had only one friend who had breastfed. Breastfeeding was not important enough for me to pay much attention to since I did not have many friends or nearby relatives with babies. I started out breastfeeding my daughter without any real or practical

knowledge, a personal experience that is shared with many women in Nova Scotia.

By reading everything I could find on breastfeeding babies with heart defects and breastfeeding in general, I realized the best way to reach my feeding goals would be to build a support network to help me through the early months, which I knew would be challenging. As part of that effort, I began attending La Leche League (LLL) meetings before my daughter was born, becoming connected with a network of strong, wise and knowledgeable mothers I still rely on for support. LLL is a non-profit, peer-support organization whose volunteers have supported breastfeeding mothers all over the world in meeting their infant feeding goals. Although it can be criticized for its seemingly staid and hierarchical, even patriarchal, structure, it is in the process of transforming itself. The organization in Canada has identified the need to diversify from its primary audience of middle-class, educated, racially white, heterosexual, married mothers to survive in a context where the concept, structure and nature of family and the demographics of our communities are changing rapidly. About a year after attending my first meeting I was invited to start the training process to become a group leader. As a leader, I now facilitate monthly meetings while providing email, phone and in-person support to new mothers facing challenges with breastfeeding.

To begin to give context to the local conditions, the first chapter is a scan of the infant feeding environment in Nova Scotia including statistics, some of the stakeholders, and the current policy framework. Breastfeeding initiation and duration rates are discussed, and an overview of breastfeeding support organizations, programs and initiatives on the provincial and local levels is provided, laying the groundwork for the second chapter.

The second chapter is a discussion on theoretical viewpoints on infant feeding,

weaving theory with historical policy developments around infant feeding in Canada and Nova Scotia. In this chapter, I consider feminist and human rights frameworks for breastfeeding; intersectionality; systems of oppression; infant feeding in a late capitalist context and embodiment. Central to Chapter 2 is how social values, ideology, policies, and programming have influenced the culture of infant feeding in contemporary Canada and Nova Scotia.

The third chapter details the methodology used for my research. Two focus groups were conducted – one with immigrant mothers and one with Canadian-born mothers. I chose to collect my primary data through focus groups because they are considered an ideal format to gain insight into participants’ values, beliefs and practices (Litoseliti, 2003; Wilkinson, 2011). Three stages of analysis were performed – the first to identify salient themes overall; the second to refine the themes and determine how they fit together; and the third stage to identify common and divergent themes between the two discussions.

Central to the fourth chapter is the descriptive analysis of the primary data collected through the two focus groups. Salient themes are discussed in chronological order of the conversations and are supported by participants’ narratives selected from the two focus group discussions.

Finally, the fifth chapter is a discussion of the results of my research and how the findings can be applied through practice. Recommendations for improving infant feeding support derived from the literature, feedback from participants and personal observations as a breastfeeding supporter are presented.

The concepts of relational empowerment<sup>1</sup> and mutuality are important to the integrity and transparency of this work, allowing me to explore my location as a researcher and LLL leader in a differential power environment (i.e. the focus groups). I hope this work sparks more qualitative research on the spectrum of infant feeding practices in HRM as well as the province. Also that it contributes towards a deeper understanding of how women's attributed social positionalities influence their infant feeding practices and how breastfeeding support workers can best meet mothers where they are, within the framework of privilege and oppression.

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<sup>1</sup> Relational empowerment in research means that everyone involved brings something to the event and are affected by the process (VanderPlaat, 1999).

# Chapter 1

## Setting the Scene: Infant feeding in Nova Scotia

### 1.1 Intersections of the social and structural in infant feeding practice

In the contemporary era of scientific motherhood, childrearing is highly intellectualized and empirical in many respects. Mothers as individuals are charged with making important, life-affecting decisions about their children's physical and emotional health on a daily basis and are encouraged or expected to consult experts and health professionals for the right answers. In the context of her historical work, Rima Apple found that

Mothers offered numerous explanations for doing as they did for and with their infants, demonstrating that women were not, and by extension *are not*, merely passive recipients of medical advice. This diversity suggests that individual women had agency and were active participants in decision-making about their child's health. (2014)

In the case of immigrant mothers, mothering work is done while trying to negotiate complex cultural and personal transitions, (Yax-Fraser, 2007) which adds even more complexity to the process. At the same time that mothers who have migrated to Canada negotiate parenting, they also negotiate fluctuating senses of belonging and identity. Transformations involved include the transition for many from a community parenting model to the nuclear family model; shifting from career life to full-time mothering, as well as experiencing decreased social mobility (Yax-Fraser, 2011).

One of the earliest and most important "decisions" a mother makes is how to nourish her baby. Although breastfeeding is recommended by organizations and institutions based on myriad benefits for babies and mothers, it is not common for mothers in Canada generally and Nova Scotia specifically, to breastfeed their babies for

the recommended period of six months (Brown et al, 2013; Gionet, 2013; Kirk et al, 2012; National Childbirth Trust, 2008). Decisions surrounding whether to breastfeed, formula feed or any kind of mix of both are not clear-cut and the process involves a multitude of factors that interact on multiple levels. Whether mothers have full decision-making ability that is informed and without constraints is questionable among researchers who see breastfeeding as intricately tied to feminism and questions of women's rights (Blum, 1999; Hausman, 2003; Hausman, 2012; Nathoo and Ostry, 2006; Palmer, 2009; Rippeyoung, 2013; Smith et al, 2012).

Despite being framed as a choice, infant feeding practices are influenced by structural and social factors. As a result of their positionalities within a patriarchal system, Canadian mothers face structural constraints which make breastfeeding challenging for many. As previously mentioned, mothering is invisible work and more value is placed on women's contribution to the wage economy than the labour put into mothering their children (Hausman, 2003; Nathoo & Ostry, 2009; Palmer, 2009). Not all women in Nova Scotia can afford to take advantage of a full year of maternity leave to care for their babies, making it difficult for many mothers to maintain breastfeeding. Among those who work it is difficult because they are not always able to pump during work hours or have their nursing babies in daycares close to their work places (Rippeyoung, 2013). Although most mothers in HRM intend to breastfeed (Nova Scotia Atlee Perinatal Database, 2014), only a minority of mothers manage to have all the pieces fall into place to be able to do so, mainly due to their privileged positions in society. These mothers are generally educated, middle class, married women who are over thirty, with class being an exceptionally strong determinant of breastfeeding over other factors (Gionet, 2013; Brown et al, 2013).

## **1.2 Policy in a constrained environment: Canadian and Nova Scotian contexts**

In 2014, Health Canada, the Canadian Paediatric Society (CPS), Dietitians of Canada and the Breastfeeding Committee for Canada (BCC) underwent a joint process to revise their infant feeding recommendations for children between birth and two years. As per the WHO recommendations (2002), and the previous recommendations of the above-mentioned agencies, the ideal feeding method is exclusive breastfeeding for at least six months while supplementing with vitamin D. The second main message in the new infant feeding recommendations is that mothers should “continue to breastfeed for up to two years or more” or however long parent and child want, while feeding complementary solid foods from six months. Prior to 2004, Health Canada and CPS recommended exclusive breastfeeding for between four and six months of age. Even earlier than that, the Division of Child Welfare in 1920 recommended exclusive breastfeeding for nine months before introducing solids.

At the provincial level, the Nova Scotia Provincial Breastfeeding Policy was put into place in 2005 and updated in 2006. Like the international and federal recommendations, it also recommends exclusive breastfeeding “for the first six months of life for healthy term infants with continued breastfeeding for up to two years and beyond...” Although Nova Scotia’s Department of Health is on the same page as Health Canada, federal agencies and international agencies like the WHO and UNICEF, there is a gap in the breastfeeding initiation and duration rates between women in Nova Scotia and the Canadian rate. Breastfeeding initiation rates reported by the Canadian Communities Health Survey (CCHS) look high at 89% in 2011-2012, however they are deceptive, measuring the number of mothers who breastfed at least once during their



hospital stay following birth (Health Canada, 2012a; Health Canada, 2012b). The majority of Canadian-born mothers end up introducing formula before the recommended age for many, often very personal, reasons with only 26% breastfeeding exclusively (not supplementing with other foods or solids) for the recommended six months in 2011-2012. It is no wonder that duration rate drops so steeply within the first few weeks, when many mothers find themselves without the support they need to make it through the critical period of establishing breastfeeding (Giles, 2003; Gionet, 2003; NCT, 2008).

The 2011-2012 breastfeeding rates rose from 2003 when 85% of mothers initiated breastfeeding before discharge from hospital and 17% reached six months- duration of exclusive breastfeeding (Health Canada, 2012a; Health Canada, 2012b). Breastfeeding initiation rates vary widely from region to region, with the 2011 rates highest in British Columbia and the Yukon at 96% and lowest in Newfoundland at 57%. Nova Scotia falls in between, with an initiation rate of 77% in 2009-2010 according to data collected through the CCHS (Kirk et al, 2011). Despite the diversity of infant-feeding experiences and practices, there is no detailed breakdown of data available on mothers who switched to formula within the first six weeks, how many switched at, for example, four months or how many fed formula and human milk simultaneously for any length of time. Although it provides some useful information on infant feeding practices in Canada, the CCHS data are quite limited and fail to give a clear picture of the myriad of practices and possibilities.

According to the Nova Scotia Atlee Perinatal Database (NSAPD), the breastfeeding initiation rate, or the rate of breastfeeding at discharge, in Nova Scotia was 79.5% in 2011, compared to 66.5% in 2002 (2014). The rate rose steadily each year however the numbers are reflective of mixed feeding as well as exclusive feeding, which

is why they are slightly different from the CCHS statistics. In terms of exclusive breastfeeding for at least six months, the Nova Scotia rate was 18% in 2009 (Kirk et al, 2011). The increases in initiation and duration do not seem significant given the policy and public health work that has been done around encouraging mothers of newborns to breastfeed.

In their 2012 evaluation of the Nova Scotia Provincial Breastfeeding Policy, Kirk et al identified five key themes critical to increasing duration rates in Nova Scotia: 1) a supportive breastfeeding environment; 2) strong leadership of head provincial initiatives; 3) increased knowledge about breastfeeding among physicians; 4) better understanding of the International Code of Marketing and Breast Milk Substitutes<sup>2</sup>; 5) “breastfeeding as a way to address childhood obesity.” The last item is because the provincial government has a current focus on the prevention of childhood obesity so funding is being distributed based on initiatives’ abilities to address that specific issue.

A fact made apparent through the CCHS is that mothers surveyed who were immigrants and those who self-identified as belonging to ethnic minorities like African-Canadian and Asian-Canadian were more likely to initiate breastfeeding (Gionet, Breastfeeding Trends in Canada, 2013; Health Canada, 2012a; Health Canada, 2012b) than other groups of women. Though the initiation rates are higher, the duration rates are about the same between immigrant, African-Canadian, Asian-Canadian and mothers from other self-selected categories used in the survey. Although these mothers are more likely to initiate breastfeeding, the survey data reveals a higher drop off rate in that a higher

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<sup>2</sup> The International Code of Marketing and Breast Milk Substitutes (2011) was developed in partnership with the WHO, UNICEF and other organizations in order to address unethical marketing practices among artificial human milk producers and manufacturers. Although legislated in many countries around the world, Canada has ratified the code but has not enacted legislation.

percentage of mothers initiate breastfeeding but the duration rates are comparable to the average Canadian duration rate.

Researchers from the Region of Peel in Ontario (DaCosta and Gillespie, 2012) found that mothers in their communities mirrored the CCHS findings, though when they dug a bit deeper they found differences in duration rates between mothers who are newcomers (or who have been in Canada five years or less) and immigrant mothers who have been in Canada for more than eleven years. They found through their 2009-2010 Breastfeeding Duration Study in the Region of Peel that most women in hospitals in the region initiate breastfeeding. Newcomer women who had immigrated within five years had the highest rates of breastfeeding initiation and they were more likely to report breastfeeding at six months postpartum, with 66% of recent immigrants reporting breastfeeding at six months as compared to 53% non-immigrant mothers. They found that acculturation affects exclusivity - the longer an immigrant mother has lived in Canada, the more she is influenced by the cultural practices here. This is reflected in the lower duration rates for mothers who had migrated here eleven or more years before undertaking the survey. Fourteen per cent of mothers who had been in Canada more than eleven years were exclusively breastfeeding at six months compared to 26% of mothers who had been in Canada less than five years. Culture is a strong influencer in immigrant mothers' decision making processes as they navigate the terrain of dual culture parenting (Yax-Fraser, 2007), however in this case, it seems that the cultural influence of the women's original home country lessens with the amount of time spent in their new home country.

### **1.3 Charting a course to a breastfeeding environment in Nova Scotia**

Providing culturally congruent, non-judgmental support for all mothers who strive to make and put into practice informed infant feeding decisions is essential in a postcolonial, transnational context such as Canada. Having an understanding of how culture intersects with other axes of women's complex positionalities allows for better support to be provided to individual women. Breastfeeding is a preventative health behaviour that is "heavily influenced by socio-cultural factors" (Dodgeson et al, 2002, p. 235) so culturally congruent support and understanding should be practiced when supporting mothers as they attempt to establish good breastfeeding relationships with their babies.

Support can be considered culturally congruent when a community's beliefs, values and practices are explored in depth and insights gained are incorporated into the support system (Dodgeson et al, 2002), a process that is never-ending and constantly evolving. Chinese mothers who participated in a breastfeeding study in Vancouver, British Columbia were found to focus on harmony between mother and baby while incorporating concepts from traditional Chinese medicine and Western biomedicine into their breastfeeding practices and decision-making processes (Chen, 2010). Chen concludes her article by recommending that health care providers consider Chinese mothers' cultural perspectives and experiences when providing care and support to breastfeeding mothers from the Chinese community in British Columbia. In their article on the cultural influences on breastfeeding practice, Pak-Gorstein et al recognize the need for health professionals to "appreciate the cultural beliefs influencing infant feeding practices for both recent immigrants as well as for resident US ethnic groups," (2009, p. 11). Although the infant feeding landscape differs significantly between the United

States and Canada, it stands that this need is shared by mothers living in Canada and the US.

Like many aspects of “women’s work”, including mothering, breastfeeding is not a socially valued activity in Canada beyond the first few weeks of babies’ lives. In addition to structural constraints, some of which have already been mentioned, socio-cultural constraints like the acceptability of breastfeeding in public come into play. Jessica Babineau and Patricia Spurles have researched the responses of young Maritime students to breastfeeding and have found that although attitudes towards it are generally positive, with most participants indicating an intention to breastfeed future children, individual reactions to it are often negative (Babineau & Spurles, 2011).

In 2012, three stories came out in the local media that involved mothers breastfeeding in public. In late December of 2012, one mother was officially warned for the second time in six months by food safety officers from the Department of Agriculture not to breastfeed her son while working in her restaurant (CBC News , 2012a). Two days later, a report came out that an official from the Department of Agriculture retracted the warning, stating that breastfeeding is not a safety risk and apologizing to the mother (CBC News, 2015b). Days after that the media reported on a mother who was asked to leave a store in a local shopping mall for breastfeeding her infant despite store policy supporting breastfeeding mothers (CBC News, 2012c). The day after the story made national news, a media report was released stating that store management had issued an official apology (CBC News, 2012d). The incident was followed by a nurse-in by about seventy women, men and children outside the same store a week later (CBC News, 2012e). In addition, the owner of a dry goods business at the Halifax Seaport Market was cited for breastfeeding her baby at her business location, also by a food inspector from the

Department of Agriculture (CBC News , 2012d). Looking in the long term, these women who raised their voices in the media helped bring change. Recently the mall opened up a feeding lounge, a space available to mothers and babies to relax and feed in private should they or their children want to (Mic Mac Mall, 2014).

More recently, in the first week of November of 2015 a young mother was asked by a judge in the Nova Scotia Provincial Court to leave the courtroom because she was breastfeeding her four-month old son (Chronicle Herald, 2015). The difference between her experience and the other mothers' was the public outcry, particularly on social media. As the story spread through social media, the young mom received much more support than the other mothers, who were also supported in the community but not to the same extent. There seems to be more awareness now, whether it is due to increased public exposure to breastfeeding or advocacy work is hard to say but something is working.

#### **1.4 The breastfeeding support landscape in Nova Scotia**

Tatamagouche, a small rural community in Central Nova Scotia, reputedly has one of the highest breastfeeding initiation and duration rates of any other community in Canada and is an example of a breastfeeding-normalized environment. The average age at weaning is eleven months in the Tatamagouche area and fourteen months among mothers who participate or have participated in the Tatamagouche and Area Breastfeeding Support Group (TABSG) (Price et al, 2013). An evaluative report commissioned by the Central Nova Scotia Breastfeeding Coalition (CNBC) done on breastfeeding support in Tatamagouche paints a picture of an “informal” community-based group taking action to support breastfeeding families at the community level. To a limited extent, they work in partnership with government bodies in that they have begun to receive some locally

accessible funding for their activities through the regional Community Health Board (CHB). A more substantial and robust partnership with government would be beneficial to both sides, in the sense that TABSG members and leaders could have policy and program development input in an area they have expertise in. Perhaps in this way they could gain access to more diverse sources of funding in order to keep expanding on their important work. Price et al (2013) describe support provided by TABSG as informal, but in reality it is very strategic, organized and time intensive. Judging by the short documentary, *Mother Milk* (Singh & Singh, 2009), TABSG is seeing the success in their work through the shift that is happening in their community, from a bottle-feeding to a breastfeeding-supportive culture. The group has established a hub model of breastfeeding support, a model that is being applied to other contexts in rural and urban areas.

TABSG differs from breastfeeding support organizations like LLL in that the philosophy encompasses the social and environmental contexts of breastfeeding, thereby shifting away from framing it solely in terms of lactation. The comprehensive approach used by TABSG focuses on pre-natal education, including preparing parents for the challenges of breastfeeding and intensive post-natal support. Leaders focus on building strong relationships between women and families in the community who fall across the perinatal continuum. There is a perception of instant support among mothers, rather than a perception of scarce resources (Price et al, 2013) and within the community itself, breastfeeding has become normalized. The efforts made by the leaders and members of TABSG have resulted in a real impact on breastfeeding rates and, just as importantly, in terms of actively encouraging a shift in how breastfeeding is practiced and perceived in the community. The story of TABSG is part of a wider story about a rural community whose citizens are being creative as they find unique solutions to meet their own needs.

The founders of TABSG have built a support system that works best for the mothers in their community and are inspiring other breastfeeding advocates to seek solutions built on successful models adapted to their communities.

There is a lot going on in Nova Scotia around breastfeeding and it is difficult to keep up with new partnerships, coalitions and organizations advocating for changes to the infant feeding culture in the region. The umbrella group for most of the breastfeeding activity going on in the province is the Breastfeeding Community of Practice (CoP) (Breastfeeding Community of Practice, 2016a). The Breastfeeding CoP maintains a helping tree, listing most of the breastfeeding resources available in the province, while taking the lead on initiatives like Making Breastfeeding Your Business (MBYB) (Breastfeeding Community of Practice, 2016b) and milk bank advocacy. MBYB is an initiative that provides businesses and employers with tools allowing them to support breastfeeding among their staff, clients and customers. A number of regional coalitions composed of members of various not-for-profits, representatives of government agencies and others with stakes in encouraging breastfeeding in their communities have formed in the last couple of years, like the South Shore Breastfeeding Coalition (SSBC) and the CNBC. A psychology professor at St Francis Xavier University in Antigonish, Dr. Erin Austen, has become involved in advocacy work as part of the non-profit organization, Building a Breastfeeding Environment (BaBE), and has supported students in the production of two videos aimed at helping shift negative attitudes towards breastfeeding in general and breastfeeding in public specifically (BaBE, 2014). The group has produced two public service announcements with provincial government funding— one aimed at students and one aimed at the general public – the objective of which is to increase awareness of breastfeeding in the community.



In terms of breastfeeding supports in HRM, La Leach League (LLL) has three groups in the municipality alone and there are currently five monthly meetings in different parts of the city on offer (LLLC, 2016). Trained volunteer LLL leaders lead meetings and offer mom-to-mom support by email or by phone. Since the Public Health Breastfeeding Hotline was removed in 2015 and Public Health Nurses offer fewer home visits to mothers with new babies, my LLL colleagues and I have noticed an increase in requests for home visits from mothers.

Mother and baby rooms are becoming more common in public spaces for mothers who prefer to use them and locally owned retail stores host regular breastfeeding support groups. Public Health drop-ins are held in community rooms in supermarkets across the city and family resource centres serving neighbourhoods and larger geographic areas offer many types of support. This past September saw evidence of a shift in Nova Scotia Health Authority's (NSHA) focus from all moms to targeted groups of moms (Chiu E., 2016) with the diversion of the services of a community health nurse from a community breastfeeding peer support group in a more economically advantaged neighbourhood to a neighbourhood where residents have less economic advantages. In a perfect world public systems would have the resources and capacity to provide services that are universal, unfortunately ever-shrinking budgets and resources are the reality. The challenge presented to government agencies and non-profits is how to best collaborate to stretch sparse resources in order to provide support to all mothers who need it.

Although policies are in place, the social environment seems at first glance to be limited in its support for breastfeeding mothers and babies, which points to an issue that relates to women's rights to choose how they feed their babies. If it is the case that most women would have liked to breastfeed for longer but didn't for socio-cultural rather than

physiological or medical reasons, then women's rights are being limited. There does, however, seem to be a continual and quiet shift towards more exposure to breastfeeding and continual normalization of the practice. Once it is normalized, it seems that providing support to breastfeeding mothers will be much easier since there will be more people in the community who will know the kinds of ideas, suggestions and help to offer. As evidenced by Tatamagouche, where mothers are provided with the fundamental requirements for "successful" breastfeeding and the whole community is involved in and benefits from the practice. My hope is that breastfeeding support workers will use the insights and feedback of focus group participants to help improve their practice as they work with mothers to reach their breastfeeding goals, whether it is through advocacy or direct support work.

## **Chapter 2**

### **Theorizing Infant Feeding**

#### **2.1 Infant feeding, feminism and rights: Making the connections**

Public debate around infant feeding in postindustrial societies is riddled with nuances and complexities. In making infant feeding decisions, women face dilemmas around social expectations about how they should feed their babies, which can contradict their actual experiences and knowledge. Women's decisions around infant feeding are also limited by economic, cultural and political constraints, which will be expanded on through this chapter. In chapter two I will also explore why feminism, in particular the intersectional approach, is a useful framework with which to consider infant feeding because it allows for exploration of similarity and difference in mothers' experiences based on attributed socio-demographic characteristics. Infant feeding decisions are strongly associated with women's positionalities within systems of privilege and oppression so intersectionality is helpful for delving into mothers' lived experiences. Using an intersectional approach based in a feminist framework, I discuss how breastfeeding can be considered as a human rights issue. Finally, I consider how the medicalization of infant feeding and public health initiatives have acted as impediments to breastfeeding and how these factors affect mothers' embodied experiences of infant feeding in general and breastfeeding specifically.

Among some feminist researchers and scholars, infant feeding is viewed as an individual choice (Wolf J. , 2013; Barston, 2012) and human milk substitutes are considered as equivalent to human milk. Others (Bartlett, 2003; Gionet, 2013; Smith et al, 2014; Hausman, 2003; Kent, 2001; Nathoo and Ostry, 2009) view human milk as the physiologically normal food for infants and breastfeeding as a reproductive right that is

not fully accessible to all mothers because of constraints that limit their freedom of choice. In this work, breastfeeding is considered a human rights issue given the fact that women are not able to make free, informed decisions around infant feeding in the current social, economic and political context. I see human milk as the physiological norm for infant feeding and believe that most mothers who want to breastfeed (85.3% according to a survey of new mothers in Ontario (Lutsiv, et al., 2013)) are prevented from doing so because of the constraints they face in post-industrial societies like Canada.

In the 1990s, feminist attention on infant feeding focused on the political meanings of motherhood and gender but did not take into consideration the biosocial significance of the practice of breastfeeding (Hausman, 2003). The dialogue is changing and breastfeeding is being recognized as a physiological caretaking practice that is strongly influenced by socio-cultural factors, one that can be considered in the light of equal rights of women (Bartlett, 2003; Hausman, 2012; Kitzinger, 1995; Labbok, et al, 2008; Ostry, 2006; Palmer, 2009; Smith et al, 2012; Van Esterick, 2012). Ultimately, “limitations on women’s freedom and ongoing unequal relations between the sexes negatively affect women’s ability to breastfeed,” (Smith et al, 2012, p. 17).

Intersectionality posits that social categories and attributed characteristics like gender, ethnicity, race, socio-economic status, religion, nationality, language proficiency, among others, contribute to identity and lived experience. It is a practice that focuses on advocacy and pedagogy in addition to theory and analysis. According to Dill and Kohlman:

Intersectional work emerging predominantly from the social sciences and humanities is an alternative mode of knowledge production that seeks to validate the lives and stories of previously ignored groups of people and is used to help empower communities and the people in them. The production of knowledge to address

real-life social issues and problems and apply and use the knowledge to solve problems of inequality has been fundamental to the intersectional project of promoting social justice. (2009, p. 165).

It is an alternative model that is particularly useful in interdisciplinary studies and when considering differentials of power and privilege. As a framework, intersectionality sheds light on how overlaying systems of oppression impact people's life experiences and daily lives by clarifying how attributed characteristics interplay to determine individuals' status, privileges (or lack thereof) and ability to exert agency in society or social situations (Collins, 2009; Hausman, 2012, Nathoo & Ostry, 2009; Smith et al, 2012; Van Esterick, 2012). Intersectionality allows researchers and practitioners to identify differing and similar experiences as a result of categorization with different attributed characteristics and gives voice to those who may not normally have an opportunity to speak about their lived experiences (Van Esterick, 2012; Hausman, 2012; Collins, 2009). These complex intersections contribute to the construction of women's experiences through their material and ideological impacts (Smith et al, 2012).

Mothering is affected by the intersectional positionalities of women because of the socio-cultural nature of the practice, like infant feeding. The value of an intersectional approach in researching infant feeding decisions is apparent when the attributed characteristics of mothers who practice breastfeeding compared to formula-feeding are broken down. Intersectional analysis can help shed light on the differences in infant feeding practices among different communities of women in the Nova Scotian context as well as on the constraints women face that limit their decision-making power around infant feeding.

By looking at the statistics, it becomes evident that breastfeeding rates are higher among mothers of middle- and upper-socioeconomic levels; those who are older; those

who have a college diploma or a higher level of education; and those who are married (Gionet, 2013). According to data collected by Health Canada through the Canadian Community Health Survey (CCHS), women who identify as belonging to the dominant “white” racial group are more likely to breastfeed than Canadians who self-identify as “black” whereas immigrant women, especially newcomer women who have been in Canada for five years or less, are more likely to breastfeed than any other group of women (Health Canada, 2012b). The statistics mask complexities that are difficult to untangle as categories used to collect statistics can mask differences that reinforce stereotypes resulting in misunderstandings between women receiving care and health care providers. The health system is stratified by race and class resulting in a situation where “ideal” motherhood is more disempowering to women who are racialized, less educated and in lower socio-economic categories (Hausman, 2003; Smith et al, 2012; Collins, 2009; Van Esterick, 2012). Deeper research interactions, like those facilitated through qualitative methods such as focus groups and individual interviews, can help tease out some of these complexities.

In her work on the concepts of nationalism, transnationalism and belonging, Floya Anthias (2011), argues for the use of an intersectional approach rather than multicultural, hybrid, diaspora or cosmopolitan approaches to researching the experiences and lives of people who are immigrants. She argues that other frameworks do not take gender and class into consideration in the way intersectionality can in that it allows researchers to consider identities of legitimization, resistance and locations where dominance and subordination intersect. Using this approach has clarified how axes of intersection and difference influence the specific experiences and practices of Canadian-born and immigrant mothers in a way that goes beyond multiculturalism.

By using intersectionality as an approach, researchers have shed light systems of oppression at work in the process of decision making around infant feeding (Cormier, 2014; Dodgeson et al, 2002; Hausman, 2014; Labbok et al, 2008; Rippeyoung, 2013). As such, mother's freedom to do what they think is best for themselves, their babies and their families are curtailed, making infant feeding a social justice issue. VanderPlaat and Teles (2005) explore the usefulness of a human rights framework for encouraging concepts of social justice (which is exemplified in dignity, non-discrimination and participation) and in public health to "inform policy, intervention strategies, evaluation and evidence-based measures of effectiveness," (p. 34). Moving beyond a biomedical approach by using a human rights approach can introduce concepts of power and social inequality into health work and give populations more power in determining their pathways to health by focusing on power relationships, solidarity and justice. Social determinants have critical impacts on individual health so it makes sense to consider a human rights approach over a biomedical framework which places individual responsibility on health and illness (VanderPlaat and Teles, 2005). In their paper, VanderPlaat and Teles (2005) point out that placing a feminist focus on difference and diversity can also facilitate the disaggregation of data in order to highlight differences in lived experience based on intersectional positionalities.

## **2.2 Whose rights - baby, mother or dyad?**

In 1997, INFACT Canada asked why breastfeeding should be framed legally or as a human right if it is a physiological practice that is part of the female reproductive lifecycle. Their view as an organization is that breastfeeding has become incompatible

with other roles women fill and that women's right to breastfeed should be included as a component of human rights because

...dominant social values, structures and institutions, which are rapidly spreading across the globe, often exploit and undervalue women's physical needs, their work and reproductive contributions.  
(INFACT, 1997)

As a result of the dominant values and structures of post-industrial societies, women face constraints to breastfeeding in the form of: the structure of postindustrial employment and masculine-centred workplaces (Smith et al, 20140; attitudes including the sexualized view of breasts and breastfeeding as “gross”, “disgusting” or obscene (Babineau & Spurles, 2011); the influence of commercial interests of infant formula companies and the dairy industry (Fentiman, 2012; Nathoo & Ostry, 2009; Ostry, 2006; Palmer, 2009); and weak governmental policies around marketing, labour rights & workplace provisions (Hausman, 2003; Rippeyoung, 2013), among other factors.

George Kent (2001; 2006) recognizes breastfeeding as the optimal form of infant feeding and the effect of socio-cultural factors on limiting mothers' freedom of choice in matters of feeding. He argues that children have the right to receive the best possible nutrition at the same time that mothers have the right to make an informed choice and be provided a supportive environment to make her choice a reality. Since mother and infant form an interdependent dyad, the concept of breastfeeding as a human right is complex and not clear-cut in terms of whose rights are more important – the mother or child? It is important to contextualize considerations of human rights and infant feeding because, in Kent's words, “human rights are not intended to prescribe optimal behaviour, but rather to place outer limits, saying it should not go beyond certain extremes...From the human



rights perspective, the main concern is with protecting the woman-infant unit from outside interference.” (Kent, 2001, p. 97).

Kent (2001) focuses on the human rights of infants because of their lack of power and agency in care-giving relationships. He locates infants’ human rights in the context of international human rights law and conventions like: the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (1979)<sup>3</sup>; the Convention on the Rights of the Child (CRC) (1989)<sup>4</sup>; the International Labour Organization’s (ILO) Conventions on Maternity Protection (1919, 1952)<sup>5</sup>; the International Code on Marketing of Breastmilk Substitutes (UNICEF, 1981)<sup>6</sup>; the Innocenti Declaration on Infant and Young Child Feeding (UNICEF, 1991)<sup>7</sup> along with other conventions and policies at the international, national and local levels. The reality is that these declarations and conventions are yet to have a concrete impact on women who are trying to meet the breastfeeding goals they set out for themselves in many communities.

There are a couple of issues with Kent’s perspective on infant feeding and human rights. First is its heteronormativity, which does not accurately reflect the changing

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<sup>3</sup> Canada ratified CEDAW in 2002 but no signatory date is listed on the list of signatories (United Nations, 2016).

<sup>4</sup> The CRC was signed by Canada in 1990 and ratified in 1991 (United Nations, 2016).

<sup>5</sup> Canada never signed on to the Conventions on Maternity Protection in 1919 or 1952, however in 1971 a paid maternity leave for fifteen weeks at 66% of the mother’s previous salary was legislated. Since that time paid maternity leave has been expanded to twelve months and has evolved into paternity leave which is accessible to some fathers and adoptive parents (Canadian Labour Congress, 2015). Although maternity leave has been legislated in Canada it is by no means universally accessible.

<sup>6</sup> Canada has only made a few of the provisions of the International Code into law (UNICEF, 2011) and as a result of a strong lobby effort, handed over the regulation of formula marketing over to the industry for self-regulation.

<sup>7</sup> Finally, adoption of the recommendations of the Innocenti Declaration has been slow and piecemeal in Canada, with only seven Baby Friendly Initiative (BFI) hospitals in English-speaking Canada and five in Quebec (Breastfeeding Committee of Canada, 2015) at the time of writing. It was only in 2015 that the largest maternity hospital in Nova Scotia, Atlantic Canada even, began the process for BFI implementation.

composition of contemporary families. He focuses solely on the inclusion of fathers in educational initiatives, rather than keeping it open to partners who do not identify as fathers and other primary caregivers of babies. Kent's framework still puts the onus on mothers and does not take into consideration a holistic view of the political, social and economic constraints placed upon women. He begins to delve into these constraints but not to the same extent that Hausman (2003, 2006, 2012) and her contemporaries like Labbok et al (2008), and Van Esterick (2012) have done. He still comes back to the choice framework, which the above feminist scholars have moved beyond in the way they interpret infant feeding as a structural issue.

A shift needs to be made from viewing breastfeeding as a lifestyle choice to a paradigm where breastfeeding is considered a reproductive health, human rights and social justice issue in order to eliminate the social, economic and political constraints to breastfeeding. In a context where breastfeeding is viewed as a right, women would not lose economic security or any rights or privileges as a result of making the decision to breastfeed, as is the case in our current system. Although they do not explicitly state that their research is based in a human rights perspective, Nathoo and Ostry (2009) also maintain that breastfeeding practices are more than a matter of choice and that mothers are greatly influenced by structural determinants, which they believe policy and programming in Canada has not yet fully acknowledged.

### **2.3 The medicalization of infant feeding**

Medicalization is the regulation of health practices through biomedical perspectives and the use of “surveillant” care (Apple, 2014; Bartlett, 2003; Blum, 1999; Ehrenreich & English, 2010; Hausman, 2012; Nathoo & Ostry, 2009; Ostry, 2006;

Palmer, 2009; Wolf, 2012). The medicalization of infant feeding began in the late nineteenth century and was firmly entrenched in industrialized societies by the 1940s. By that time breastfeeding had all but disappeared, having been taken over by the use of human milk substitutes. Most researchers in the field attribute the medicalization of infant feeding to industrialization and urbanization, the rise of pediatrics and obstetrics, and the development and manufacture of infant formulas (Apple, 2014; Bartlett, 2003; Blum, 1999; Ehrenreich & English, 2010; Hausman, 2003; Nathoo & Ostry, 2009; Ostry, 2006; Palmer, 2009; Wolf, 2012).

Although Rima Apple is one of the foremost researchers on the medicalization of motherhood, developing the concept of “scientific motherhood” (2006; 2014), her analysis focuses primarily on the biomedical aspect of scientific motherhood and generally does not attribute much to the effects of industrialization on the rise of scientific motherhood (Ostry, 2008). As industrialization and urbanization took place, more people from the lower classes were using hospitals for birth and death, which had previously taken place at home, because of lack of space in the cramped dwellings of overcrowded urban areas (Historic Canada, 2014). Another attraction of hospitals for birthing mothers was the availability of pain medication. A rapid shift from a reliance on mid-wives to physicians began significantly in 1912 with the formation of the medical Council of Canada (CMNL, 2015) and coincided with the belief that hospital births were safer than home births. Soon afterwards the status of midwives became “alegal” in many parts of Canada, including Nova Scotia, where they remained so until new legislation was enacted in 2006 (Mah, 2013).

In the past, information and advice on motherhood and breastfeeding came from social and familial circles but since the late nineteenth century there has been a shift to

management of infant feeding by physicians, pediatricians and other experts (Apple, 2014; Barlett, 2003; Blum, 1999; Ehrenreich & English, 2010; Hausman, 2012; Nathoo & Ostry, 2009; Palmer, 2009; Wolf, 2012). As physicians became more accepted as practitioners, they started to make more money and were thereby integrated into middle-upper- and upper-class society. At the same time, midwives (who were not organized and were left out of positions of power) cared primarily for women in lower socio-economic classes so did not gain the money-making power that physicians did at the time (Midwifery Today, n.d.; Biggs, 2004). By World War I, most women using midwives were immigrant women. Before then, women had strong support systems - up until the beginning of the twentieth century it was common for a midwife to stay with rural, under-resourced families for weeks postpartum to help care for mother, baby and establish a new routine (Ehrenreich & English, 2010). Women's health care was not medicalized, it was something that women took care of themselves, often using plant medicine that was passed down through families.

Before the late nineteenth century, breastfeeding was the normal way of feeding infants and young children. In 1725 the average weaning age in the US was four years old, which is today's average age for weaning globally. If a middle-to-upper class mother could not breastfeed, a wet nurse would be employed, or, depending on the context, a lactating servant or slave. Generally wet nurses were women from lower socio-economic positions who, more often than not, had their own babies at home to feed (Ehrenreich & English, 2010). By the 1890s, physicians were beginning to develop and prescribe infant formula for babies who could not feed well and mothers who could not produce enough milk (Apple, 2006; Blum, 1999). It was also a useful tool for the many women who began working outside of the home at factory and other strictly scheduled jobs during the

industrial revolution. Pediatric specialization began in the late 1800s and was entrenched in the culture by the early decades of the 1900s (Apple, 2014; Blum, 1999; Ehrenreich & English, 2010; Wolf, 2012). At the same time, there were the beginnings of the move away from midwifery towards obstetrics for childbirth, resulting in a shift away from women controlling their own bodies and knowledge about their bodies to men controlling women's bodies with little understanding of women's biological and social experiences (Apple, 2014; Ehrenreich & English, 2010; Nathoo & Ostry, 2009; Wolf, 2012).

Public health advocates in Canada have been promoting exclusive breastfeeding since the 1920s as a result of social reformers'<sup>8</sup> interest in reducing infant mortality. At the time, infant mortality rates were very high resulting from poor living conditions due to the process of urbanization that accompanied the industrial revolution (Ostry, 2006; Nathoo & Ostry, 2009). Urban areas had high population densities with many people sharing small living spaces, facilitating rapid spread of disease and illness before widespread knowledge and understanding of germ theory. The social reform movement and their promotion of breastfeeding was spurred on this growing awareness of disease prevention through sanitation, a concept developed by Joseph Lister in the 1870s (Ostry, 2006). By that time, the use of wet nurses had all but ceased and supplementation was done using dairy products that were frequently adulterated with substances like chalk and water and that were not stored in appropriate conditions (Nathoo & Ostry, 2009; Ostry, 2006). Social reformers observed the conditions that people in lower-economic classes were living in, including immigrant families, and saw breastfeeding as a way to improve

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<sup>8</sup> The social reform movement was a middle-class, Christian response to the social issues arising from industrialization and urbanization in Canada between the late 1800s and the 1920s. The social and domestic environment were considered primary factors in community development, placing focus on the role of the mother as she contributes to the quality of family life (Gagan and Turner, 1982).

infant mortality. The irony is that although the social reformers targeted immigrant families with their educational efforts, immigrant women had higher breastfeeding rates, as is the case today (Nathoo & Ostry, 2009; Ostry, 2006; Gionet, 2013). The social reformers lobbied for and helped establish the public health and child welfare systems in Canada (Nathoo & Ostry, 2009; Ostry, 2006) with the establishment of the federal Department of Pensions and National Health in 1919 and its Division of Child Welfare in 1920.

Despite increasing education on breastfeeding, breastfeeding rates declined consistently until the natural childbirth movement came about with second wave feminism in the 1960s (Nathoo & Ostry, 2009), resulting in a resurgence of interest in breastfeeding. By this time, though, lay knowledge about breastfeeding had been replaced by the well-established medical paradigm of scientific motherhood (Apple, 2014; Blum, 1999; Nathoo & Ostry, 2009; Ostry, 2006). This shift led to the view of breastfeeding as a biomedical practice supported by technology, science and the expertise of health professionals and experts rather than a normal biosocial practice based on women's experiences and lay knowledge of their bodies and reproductive cycles (Apple, 2014; Blum, 1999; Ehrenreich & English, 2010; Hausman, 2003; Nathoo & Ostry, 2009; Palmer, 2009; Wolf, 2012).

Hausman (2003) conducted a Barthian analysis on the shift from breastfeeding to formula feeding and furthered the concept with a Foucauldian perspective. According to her Barthian analysis, the common memory of adults is lost through a shift in an ordinary or normal practice. Within a couple of generations, the new practice becomes the norm and a new paradigm emerges: "No one really remembers when breastfeeding was ordinary and equally obscure are the social values that supported its practice," (2003, p.

93). She furthered this idea with a Foucauldian perspective, where western ideals of self-regulation and individual autonomy made the adoption of bottle-feeding inevitable with the invention of formula as an outcome of the development of technical expertise and conceptual ideals of the time, where mothers and babies were thought to be separate entities and the relationship between a woman and her spouse was seen as more important.

Medicalization and how it influences the practice of breastfeeding undermines the practice. Scheduling as well as concepts of separation, autonomy and independence are all factors that can undermine mother's attempts to establish and maintain breastfeeding (Apple, 2014; Hausman, 2003; Wolf, 2012). Scheduling is problematic because the more a baby suckles, the more milk a mother will produce, so once feeding and suckling is restricted, there is a risk of the mother losing her supply and not being able to feed her baby with her own milk (Kitzinger, 1995; Mohrbacher, 2010). Wolf (2012) puts forth the idea that physicians at the time did not recognize the risk of scheduled breastfeeding and viewed supply issues as physiological rather than related to breastfeeding style or the way breastfeeding is practiced. As such, mothers' bodies became the site of problems and subject of medical solutions, like supplementation with human milk substitutes (Hausman, 2006; Hausman, 2007; Smith et al, 2012; Apple, 2014; Bartlett, 2003; Ehrenreich & English, 2010; Nathoo & Ostry, 2009).

Along with the view of mothers' bodies as being problematic, came the need to monitor and control how babies were being fed, a belief that propped up the rise of pediatrics. Infant feeding became further medicalized with the linking of the breast with disease (cancer, mastitis and infection) and risk (Wolf, 2012). When physiological issues were experienced, physicians pathologized them and recommended that mothers switch

to formula instead of trying to resolve them. Instead of breastfeeding being viewed as physiological, it became viewed as pathological (Wolf, 2012). As this ideology of pregnancy, birth and breastfeeding as pathologies took hold, so did the grip of experts and the influence of their advice among mothers, overtaking traditional women's knowledge about reproductive cycles (Apple, 2014; Blum, 1999; Ehrenreich & English, 2010; Hausman, 2003; Nathoo & Ostry, 2009; Ostry, 2006; Palmer, 2009; Wolf, 2012).

The medicalization of infant feeding was also helped along by the publication of expert advice in books, magazines, articles and pamphlets on baby care and childrearing that were aimed toward mothers (Apple, 2014; Hausman, 2003; Nathoo & Ostry, 2009; Ostry, 2006). The tradition of breastfeeding advice being directed at mothers through publications, and now internet resources, continues and may be more pervasive than ever. According to Phyllis Rippeyoung (2013), the expert advice industry is growing and in some contexts puts undue pressure on mothers to parent in a way that is costly beyond the monetary figure. It is an industry built on mothers' insecurities and their perceptions that they require expert advice to mother well.

Aimee Eden (2012) sees lactation consultants as the embodiment of professional breastfeeding knowledge in contemporary culture in the US. The profession of lactation consultant is relatively new, having become a professional designation in 1985. Her work provides a feminist analysis of the relationship between the medicalization of breastfeeding and professional breastfeeding support by lactation consultants. She concludes that lactation consultants can bridge the gap for women between women-centred philosophies and the biomedical world:

Even if LCs contribute to the medicalization of breastfeeding, often working in a medicalized context, their maternalist roots and women-centred philosophy of care allow them to think



about breastfeeding in a broader, even feminist way - as a women's right, a valued role, and a cultural issue that challenges women. (p. 148)

Although this may be the case, not many mothers have access to lactation consultants in Canada. They are sometimes part of the complement of hospital staff, as in some districts in Nova Scotia, but they are generally contracted on a private basis, making them more accessible to middle- and upper-middle-class mothers.

## **2.4 Individualism and embodiment as constraints to breastfeeding**

In Beyond Choice, Beyond Breast (2012), Smith et al consider the development of breastfeeding policy and public health programs and how they have been shaped by maternalist, medical and capitalist values. The fact that public health messaging focuses on mothers' individual responsibilities and behavioural change rather than attempting to reduce social, political and economic constraints to breastfeeding is evidence of this. In this sense, public health messaging focusing on education can be seen as a constraint given the pressure it puts on women to make the "right choice". Rather than seeing breastfeeding itself as limiting mothers' freedom, these scholars view "constraints to breastfeeding as part of a larger pattern of sex discrimination excluding mothers from employment and public spaces." (Smith et al, 2012, p. 14).

Other feminist researchers (Bartlett, 2003; Smith et al, 2012; Hausman, 2003; Ryan et al, 2010) link choice with consumerism and do not believe it is truly reflective of the concept of rights or real freedom of choice outside of the consumer marketplace. Bartlett (2003) equates the concept of "choice" to private ownership, individualism, consumerism and freedom of choice in the market, which "was achieved through a conflation of the disparate meanings of choice, so that selecting from a range of items and

the freedom to determine one's fate became elided in a kind of consumer heaven.” (Bartlett, 2003, p. 153). Bartlett argues that the concept of consumer choice became a characteristic of late-capitalist ideology in the 1980s, at the same time that the body became commoditized in the marketplace. This fits in with the ideology of consumerist societies and practice of raising consumers from birth by looking to the marketplace to solve problems related to childrearing, an idea that will be expanded on later in this chapter.

As a result of public health messaging and social pressures, women are, or at least feel, judged and judge themselves for their infant feeding decisions. The dichotomized moral attributes associated with infant feeding lead to the idea of the “good mother” who does what is recommended by the public health and medical community and the “bad mother” who does not (Bartlett, 2003). According to Bartlett (2003, p. 157), binary oppositions associated with infant feeding include:

good: bad  
breast: formula  
natural: artificial  
self-sacrificing: selfish  
responsible: irresponsible  
health benefits: health risks  
bonding: bonding risked  
caring: negligent

Moral judgments are associated with race and class (Bartlett, 2003; Hausman, 2003) and formula feeding can be interpreted as a form of cultural resistance in the face of persistent messaging, or a cultural representation of the “bad girl” who is more highly valued, holds more agency and has more options and power than the “good girl” in late capitalist culture which values independence and individuality (Bartlett, 2003).

Ryan et al (2010) researched “moral work” in mothers’ narratives about infant feeding, in particular, narratives of self that mothers created when their embodied experiences do not meet their expectations of breastfeeding. By conducting Foucauldian analyses of mothers’ stories about their breastfeeding experiences, the researchers found that mothers’ “narratives of their breastfeeding experiences are sites of construction and reconstruction of self as they undertake moral work in relation to feeding their baby.” (p. 951). Mothers construct and reconstruct their experiences to match societal expectations in a medicalized context around feeding and to restore their self-image and internal harmony. The moral work mothers do is a way for them to repair internal damage they experience for not conforming to expectations or prevalent parenting ideology in an environment in which they face multiple constraints and feel pressure. This moral work also acts to realign mothers’ embodied experiences and self as moral subjects. Although Ryan et al (2010) do not use the discourse of breastfeeding as a human right, the way in which they discuss women’s decision making processes and the structural constraints that impact/influence women’s decisions lead the reader to conclude that they do not see infant feeding decisions as freely made by mothers, thereby creating the need for mothers to construct narratives allowing them to fit into social and policy-framed expectations of feeding.

Breastfeeding is an embodied and culturally influenced biosocial practice, not just a method to deliver nutrition to a baby (Hausman, 2003). Hausman goes as far as to say that breastfeeding is a “radical embodiment” in the way that the close physiological relationship is shared between a mother and baby. There is a lack of autonomy for mothers in breastfeeding, which is difficult for many feminists to accept, and it is also difficult for women themselves to reconcile when breastfeeding their babies (Ryan et al,

2010). In post-industrial societies, breastfeeding is viewed as a sacrifice a mother makes for her children and in making this sacrifice she loses her autonomy, independence and freedom. Although some feminists view breastfeeding as a way to regulate mothers (Barston, 2012; Wolf, 2013), it can be empowering for individuals as well as entire communities as a practice based on mothers' communal knowledge.

Breastfeeding presents challenges with embodiment, especially in a context in which women's bodies in general and breasts in particular are hyper-sexualized by the media. Mothers' challenges with embodiment associated with breastfeeding can be solved by bottle-feeding, which also fits into scheduling norms of industrialized societies (Palmer, 2009; Hausman, 2003; Nathoo & Ostry, 2009; Ostry, 2006) and with the hegemonic cultural ideals of our time and place, like individualism, personal autonomy and consumerism. At the same time, there is a counter-shift occurring in majority world countries which may be interpreted as a colonization of body image where late capitalist ideas of the body and infant behaviour have begun to "colonize body consciousness" (Hausman, 2003, p. 102) in other regions, spurring a shift from breastfeeding as the norm to bottle-feeding as the norm in the majority world. This idea will be explored further in the analysis of the focus group discussions.

In most western societies, there is a division between the sexual and utilitarian function of breasts (Palmer, 2009; Hausman, 2007). This division between the utilitarian and sexual breast is not the embodied reality of many women, especially since reproduction cannot be separated from sexuality. This is complicated by the fact that media outlets frequently use images of breasts as a means to encourage consumption of products. Hausman argues that there is "a fear of blurred boundaries between maternity and sexuality and an attempt to regulate women's experiences into socially acceptable

functions,” (2003). Barlett (2003) argues the lactating body is perceived as anarchic, chaotic, volatile, dynamic and shifting. The lactating body is unlike passive bodies in that it is going through the changes associated with the reproductive lifecycle. The ideals of beauty and embodiment focus on the social concern of controlling the body (Bartlett, 2003) and “restoring” the body to the pre-pregnancy form.

Hausman (2003) puts forth the idea that the lines between women’s “biological capabilities and practices” (p.77) and women’s social roles are blurred in part because of the dominant view of the female role as more biological than the male role, given the dominance of the female body in reproduction through her life compared to that of males. She points out that the view of the biologic role is problematic because at the same time as being governed by biology and physiology, breastfeeding is deeply embedded in culture. There is also the idea that roles need to be adjusted to and if they are not, mothers will be judged for their insufficiencies.

The dominant economic framework supports the belief that feeding problems, or problems with babies in general, can be remedied through the consumer marketplace. Human milk itself has become a commodity that can be separated from the physiological act of breastfeeding (Bartlett, 2003; Fentiman, 2012). Because the norm of feeding in post-industrial societies has been based on commercially-based formulas which are industrially processed and sold through invasive marketing techniques, it makes sense that human milk be distributed in this way as well. In fact, components of human milk have been patented and fortifiers made from milk that mothers sell to corporations like Prolecta Bioscience, exemplifying the status of human milk as a commodity (Fentiman, 2012),

In Phyllis Rippeyoung's analysis (2013) of the compiled works of the Sears family<sup>9</sup>, she unites the idea of expert advice with increasing commercialization of parenting advice and products. She sees the Sears' empire as a major driver in the increasing pressure mothers face to practice intensive parenting and links the practice to class, viewing women as the "primary bearers of the associated costs of mothering," (p. 1). Rippeyoung analyzes the cost of mothering in the context of intensive parenting as promoted by the Sears, which she sees as reinforcing "the relationship between "good" mothering and socioeconomic status, while providing justification for neoliberal policies that minimize state supports for working families." (p. 2). She argues that mothering and the associated decisions should not be viewed as the individual responsibilities of mothering through attachment or intensive parenting, but that there is a need for structural change - like more accessible maternity leaves, more flexible employment situations and more options for families - in order to support all mothers.

Rippeyoung (2013) also considers the cost of intensive mothering, of which breastfeeding is one aspect, through the purchase of products and lost earnings. Mothers who breastfeed for less than six months have lower salary declines compared to mothers who breastfeed for more than six months. The longer a mother breastfeeds, the fewer hours they will work, the more likely they are to exit the workforce completely and the higher the chance that they will experience ideological shift away from the value of waged labour and careerism.

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<sup>9</sup> The Sears family is a (large) family of attachment parenting "gurus" and have over decades become the key experts in the practice. The parents, a Registered Nurse and a pediatrician, practiced attachment parenting and Dr. Sears spread their set of parenting philosophies and practices through his medical practice. They now preside over an empire of publications, products and web presence and are oft-cited among attachment parenting practitioners.

In Canada the earning trajectories are poorly understood but the maternity/paternity leave compensation is one of the lowest of the countries with legislated leave benefits. There is even differentiation among provinces, with Quebec paying the most at 70% of a parents' salary compared to 55% in the rest of Canada, with the onus on the employer for topping this up to a higher level (Rippeyoung, 2013). Working breastfeeding mothers are also at a disadvantage in Canada as there is no legislation mandating paid breastfeeding breaks.

Along the same lines, Barlett (2003) proposes that time is a “point of contradiction for contemporary lactators in industrialized nations” (p. 162) and that breastfeeding gives mothers a different perspective on time leading to a revaluation of priorities outside of the “rational and profit-driven economy of late capitalism” (p. 162). It allows for an expanded worldview, purposeful thinking and a keeping of time that differs from that of industrialization. There is also the point that lactating women's work, which falls under both care-giving and reproduction (Hausman, 2012), is generally not considered as having economic value, although some countries, like Australia and Norway have calculated the cost benefits of breastfeeding in terms of savings to the health care system and GDP. Canada is among a small number of countries that acknowledges the contribution of unpaid care work to GDP, with Statistics Canada attributing an estimated 41% of the GDP to unpaid housework. There is also a tax credit for unpaid care work that was added to the federal budget in 1996 (Mulford, 2012).

Hausman (2003) argues that couching infant feeding decisions in terms of equalizing parenting responsibilities is problematic from a biological perspective. Feminists do not argue that men take on the biological role of gestation and birth. If breastfeeding is seen as part of that process, it also is a biological role that cannot be

taken on by men. Of course, there are situations, like female to male transition when the full process has not been undertaken and this is a possibility. For example, Trevor MacDonald has breastfed two babies through his transition from female-to-male and is now the first La Leche League leader to identify as male. In fact, even with the practice of men bottle feeding babies, efforts to make the division of household work and childrearing responsibilities have not worked – women are still responsible for the greater part of this work at the same time as continued marginalization in the workplace (Hausman, 2003). Hausman maintains that breastfeeding should not be considered as domestic labour because the practice of sharing this type of labour with men cannot be done without the disembodiment of mothers.

Post-enlightenment societies, such as Canada, value individualism so it is often difficult and sometimes burdensome for mothers to have a baby who is so dependent on them for total care. The provision of nutrition in and of itself is very intensive in the early months of life when baby is completely dependent on a diet of only milk (Hausman, 2003; Kent, 2001; Kent, 2006). In her 1999 work, Sarah Blaffer Hrdy puts forth the idea that mothers use cost-benefit analysis in their decision-making processes around mothering. Although mothers know that human milk is better for infants through the scientific literature, public health messaging and education, most use infant formula. Hrdy proposes that reduced maternal investment “can provide breathing space for mothers expected to be sacrificial, attentive and ever-patient,” (Hrdy, 1999, p. 151). This theory helps explain why, in the cultural context of North America and other post-industrial societies most mothers forego breastfeeding and switch to infant formula. The common view is of mother and baby as two independent individuals rather than an interdependent



dyad. In the interdependent couple, the infant is more dependent on the mother so the dependence is imbalanced (Kent, 2001).

Public health messaging since the 1920s to the present has focused on the promotion of breastfeeding (Nathoo & Ostry, 2009), although specific recommendations have changed over time. Throughout this time, breastfeeding promotion has had little to do with helping improve or draw attention to material conditions of women's lives and the messaging has also generally undermined successful breastfeeding among mothers. Ostry and Nathoo (2009) argue for the consideration of the historical circumstances of infant feeding practices to be considered when developing policies around and holding discussions and debates on infant feeding. They also call for breastfeeding "success" and "failure" to be defined by women themselves, rather than through public health policy. In terms of mothers' perceptions of whether or not they have been successful at breastfeeding, Leff et al (2003) argue that narrow definitions of successful breastfeeding "may inadvertently undermine the self-confidence of a mother who decides to breastfeed for a shorter time." (2003, p. p. 99) and that "successful" breastfeeding has "components of values, attitudes and beliefs about mothering, breastfeeding and lifestyle" (2003, p. p. 103). The idea of mothers' perceptions of success will be discussed through this paper

Hausman (2003) puts forth the idea that cultural factors influencing breastfeeding are not considered by researchers because researchers themselves do not pick up on them, let alone consider them theoretically since we are so embedded in our own cultures. She critiques the optimizing view of breastfeeding (i.e. breast is best), which serves a medicalized view of biosocial practices in favour of a normalizing view where breastfeeding is the default choice and formula is view as a substitute for human milk. Hausman feels that the "breast is best" mantra puts individual responsibility on mothers

to make the “right” decision for their child by making a choice that is generally limited by constraints. Educational campaigns do not address structural constraints like poverty or lack of support for new mothers and mothers of older babies. Some solutions to those constraints include living wage jobs, safe and affordable housing, access to clean water and nutritious food.

Now breastfeeding means belonging to a community of practice, “a group which shares a particular set of practices (like breastfeeding), and membership entails not only expertise in the practice itself but also becoming embedded in the culture that surrounds it” (Bartlett, 2003, p. 155). Breastfeeding culture is very organized, more so than formula feeding culture, with support groups, organizations and products like pillows, pumps, magazines, books, clothes, etc. available to breastfeeding mothers. Formula feeding culture is less organized and more normalized. The practice of breastfeeding is not facilitated in the late capitalist/postindustrial context but rather in a context where work life is flexible, social and financial resources are available and professional as well as lay support networks are easily accessible to mothers and babies’ other caregivers.

## **Chapter 3**

### **Methodology**

#### **3.1 Epistemology, frameworks and tools**

This chapter is a detailed account of the methodology used to gather and analyze the primary data for my thesis research. To start off, I discuss the epistemology, which is based in the ideas of postmodernism and feminism, as well as the tools used in the research and analysis processes. Next is a discussion on the limitations of focus group research and how those limitations can be overcome. To tie up the chapter, I go into detail about how I recruited participants, how focus groups were coordinated and facilitated and how the analysis proceeded.

Staller et al define methodology as “a perspective or theory of social reality,” (2008, pp. 28). I found the postmodern perspective a useful lens for viewing this research.

According to Cosgrove and McHugh, postmodernism is

... a radical rethinking and questioning of some of our most taken-for-granted assumptions about the nature of reality, truth and knowledge. It is an approach to knowledge generation and science that questions the belief in absolute or ahistorical truths by emphasizing the partial and impermanent nature of knowledge. (2008, p. 74)

In other words, knowledge and the understanding of reality is plural, ephemeral and partial, leading to an imagining of it that is dynamic, somewhat incoherent, and fragmented. The power of language is important in postmodernism because it helps mediate and thereby constitute reality (Cosgrove and McHugh, 2008; Getty, 2009). When we study language through discourse, we can glimpse a reflection of experience in the world as the discourse is constructed (Weedon cited in Burns et al, 2010). Post-

conversation we can analyse language to gain insight into the motivators and restrictors of action and mechanisms by which thinking is influenced (Burns et al, 2010).

When conducting a postmodern critique, the dualities and dichotomies of modernist thought, which are themselves invented and influenced by the politics of power rather than being inherent or invariable, are thrown out of balance (Burns et al, 2010).

Black and white divisions like subject-object; nature-culture; and mind-body are reductive instead of inductive or abductive<sup>10</sup>. Discourse is shifting from the practice of identifying these dualisms to exploring how they ground epistemology, influence methodology and ultimately structure how we think (Cosgrove & McHugh, 2008). Since the construction of attributed characteristics<sup>11</sup> is based on the interaction of complex processes, the postmodern practice of deconstruction of difference makes these processes more evident (Cosgrove and McHugh, 2008). Hesse-Biber and Leavy (2006) bring Merleau-Ponty's rejection of the Cartesian separation of mind and body and his view that experience happens through the lived body into their discussion. They recommend that social scholars consider experience as embodied by bringing embodiment into their analysis and interpretation of experiences of racialization, sexualization, heteronormalization and other processes. One of the assumptions of this approach is that

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<sup>10</sup> Reductive logic reduces problems to what researcher believes is the essence of the issue; deductive logic begins with a premise or assumption and attempts to determine what can emerge from the assumption. With inductive logic, conclusions are derived logically from the data, in other words, the theory is grounded in the data. Abductive logic "is sensible and scientific as a form of inference, however it reaches to the sphere of deep insight and new knowledge. Abduction is intended to help social research, or rather social researchers, to be able to make new discoveries in a logically and methodologically ordered way." (Reichertz, 2009, pp. 7).

<sup>11</sup> Attributed characteristics are labels placed on people based on their positions in networks of power and systems of oppression. These labels include race, gender, class, religion, ethnicity, nationality, education level, language proficiency, ability, among others.

knowledge, as a productive activity “cannot be objective and value-free because the basic categories of knowledge are shaped by human purposes and values,” (Rosser, 2008, p 57). Rosser works from a Marxist perspective but the idea of impossibility of objective knowledge is shared among postmodernists.

While postmodernism aims to reject the objectivity of science, we need to be aware that the standard approach to research, including social science from a postmodernist point of view, is still based on a natural science model. According to Mellenbergh et al, (2003, cited in Staller et al, 2008) this model generally has five phases:

1. definition of a research problem;
2. planning and development of a concrete design including measurement procedure(s);
3. implementation cycle where the study is carried out and empirical data is collected;
4. analysis of data set(s) where raw data is processed to yield information related to the research question;
5. reporting on the research question, including a description of the study and detailed interpretation of the results.

Although it has not completely revolutionized the way research is done, the postmodern framework has helped researchers become more culturally aware, sensitive and politically engaged while redirecting positive attention “to the larger socio-political context of individuals’ experience.” (Cosgrove and McHugh, 2008, p. 78). Researchers need to take “the perspective that all research is “political”” (Cosgrove and McHugh, 2008, p. 83) – at every stage in the process we endorse certain values, worldviews, and beliefs while marginalizing others. Habermas (cited in Getty, 2009) viewed language as

an integral part of the formation of meaning and creation of knowledge. In this way, the practice of a Foucauldian genealogy is important as a way to question underlying power dynamics and how those dynamics came to be.

Relational empowerment is a process involving the recognition of the agency and subjectivity held by everyone involved in the research, no matter their position of power and privilege (VanderPlaat, 1999). According to VanderPlaat's description of relational empowerment, everyone involved in the research can help work towards the empowerment of others or be empowered, and often do both simultaneously. She writes of a shared recognition of the power and ability of all of us to "contribute to the construction of knowledge and social change", adding, "in that process, all of us have a lot to learn." (VanderPlaat, 1999, pp. 777). As researchers we can use relational empowerment to determine where all parties fit into empowerment discourse, thereby recognizing ourselves as part of the discursive community and by extension, potentially oppressive<sup>12</sup> systems. As academics and scholars, we can use our privileged positions "to break down the policies and practices within our own disciplines and organizations that contribute to the disempowerment of others" by being "empowered by the communities we serve." (VanderPlaat, 1999, p. 783). Staller et al (2008) advocate for a shift in the research process whereby researchers openly and honestly question our roles, authority and responsibilities in the process while identifying ourselves as a "variable in the endeavour" (Hesse-Biber Leavy, 2008b, p. 38). Hesse-Biber and Leavy (2008a) also

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<sup>12</sup> Oppression is the situation that occurs when one group determines and limits the behaviour of another (Getty, 2009, p. 6). According to Friere (1972), liberation comes from the oppressed as they reflect on their situation, ultimately naming inherent problems of the system and acting to change conditions. The challenge with referencing Friere is that he was limited by his Eurocentric view and the focus on the individual, therefore the process ultimately ended with assimilation rather than emancipation.

advocate for paying more attention to the balance of power in the research process by practicing reflexivity in our research endeavours, through consideration of the relationship between the researcher and the researched, subjectivity and authenticity, as well as other relational aspects.

Staller et al point out that the use of personal narratives by sociologists provides “unique insights into the connections between individual life trajectories and broader social structures.” (Pierce, 2003, cited in Staller et al, 2008, p. 43) and that agency is constructed and inherent in individuals simultaneously (Pierce, 2003 cited in Staller et al, 2008). Based on an emic perspective, focus groups are a means to gain a deeper understanding into people’s beliefs, values and practices from the social narratives emerging out of the discussions. Given the nature of my thesis research, I found focus groups to be the ideal tool for gathering my primary data. Unlike ethnographies and participant observation, focus groups do not provide comprehensive, detailed and interpreted accounts of aspects of participants’ daily life. They do, however, aim “to ground interpretation in the particularities of the situation under study and in participants’ (rather than analysts’) perspectives,” (Wilkinson, 2011, p. 179).

Focus groups have been used in feminist research since the 1990s and their frequency of use is increasing (Wilkinson, 2011). According to Litosseliti, focus groups are “small structured groups with selected participants, normally led by a moderator. They are set up to explore specific topics, and individuals’ views and experiences, through group interaction,” (2003, pp. 1). They are suitable for exploratory research but require careful design to gain insight into participants’ perceptions of a topic in an environment that is open, encouraging and non-threatening (Litosseliti, 2003). During the focus group, participants share, interact, respond to others’ comments and ideas, resulting

in primary data that can be analyzed for similarity and diversity in experience among participants. The method is effective at gaining a postmodern perspective on a topic because of the kind of questions asked and the knowledge being sought, which is centred on participants' everyday experiences as embodied beings situated in complex networks built on systems of oppression.

Focus groups are helpful in bringing to the surface the social values and shared beliefs that underlie individual values and beliefs. Data can show researchers how individual beliefs are socially and culturally contextualized, at the same time that it can be used to explore dominant cultural values, the feelings and opinions of members of a target group and how the personal and systemic interact (Warrs, 2005). Focus groups have been used in community education; public health; media studies; and social science research for determining program development and communication strategies. They also useful for:

- a. understanding the gap between institutional messaging and behavior on the individual and community levels;
- b. exploring how individuals receive and interpret media messages;
- c. analyzing rhetoric;
- d. gaining insight into perceptions, opinions, attitudes and sensibilities.

(Litosseliti, 2003; Scott & Mostyn, 2003; Wilkinson, 2011)

As a result of their relatively non-hierarchical and contextual nature, focus groups are ideal for feminist research, having the potential to “spotlight group norms and processes and make them available for analysis” (Warrs, 2005 pp. 201) and to highlight “processes of social interaction” (Warrs, 2005, pp. 201) as participants present, explain and defend their opinions and beliefs. Quantitative research explores what people do and how many people do it whereas qualitative is about the why (Scott and Mostyn, 2003, pp.



270). Because focus group discussions can highlight points of convergence and divergence, they are useful for considering processes of social and personal transformation (Warrs, 2005). Interactions that take place in focus groups are a blend of public and private accounts, making it a “research method that explicitly bridges personal and social contexts,” (Warrs, 2005, pp. 222). Focus groups are generally viewed as less intimidating than individual interviews with a researcher, and more effective in oral cultures (Jessri & Farmer, 2013). They are spaces where, in this case, women are given the opportunity to construct and co-construct their everyday lives. “Naturalistic” possibilities of data are enhanced with focus groups where more spontaneity and flexibility around topics means the possibility of more control by participants. Factors can combine to result in the validation of participants’ experiences and viewpoints.

Increased recognition of the utility of the focus group, has resulted in their increased use in cross-cultural research. Warrs (2005) comments on their usefulness in health research relating to social and behavioural issues, giving the example of cultural norms associated with breastfeeding. The particular benefits of focus groups are heightened if natural groups are brought together in discussion. Focus groups composed of participants who belong to “preexisting social groups can recreate aspects of their social relations as participants exchange opinions and engage in processes of persuasion.” (Warrs, 2005, p. 201). It is also important to keep in mind that historical elements can affect the research context by influencing the person-environment dynamics (Dodgeson, 2002).

Hennick (2008) also suggests that researchers consider the effect of participants being familiar with each other – in some cases this is beneficial, in others not and she suggests discussing this with local collaborators (Hennick, 2008, p. 217). When I began

the recruitment process for these focus groups, I consulted with the women who were considering joining to see what their preferences were in terms of composition of the groups. My primary contact among the immigrant women advised that she and her colleagues who were interested in participating preferred doing the focus group together as a group. Although they had lived in Canada for several years, they felt that as immigrants – some of whom are racialized, some of whom are Muslim and most of whom speak English as an Additional Language (EAL) - they would not feel as comfortable speaking openly about their experiences, observations, beliefs and values around infant feeding among the group of Canadian-born mothers. By the end of the data gathering process, participants from both groups were eager to meet with each other and share in the experience which was an important, unintended outcome of the research process.

Both groups were quite small, with four participants each. This is classified as a “mini-focus group” by Litosseliti (2003, pp. 3), with an average focus group size being six to ten participants (Goss & Leinbach, 1996 cited in Litosseliti, 2003). Twelve is suggested as an ideal maximum, with conversation often becoming relatively unmanageable after that. Group size can also vary with the type of research being conducted. More than ten can be good for brainstorming although for other types of research, a large group can make moderation and analysis more difficult. Smaller groups are good for exploring complex, controversial, and emotional topics, in addition to being easier to coordinate and manage (Litosseliti, 2003). In terms of the focus groups for this project, four was an ideal number of participants for the first focus group where all of the participants knew each other. One participant brought her thirteen-year old daughter as an observer, which lent an interesting dynamic and a situation where participants had an opportunity to impart their knowledge and values around infant feeding to a member of a

younger generation. Some participants in the second focus group knew each other and although others did not, all participants related to each other through shared experiences.

In focus groups, interactions between participants are considered valuable data, unlike in structured interviews, where the interaction is often more forced, directed and less natural. In addition, it is not only data from the content of conversation that can be gathered and analyzed from focus groups - other elements include how personal beliefs and experiences inter-face; how participants articulate their viewpoints; frames of meaning used by participants to interpret situations; and representations of local conditions, (Hennick, 2008). Discourse analysis consists of a more political approach to the research process, and has the goal of empowering participants thereby leading discussion towards ideas of structural versus individual change strategies (Cosgrove and McHugh, 2008). Like content analysis, discourse analysis is not a static technique, the goal is to explore the production of meaning in communication events where the constitutive function of language is emphasized, and the reproduction of power relations is addressed in narrative accounts. Approaches like Derrida's deconstruction and Foucault's structuralism come together in discourse analysis, helping researchers and analysts identify "cultural truths", marginalized perspectives and influences of power and control at play (Burns et al; 2010; Cosgrove and McHugh, 2008).

In the poststructuralist view, accounts of experiences are "located within a complex network of power relations" (Cosgrove and McHugh, 2008, p. 78) which contribute to the impossibility of researchers, or anyone for that matter, gaining "unmediated access to experience," (Cosgrove and McHugh, 2008, p. 78). Basic assumptions of discourse analysis are that "meaning does not exist prior to and apart from representational *systems*," (Cosgrove and McHugh, 2008, p. 78) and that "because

meaning is produced in complex and intricate ways, any account of experience will inevitably be located within a complex network of power relations,” (Cosgrove and McHugh, 2008, p. 78). Due to the recognition of multiple competing and fluid discourses, there is an analytical focus on consistencies and inconsistencies in dialogue. It is in these spaces that we find possibilities for resistance (Cosgrove and McHugh, 2008) and insights on how “individuals construct and interpret their experience in relation to contemporary discourses and practices,” (Cosgrove and McHugh, 2008, p. 78). Discourse analysis is not performed in order to find truths, it is more a contemplation of the function of discourse where context and meaning are considered. Results are based on “a web of responses and how these are pursued, grounded and clarified through group interaction,” (Litosseliti, 2003, p. 6), a form of analysis which increases depth of response.

### **3.2 Recognizing and overcoming the limitations**

Some limitations on focus group research are inherent, like the fact that it is not possible to collect quantitative data, which limits the use of data in terms of generalizations. In the case of this research, the goal is to access in-depth narratives about participants’ lived experiences, not to end up with generalizations based on data sets. Although the data gathered for this project is not generalizable, it can be used descriptively and as a narrative that gives voice to mothers (Litosseliti, 2003).

A variable limitation is the fact that the quality of the data depends on the facilitator’s skills (Synnott et al, 2007). Litosseliti (2003) discussed a number of limiting aspects of qualitative research in general and focus groups in particular and provided suggestions on how to counteract these limitations. One common limitation is the potential of bias which can result in manipulation in the form of encouraging participants

to say what they think the researcher wants to hear. False consensus can occur when some participants say they agree with something others are saying even if they do not as individual behaviour becomes subject to group influence. Researchers may find it difficult to distinguish between group and individual views because participants may respond more emotionally than normal in the focus group environment. Careful planning and moderation is key in counteracting these limitations. A topic guide or focus group schedule is useful when trying to deflect attention to or from a person or a topic that may come to dominate the conversation. In terms of managing bias and manipulation risk, paying attention to how people actually behave in addition to what they say they do is useful. Navigating participants' motivations is difficult and it is important to keep in mind that some participants may hold back personal details or rationalize behavior because they are uncomfortable revealing certain things (Litosseliti, 2003).

According to Rosser (2008), the reflection of unintentional bias in scientific research can be found at every stage, including the selection of research questions, methods and approaches and the drawing of theories and conclusions from the data. Male dominance in certain fields and sectors leads to bias based on decisions taken at the levels of project funding, design and implementation. Instead, studies and research focusing on the health problems of the privileged (i.e. males) are much more commonly funded (Vanderplaat & Teles, 2005). Slaughter (2015) gives the example of the fact that we know so much about heart disease in men and so little about it in women – the research has historically been male-centric. In addition, the language of theories and research can often be “androcentric, ethnocentric, or class-biased...” (Rosser, 2008, p. 57). Examples are “tomboyism” (Money and Erhardt, 1972 cited by Rosser, 2008); “aggression” and “hysteria”, all terms that reflect gender-based assumptions of behavior. The fact that very

little is known about breastfeeding and human milk is indicative of this bias, demonstrating its limited relevance as a social issue in that it is not considered important by those in positions of power who make decisions around fund distribution and the relevance of research questions (Hausman, 2003).

Representability is hard to achieve in most cases (Litosseliti, 2003) because focus groups attract individuals who are more vocal instead of people who may not be overly confident or who may have communication challenges and other limitations, but this is a challenge in many types of research. Gamson's research (1992) showed that in "sociable public discourse" (p. 19) events, participants may not be used to speaking in front of an audience and may feel obliged to censor their language and curtail their personal opinions. People's motivations become more complex in group settings (Litosseliti, 2003). All of the limitations mentioned above can be managed to some extent through preparation, moderation and by identifying interactions and events that can be critically analysed.

More specifically to this project, due to the very limited resources available I could only conduct one session per focus group with four women at each one. It has been proposed that three focus group sessions with each group are the minimum required for data saturation (Reed and Payton cited in Jessri and Farmer, 2013; Litosseliti, 2003), however four to five is ideal. Ideally with focus groups, data is gathered until data saturation is reached, or when there is no new data coming out of focus group events and this redundancy of response means that data gathering can come to an end (Dodgeson et al, 2002). As a result of the limited number of focus groups I was able to facilitate, no saturation of data or redundancy of response was reached, though some similar points came out in both focus group discussions. The fact that I was not able to gather data from

more focus group sessions on the same topic is a limitation of this research and means that the data gathered can illustrate a very small number of experiences. Despite this, I believe this research can provide some insight to women's experiences in our community and is useful as the foundation for a larger study that encompasses qualitative and quantitative methods while delving deeper into the practice of breastfeeding and how it is connected to social, physical and emotional health.

A second limitation is my status as a cultural outsider amongst the immigrant women I worked with, however I feel that our shared experience of motherhood allowed for bonding and encouraged them in sharing their experiences. Efforts were made to make participants as comfortable as possible and to let them know that their opinions, thoughts, perceptions and beliefs were valuable and valid and could be used to influence change in the status quo. In order to ensure maximum credibility in the research context I aimed for mutual agreement among the focus group members that all of the discussions were covered in such a way that all felt that their views were addressed. Questions were kept open-ended and flexible and I had them reviewed by other stakeholders before using them in a focus group setting. These steps helped establish credibility and ensured that participants' genuine voices came through.

### **3.3 Hitting the ground running: the research process**

Prior to recruiting participants, I obtained approval from the Saint Mary's University Research Ethics Board (REB) in order to conduct research with human subjects. The advantage of having to go into so much detail for the REB application (for example, writing consent letters, drawing up focus group schedules, drafting posters to distribute as part of the focus group recruitment strategy) was that all of the necessary

plans and materials for the project were made in advance and only needed to be changed slightly when it came time to use them.

I used a variety of ways to recruit participants – emailing and dropping off recruitment posters (Appendix A) to local libraries, family resource centres and doctors' offices. In addition, I contacted representatives at local immigrant settlement agencies, family resource centres and libraries, asking for their help in spreading the word about my research. An LLL colleague who is part of an active attachment-parenting group on Facebook, posted a request for participants on the group page. As a final measure, I approached personal contacts about my research to find out if they were interested in participating or if they knew of anyone who would be. I did not receive any responses as a result of posting efforts or through local organizations. I was contacted by four members of the Facebook group who were interested in participating and two of them initially committed to attending a focus group but could not come at the last minute. It was the snowball method, where committed participants helped recruit others, that proved most effective in this case. In the end this worked well since a couple of Canadian-born participants knew each other and all of the immigrant women knew each other, making for more relaxed and natural conversations.

The coordination of focus groups is a difficult task, in that time and location both pose challenges and require negotiation. The scheduling of events with mothers is particularly challenging because of their availability and preferences. Some mothers are comfortable leaving their children for a period of time, some are more comfortable bringing children to evening sessions whereas others prefer not to disturb their children's night-time routines. For both groups, I contacted potential participants to find out what time of day worked best for them and scheduled the gatherings during times and at



locations best for the majority and manageable for all. The immigrant mothers from the first focus group had older children and were all working full time, with most doing shift work, so we met during the afternoon in the middle of the week. Similarly, the group of Canadian-born mothers found an afternoon during the week easier to manage, with two mothers on maternity leave, one working shift work in the evenings and another a full time mom. Attesting to the fluidity of mothers' lives, when the time came to schedule a feedback meeting a few months later, many participants' availability had altered significantly. Two had gone from working shifts to working Monday to Friday during the day. Two others had returned to full time work after being on maternity leave. One had shifted her attention to her independent home business and still another had gone on maternity leave with a new baby.

The focus groups for this project follow Wilkinson's (2011) three guidelines which are: the use of a "schedule" based on a series of questions; facilitation by a moderator who is usually the researcher; and the key element of interaction and stimulation of conversation among participants. Both focus groups were based on the same semi-structured discussion schedule (Appendix B) and I acted as moderator for the sessions, which had the goal of encouraging an engaging and interactive discussion inclusive of all participants. Both focus groups lasted about 1.5 hours and were video recorded for analysis, as recommended by Litosseliti (2003). Questions were open-ended and exploratory, focused on methods of feeding, beliefs around infants' health, feeding intention during pregnancy and sources of feeding information and support. I am a hands-off facilitator and believe that the conversation works best when it flows freely and naturally. I had certain questions I wanted participants to consider and found that with the first group, I did not need to guide the conversation much since participants covered the

questions I wanted to discuss. I was slightly more hands-on with the second focus group but found I could gently nudge participants to focus on the topics I wanted to consider in my research. Focus Group B's conversation tended to come back to the themes of the judgment and pressures mothers feel from external sources.

The presence, role, background (including perceived) of the researcher and interactions with participants influence the data produced (Litosseliti, 2003). In an attempt to minimize bias and risk of manipulation, at the beginning of each session I introduced myself, my research and my volunteer background in the breastfeeding community. Throughout each session I made an effort to gently encourage the flow of conversation and open discussion between participants, which was not difficult once the conversations got going. I focused on the participants with the plan to attempt to extract the meaning emerging from their discourse and interactions at a later time in my analysis stage.

A collaborative approach to developing and reframing views using participants' own language can make participation in a focus group an empowering experience for everyone involved (Vanderplaat, 1999). In both of the focus groups I facilitated for this project, I experienced mutuality of empowerment. At the end of the first focus group session I asked participants if there was anything they would like to add or discuss further and one participant mentioned how good it felt for her and the other participants to be considered "experts" or knowledgeable about a topic, and to be provided with the opportunity to share their knowledge. In turn, I felt empowered through participants' reactions to my questions and their willingness to talk about the topic I approached them with. This reassured me that the topic of my research was relevant to mothers in our community.

In my analysis, I used a grounded theory approach, where I went into the data collection event and subsequent analysis without many assumptions about what I would find, believing that the data would reveal salient issues (Litosseliti, 2003). According to Hesse-Biber & Leavy's interpretation of Kathy Charmaz's work, grounded theory is an "emergent logic" that replaces reductive logic with inductive and abductive logic. They view emergent methods as "inductive, indeterminate, and open-ended," while being "sensitive to the unanticipated directions that may emerge during the research process." (2008, pp. 20). Like Cosgrove and McHugh<sup>13</sup>, I also consider objectivity (2008) impossible and see a need to place the focus on power and the "value-laden nature" (2008, p. 73) of science and social science. They go as far as to argue for the "need to explore the relationship between epistemology and methodology and recognize the impossibility of *any* method as a guarantor of truth," (2008, p. 73). Through my use of postmodern approaches like feminism and Critical Social Theory (CST), I incorporated these views and recommendations into my work, taking into consideration the intersectional spaces and accompanying positionalities held by and the experiences of women from diverse backgrounds.

I used discourse analysis as my central epistemology, a technique based in the idea that the conversational exchanges as well as interactions between participants should be considered in the analysis of the focus group content. (Wilkinson, 2011, p. 174). In terms of analysis, the explanations of everyday produced by participants were the focus. I took advantage of the tedious task of transcription to get more familiar with my data and to begin the discourse analysis of the focus groups. My first step was to

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<sup>13</sup> Cosgrove and McHugh define objectivity as "an unmediated relationship between the world and our knowledge" (2008, pp. 72)

listen through each focus group session twice before beginning the transcription. By the time I was ready to begin the transcription, I was already relatively familiar with the content and interactions between participants.

In the analysis process, I identified dominant themes, or topics, that recurred throughout the discussion or were concentrated on in particular, as recommended by Scott and Mostyn (2003). After the first stage of analysis, I summarized each theme and picked out crosscutting themes and patterns through the process of data coding, as advised by Scott and Mostyn (2003) and Brown (2007). Categories of analysis were developed based on patterns emerging through a three stage analysis that included coding, categorizing, creating descriptive summaries for each category and identifying patterns across groups. The first stage of analysis was done twice at the group level to fine-tune the coding system I used, the labels of which were drawn from the discussions. In the second stage, I handpicked parts of conversations that focused on certain topics brought out in the focus group discussions. This allowed me to tease out specific interests, beliefs, values, practices and perceptions of the participants. In third phase of analysis, I merged the two data sets, did more fine-tuning of the categories and themes and compared and contrasted the emergent themes from each group.

The women who participated belonged to multiple categories that O’Leary (2010) associates with disempowerment and marginalization rather than power and privilege. Some of the mothers participating in my research are racialized, from developing countries, speak English as an additional language, and they are generally well-educated with sufficient economic resources. In terms of possible attributes on the power and privilege side, I exhibit many – white, educated, middle-class, and married, brought up in a Christian environment, among others. Through understanding and managing my own

subjectivities, building trust with stakeholders, being consistent about my methods and fulfilling ethical obligations to all those involved, I feel I have mitigated these ethical considerations as best as possible.

Through the process, I have strived to recognize the multiplicity of experiences and voices among women from diverse cultural backgrounds and life experiences. To ensure that conclusions drawn from my observations and analysis are in line with the cultural beliefs and practices of the women who participated, one of Dodgeson et al's (2002) central recommendations for ensuring cultural competency in research, I consulted with a core group of participants in a variety of ways at critical stages in the investigation, before, during and after. The research design included presenting the analysis results to participants to ensure that I had accurately represented their views, beliefs and practices. In March, five of the eight participants (two from Focus Group A and three from Focus Group B) attended a meeting where I presented my results, which were enthusiastically supported by the participants present as reflective of the conversations we had and their views on the issue. A primary goal of my research was to give voice to mothers around a mothering issue where their voices are not normally heard by formal institutions which, based on the responses of participants, I believe I have done.

## **Chapter 4 – Descriptive Summaries of Focus Groups**

As discussed in Chapter 3, focus groups are ideal for exploring abstract concepts like attitudes, experiences and dominant cultural values (Dodgeson et al, 2009; Scott & Mostyn, 2003; Synnott et al, 2007). In this research project I used focus groups to gather data on how some mothers in HRM feel socio-cultural factors influence their breastfeeding decisions. My analysis of the focus groups consisted of three stages, the first of which consisted of reading and re-reading texts to discern discrete segments of conversation. Next, I worked on identifying the important themes and subthemes that emerged from each discussion. In the second stage, I selected the most salient segments of conversation and developed descriptions of each segment. In the third stage of analysis, which I talk about in more detail in the discussion section of Chapter 5, I brought together the two sets of data and merged the emergent themes, sub-themes and topics from each conversation, which facilitated a comparison of the two data sets. In this chapter, I will provide a descriptive analysis of each discussion while focusing on the more prominent themes and topics of both conversations, highlighting convergences and divergences in practices, values and beliefs within groups. In the discussion section of Chapter 5, I will discuss the convergences and divergences between the perspectives, beliefs and practices of Focus Group A and Focus Group B participants.

### **4.1 Breastfeeding as “the normal way”: A descriptive summary of Focus Group A**

Participants in Group A were immigrant women who had come to Canada via diverse avenues more than five years ago and they were all known to each other, having become friends at a common workplace. This made for an interesting dynamic in the

sense that they morally supported each other and developed the conversation as a group. All of the participants in Group A have worked with new mothers and babies so had unique insights on the topic. They had very keen observations on how breastfeeding can be appropriately supported in the early days and the differences between breastfeeding in their cultures and breastfeeding in the Nova Scotian context.

At the time of the focus group, each of the mothers in Group A had two or more children, spanning a range of ages from toddlers to the twenties. Helen, who originally came to another province in Canada from West Africa as an international student, was the mother of two. She breastfed her eldest daughter for eighteen months and was still breastfeeding her one-year-old daughter when the focus group session took place. Mona was the mother of two teenagers and came to Canada from the Middle East. Her children, one of whom was at the focus group session, were both breastfed. One of her children was born prematurely in her home country and was breastfed from birth until fourteen months of age. Roberta came to Canada as a refugee from East Africa, her first child was born when she was in her late teens and living in a refugee camp. All of her children were breastfed until about two years old, with two of her younger children being mixed fed due to her work commitments and pursuit of an education. Adina had a pre-teen and a teenager, both of whom were born in Canada. Adina also came to Canada from East Africa as a refugee when she was in her early twenties and she gave birth prematurely to her first child soon after arriving in Canada. She breastfed both of her children for an extended period, even through the challenges of the hospitalization of her first child. The participants in Group A were very comfortable with each other, even when talking about very personal topics in the focus group context.

Group A's conversation started off with brief introductions, more for my sake because all of the participants already knew each other. Through the introductions, the participants wove in their own knowledge and beliefs about infant feeding, especially breastfeeding, a topic that they are all very passionate about. The introductions were peppered with anecdotes like the story of Mona's friend who had an abundance of milk, enough to feed her own and another friend's baby who could not produce enough; and myth busting, like the fact that one can still get pregnant while breastfeeding if the conditions are right. Although I did not request specific information in the introductions, each participant mentioned whether she had breastfed or formula-fed. All had breastfed at least two children for an extended period (over one year) and all participants were breastfeeding supporters in their personal and professional lives.

Helen voiced her strong belief that human milk is the ideal food for her children and she talked about how she had a hard time even considering feeding her babies formula. In her introduction, she told the group a little bit about her experience becoming a mother while she was still at university:

So for me, at twenty-four when I was pregnant with my first daughter, that's the first I know that's what I have to do - I have to breastfeed my child. It was actually a difficult time because I was in school, my partner was away, my family - I was just living with my daughter at the time. So, it was pumping three, four times a day; it was coming home and breastfeeding and waking up at night. But for me there was no other source of food other than breast milk because that was what I saw all the time.

Roberta shared parts of her experience as a refugee in East Africa when she discovered she was pregnant at seventeen. Although she held the same strong belief as Helen in the benefits of breastfeeding and she placed the same value on breast milk as the ideal food,



this was in spite of not having much direct exposure to breastfeeding while she was growing up:

I was the youngest of my mom's children so I never seen my mom breastfeeding but I had back in my head, as they say (nodding to the others), breastfeeding is the way. You have the baby, you put his mouth to your breast. (laughter from others) whatever comes out! (more laughter) ...

Through Roberta's memories of having three babies while living in and out of refugee camps in East Africa shine nuggets of breastfeeding knowledge. She recounted how she learned how to use compression to control overly leaky breasts from another woman who saw her in a clinic in the city leaking all over herself. The woman managed to share this helpful tip with Roberta even though they did not share the same language.

Two women, Mona and Adina, had babies who were born prematurely and both were advised to feed the babies human milk, which they both mentioned in their introductions. They empathized with each other as they told their stories about pumping and expressing for extended periods, a shared struggle. Both said they believe that human milk is the "only source of food", citing their cultural upbringing as foundational to this belief. Mona's baby was fed formula soon after his birth and he had a reaction to it, ending up with diarrhea, which added to the challenges of the early days of his life.

After the introductions, Roberta brought up the treatment of mothers by hospital staff, sharing her feelings that hospital staff and other health professionals do not give credit to mothers for their capacity, whether instinctual or learned, to bond with, care for and nurture their newborns. Although she breastfed all of her children, one of her younger children was introduced to formula early on because she was working and going to school at the same time. Unfortunately, like Mona, she soon found out that her baby had a sensitivity to artificial milk. Of her need to feed formula to her baby, Roberta said "I was

kind of selfish because I was going to school and lazy,” as if going to school, working and having a baby at the same time is lazy! She spoke of the events leading up to her decision to try formula with this baby:

Right away, my husband brought me the baby and I used to breastfeed in some of the rooms (at work). So I was a kind of stressed, “oh, oh, oh, that’s it!” cause I want to go out and work and school and this and that so I said “I’m gonna stop breastfeeding him” but he had a problem for every formula.

She went on to talk about how she went back to breastfeeding with her youngest children and about how much she enjoys it, echoing the sentiment Adina expresses in her introduction.

Mona brought up her challenge of breastfeeding a toddler, which seem to veer from the other participants’ experiences as they all talked about enjoying extended breastfeeding. Mona’s son was relatively high needs, aggressively demanding feedings when she arrived home, especially if she had been away for a long period of time:

Yeah, I quit at fourteen months. Especially when I came from outside from where I was, if I had a visitor, he saw me, right away he was screaming he just wanted it. That was really, really, he was so loud and biting and kicking. And at night...

Not much was said about night parenting at this point and the conversation quickly shifted to breastfeeding in public.

Breastfeeding in public was a significant topic for this group, as it was with participants in Focus Group B. Group A participants saw a significant difference between how breastfeeding was practiced and received in public here versus the other countries they had lived in before settling in Canada. The participants who are from Africa in particular talked about the differences:

Helen: Another thing is that in most African countries women feed everywhere.

Adina: Yeah!

Helen: Everywhere. Everywhere! It's not something you have to think about, it's just acceptable.

Mona: Everywhere, grab your baby, they have a shawl, they just, oop, this one and grab the baby and just feed him.

Adina: In my country there are beggars on the street, even low income families, they don't have a shirt to cover, they just do that in the street, everyone is going. Nobody cares to look at them, breastfeeding is the normal way.

Roberta: Sometimes they have a business, they sell something, you can see the baby (lifts arm up and gestures under her arm as if there's a child there in a sling or wrap) feeding himself and she doesn't care. And later on he just left the boob and when the baby leave, still the breast is (gestures as if she has a breast hanging out of her top)

Helen brought the recent media stories of mothers breastfeeding in public (discussed in Chapter 1) into the conversation. She used these incidents as indicators of the context of public breastfeeding in Nova Scotia, though to concentrate only on the outlying stories of mothers' experience may limit our views given the greater acceptance and further normalization of breastfeeding as the ideal method of feeding a baby that is happening currently.

Because of their professions, all Focus Group A participants have done various training modules, including on breastfeeding. They all believed that this training does not take into account trainees' previous knowledge, and what participants saw as their "natural instinct", something which not many Canadian-born participants felt they had.

When I brought up the Loving Care book series provided to new parents at the hospital up to Group A participants, Adina responded:

It's natural (breastfeeding) and by putting those books, they are supporting some people if they have hard time but there is this guide or way, so you do it this way so everybody thinks if I don't do it this way, it's the wrong way. Now I'm ruining my breasts, my nipples, and I will be feeding this baby, stress on top of stress. Then you become, you say "to heck with it I'm not breastfeeding no more."

This comment encouraged Helen to reiterate her view, which was shared among all Group A participants, that breastfeeding is natural for mothers from other cultures. In her opinion, this is why more mothers who are immigrants do not tend to seek support from formal organizations like La Leche League (LLL):

Because we are not out there, they (LLL) don't see what we do. But for them (middle-class Canadian-born women) they know their resources. Imagine if you are an immigrant, they don't know where to get their resources and beside for you, that's how you know to feed your baby. So you would probably not go again look for those resources. It comes to you naturally.

A discussion on the socio-demographics of infant feeding ensues, with Mona pointing out her observation in her professional capacity that women of higher socio-economic status are more likely to breastfeed whereas women with lower socio-economic status are more likely to formula-feed. The conversation touched on inequalities that exist in terms of accessing breastfeeding support, in particular the fact that if a women of higher economic status has breastfeeding challenges, she has increased opportunity to access the support of a certified lactation consultant given they operate on a fee-per-service basis. Mona rightly attributed the lack of breastfeeding in lower-socio-economic groups partially to lack of exposure and transmission of knowledge to mothers who grew up in a formula-feeding generation:

.... because there is a lot of lack of knowledge. Way back, that time you were raising the family all breastfeeding, "I saw my mom, I saw somebody else, I saw somebody else" and we know that ... But right now, this generation, twenty years, twenty-five years, they lost...it was cool feeding baby formula.

From there, the conversation quickly moved on to a discussion of the limited exposure to breastfeeding people in Nova Scotia receive. Helen pointed out how deep the preference to formula-feeding has drilled down, with the norm being signified even in child's play

with baby dolls that always come with bottles. She asked the group, “You see all these toys with bottle-feeding baby – have you ever come across any toy that a mom is holding baby to the breast? No!” The assumption is not that play would entail pretending to breastfeed a baby-doll, which many breastfed children do spontaneously anyway, without prompting from toy-producers.

Mona went on to comment on the lack of exposure to and knowledge of breastfeeding she saw on a daily basis in her former workplace:

They don't know about the breastfeeding, they didn't see. At the hospital first they (the moms) give the baby formula. Because the woman, she shouldn't stay home. Modesty. She shouldn't stay home, she should go out, that's cool, why not formula? And now this kid, now new moms, they have no knowledge about breastfeeding.

Lack of knowledge and distractions such as smartphones and social media were cited by Mona as factors interfering with coaching new mothers on breastfeeding post-birth:

And that's the book, some of them they read, some of them they don't care, now it's the phone all the time, they are busy, when you go to teach them they are busy on their phone and this kind of stuff. But we, again and again, every (staff member), we go and teach them about that. And now, in the beginning when I start working there, probably 50% breastfeeding has gone up.

Although participants have seen firsthand the increasing breastfeeding initiation rates in Nova Scotia, they lamented the direction things have taken in their own countries, especially those from African countries.

Helen shared her knowledge of Nestle's activities when they actively created a market for their infant formulas in West Africa. It is a story of unethical, coercive marketing and promotions, a compromising of traditional culture in local communities and a seeming ignorance to the realities of environmental and economic conditions in the region. Participants discussed the idea that pervasive marketing and promotion of

formula as used by Nestle and other formula companies in Africa has resulted in formula becoming a status symbol among mothers:

Helen: And during that time they did a huge marketing, so now, even in Africa, just like Mona is saying, you see people and they try to even use formula, because to them, if you are able to afford it, it means you are rich.

Mona: A status symbol.

Helen: Yes, a status symbol because that's what was sold to them at the time and just like she said, the new generation, that is what they buy because they don't see it (breastfeeding) around them. They go to market, they go to Superstore, that's what you get.

When women are convinced, have or choose to feed their babies in ways other than breastfeeding, we lose knowledge and it becomes more difficult for anyone in the community to breastfeed. Formula-feeding becomes normalized and breastfeeding becomes a fringe activity or practice, especially when formula becomes a status symbol for the members of the emerging middle-/upper-middle class.

Mona linked the idea of formula as a status symbol again to the fact that many young women generally do not see other women breastfeeding in their immediate environments. Roberta made the connection between shifting infant feeding practices, use of formula as a status symbol and shifting ideals of beauty, linking all to media messaging. She began by talking about the loss of knowledge that the shift to formula-feeding has resulted in:

You know, the time changing have advantage and disadvantage for the people all over the world. Even Africa, you know. It used to be "breastfeeding, ok, I don't need any knowledge." You are nine years old have a baby, you are ten years old have a baby. They used to just feed. Right now, what I find out, it's like "oh, I don't know how to do it." Even Africa.

She recounted a recent conversation with a sixteen-year-old relative in Kenya. When Roberta asked the mother-to-be if she planned to breastfeed, she said no because she did not want her breasts to sag, her hair to fall out and to become old-looking (and therefore,

according to western norms of beauty, ugly) as a result of breastfeeding her baby. Roberta linked these beliefs directly to media messaging:

Roberta: She said “I don’t wanna”. She said “A year, if you do that, the baby’s going to take a lot of nutrition from you that makes me old quick. I don’t wanna lose my hair” she said, “I don’t want discolouration” she said. And that, I think, is all coming from media.

Helen: yep. (nodding emphatically)

Mona: ahh

Roberta: That is all coming from advertisement, you know. You do that, you know, you gonna ... Like the advantage is there are some people out there encouraging the benefit of the breast milk, and there’s people out there saying, “well if you do that, you gonna be ugly.” And that’s the thing. Like, right now, beauty.

Helen: Oh yeah it sells!

Roberta: It sells. It’s a beauty, it sells. Like, “oh you look like this, I can make you look like that picture”. This picture in the magazine.

Roberta talked about young women she has encountered in Nova Scotia who also know the benefits of breastfeeding but introduce formula for reasons Roberta found less than legitimate:

Roberta: So even now I find out here, when you try to educate the young people, as Mona said, like, “can you please feed your baby, your milk is wasting.” And she says “ah, no, I’m not interested” because maybe she already knew the benefit of the breast milk, but she does not want to make that kind of sacrifice because of selfishness. Especially the young.

Mona: Yeah.

Roberta: Especially the young, yeah, I don’t want it because of my beauty. And whatever is going to happen to me is more than this baby because there is formula. He’s not going to die.

It was apparent that Roberta was somewhat frustrated with the lack of concrete results she saw from extensive promotion of breastfeeding among mothers-to-be and new mothers. What she considered selfishness may possibly an attitude that stems from the fact that new, and in particular young, mothers who do not have extensive support networks know that this is a liability to successful breastfeeding so choose to feed formula instead from the beginning.

Although participants cited some positive aspects of breastfeeding culture in Nova Scotia, like the numerous institutional, grassroots and private sector support networks, they quickly moved on to the elements that are missing in our community. Mentioned in the conversation were infrastructure like mother and baby rooms and the fact that education alone is not enough to normalize breastfeeding –what is needed is a diverse portfolio of strategies. Mona talked about how the mother and baby rooms she remembers seeing at bus and train stations and other public places in Russia made an impression on her, even before she had children. Helen mentioned that it is not enough to just teach about infant care and feeding in school, that children and youth need to be exposed to babies in person and thereby be exposed to more of babies’ behaviours and our practices around them.

When asked if she had sought support as a student with a newborn, Helen said she had not overtly sought help but breastfeeding was normalized within her community in Toronto. One of her challenges was pressure from her close Canadian relatives to formula feed her baby, which she viewed as a cross cultural difference – to her breast milk was the normal food for her baby and she saw formula as an intervention that her baby did not need. It was difficult for her to even conceive of feeding her baby formula in the situation.

In her words:

I remember when my Canadian mom came, she was visiting with me and she’s like “Why are you up all night? You’re feeding, you’re going to be tired.” Like, “Get some rest. You can give baby some formula and get some rest.” And to me, I’m like “Oh no, I’ll just feed baby”, it’s like (putting her hands up as if giving up). Yeah, but, I don’t know, it’s just something I guess.

The other participants did not relate to this experience and have most likely not had anything like this happen to them in terms of facing pressure from a family member to



formula feed. They went on to discuss the difference in attitude towards night feeding between their home cultures and what they see here:

Adina: Back home, they will get up in the middle of the night, they will feed the baby. Like any other baby, Canadian, any other baby.

Helen: Yeah.

Adina: But they never complain.

Helen: No

Adina: It's almost like your duty, you did it, you feed the baby. But here, when they, even if they woke up twice, even me, I start complaining with my second baby.

Helen: Yeah, yeah! I mean, I'm sure she was feeling sorry for me.

When she come to visit she was like "oh my God, you have a paper due and you're giving that feeding. Give formula, you know, she will sleep for a couple of hours." I'm like "but I can't do that" and like, two heads, like she couldn't understand why. I guess, she just knew that I am stubborn.

Roberta: Most of the people here believe "I have to get up in the morning so I cannot stay awake during the night. I have to work, I have to drop the other kids." You know, "I have something to do in the mornings, so instead of me wake up, give him formula. I have to take the baby even to daycare, instead of me going back and forth traveling and breastfeed, or pump", that will take time so, busyness is not going to help too here.

In Roberta's view, the hectic schedule of "everyday life" contributes to the challenges of breastfeeding a baby beyond the early weeks, especially while working or studying.

From talk about the busyness of life in contemporary Nova Scotia emerges a kind of nostalgia about the rest period, a practice common in majority world cultures where a mother with a new baby is cared for by relatives, neighbours and friends. For a few weeks, the mother's only responsibilities are the direct care of her newborn, including breastfeeding. All of the participants seemed happy, laughing and smiling, when sharing about the rest period:

Helen: I never had a baby at home. But back home, what I saw growing up, when you have a baby you get rest, you don't do anything.

Everyone talking at once, excited by the topic, agreeing.

Helen: Your job is to breastfeed baby ...

Roberta: Breastfeed, wash his clothes ...

Helen: Wash his clothes... Yeah, everybody's there to help you.

The other participants asked Mona if there was a similar practice in her home country and she talked about the support other women gave each other those first few weeks after birth. In her experience:

Even you have some people they don't have a family, they live far away, they say "oh that lady, she just have a baby, let's go there in turn. One lady then the other lady. Even they told her, she just have a baby, she needs help ...

Adina: It's not like, you know, "let's help each other", they just go do it. As if you know, we have to do it, this woman, she have a baby, she have to rest.

Roberta's experience and observations as a refugee away from her home country align with Mona's and she linked early, intensive support to getting breastfeeding off to a good start. Ideally, the new mother rests and feeds her baby freely while being provided food and drinks meant to help her heal and establish her milk supply.

While participants spoke about food and drinks that help increase milk production, it was the routine offering of iced drinks following births that for them exemplified the disregard for other cultural beliefs and practices within the institutional setting. They agreed unanimously that some health care practices they observed were detrimental, according to their beliefs and practices, to establishing breastfeeding. When asked if they ever suggested to anyone that mothers be offered warm drinks all participants agreed that they did not believe they would be listened to or taken seriously:

Adina: I say: "Why are they giving them cold ice?" But the Chinese, like other people, they don't drink ice water. They will tell you "no, no," they didn't pick it up right away. But Canadian women, right away they drink. Because they don't know, and I can't explain: "because in my culture you don't do that." You keep quiet.

Helen: No.

Researcher: Are people receptive, do you find, at work if you bring things like that up?

Adina: I would be scared I don't wanna get...

Helen: No, I don't bring it up.

Shifting the conversation, Mona mentioned how she recently came across a study supporting the use of fenugreek as a galactagogue, an herb used in her culture to help mothers recover from childbirth. Although she knew its use was linked to post-birth healing, she had not known about the breastfeeding connection, which participants took as evidence that even if a practice is not scientifically proven to be beneficial, the benefits are proven through centuries of successful use in their own cultures.

Despite participants' traditional and expert knowledge, they felt they do not have the spaces or opportunities to share it. Roberta shared her thoughts about the level of expertise currently needed to provide post-natal support to breastfeeding mothers:

Roberta: It's like, one reason I can't just walk in the room and say "oh lady, don't drink it cold, drink a hot soup or hot things, it's because she, or the people, believe in science, or identity. If I say "oh, this is my ID, I'm from breastfeeding community," or if I say "I'm just a CCA, you don't drink that because I know better"? She will say "Who the hell are you?"

Helen: (Laughing)

Adina: There you go (nodding)

Roberta: "CCA? You are just a CCA," (fake laughing) "who gave you this knowledge?" But if I come and just say "oh, I'm ..." just say, "oh, long name ..." (pointing to her held up palm as if she were reading it off of an id card)

"...breastfeeding community dash dash and I have to, I want you to right now stop drinking cold and drink" even if I give something "warm water, here, warm water." She will drink because the people believe in science ..." (yeahs, nods and mmm hmms from others.) And the science is proving now, our way, we were right.

Instances in the workplace like these, where participants' voices are muted and the expression of beliefs and opinions is not being encouraged and valued are concrete examples of low-grade, constant acts of oppression against women who are labeled with

attributed characteristics like their immigration status, racialized categorization, gender, class and formal educational attainment.

While participants talked about their cultural practices, they were also curious about practices in Canada. Roberta asked when breastfeeding was a cultural norm here, which led into a discussion about wet nursing and how the practice related to class differentials. From there, Adina, began to question again why many low-income mothers formula feed when breastfeeding is an obvious benefit to them economically. The participants were happy with the experience at the end of the session and Roberta commented on how rare it is for her and her friends to be asked to talk about their own experiences:

Roberta: You know, you come and say “oh, tell me about having children.” ...Like breastfeeding. I have lots to talk about breastfeeding and benefit and how easy, that’s why we’re so excited to talk about it. And especially when it becomes like the third world, people think like a stereotype about the third world - people do certain things that which stupidity – it’s not true. Yeah, that’s why we’re so excited to talk about – “that’s not true”, like, that’s false. People are spreading every negative things. Every topic, the negative part...

Adina: From Africa.

Roberta: From the third world, from Africa, Africa.

As Nova Scotians, we are familiar with the geographical racism experienced by African Nova Scotians and the Mi’kmaq people historically and in the present. These women experience the same phenomenon but in a different context and see the focus group session as a way to give voice to their experience of being mothers who are immigrants, along with all of the associated stereotypes and misconceptions.

Helen was open about how she feels as a woman from Africa in Nova Scotian society:

B: Yeah, I think, you know, a lot of people, one, they generalize things, and two, they really look down on Africa, they are very

ethnocentric, where it's like, my culture is the best, what do you know? But really, if everybody can bring what's good in every culture, the best we could, (agreement from the others) instead of saying "mine is better than yours. Because there's good in every one. And I think that's the problem.

Her comment hit to the core of the problem we have as Nova Scotians in terms of our capacity and desire to welcome people who come here as immigrants into our communities. The work toward an intercultural environment/community involves listening to others and valuing their experiences and points of view as legitimate. Interculturalism is a give and take, with an open lines of communication between all members of our community. When members of our community feel they are being shut out by members of the dominant social group it indicates that work must be done collaboratively to open lines of communication through which all voices can be heard.

The participants were reluctant to leave and even after starting to wrap up, they went on to talk about one last topic - co-sleeping. In their view, it is a normal and beneficial practice but in their former workplace, they felt trapped in a classic scenario of people versus policy. They were not allowed to advise mothers on co-sleeping because it is a practice that the Canadian Paediatric Society (CPS) advises strongly against. Despite this, participants talked about how in their view it was the preferred sleeping arrangement:

Adina: The same thing back home – you have a baby, baby sleep with you.

Helen: Yes.

Adina: Co-bedding. Now they are starting.

Helen: Now they are starting, you know why. It's improve breastfeeding.

Adina: Yeah, it improves breastfeeding...

To the participants, technology (like baby monitors) and caregiving were not congruent, nor was the separation of parents and babies at night:

Roberta: You know, I can sleep, I don't know how people do, I can't sleep tranquility "okay I'm sleeping", put back baby and the baby's over there and there's a machine beside me and I'm going to miss something if the baby wakes up.

Participants were well-aware of factors that increase the risk of co-sleeping and were also well-aware of the benefits, citing better quality sleep, improved breastfeeding outcomes and improved bonding. A salient point that came out of the discussion of co-sleeping is that the policies do not reflect social practice.

All of the Focus Group A participants reporting seeing shifts in breastfeeding practice in Nova Scotia in the time they have made the province their home. Adina summed it up at the end of the discussion:

Adina: It's coming. I feel like, you know, so many of the things we do back home, it's here, coming soon to Canada (laughs). It is, honest to goodness, so many things you see back home you see here now. So, it's good, you know, like Helen say, take the good one.

Helen: Yeah.

Adina: I'm not saying Africa is the best place, you know...

Helen: No.

Adina: But, so many things they do, it works.

#### **4.2 "Damned if you do, damned if you don't": A descriptive summary of Focus Group B**

All of the participants in Focus Group B were born in Canada – three in Halifax and one outside of the province, having moved to Nova Scotia a few years ago. Two of the participants were related and one of those participants had gone to high school with another. Despite the fact that some of the participants knew each other and others did not, the conversation flowed well and was fruitful. Participants related to each other as they shared experiences and empathized when experiences that were not shared came up in the conversation.

Three participants in Group B had two or more children at the time of the study and one had one child. Kelsey was a single mom of one who breastfed for two months with very limited informal and family support. She was on maternity leave at the time of the focus group but planned to return to work soon afterwards. Johanna had two children and was breastfeeding her younger son at the time of the session. Her older son was adopted as a toddler around the same time that her biological son was born and had been fed formula during his infancy. Johanna was on maternity leave at the time of the session and planned to return to work a few months early - her husband took on the role of stay-at-home dad when both of their sons came into their lives. Elise had two pre-school-aged children, both of whom were breastfed for an extended period. At the time the focus group took place she was the primary caregiver for extended periods while her husband worked out of province. Kathryn, a busy mom of three was working part time at her home business and part time outside of the home. She had breastfed all of her children for a few months and was supportive of breastfeeding while being sensitive to the experiences and feelings of mothers who formula-fed.

At the outset of the discussion, Elise was very open about the lack of support she received from her family, friends and those around her. In addition, she talked about how she had never seen anyone breastfeed before she had her own children:

Right, so I think I must have not noticed people with a blanket or whatever over them but I had never seen...either breastfeed or pump, but I don't think it was happening around me, I would have noticed. I don't know. Now that I have kids and go to mommy's groups and things, it's like this underground world. People with kids, I'm like, it must have been happening before.

In her commitment to breastfeed her children, Elise overcame the dual obstacles of limited exposure and limited support to go on to breastfeed for a duration beyond her

intention. Her disclosure spurs a conversation about breastfeeding in public with participants discussing practices as they relate to the where, when and how of it.

Like many mothers, Kathryn's use of cover-ups changed through the time she breastfed her children. She told the group that as she became more comfortable with breastfeeding, she used the cover less:

I find myself, I used to cover up with my first and I think it was more because you're trying to get more in that zone where you're comfortable and you're getting them (the baby) in the right position, not trying to expose yourself too much, you know, you're trying to do a lot of juggling so that you can get comfortable and get the baby comfortable and when I had my second and third I was far less likely to be concerned about covering up in front of people and I felt at that point, half the people I was spending most of my time with, my friends, my family, they were comfortable seeing me feeding the children knowing that was what I had chosen to do so they weren't uncomfortable so I was a lot more comfortable with it. And then because of that, I really didn't think too much about just feeding openly in public, like I felt fine about it because I thought "these people don't really know me" if they're, you know, I don't want to do anything that's offensive to other people, but I thought feeding your child isn't offensive, and people don't want to see it they can just look the other way.

Kathryn recounted that her behaviour was influenced by who she was with and where she was, similar to other participants in the focus group. Johanna talked about the advantages of being among a group of friends who had all had children around the same time. She and her partner were not among the first in their peer and sibling groups to have children so they had been exposed to breastfeeding leading up to the births of their babies.

In addition to seeing friends breastfeed at gatherings in people's homes, infant feeding is a popular topic on social media platforms and forums. While Johanna noticed more people around her feeding their babies, she also commented on the increase in the number of discussions on infant feeding she observed on social media:

It's funny, I didn't notice one way or the other probably before I had kids. Most of the people I know in my circles, breastfeed, right?



So if they're at the house, at my house or I'm at their house it would be typical to see them breastfeeding openly but when I had (my first baby) I started seeing all these things about, like, I'd see things on my Facebook page, "luckily I don't have to feed my baby in a bathroom stall." Because, like, in the UK, they're feeding their babies in bathroom stalls because it's not openly accepted. Or maybe it is now but the generation that was telling the story wasn't openly accepted. And then I guess, I just pay more attention to mom blogs or mom issues.

Participants were sensitive to the judgments and pressures mothers feel around the "decisions" they make around infant feeding, and parenting in general. Kathryn pointed out how presumptuous it is to judge mothers about bottle-feeding when it is assumed that the contents of the bottle is formula rather than breast milk given the number of breastfeeding mothers who occasionally pump and bottle-feed breast milk to their babies.

Kathryn also pointed out that one of the pressures that mothers feel is competition, which is thought of among participants as unnecessary and a significant factor in the stress that mothers feel. In Kathryn's opinion:

It's almost like nowadays everything can be turned into some kind of competition. Like, who's doing the best, who has the most on their plate, you know, now that people are really choosing to go the natural route with a lot of things, whether it's actually breastmilk versus formula, just specific foods that you're supposed to feed your children, now natural seems to be the way that people are going. So I've definitely been in situations where people are being judged or being spoken about. For you, know, doing formula instead of nursing.

One simple way mothers can be shown more sensitivity, whether they are breastfeeding or formula feeding, is by providing comfortable locations for mother and baby to feed.

When Kelsey joined the group, she was very open about her use of formula when breastfeeding did not work out for her and her daughter. She was very enthusiastic about a new mother-baby lounge in a local mall:

I'm all for whatever. I feel like society is more open now to breastfeeding. There's that Micmac room, I like that room. Yeah. Pretty cool, like a couple of years ago I never saw that.

Johanna, who is very open and proactive about breastfeeding in public as a way to normalize the practice, talked about her experience using the mother-baby room and what made her decide to try it:

The reason I went there was we uh, I felt like sometimes at the mall if your kid erupts you know you don't expect it, you're like "oh, I thought he had lots of energy in the tank" but it's a nice quiet place to go sit in the chairs those lazy boy chairs and feed him independently.

It seems like more facilities like the one in a local shopping mall in different public places could help mothers establish and maintain breastfeeding while being allowed the freedom to be in public places without feeling uncomfortable when feeding time comes around.

To further the reasoning behind the need for mother and baby rooms, Elise expands on the ways she feels mothers are judged and not supported by those around them:

I feel that moms feel judged on both side of the fence. I know that when I was talking about this with the parents at X program, and this certainly happened with the parents I knew out west, there was a lot of pressure to breastfeed and I know with her ... I was so stressed out about breastfeeding from the information that I got from the hospital. So I think that I do have friends that when they have to do that or they decide to bottle feed they feel like failures because they just had this, I think it's because of education, I'm not sure. So I feel like I had friends who bottle fed and didn't have a lot of support for bottle feeding and I breastfed and didn't have a lot of support for that so I'm not sure how you win. I guess there are some other people that are supported with their choice, I don't know a lot of them actually.

Effective support is such a critical element of successful breastfeeding and it is something Elise did not have a lot of to help her get through the challenges she faced, which she talks about later on in the session.

Kelsey had many factors contributing to her challenges establishing breastfeeding with her daughter and she shared her experience in the hospital following her birth:

The hospital was really really tough for me, she didn't latch, the first three weeks were really really tough, um, I guess I've had quite a bit of support, like a lactation coach, someone who tried to help me to get her to latch, then finally she just wouldn't eat I took her home and I still couldn't breastfeed, like she was not latching, and she was my help as well, and so I kind of just gave up at two months. Well, I gave it a good shot.

Kathryn empathized with Kelsey, sharing in the experience of having these challenges in the early months. Kelsey went into detail about her arduous attempt at breastfeeding and establishing a milk supply following a traumatic birth experience:

Kelsey: I was pumping, massaging, I was taking pills, pills fenugreek? And then, I felt caged in my house, pumping, it could out or the milk would go sour, and I bought certain bags and I found they went sour in the fridge! And I was like, "all this pumping" and it was sour and just, yeah...

Kathryn: it makes you not enjoy those first couple months that you have, when you're...

Most people who work supporting mothers are doing so for this very reason – so that mothers can relax into trusting their intuitions, find what works best for them and their families and enjoy the newborn period instead of being stressed out, overwhelmed and afraid.

Like the supports Roberta talked about in Focus Group A, Kelsey took advantage of every one she could find, ending up with supports that helped enable her to feed her daughter breast milk for two months. She consulted with a lactation consultant at the hospital, had a volunteer from a peer-to-peer support program, and joined a breastfeeding group at a local kids' store. She surrounded herself with as much support she could and gave it her everything for the benefit of her little one.

Johanna brought up the narratives used by mothers to explain their infant feeding experiences, especially if they use formula for any reason despite their intentions and efforts. In the words of participants:

Johanna: She was quite outspoken about why she didn't, about why and I don't think she was dismayed at all about it, but she...  
Elisa: Felt like she needed to explain herself?  
Johanna: Yeah! Yeah, yeah.  
Kelsey: I do too.  
Johanna: I think she really went out of her way to tell people that "I tried this..."  
Kelsey: Me too  
Johanna: "...and this happened."  
Kelsey: I think so, a lot of the strangers I meet I tell them, same thing I guess you're right.

Their experiences are similar to those described by participants interviewed by Ryan (2010), who found that the mothers who participated in their research often formed narratives if they engaged in practices not supported by public health institutions. It is as Elisa succinctly put it early on in the session: "you're damned if you do, damned if you don't".

Like most discussions of public feeding, participants talked about how their decision-making processes were framed in terms of their surroundings - where they were, who was there, and what activities were going on. Johanna also pointed to a generational gap when it comes to attitudes towards and perceptions of breastfeeding that she felt influences her practices:

Johanna: Yeah. I think that, maybe it's just my family and who I'm surrounded with, I felt like I was amazingly supported. And the only time I really feel awkward is, I went out for a dinner with my husband's entire extended family, like eight or nine aunts and uncle groups, there were about thirty of us, and I had to feed at the restaurant and I'm like "I'm not going to the bathroom to feed my baby". But then it was like all my husband's aunts and uncles, right? So, when it's yourself, when it's me and just a few people, I don't feel bad, or if it's people that don't know you, I don't feel bad but it was really awkward in this other

generation of people that didn't breastfeed in public, right?

Elise: Mm hmm

Johanna: But my mother-in-law supports me and my husband supports me so I don't??. But I could kind of feel everyone in our private dining room was like (pauses) "is she gonna whip that out right here in front of us?"

Kelsey: laughs

Johanna: And I didn't, I covered up, I used a swaddle blanket, but that's the only time I've ever felt awkward about it. Yeah.

Luckily for Johanna she had a strong support network, including close family members and her friend group, which contributed to her self-efficacy and confidence around breastfeeding.

Breastfeeding in restaurants is a contentious issue, as evidenced by Spurles and Babineau's (2011) research with young people in New Brunswick. Kathryn worked part time in a restaurant and shared some of her observations with the group:

Well, I work in a restaurant and it happens not super-regularly but definitely there are times when women will just full on not cover up and are feeding very openly and you can see the stares coming from other people. Like it's, people are definitely like (makes a funny face of someone giving a funny look). I don't know if it's because maybe, if you're in a restaurant and other people are eating that some people aren't comfortable with it. But I find for the most part the women that do come in are, they're comfortable with it, like I see more people that will come in and just openly feed than women than will come in and cover up.

Johanna's perspective sheds some light on what some mothers may be think about breastfeeding in public, especially interesting is her view of others as "periphery people", a strategy that may be useful for other breastfeeding mothers:

We went for a date, just (husband) and I, and I kept him [baby] under a swaddle blanket and had him on the breast almost the entire night and I didn't feel any way about it because I don't know anyone else in the restaurant. It's just when you, I think sometimes you know, they're periphery people, that you don't have an opinion about something?

Johanna's practice of making others into "periphery people" may relate to Kathryn's observations. By placing unknown others on the periphery, Johanna can take them out of the equation, making her decision-making process around feeding her baby in a public place simpler.

Anxiety and doubt are common feelings among all mothers. Elise talked about her experience as a mother who did not receive informal support from family and friends, making her anxious and doubtful about her capacity to feed her babies:

Elise: My main issue wasn't strangers' judgment, it was family and friends. Which is, that can affect you more. That was, I remember when I first had both of my kids, especially with her, I don't use the cover a lot, a lot of times it's just a sweater or something with him, but with her, I was like (covers chest with hands and forearms) so nervous. But I'd have her on me as an infant just so we could play cards in the evening, she'd be under the blanket on me the whole time and it was like, "oh my gosh".

Kelsey felt, like Elise, that she had very limited support from family, whereas Johanna felt she had a good support network, which most likely contributed to her high degree of breastfeeding self-efficacy and confidence. Both her mother and her mother-in-law breastfed and she cited her pre-natal classes as having an impact on her decision to breastfeed as well. Despite the support and information she received beforehand, she felt she was not totally prepared for what breastfeeding actually entails:

"...basically they said: "You are going to have this child attached to you twenty-four hours a day in the first month or two." But I didn't really understand what that meant until you (Kathryn). Kathryn was like, "Jesus, can I have a shower by myself please?""

It is easy to see why so many mothers do not meet their breastfeeding goals considering the challenges that even women as empowered and privileged as Johanna face.

Just as some participants felt they did not have adequate support for breastfeeding from the people close to them, some felt that something that was supposed to be “natural” did not feel that way for them at all. According to Kelsey and Kathryn:

Kelsey: I had to work at it, so nothing came natural to me.

Kathryn: Yeah, I was the same way.

Kelsey: This still isn't natural. (laughs)

Although it does not feel natural to a lot of women, many women's perceptions of breastfeeding change once they become mothers, and sometimes even once they become pregnant.

Elise went into detail about how her feelings towards breastfeeding shifted once she became pregnant and how the lack of support she had from her friends and family affected her experience. In her words:

I couldn't believe how hard it was actually, yeah. But again, I saw my sister breastfeed once before I had my kids and I had never seen anyone else breastfeed in public until my mid-20s, so good thing I didn't have my kids young. I was like “oh, I'll never breastfeed, I'll definitely bottle feed cause that's gross” (with disgusted look on face) and I would've been one of those judgmental people so ... the only thing I ever heard was “yeah, that's pretty weird” so I just thought it was too until I started, got pregnant and got some information. Yeah, but they still didn't tell me how hard it was going to be.

Shifting views is not uncommon once one becomes a parent. There are always things people say they will never do as parents when they are not parents, however upon becoming a parent, things often change. Kathryn was resolved not to use formula with her first baby, however circumstances changed for her through the first few months:

I know when I was pregnant with my oldest daughter, I thought, in my head, “I am definitely going to try to breastfeed her, 100%, but if it doesn't work, then it doesn't work. Either way, a child has to be fed and if it's going to be breastmilk or a kind of formula, it's going to be fine but then after I had her, and I was in the hospital, and I really struggled with her at first, probably for, maybe not that long but in my mind it was a very, very long time. But probably the first ten days were very, very

challenging and I felt so discouraged, defeated, that I couldn't do this thing that I was supposed to be able to do. And like, "ok, I'm a mother, I'm supposed to be able to feed her, why can I not do this? What's wrong with me?" So I felt really discouraged at first and then I had a lactation consultant, spoke with La Leche League, and all those sorts of things, trying so many different things and I still, "ok I cannot do this". I really didn't expect those feelings because when I was pregnant I just thought, "ok, if I can breastfeed her, great, if I can't, it's totally fine" and then when I couldn't do it, my opinion completely changed, I don't know why. And it was just a personal opinion, that I had for myself, again, that journey is different for every single person, no doubt about it, but that was my experience in the beginning.

Both Elise and Kathryn's views of infant feeding changed once they experienced the reality of feeding their babies. Both accessed a range of support services but Elise did not have the support of her family, friends and those close to her, whereas Kathryn did. Both exhibited self-efficacy and tenacity, allowing them to breastfeed their infants through a range of challenges.

Kelsey observed that many of the mothers she interacted with seemed to be having more challenges than they had experienced since she first met them. Kathryn suggested this may be because more people they know are talking about feeding babies because they are getting to that stage in their lives:

Or maybe it's even just like an age thing too. Like I know a lot of my friends now are just starting their families so I'm starting to see, like you (Johanna) said, a lot more online posts about it and things like that. Whereas when my husband and I started our family, we were really the only people within our group of friends, like our age group, that had children so I didn't really have anybody to talk about my experiences with that I knew close to me.

In Kathryn's experience, she was the first among her sisters to have children and breastfeed even though she was the youngest. When she had problems at the beginning and had exhausted all other options, she gave herself a short term goal of breastfeeding for another twenty-four hours. It was long enough to turn things around for her and her



baby and contributed to her own feelings of success as a mother. It also gave her sisters an example to look to when they went through similar challenges later on:

I have two older sisters and they both had children after me and they both struggled a lot. I think just having somebody that you've seen have the struggles too and then get to that turning point, for them looking at me it was like, "ok, if I can just get to this point, maybe it will work out." You know? But when you don't have a support, like another friend that's been able to, you know, give you a little bit of encouragement along the way it's really challenging. I know with my oldest, I had spoken to, I was on the brink, like I was, it was that day, I was either going to persevere and keep going or like, that was it. And I got on the phone with a woman, a lactation consultant, and she said, she said to me "Just don't give up, just make it till tomorrow" and for me, that was the encouragement because it was that day that finally it started to come together. You know? And I mean, if it had of been another couple of days, I wouldn't have kept on going because I was at that breaking point for myself where, as a new mother you're not sleeping, and everything is brand new it was just, I was getting to that point where I felt it was too much, like it was too much, so. Yeah, it was a good thing I had spoken to that person on that day because otherwise I wouldn't have had, I don't think, the ability to push through at that point.

Having someone there to give her that extra push, that extra bit of confidence helped in part to get her over a bumpy beginning. Kathryn's story also shows how mothers themselves are contributing to the normalization of breastfeeding and culture shift within their communities.

Some of the participants linked the lack of exposure and knowledge of different methods of infant feeding to the fact that women in Nova Scotia no longer have access to traditional women's knowledge, knowledge that centres around our reproductive lifecycles. In a previous professional role, Johanna travelled extensively and worked closely with colleagues in other countries. She noted her observations of some of the differences between the topics of conversation among her international colleagues and those of Canadian-born women:

I think there's something in our culture right now, women don't really talk about traditional women things anymore. I feel like when I'm in another country, like Turkey or Nigeria, people talk to me all the time about child birth, child death, they talk about breastfeeding, they talk about people losing pregnancies, they talk about all kinds of things and they're very open with their emotion about it (agreement from others). And I feel like here, we talk about the weather, and we talk about, I don't know, gossipy things, or you know, what politicians are doing but we don't say like, real issues ... it seems like everybody wants to sugar-coat every situation.

Participants voiced beliefs that women of our grandmothers' generation would have held such knowledge and would have shared it with each other. Things have changed since our grandmothers' time, and participants had some interesting ideas on the how and why:

Johanna: I don't know whether it's good or bad but I feel like, you know, probably our grandmothers' generation spent a lot more time with women growing up so they talked about it in terms of if they knew about women's things, whereas it's very...

Kelsey: For sure, society was very different back then, there's no TV, there's no nothing, like...

Johanna: If you're not distracted you're in tune with the people around you. People probably had, you probably just knew it because you were around it all the time, whereas now we move out of our parents' house young and we spend time with, you know, all genders and all?? So I feel like it's not something that we see all the time. By the time I was six, right?, my mom would've stopped having babies and breastfeeding whereas in other cultures, my mom probably would've had three more children so I would've grown up, as the oldest, I would've seen more about child rearing, right?

Indeed, Kathryn was older when her mother had a new baby and she remembered aspects of childcare, including breastfeeding:

Yeah, I can relate to that because I was almost nine when my little sister was born so I definitely remember mom breastfeeding her and taking her out in public and feeding her and, you know, that was something that, to me, something that was always a normal thing. Because I do remember seeing my own mother in that role.

Although normalization happens primarily through exposure to a practice in everyday life, educational initiatives can help increase the impact of everyday exposure by adding

additional information that the observer can use to better understand the context of infant feeding.

All participants agreed that including tools and activities that familiarize children with aspects of infant feeding in the school curriculum is a good idea. Kathryn and Elise both felt that initiatives like that could help reduce negative judgments towards mothers:

Kathryn: I think it's important to see that early and it also gives, I think people, children as they're getting older, you know it shows them, like you said (signaling to the researcher) the advantages of both, you know, so you don't get to the point that you're being judged for either decision so the benefits of both. And maybe the struggles that come along with both as well, so I think that would definitely wise.

Elise: I think it'd be great to have it in schools, even just to touch on it so that I think it's not only helping women when they go to have kids. I think that one of the most judgmental crowds is the one that don't have kids. Right? (Others signal agreement) They might just treat a new mother differently just because of having that little bit of information on the small section in sex ed or whatever.

Along with seeing breastfeeding from an early age, it is important that adults are exposed to the practice as well. In that way, Johanna is definitely a “breastfeeding normalizer” – someone who gets out into different environments and breastfeeds with confidence, sharing her experiences and confidence with other mothers she comes in contact with and educating non-mothers about babies and feeding them. At this point in our conversation, she talked about how she approached breastfeeding at a work meeting:

I took (baby) to work last week for a meeting and two of the people in the meeting don't have kids and I breastfed him at the meeting because he needed to eat. I warned everyone, I said “Just so you know, I'm coming into this meeting but I'm bringing ...”, like I said it out front, like “Charlie's coming with me, he has to eat, he's gonna eat”. So, they were forewarned and they still wanted me there, so ...

Because of her insistence on bringing her infant to meetings, more people in her workplace have now been exposed to one of the ways work and breastfeeding can be incorporated.

When asked about infant feeding norms in Nova Scotia, Kathryn brought up the fact that many women went into motherhood with the intention to breastfeed exclusively for six months. Elise talked about how she has heard a narrative from a number of mothers she has met in Nova Scotia entailing self-weaning by babies at relatively young ages. We know that some mothers who are not able to breastfeed develop narratives to explain why they are not breastfeeding. Could it be that there is a regional tendency to shift the act of initiating weaning to the baby? Could it seem more prevalent to Elise because the percentage of mothers who wean or introduce formula before the six-month mark is higher in Nova Scotia than the region she recently moved from?

Kathryn countered Elise's observation by delving deeper into her own experience of weaning early:

My experience was, like you said (Johanna), that life just kept on going and I found I breastfed the longest with my oldest and then it was a lesser period and an even lesser period with my third because just not being able to already take care of two other children. Right? Then having a newborn baby just didn't allow for me to take the best care of myself ... that would allow me to continue breastfeeding maybe as long as I would have liked to. V was my third, I breastfed her for about four months because I just didn't have enough milk to keep her going. It wasn't going to sustain her for long so at that point we switched her to formula and I was completely fine with it at that point because I knew that ... it's better for her. She needs to eat and then also with giving her formula she would sleep through the night and I thought "Ok, I can be a better person because I can give more during the day. That you know, if I'm well-rested. So at that point I felt that was the best way for us to go.

Kathryn is lucky that her daughter slept longer when she was switched to formula.

Although many people believe that feeding an infant formula will help them sleep longer, Kelsey and Elise did not find it worked for their children.

Sleep was an important topic for participants of Focus Group A as it was for Focus Group B. The conversation quickly moved to co-sleeping, with Kelsey noting that she and her daughter co-sleep because “I’ll do anything just to get a couple hours sleep.” It turned out that most participants in Focus Group B found co-sleeping made things easier for them at night time and some found it easier for continuing with breastfeeding:

Elise: If I didn’t co sleep with my kids, and again I didn’t even know it wasn’t safe, but on the third night of having no sleep having her home I thought maybe I’ll sleep with her breastfeeding and then I woke up like three hours later, it was the longest sleep I had in three days and I was like, “we’re doing this” ... It’s great. And I don’t think I would be able to breastfeed my kids as long as I did if I didn’t co-sleep because I just, for me I can’t get up that much. I would have had to to formula feed Johanna: I am co sleeping right now with (baby boy) and it makes it so much easier. Because, like, with (baby girl), I’d get up, I’d go to another room, I’d sit in a rocking chair and like, I wouldn’t be at my best alertness to be with her. Do you know what I mean? ... When (husband) went to China, to collect our other son, I just let her sleep with me, I thought, “This is awesome!”

Kathryn: Yep. Oh yeah, I did the same thing with (eldest daughter) because again, like you just said (Kelsey), I would’ve anything just to get a few hours of sleep.

Although it is somewhat of an underground practice, more parents are starting to talk about how co-sleeping makes life easier for them.

Pumping has become a normalized part of feeding and many mothers are given pumps at baby showers. In the early months, pumped milk is generally given if a baby has a problem suckling directly from the mother or if someone other than the mother feeds them. In terms of the difficulty of pumping, when asked if she felt pumping was harder than formula feeding, Kelsey responded:

Pumping was too much. Yeah, way too much. So how would I pump, she would have a nap so I would have that, maybe 15 minutes. What do you do? Shower or do I eat or do I pump? I lost at least 20 lbs when I was pumping.

Johanna described her own brief pumping experience:

I only pumped for 3 hours, I had to give him milk but he was in the NICU overnight ... and I just did it for one evening because by the next morning my milk had come in but it was painful, and high stress and I just, like someone asked me, you know, will you pump when you go back to work and I thought “I don’t know”, maybe, but it wasn’t comfortable, I didn’t like it at all.

Elise’s challenges with pumping included finding the time to do it and feeling pressure from her family to let them bottle feed her baby: “Not gonna work! I wanted to, I had a great pump so that I could get some freedom.” Elise found that if she pumped after feedings, she could not produce a sufficient quantity and if she waited, her babies would want to be fed again by the time she was ready to pump. Timing is a big challenge when trying to pump while breastfeeding exclusively. Johanna, who preferred not to pump, echoes the sentiments of Focus Group A participants in her enjoyment of breastfeeding and has found that “... when it’s working properly, it’s peaceful,” a feeling she contrasted with the stress she associated with pumping.

In addition to the stress of pumping, two participants in particular talked about experiencing pain during breastfeeding in the first few weeks. Participants felt they were not told or “warned” about the pain sometimes experienced when breastfeeding, especially at the beginning. As with Elise, many mothers find the expectation of pain during feeding causes them to feel reluctant to feed when baby shows signs of hunger, especially if feedings seem very closely-spaced, which is common in the early months:

It’s very stressful too when you’re trying to, like for her (her daughter) in the first, I’d say ten days, when I was so sore, she was colicky so she cried all the time. But I know my husband and my mother in law were like, “you need to

feed her again, she's crying" and I'd be like "What time is it? No, I just fed her, I'm not feeding her again." And I told myself to, I made a deal, I said to my husband, "three more days of this" and (husband) was like "one, not two, just one more day of this, that's it." And that was, I don't know what happened that within those twenty-four hours but it stopped being so painful. But that was, yeah, you're supposed to be, it's not supposed to be stressful.

Sometimes when mothers are told about the pain that comes from issues like poor latch, engorgement or even infections, the information they receive is not necessary useful or practical and can sometimes cause more damage. Kathryn received troubling advice from a friend of her mother's, who is a retired nurse:

Kathryn: Nothing could have prepared me for the pain of my first experience.

Elise: Yeah, holy

Kathryn: absolutely nothing. And I remember, one of my mom's best friends is a nurse and she was telling me one day, I was pregnant and she was like, "you've got to do..." try and do all these things to toughen up your breasts and she said, you know "take a wash cloth, a wet cloth and rub it"

Kelsey: (laughing) that's funny!

Kathryn: She said "because there's going to be all this friction and pain", you know, she said "These are things that you can do" ... and I'm like "Oh it can't be that bad (hugging her chest), can it? And I was the same way (referring to Elise again), there was nothing that could have prepared me for how much pain I would feel in the first little bit. I mean, oh my god, it was ... Yeah.

Both participants had points during the first few weeks where they were ready to stop breastfeeding but gave themselves timelines to keep trying. Both ended up passing those deadlines and continuing to breastfeed longer, which speaks to the usefulness of setting short-term goals for mothers who are facing challenges with breastfeeding.

Support is not just important once mothers are home, the support mothers receive at the hospital in the hours and days after the birth can have a significant impact.

Participants had mixed experiences with hospital staff following their births, with one participant coming out feeling like she and the nurse assigned to her "didn't click" and

that she received conflicting information about establishing breastfeeding. Participants with more than one child felt that their experiences at each birth varied:

Kathryn: I had different experiences with the nurses that I had as well and with my second child - he was also three and a half weeks early - and the nurse that I had with him, she was very aggressive with me when I was trying to get him to feed and I felt very uncomfortable. If that had been my first exposure I probably would have had a very different opinion of what I was capable of doing, you know, cause I kind of wanted to just, I had said, "Look, you know I did nurse my other, you know, my older child and I just wanted to take a minute to get comfortable" and she was forcing him, "You've got to do it like this, get him on like this" and I felt like if that had been my first child I would have said, like "No, no, no." Right? So I felt more, at least I had another experience with a nurse that was, I was comfortable with and she really encouraged me and was very soft with me.

Although both of Elise's children were born outside of the province, she could relate to

Kathryn's experience:

I had very different experiences too. I don't know if it's because I told them I had already breastfed one child but I had so much support with her and so much, to the point where I felt they were kind of insisting that I breastfeed and I wanted to so it was helpful but I was really scared not to, but, you know I did struggle so I did have support ... And then with him, it wasn't as bad but it was still painful. Nobody asked me at all about that, there was nothing there about "oh you ???" because I had a baby, I had already breastfed so it's a good thing that I wasn't really struggling very much with him because ... Yeah. I guess it's really just who you get, right? Cause I had the same hospital, but totally different experiences.

Johanna also commented on the difference in how she was treated by different staff members and determined that her experience was a case of people versus policy, where there is such a strong focus on hospital policy around breastfeeding that the people sometimes get lost in the shuffle. She told about her own experience in the hospital with caregivers who had very different approaches:

Honestly, I'm sure everyone's trying their best, it's stressful for the nursing team, I feel like there's a wide variance in the care that we received. Some people are so gentle and nurturing and helpful to the



point that your turn gets to be I guess a very positive one and I felt other people were just to the point of aggression (others agreeing) ... I'm sure they all have the same qualifications and the same training and the same standards they follow but very different ... policy versus people, you know what I mean?

Elise suggested this type of treatment of mothers may be a result of the hospitals operating within a quota system in terms of meeting targets for breastfeeding. This can make mothers feel like they are just a number or that their individual situations and experiences are not being taken into consideration.

As a whole, participants were very knowledgeable about infant feeding, including the challenges and constraints that mothers face with respect to all methods and associated practices. Although I used virtually the same focus group schedule, the two conversations were very different and took divergent trajectories. Both discussions convey a range of attitudes, feelings, perceptions, and beliefs around infant feeding, and at the same time participants touched on similar topics in both conversations. Chapter 5 includes a more in-depth discussion of some of the ways in which the conversations diverged and converged as well as ideas for going forward.

## **Chapter 5 – Discussion and Recommendations**

The goal of this research was to explore how immigrant and Canadian-born mothers feel socio-cultural factors influenced their decisions around feeding their infants and young children. Through focus groups with immigrant and Canadian-born mothers, I gathered first-hand accounts on how attributed social categories such as gender, socio-economic status, nationality, race, ethnicity, etc., intersect with social values, beliefs and ideals in the lives of mothers as they decide how to best nourish their infants. Analysis of the focus group data has allowed me to explore differences and similarities between Canadian-born and immigrant mothers in terms of experiences, beliefs, values and resulting practices.

As a whole, participants were very knowledgeable about infant feeding, including the challenges and constraints mothers face with respect to all methods and associated practices. Although I used the same focus group schedule, the two conversations were very different and took divergent trajectories. Both discussions convey a range of attitudes, feelings, perceptions, and beliefs around infant feeding, and at the same time participants touched on similar topics in both conversations. One way in which the two focus group sessions differed was the overall mood. Although Focus Group B participants developed a good rapport and the conversation had a good flow, the feel of Focus Group A was joyful, accompanied with lots of laughter. The topic seemed to bring out positive feelings and sentiments from this group of women who all valued breastfeeding and to whom it brought joy to talk about the topic amongst a group of good friends. Chapter 5 includes a more in-depth discussion of some of the ways in which the conversations diverged and converged as well as ideas for going forward.

## **5.1 Medicalization, expert advice and commercialization**

Participants in Group A were very interested in discussing the impacts of treating infant feeding as a medical issue rather than a normal part of the female reproductive lifecycle. All Group A participants agreed that traditional knowledge has a legitimate basis even though it is not proven empirically, a trait they perceive as valued more in post-industrial societies like Canada than in their home countries. Despite this, participants identified a shift in the direction away from strictly allopathic medicine to a growing acceptance of traditional, or non-allopathic, solutions to the challenges of infant feeding in Nova Scotia. Although much of the traditional breastfeeding knowledge has been lost among Nova Scotian women, there is a recognition of what has been lost. While Group A participants talked about the practices and beliefs of their cultures of origin, Group B participants talked about the differences between how we live amongst and relate to extended family members, friends and neighbours now compared to their grandmothers' times. Despite the knowledge that women gain through their own experiences, there is a wider body of women's knowledge, especially around breastfeeding, that participants felt has been lost since formula-feeding became the cultural norm.

Some participants from each group found that knowledge gained with previous babies was useful to them and respected by hospital staff. They found staff were less insistent when trying to coach them on breastfeeding and mothers felt less pressure to get their babies latched on. One Group B participant found that previous experience with other babies didn't matter much to hospital staff, they were still pressured to breastfeed quickly and not in their own time. In addition to perceived differential treatment based on

whether or not a mother had nursed a baby before, many mothers felt that there was variation in the quality of care provided by individual nurses. For the most part, all second-time mothers in Group B and one from Group A said they felt their previous experience was respected by hospital staff. This new respect was something they did not feel during their first birth experiences and is indicative of the knowledge that comes along with the experience of childbirth and infant feeding.

Maybe the high value placed on privacy and confidentiality when it comes to physical and mental health has led women away from discussing normal functions of our bodies and shared aspects of our life experiences. Like Johanna pointed out, it is not within our norms to talk about topics like female health and reproduction, mental health, life cycles and life experiences. According to Palmer (2009), the influence of second wave feminism led to the removal of biology from the equation of gender equality because it made the issue too complex to piece everything together. Could this also be a factor that keeps us from feeling comfortable talking about certain aspects of our shared experience with each other as mothers and women in general? The knowledge transfer web has been broken among women in Nova Scotia and knowledge taken out of the hands of women themselves and put into the hands of health care professionals and experts who still are predominantly male. Now that women are breastfeeding more in Nova Scotia, there are more opportunities for support and more mothers who can offer help to each other.

One characteristic of expert-based knowledge is the fact that much of it is transmitted through the medium of text, and there are a multitude of texts related to childbirth, breastfeeding, methods of parenting, etc. Although some women, like Adina from Group B, found that written texts on topics like breastfeeding served to make her

and other mothers more stressed and pressured, Elise from Group B found the information in guides published by the public health agency in the province she lived in during her first pregnancy helped spur her on with breastfeeding in the early weeks. In her experience, “It made me keep going with breastfeeding. In a little bit of a pressure and stressful way, but I mean, there was also some really good information and, yeah, it did help.” The difference between how Adina and Elise viewed infant feeding literature produced by “experts” and government bodies demonstrated the range of perspectives and needs of mothers. It shows us the importance of considering a mother’s experience as a whole and listening empathically in order to provide the best support.

Experiences with systems of oppression based in power and privilege shape all participants’ lives but were focused on more by participants in Group A. A topic of conversation that came up regularly was their inability to understand why it is in Canada that mothers from lower socio-economic levels are less likely to breastfeed despite the well-documented health, social and economic benefits. The fact that there is an economic differential between breastfeeding and non-breastfeeding mothers was not discussed in Group B. In that group, the focus was more on lack of support for, pressure on and judgment towards mothers and their feeding decisions, all topics which will be discussed later in this section.

As healthcare professionals, Group A participants talked about their colleagues’ receptivity to other ways of doing things. The example of a cultural practice that seems particularly important to participants is the provision of warm or hot water to patients from certain cultural backgrounds instead of making the assumption that ice water is an appropriate refreshment for everyone post-birth. They vocalized their reluctance to bring up ideas that may make women from non-dominant cultural backgrounds more

comfortable to their work colleagues and supervisors. They felt their knowledge and experience were not acknowledged or valued in general in their workplaces and was sometimes actively devalued by patients as well as colleagues due to their positionalities in the hierarchy of power and privilege, in their workplaces and in the community.

Three Group A participants talked about how they felt they are treated in Nova Scotia as women from Africa, as outsiders who do not possess insight or expertise in the home culture. They saw the focus group session as a way to give voice to their experience of being mothers who are immigrants from Africa and as an opportunity to set straight some of the stereotypes and misconceptions they face as a result of their status as cultural outsiders.

In Group A's discussion of challenges in the workplace, participants called out a general environment of discrimination, racism and ethnocentrism in Nova Scotia, where a person's cultural background, religion, race, language proficiency and other attributed characteristics are often considered a legitimate basis on which to judge whether a person's opinion or knowledge is valid. Instances in the workplace where participants' voices are muted and the expression of beliefs and opinions is not being encouraged and valued are concrete examples of low-grade, constant acts of oppression against women who are labeled with attributed characteristics based on constructed categories like immigration status, racialized categorization, gender, class and formal educational attainment.

To provide additional detail to the context in which the western faith in the expert thrives, participants reported regularly experiencing instances of disempowerment based on their level of formal qualifications attained (or perceived lack thereof). No credit is given to experience and Group A participants talked about being provided little respect in

terms of their expertise based on others' perceptions of their identities and positionalities, especially others belonging to the dominant cultural group. They all believe that the training they were required to do does not take into account trainees' previous knowledge, and what participants see as their "natural instinct". They viewed expertise as a position of privilege and power, whereas the concept of power and oppression was not as explicitly acknowledged in the conversation Focus Group B participants had.

The focus on "the expert" points to the hierarchical nature of the ownership and distribution of knowledge in Nova Scotia as well as the unequal distribution of power in a patriarchal, medicalized system. Group A participants said that in their experience, families are looking for advice based in science delivered by experts, and that they themselves do not represent "the expert" to members of the dominant culture. Ultimately, their experience is perceived by members of the dominant culture, including patients, colleagues and supervisors, in a way that limits their ability to participate in the distribution of knowledge about birthing and infant feeding. Focus Group B participants imagine how different things would have been in their grandmothers' and great-grandmothers' times. All participants believed that women in previous historical eras had more knowledge about birth and breastfeeding as a result of more exposure to practices like midwifery and breastfeeding itself in the home and the community.

According to Kitzinger (1995), "the context and pattern of breastfeeding are to a large extent controlled and dictated by men and nowhere more so than where birth and breastfeeding are medicalized and when technology has been developed..." (p. 386). Technology associated with infant feeding includes the development and manufacture of infant formula, bottles and related tools and pumps, to name a few. With such investment and expense going into research and product development, not to mention distribution

and retail sales, it is in the interest of large corporations to retain current markets, even to sell them a more diverse portfolio of products, and to expand their markets through the promotion of their goods and the manufactured lifestyle associated with their use. While shifts are occurring away from the focus on allopathic care in post-industrial societies and acceptance of other ways of knowing is beginning, traditional practices are undermined and undervalued while new practices from the medical industrial complex are held up as ideal in the majority world through the media, corporations and institutions.

Commercialization and consumerism were themes that emerged primarily in Group A. Roberta provided her views on the media's effects on breastfeeding in Nova Scotia as well as in East Africa, where she comes from originally and where many of her friends and family still live. Her contribution launched a discussion on commercialization and consumerism as global cultural influences behind intensive (and often unethical) marketing practices, global production and strategic distribution by the corporations that produce infant formula. According to Group A participants, their home communities - where breastfeeding was once the norm - are experiencing a loss of women's knowledge and a shift towards bottle feeding as the norm. They believe that the ideals of beauty they grew up with are also shifting towards western ideals due to the influence of the media, commercialization and cultural shift promulgated by corporations, including those which produce, distribute and sell infant formula. Breasts have gone from being a source of sustenance and nurturing for children to objects sexualized by the dominant culture primarily for heterosexual men (Palmer, 2009; Hausman, 2003; Hausman, 2007; Blum, 1999).

Helen from Group A brought up the events leading up to the Nestlé boycott as they played out in West Africa, which she remembers hearing about growing up in



Ghana. She pointed out that dependence on formula starts off with the provision of samples by the company – once formula is introduced it begins to compromise the delicate balance between mother’s milk production and baby’s needs. Another issue with formula use in the majority world is lack of access to safe, potable water, which is often deadly for formula-fed babies around the world, including North America where, lead from antiquated public and private infrastructure is a concern for formula-feeding infants. In many First Nations communities the lack of access to clean water as a result of contamination and limited access to treatment facilities is a dire problem.

The trouble with the pervasive marketing tactics used by formula companies is that the product has become a status symbol for many mothers in the majority world, as discussed by Group A participants. Unethical promotional efforts are evident at the level of the media as well with promotional and marketing efforts and in institutions in the form of strings-attached grants to hospitals and research institutes. They are at play in communities where formula advertisements are on display in doctors’ offices and with formula representatives like the “Nestlé nurses” as well as tactics like direct mail outs of samples.

The evolution of formula into a status symbol is the result of its adoption primarily by middle and upper-class women through the decades (Nathoo and Ostry, 2009), the group of women who still form the vanguard of mothering trends today (Hausman, 2003; Palmer, 2009). Cultural change is pushed by corporations through the media in the interest of producing more consumers of products while the media is also responsible for propagating ideals of beauty and of prompting shifts in those ideals or upholding the status quo, like underweight models and the practice of airbrushing in the quest for perfection of ideals in the fashion and celebrity industries. The normalization of

pornography has also led to a deeply ingrained sexualization of the breast in mainstream North American culture.

Globally, corporations are expected to adhere to the mandates of the International Marketing Code for Infant Formulas (the Code) (UNICEF 2011) but are frequently in violation of them. It does not help that in Canada, no items of the Code are legislated and corporations are self-regulated in terms of their adherence to it. Participants from both Group A and B recognized the loss of female-specific knowledge that is associated with increased formula use, in addition to the cultural retention of certain ideals of beauty and modesty. Although Group B participants did not delve as deeply into the topic, Group A participants started to flesh out the pattern of formula take-over, which they see playing out in their birth countries. In a formula-normalized environment, breastfeeding becomes a fringe practice, especially when the product becomes a status symbol for the emerging middle- and upper-classes.

Despite exposure to marketing messaging from formula companies, two mothers in Group B experienced a shift in attitude with respect to infant feeding after having children, signifying a shift from the status quo to what felt right during their transitions into motherhood. Elise and Kathryn reported feeling either negatively or neutrally about breastfeeding before having children and more positively after becoming pregnant. Kathryn, who had committed to trying breastfeed with her first child, said that before giving birth she did not think she would be disappointed if it did not work out. Her feelings changed when she had her baby and she became deeply committed to breastfeeding. Elise went from having negative associations with breastfeeding, even feelings of disgust, to full-on acceptance and commitment once she learned more about it, pushing through various struggles at the beginning without much support. Elements that

came out of Elise and Kathryn's narratives were their beliefs about themselves and their capacity; their motivation; levels of stress; and the individual nature of the journey as well as aspects that were shared.

Elise and Kathryn's experiences can be contrasted with the experiences of Group A participants who all reported that they had no doubts at any time as to which feeding method they preferred for their children. All of them were highly committed to breastfeeding even before becoming pregnant with their first babies. Many of the practices associated with positive breastfeeding outcomes, like unscheduled feeding, extended feeding and co-sleeping, are normal to Group A participants but are still considered as stigmatized to some extent among Group B participants. All participants agreed that in Nova Scotia, people have limited exposure to infant feeding practices, a fact that makes infant feeding a difficult endeavor for many mothers.

Significant controversy also exists around night feeding and sleep. In 2012, the Public Health Agency of Canada released a position statement on co-sleeping strongly advising against the practice. In reality, recent research shows that co-sleeping can improve sleep quality of parents and babies while simultaneously improving breastfeeding success (Tomori, 2011). It is a caring practice that has benefits for babies as well as families while it contradicts the consumer-driven norm of buying into the plethora of sleep equipment and technology that typically furnish early twenty-first century nurseries. The fact that co-sleeping is happening behind closed doors means it is rarely acknowledged as a relatively common practice. Using a model assuming abstinence is harmful because there are missed opportunities to educate people on how to minimize co-sleeping risk. As with many public health issues, discussion of harm reduction needs to be

part of the process of educating the public about factors that reduce risks rather than focus solely on abstaining from the practice.

## **5.2 The interaction of policy with everyday life**

Discussions on co-sleeping in both groups highlight the discrepancies between policy recommendations and practices among families. Despite the increasing numbers of Nova Scotian families talking about co-sleeping, policies do not reflect social practice. Co-sleeping is consistently under-reported (Tomari, 2011) and is perceived by participants in Group A as somewhat of an underground practice, one which people are reluctant to talk about for fear of being judged negatively. All of the participants in Group A talked about how co-sleeping was the norm in their home countries and that SIDS<sup>14</sup> is rarely experienced. They see the practice as a way to nurture breastfeeding, improve breastfeeding outcomes, and bond with their babies. Participants in Group B also subscribed to the practice of co-sleeping, with most also viewing it as a way of improving breastfeeding and bonding and all considering it as a means to get more sleep. Although Group B participants felt sleep was a major challenge, it did not seem to be viewed as such by most mothers in Group A. They, in contrast, viewed it as one of the most significant cross cultural differences between their first cultures and Canadian culture, in line with Sheila Kitzinger's assessment of sleep dysfunction as a western challenge

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<sup>14</sup> According to the Mayo Clinic, "Sudden infant death syndrome is the unexplained death, usually during sleep, of a seemingly healthy baby less than a year old, (Mayo Clinic, 2016)" (Mayo Clinic, 2016). SIDS has been linked to abnormalities in the part of the brain controlling breathing and sleep arousal. The measure of laying babies on their backs while sleeping has greatly reduced the incidence of SIDS where it is encouraged and practiced.

(1995). Group A participants astutely linked the sleep issue to a culture that is highly scheduled and where busyness is valued, characteristics of most post-industrial societies.

Extended breastfeeding, or breastfeeding beyond twelve months (Mayo Clinic, 2016), was another stigmatized practice that was brought up in both discussions. One mother in Group A mentioned her challenges breastfeeding her toddler son, which led to her decision to wean him at fourteen months. Other Group A participants had fond memories of breastfeeding their toddlers and all agreed on the idea of letting a mother and child decide together when to stop breastfeeding. In contrast, participants in Group B felt extended breastfeeding was a challenge and a more common goal for Nova Scotian mothers is to breastfeed for the recommended six months rather than much more beyond that. Based on the conversation around extended feeding in Group B, it is evident that it is not a commonly accepted practice and is generally viewed as somewhat of a “fanaticism” or aberration. It is a practice that not many mothers do in public because they feel they will be judged by others (Breastfeeding Grand Rounds Panel, 2105). It is difficult to get a clear picture on extended breastfeeding because the data generally aren’t collected beyond six months and often by that time mothers and babies are in different places on the feeding spectrum than when they started out. The statistics currently collected do not paint a clear or nuanced picture of the breastfeeding landscape in Canada, let alone at a provincial level.

All of the mothers in Group A breastfed for an extended period and two in Group B, which does not reflect statistical trends (CCHS, 2012), where it is reported that 18% of babies are exclusively breastfed at 6 months of age in Nova Scotia. Although public perceptions of extended breastfeeding are generally negative (Babineau and Spurles, 2011), it is recommended, “if desired by mother and baby” by the WHO (2001) and other

agencies. Policy-makers seem aware that extended breastfeeding is a socially and culturally stigmatized practice and they have made an effort to word the recommendation less strongly than the one on exclusive feeding for six months, which seems like a more realistic goal in the current breastfeeding environment.

Work and school are common barriers to breastfeeding and in most cases neither provide the supports and resources nursing mothers require. The solutions and strategies participants tried for feeding babies while working and studying were similar in both groups and included the following:

- Switching to formula;
- Pumping for bottle feeding by another caregiver - pumped breastmilk was fed exclusively or with formula;
- Having another caregiver bring baby to work;
- Bringing baby to work meetings;
- Breastfeeding when at home.

Pumping was brought up as a challenge for participants in both Groups A and B. Most participants, even if they had not pumped themselves, associated pumping with work, school, and other social or familial responsibilities. Two mothers in Group A were fine with pumping, though Helen did run into the challenge of finding a place to pump on campus as a university student. In Group B, three participants had challenging experiences with pumping. Johanna found the act in itself stressful, Kelsey had a baby with underlying latch issues for whom pumping was a necessity, and Elise found she did not have enough time to pump in between feedings but felt that by pumping she would be able to gain a certain level of freedom and independence.

Pumping is of interest at the policy level due to the fact that it is a market-focused solution that is minimally disruptive to the neo-liberal market system. The practice has quickly become the norm in many post-industrial societies where in general, children are

not cared for within the vicinity of our workplaces and working away from home in the early years is often required for economic reasons. It has become another expectation that mothers have to meet, another feat they have to achieve during waking hours, as well as another example of the way breastfeeding is becoming more and more commoditized. As a society we hold the belief that technology can make our lives easier, but the question remains as to whether adding pumping to the mix of breastfeeding really helps mothers or whether it complicates their lives. In most likelihood, mothers have experiences that range from feelings that pumping has helped them immensely in some way or that the pump made their lives miserable for many reasons.

Participants in Group A spoke in depth about how differently breastfeeding in public is perceived in their home cultures compared to Nova Scotia. The common experience for Group A participants is that public breastfeeding is a normal part of life in markets, at bus stations, in people's homes, on the street, in the park, and many other public places. Helen brought the recent media stories of mothers breastfeeding in public (discussed in detail in Chapter 1) into the conversation. She used these incidents as indicators of the context of public breastfeeding in Nova Scotia, however, to concentrate on the outlying stories of mothers' experiences may limit our views, and it is hopeful to see the greater acceptance and further normalization of breastfeeding as the ideal method of feeding a baby that is happening currently.

Group B's conversation focused more on participants' personal struggles and experiences with the practice of breastfeeding in public. They discussed the negotiations inherent in different contexts, as well as compromises they have made in the presence of certain people. Kathryn in Group B mentioned how it took time for her to be comfortable around her family and friends but that over time they became more and more comfortable

with her nursing. Their acceptance of it and her comfort around them extended to her feelings about breastfeeding in public, which she felt comfortable doing, although not all breastfeeding parents do. It would have been useful to learn more about Group A participants' experiences of feeding in public in Nova Scotia, not only their narratives of how public breastfeeding is treated in their cultures of origin.

On another interesting topic, Johanna talked about a friend who uses a narrative that describes her difficult struggles with breastfeeding to justify her reasons for choosing to formula feed. In Johanna's view, her friend feels guilty and ashamed for not "succeeding" at breastfeeding - she's judging herself only to be judged again by others. Kelsey talks about her own experience feeding her newborn, confirming that she felt she had to explain why she was not exclusively breastfeeding. Kelsey's direct experience with narrative creation around infant feeding trajectories affirms Johanna's idea that narratives are sometimes developed through storytelling to maintain an idealized image of self as the self relates to childbirth and infant feeding. Ryan et al (2010) found that the mothers they interviewed often formed narratives about their infant feeding experiences if they had used practices not supported by public health institutions and recommendations.

Research shows that exposure to breastfeeding increases prospective parents' tendency to see breastfeeding as a tenable, even the ideal, choice for feeding their babies and young children. Lack of exposure to breastfeeding came up in both groups as a barrier and even though participants in Group A had more exposure to breastfeeding growing up they acknowledged and understood the challenges that can result from lack of exposure. Closely linked to lack of exposure, in the opinion of most participants, is lack of support and peer support. Kathryn in particular talked about how her sisters' exposure to her breastfeeding practice was beneficial to them when they faced challenges. Mothers



themselves are contributing to the normalization of breastfeeding and culture shift within their communities by breastfeeding publicly, among friends and family members and in the workplace.

As something becomes more comfortable through practice and exposure, it can come to feel “natural”. Since Group A participants have lived in environments where breastfeeding is normalized, the practice feels natural to them, especially since they have no need to seek out expert advice, given that most of the knowledge they need is available to them through other women in their social networks. Breastfeeding feels unnatural to many Nova Scotian mothers because they rarely see it practiced and reliable information about it is difficult to access. Group B participants discussed the pressures of judgment, criticism and lack of support that contribute to the disempowerment of women resulting in reduced ability to culturally transmit important knowledge. This reduction in the cultural transmission of knowledge around breastfeeding influences how breastfeeding is perceived and accepted at the community level as well as how the experience unfolds at the individual level. Although this topic was not as prevalent with Group A participants as Group B, everyone agreed that they want to work towards greater understanding of each other’s triumphs and struggles as a way of working towards a normalized breastfeeding environment.

Roberta from Group A spoke of how the focus group was empowering for her, that the idea of sharing her ideas and knowledge about infant feeding, especially breastfeeding, was exciting to her. She and other participants were encouraged through sharing their knowledge and experiences of breastfeeding in Nova Scotia and other countries, negotiating and analyzing the diverse belief systems around infant feeding. The focus groups were ways of creating agency and space for dialogue about different ways of

being and doing things, as well as a means to come up with various recommendations for moving towards the normalization of breastfeeding in Nova Scotia.

### **5.3 Recommendations: Moving towards normalization**

In their 2009 work, Nathoo and Ostry stress the importance of having a strong understanding of historical breastfeeding patterns and socio-cultural trends in order to inform policy and advocacy. They identify four policy and practice-related areas to be considered at the federal level. First, free trade agreements need to be discussed in the context of how they relate to infant formula production and trade. In addition, breastfeeding advocates recommend increased restraints on the marketplace since it is not a good place to form and perpetuate ideas about infant feeding. Second, there must be a shift in the responsibility for the promotion of breastfeeding from the provincial to the federal level and there needs to be a level of acceptance that educational methods alone do not spark and that practical supports are also critical. Third, stronger links between the productive and reproductive work of women need to be developed in order to counteract the current tension between the two roles, which although distinct are related. Finally, breastfeeding “success” needs to be redefined at the policy level, with the focus on the knowledge and understanding of diverse needs. Nathoo and Ostry (2009) go on to suggest that while policies should focus on exclusivity and duration, promotion should focus on the quality of the experience in the mother’s opinion rather than just duration or exclusivity.

Also at the federal level, there needs to be an increase in intergovernmental cooperation between departments, like Health Canada and Industry Canada, around changing the culture so mothers can freely choose to feed their infants the way they want

and intend to. Nathoo and Ostry (2009) suggest that the provincial government should play an advocacy role while the federal government takes on a leadership role developing priority areas, coordinating educational materials and ensuring equitable policies across the country. They also recommend changes to advertising methods used by formula companies because of the psychological influence on the “physiological suggestion and environmental stressors” in the process of milk production (Nathoo and Ostry p. 208). In short, Canada must legislate the WHO Code rather than leave industry to monitor itself, a situation which has resulted in the intensification of marketing of artificial human milk substitutes in Canada since the 1980s (Nathoo and Ostry, 2009).

The current use of “change promotion”, a method of public health promotion that encourages change on the individual level, is “individualistic and victim blaming” (Nathoo and Ostry, 2009, p. 205). Certain groups are scrutinized more than others and those who receive the most negative attention, including surveillance and behaviour management, are mothers who are younger, single, racialized, of limited ability, with lower economic status, and less education, etc. Providing information to parents during pregnancy as well as practical and economic support in the months following birth have been shown to be useful in helping mothers meet the intentions for infant feeding they establish at the beginning. Lay and community groups like the Tatamagouche Area Breastfeeding Support Group (TABSG) are effective alternatives to health care professionals for providing effective breastfeeding support in the early weeks and months. The peer support model is used by other organizations, including La Leche League, and has proven useful for empowering mothers and increasing their self-confidence. More focus on building up support based on these models and on overcoming structural constraints would be beneficial across Nova Scotia.

Although the breastfeeding culture in Nova Scotia is shifting, initiation and duration rates still lag behind most other provinces (Health Canada, 2012a; Health Canada, 2012b) and there is still a lot to be done before breastfeeding as a socio-cultural practice is normalized. The IWK Health Centre in Halifax began implementing the transition to a Breastfeeding Friendly Initiative hospital (BFI)<sup>15</sup> in 2015, which although exciting, is happening twenty-five years after the launch of the initiative by WHO and UNICEF in 1991. As Ostry and Nathoo (2009) point out, support for breastfeeding in Canada has become fragmented after a decade of Progressive Conservative governance – hopefully with the recent change in government, breastfeeding as a preventative health measure can be brought into focus again and more federal support may mean a more holistic treatment of breastfeeding support and increased normalization across the country. We can only benefit from more collaboration and cooperation, from learning about other contexts and solutions can be shared and adapted across communities.

Participants believed that with more open communication of infant feeding challenges parents can be better prepared. Kathryn suggested ensuring that both sides of the feeding debate be represented in discussions with prospective parents and even youth, who seem to be far from making infant feeding decisions, but for whom early exposure can make an impact on breastfeeding success later on. Informal networks work well in communities, like Tatamagouche, where breastfeeding is normalized – parents support each other and share information and knowledge. Until the time that breastfeeding is normalized, fluid, semi-informal groups are key in order to provide a space where parents can support each other and share information. One of the key takeaways of this research

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<sup>15</sup> BFI is a ten step program implemented by maternity hospitals and birth centres with the objectives to promote, protect and support breastfeeding.

is that we need to take a more holistic and longer-term view to breastfeeding support, it is not a one size fits all scenario. Health care providers and community supporters need to be open to seeing and accepting mothers' positionalities in order to provide the best quality support to parents in all of their infant feeding decisions.

Support and educational initiatives should be more culturally accessible for mothers and families who require additional support, with anti-racism and culturally competent training as part of the training for support workers. This can help increase awareness of the lived experiences of women occupying positionalities different from the mainstream. In addition, more opportunities for diversity in the breastfeeding community of practice are critical. It is very uncommon to see racialized people or people who speak languages other than the mainstream or dominant language in the breastfeeding community of practice in the province. The community would benefit by actively making space for voices outside of the dominant culture and seeking out people with knowledge about others ways of being and doing who can help others understand difference and similarity. Cynthia Good-Mojab made some good, concrete suggestions on becoming an ally during her presentation at the La Leche League Canada Health Professional Seminar in Halifax in September, 2015. Breastfeeding support workers must:

- Proactively manage our cognitions and emotions
- Reflect and work towards the development of a “double consciousness”
- Understand and watch for cognitive dissonance<sup>16</sup>
- Engage in anti-racism training
- Recognize and relinquish unearned privilege and power<sup>17</sup>

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<sup>16</sup> In her presentation, Good-Mojab (a psychologist) talked extensively about the idea of cognitive dissonance. Cognitive dissonance is a psychological state where an individual is so disturbed by a concept that goes against a deeply-held belief system, so much so that they refuse to see how they contribute to the phenomenon itself. An example of this is privilege in that many middle-class people do not perceive of themselves as holding particularly privileged positions in society.

- Do no harm
- Become accountable to communities lacking privilege and power by developing relations, collaborating, and making room at the table in areas of leadership, decision-making, service design and service provision.

Racial inequities in breastfeeding support are pervasive in contemporary Nova Scotia. It is very rare to find breastfeeding counsellors, lactation consultants or mothers who access breastfeeding support who self-identify outside of the dominant culture or “race”. Good-Mojab encourages breastfeeding support workers to pay attention to who presents at and attends conferences and seminars, in addition to the backgrounds of representatives and members of organizations working on infant feeding issues. Can we provide culturally congruent care when we have very limited contact and interactions with professionals from non-dominant groups in our community?

In their research on breastfeeding practices of Middle Eastern women in Canada, Jessri and Farmer (2013) suggested that in order to be culturally accepted in the Muslim community, interventions should:

- Consider religious beliefs;
- Be culturally aware and practice towards cultural congruency;
- Be respectful of and acknowledge Islamic beliefs and cultural practices.

Healthcare providers could benefit from being exposed to other belief systems and need to have the chance to learn strategies useful for doing culturally congruent work, especially given the demographic shift occurring right now, where immigrant people are helping to boost the provincial population.

To address the constraint of work to breastfeeding in the Canadian context, Nathoo and Ostry (2009) called for more equitable and flexible leave policies in order to

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<sup>17</sup> Unearned privilege and power is that which is begotten from attributed characteristics, not from talent or merit.

more effectively support breastfeeding families. Workplace flexibility and length of maternity leave both influence duration and exclusivity but not initiation, which is influenced more by exposure to, provision of information and attitudes towards breastfeeding. Many families cannot get by financially on the reduced income of maternity leave and it has been shown that taking maternity leave can affect possibility of promotion in the workplace. There should be more equality in access to maternity leave benefits and less discrimination against primary care providers who take leave. Initiatives in the workplace like flexible hours, part time or shorter shifts, opportunities for nursing or pumping breaks and daycares located close by the workplace are also important provisions that help increase the duration of breastfeeding.

Human milk has been determined scientifically as the ideal food for human babies' optimal physical, intellectual and emotional development since a viable alternative became available in the late 1800s. There have been generational shifts on the perceptions of breastfeeding, from it being considered a maternal duty pre-1920 to a patriotic duty in the 1920s to something that is advantageous for the mother in the 1980s and finally for society in the 1990s into the 2010s. Nathoo and Ostry ask how to "reconcile individual choice with societal benefit, how to balance a desire to promote societal health and well-being and a desire to respect individual autonomy." (Nathoo & Ostry, 2009) Policy is one of the tools we use to solve social problems, a tool that has historically "required individual women to make decisions to remedy social problems not of their making," which is problematic.

Despite the policy and Public Health focus on individual mothers and their choices, there is more to the issue than individual choice. The method of infant feeding is shaped by caregivers' socio-cultural contexts and the focus on choice keeps us from

“examining the social forces that determine that “choice”” (Nathoo & Ostry, 2009, p. 210). This is evidenced by the way in which certain groups of mothers are scrutinized, surveilled and targeted without attention to the contexts of their lives. One solution is to acknowledge and invest in the structural determinants of choice. In this way, breastfeeding is reframed as a societal rather than an individual responsibility. Infant feeding is an emotional issue tied to mothers’ self-worth and we need to acknowledge “the feelings of grief, sorrow and the sense of failure that some women feel when their breastfeeding expectations are not met,” (Nathoo & Ostry, 2009, p. 211) in the current context. Mothers need to be met where they are and supported in what they want and what they choose, at the same time it is very important that mothers-to-be understand the impact of breast milk on babies’ short- and long-term health and development. Just as important as information is adequate support.

In her book, *The Politics of Breastfeeding*, Gabrielle Palmer (2009) says that, “By taking away women’s primordial right to sustain their own children with their own milk, through the destruction of traditional knowledge and the reorganization of work processes, dependency on a powerful dominant group is created,” (p. 731). Almost two decades before Palmer wrote her book, Katherine Dettwyler (1995) identified four assumptions held by members of the dominant social groups that hinder breastfeeding in the United States, assumptions that can be translated to the Canadian context. First that breasts are primarily for sexual purposes rather than feeding and nurturing children; second that breastfeeding only has a nutritional function; third that breastfeeding is only appropriate for very young infants; and finally, that breastfeeding is only appropriate in private. These cultural assumptions resonate with the topics that were discussed in the focus groups, demonstrating that they need to be overcome in order to normalize



breastfeeding as the ideal form of infant feeding, thereby making it easier for women who choose to breastfeed their babies for an extended period.

Going forward, I plan to use what I have learned from this research to further discussions in the infant feeding support community on the importance of providing culturally congruent care. To be effective, this discussion must include work towards recognizing systems of oppression, power and privilege that our support efforts are mitigated through. I will offer to share my work in the form of presentations and/or workshops with representatives of organizations like LLLC, the Eastern Shore Family Resource Association (ESFRA), the Nova Scotia Health Authority (NSHA), my local Community Health Board (CHB), among others. Another use of this research is to help convince bodies like the Nova Scotia Department of Health and Wellness to rethink the way they present information to families who may have different lifestyles from the dominant culture. Many publications recommend against co-sleeping if a parent smokes, drinks or has taken recreational drugs. For many families, those factors do not come into play which gives mothers the perception that the information is not targeted at them.

Through the process of this research, I have met my initial objective of further exploring the role that socio-cultural factors play in influencing Nova Scotian mothers' infant feeding decisions by analyzing mothers' stories, retelling their personal experiences, and naming their knowledge. The focus group events provided a space where women from diverse backgrounds could voice their experiences, not as anecdotal evidence, but as contributions to a complex narrative on an issue that is a fundamental part of being mothers. The data collected from both focus groups helped me to identify ways that policy, programming and outreach can more effectively support all women in Nova Scotia in their infant feeding decisions and help women develop their own

definitions of breastfeeding “success”. I came into this research with the assumption that immigrant mothers, who are generally more marginalized in our community than Canadian-born mothers in many respects, would feel that they require more formalized breastfeeding support. The focus group discussions turned my perspective around and I am left contemplating how mothers who have experienced breastfeeding in normalized environments can help foster these conditions in communities in Nova Scotia. There is still a lot to learn, a lot of get done and a lot of people to get involved before breastfeeding is normalized in Nova Scotia but these conversations can only help towards reaching that goal.

**Appendix A**  
Focus group recruitment poster



**Seeking moms who have  
fed a newborn in the past  
five years**

**to volunteer for a research study  
on how culture influences our  
infant- feeding decisions.**

**Socio-cultural factors influence the  
decisions we make around feeding  
our babies in various ways.  
If you have ever thought about how,  
consider joining this focus group!**



**Who:** Mothers who have fed an infant (using any feeding method) in the past five years.

**When:** Tuesday, March 31 from 2 pm until 3:30 pm

**Where:** Forest Hills Sobeys Community Room, 2 Forest Hills Parkway, Cole Harbour

**Questions:** Contact Lesley Magee, Master of Arts student in the Atlantic Canada Studies Program by email at [mageelesley@gmail.com](mailto:mageelesley@gmail.com) or phone at (902) 401-1915.

This research project has been approved by the Saint Mary's University Research Ethics Board (File # 15-094).

**Appendix B**  
Focus group discussion schedules

**Focus Group Schedule**  
**Canadian-Born Mothers**

Researcher: Lesley Magee  
Email: 1  
Phone: 1-902-401-1915  
Date & Time: March 31, 2015

Supervisor: Dr. Madine VanderPlaat  
Email: [madine.vanderplaat@smu.ca](mailto:madine.vanderplaat@smu.ca)

Phone: 1-902-496-8289  
Location: Community Room, Cole

Harbour Sobeys

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**Section 1: Preamble**

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The goal of this research is to explore how immigrant and Canadian-born mothers view culture as influencing their infant-feeding decisions. The reason for this focus group is to talk about the ways you feel culture has influenced decisions you have made for your babies. With your input and based on your experiences, I will be able to include real mothers' perspectives in my research. Mothering is a complex practice and this research recognizes that we as mothers need support in our work. Ultimately, the information from this focus group has the potential to inform work being done in our community around infant-feeding support.

There are a few points I would like to share before we start:

- The focus group will last no more than one and a half hours.
- Only respond to questions if you feel comfortable responding to.
- Site introduction.
- You will be compensated with a \$25.00 gift card from the Superstore in appreciation of your time.

**Permission to record:**

I am seeking your permission to record this focus group session on digital video. The reason for recording the session is so I do not miss anything that you say while taking written notes. Your name will not be included on the tape and everything you say will remain among the group.

**Confidentiality:**

I ask sensitivity from all participants due to the fact that I cannot ensure complete confidentiality in a focus group setting. I urge all participants to respect the confidentiality of everyone by refraining from discussing any details that may be used to identify other participants.

**Appendix B**  
Focus group discussion schedules

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**Section 1: How is culture taken into consideration by organizations working for women and children’s health around the issue of infant-feeding?**

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Group activity – Representations & Recommendations

- Watch “Building a Breastfeeding Environment” video by St FX students
- Discuss if and how materials from both sides influence mothers’ infant-feeding decisions:
  - What do you think is the message of the video? How does it/doesn’t it relate to your experience?
  - How effective do you think videos/projects like this are in changing infant feeding culture in NS? Perceptions about breastfeeding?

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**Section 2: What role does culture play in influencing mothers’ infant feeding decisions?**

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1. How much did you know about feeding a baby before you had yours?
2. What would you say are some infant-feeding “norms” (standard practices, beliefs, ideas, etc.) in Nova Scotia?
3. What are some attitudes you have seen around infant-feeding?
4. What are your beliefs around infant-feeding?
5. How do your practices and beliefs differ from your friends, family members, neighbours, etc.? How are they similar? Probe: Friends from similar or different cultural backgrounds?
6. What role do other family members play in making decisions about feeding infants in Nova Scotia traditionally? In your household?

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**Section 3: Do women feel that their infant feeding outcomes align with their intents?**

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1. What were your expectations for feeding your baby? Do you feel like you have met your expectations? Why do you think you succeeded/did not succeed in meeting your goals?
2. Do you feel you faced any barriers in meeting your infant-feeding goals? What were they?
3. If you switched from breastfeeding to bottle-feeding , how did you feel when you weaned your baby? Do you feel you had the information you needed to switch from breast to bottle?

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**Section 4: How do mothers envision support that works for them?**

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**Appendix B**  
Focus group discussion schedules

1. Do you feel you have/had the support and resources you need(ed) to make and execute informed infant-feeding decisions that you are/were satisfied with?
2. What are your sources of information/advice on infant-feeding?
3. Did you seek support and/or information for infant-feeding challenges? Where?
4. Do you feel the support and/or services you receive(d) help(ed) you? If not, what would make it easier for you to make informed infant-feeding choices and/or access services?

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**Closing:**

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Circle back to introductory activity

- Discuss representativeness of guidelines and marketing materials:
  - How representative of their experiences are guidelines and materials?
  - How representative of women's communities are guidelines and materials?

**Appendix B**  
Focus group discussion schedules

**Focus Group Schedule**  
**Immigrant mothers**

Researcher: Lesley Magee  
Email: [mageelesley@gmail.com](mailto:mageelesley@gmail.com)  
Phone: 1-902-401-1915  
Date & Time: TBA

Supervisor: Dr. Madine VanderPlaat  
Email: [madine.vanderplaat@smu.ca](mailto:madine.vanderplaat@smu.ca)  
Phone: 1-902-496-8289  
Location: TBA

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**Section 1: Preamble**

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The goal of this research is to explore how immigrant and Canadian-born mothers view culture as influencing their infant-feeding decisions. The reason for this focus group is to talk about the ways you feel culture has influenced decisions you have made for your babies. With your input and based on your experiences, I will be able to include real mothers' perspectives in my research. Mothering is a complex practice and this research recognizes that we as mothers need support in our work. Ultimately, the information from this focus group has the potential to inform work being done in our community around infant-feeding support.

There are a few points I would like to share before we start:

- The focus group will last no more than one and a half hours.
- Only respond to questions if you feel comfortable responding to.
- Site introduction.
- You will be compensated with a \$25.00 gift card from the Superstore in appreciation of your time.

**Permission to record:**

I am seeking your permission to record this focus group session on digital video. The reason for recording the session is so I do not miss anything that you say while taking written notes. Your name will not be included on the tape and everything you say will remain among the group.

**Confidentiality:**

I ask sensitivity from all participants due to the fact that I cannot ensure complete confidentiality in a focus group setting. I urge all participants to respect the confidentiality of everyone by refraining from discussing any details that may be used to identify other participants.

**Appendix B**  
Focus group discussion schedules

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**Section 1: How are infant-feeding representations and recommendations perceived by mothers?**

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Group activity – Representations & Recommendations

- Look at print and electronic representations and recommendations on infant-feeding from formula companies and breastfeeding agencies
- Discuss if and how materials from both influence mothers' infant-feeding decisions:
  - How do you experience and/or view advertising and marketing of formula products? What about breastfeeding recommendations?
  - Do recommendations or marketing from either side influence mothers' decisions around infant feeding? If so, how?
  - What do you think about expert advice or guidelines around feeding infants?

---

**Section 2: What role does culture play in influencing mothers' infant feeding decisions?**

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1. How much did you know about infant feeding practices before you had a baby?
2. Do you any special beliefs, practices or traditions around infant feeding in your culture? Probes: starting breastfeeding, around formula, feeding solids or other liquids
3. What would you say are some infant-feeding “norms” (standard practices, beliefs, ideas, etc.) in Nova Scotia?
4. What are the attitudes you have seen around infant-feeding?
5. What are your beliefs around infant-feeding?
6. Have you adapted your infant-feeding practices and beliefs since living in Nova Scotia? How? Have you seen other families from your culture who live in Nova Scotia change the ways they feed their babies in Canada?
7. How do your practices and beliefs differ from your friends, family members, neighbours, etc.? How are they similar? Probe: Friends from similar or different cultural backgrounds?
8. What role do other family members play in making decisions about feeding infants in your culture? In your household?



**Appendix B**  
Focus group discussion schedules

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**Section 3: Do women feel that their infant feeding outcomes align with their intents?**

---

1. What were your expectations for feeding your baby? Do you feel like you have met your expectations? Why do you think you succeeded/did not succeed in meeting your goals?
2. Do you feel you faced any barriers in meeting your infant-feeding goals? What were they?
3. If you switched from breastfeeding to bottle-feeding , how did you feel when you weaned your baby? Do you feel you had the information you needed to best switch from breast to bottle?

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**Section 4: How do mothers envision support that works for them?**

---

1. Do you feel you have/had the support and resources you need(ed) to make and execute informed infant-feeding decisions that you are/were satisfied with?
2. What are your sources of information/advice on infant-feeding?
3. Did you seek support and/or information for infant-feeding challenges? Where?
4. Do you feel the support and/or services you receive(d) help(ed) you? If not, what would make it easier for you to make informed infant-feeding choices and/or access services?

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**Closing:**

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Circle back to introductory activity

- Discuss representativeness of guidelines and marketing materials:
  - How representative of their experiences are guidelines and materials?
  - How representative of women’s communities are guidelines and materials?

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