The Infant Feeding Experiences of Urban Aboriginal Mothers: Implications for Universal Breastfeeding Policy

Tara Gauld

Department of Sociology
Lakehead University
Thunder Bay, Ontario

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Arts in Sociology with specialization in Women's Studies

September 2009

Abstract

In Canada breastfeeding rates are lower among marginalized women and studies have demonstrated that successful and exclusive breastfeeding for the recommended six months frequently requires an extensive support system, one that is often absent among marginalized women. The purpose of this study was to explore the infant feeding decisions and experiences of urban Aboriginal women, the factors that influenced their decisions, and the implications of universal breastfeeding policy for Aboriginal women. Utilizing feminist qualitative methodology, I interviewed seven Aboriginal women and seven health and social service professionals providing services to Aboriginal women in Thunder Bay, Ontario.

Results demonstrated that all of the mothers in this study were aware of the health benefits of breastfeeding, however, most of the mothers in this study used a combination of breast milk and formula to feed their infants. Numerous factors, many of which stem from the colonial history of Aboriginal people in Canada, influenced these women's infant feeding decisions. Additionally, a moral breastfeeding imperative has emerged in Western countries. Breastfeeding has been aligned with good mothering practices and other studies have demonstrated that the use of formula as opposed to breast milk to nourish infants leaves women feeling guilty and alienated. In this study, the mother's actions and key informant statements sought to establish Aboriginal women as good breastfeeding mothers. I argue that policy which promotes formula from a risk perspective contributes to this moralization of infant feeding and therefore formula should be presented neutrally. With mounting public health efforts to increase breastfeeding rates I argue that it is vital for breastfeeding policy to adopt an intersectional lens in order to ensure that the social and structural factors influencing women and the way in which these factors intersect are well understood in order to meet the needs of marginalized women.

Table of Contents

Appendices

Acknowledgements

I would like to thank Dr. Pamela Wakewich, my thesis advisor, for her immeasurable support and guidance during the planning and writing of this thesis. With Dr. Wakewich's support, I identified the theme of this thesis in one of her undergraduate courses. Her ongoing support and mentorship throughout my educational journey has been greatly appreciated. In addition, I am grateful to my thesis committee, Dr. Rachel Ariss and Mae Katt, NP, BScN for their insights and expertise. I am also greatly indebted to the mothers and key informants who participated in this study and who openly shared their personal experiences. I would not have been able to complete this thesis without them.

I am very grateful and fortunate to have been the recipient of a Social Sciences and Humanities Research Council scholarship. Their financial support eased the pressure of committing myself to full-time studies.

I would also like to thank my friends and my sister for inspiring me to explore this topic by sharing the successes and challenges associated with feeding their infants. My partner Gord has been of great support to me throughout my Graduate studies. His encouragement assisted me in taking the risk to leave stable employment to pursue to full-time studies. Finally, I would like to thank my parents for their ongoing support and encouragement.

Chapter 1 – Introduction

This thesis is an examination of the factors that influence Aboriginal mothers' infant feeding choices in Northwestern Ontario and the implications of current universal breastfeeding policy for urban Aboriginal mothers. My initial interest in this topic emerged during my employment with a local health organization which was in the process of implementing the Baby Friendly Initiative (BFI). My tenure with this organization coincided with my sister and most of my friends becoming pregnant and giving birth. Repeatedly I heard stories from women about their struggles with breastfeeding and their feelings of failure and guilt if they chose to formula-feed their infants. The women I heard stories from were similar to myself; they were Caucasian, in their late twenties or early thirties, in committed relationships, educated at a post-secondary level, and had above-average incomes.

Like most mothers, these women were dedicated to their infants and were willing to do what they believed was best for their children. These women did not question whether they would formula-feed or breastfeed, they knew they would breastfeed, but their actual experiences of breastfeeding were often different than what they had imagined. Nearly all of the women I knew struggled in some way and most felt poorly as a result. I found this phenomenon to be quite interesting and reflecting on this in the context of the new initiative in my workplace, I had concerns that the BFI might negatively impact women who struggled with breastfeeding. I asked myself, if so many women who were in a position of privilege[1] struggled

[1] The use of the word privilege refers to a benefit or advantage enjoyed by some, but generally not all, groups of people in society.

in some way with breastfeeding, what were the experiences of marginalized[2] women who had fewer resources to draw upon and who might already be facing considerably more stigma and challenges in their roles as mothers? As I began my literature review I discovered that minimal research had been conducted capturing urban Aboriginal women's experiences of infant feeding, and as Aboriginal women are a significant and marginalized population in Northwestern Ontario I decided to make this issue the topic of my thesis research.

1. Breastfeeding Recommendations and Demographics

A substantial body of research has been conducted to demonstrate the benefits of breastfeeding for mother, child, and society. According to the World Health Organization, "exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness" (2007: 1). Current policies of the World Health Organization, Health Canada, and the Canadian Paediatric Association state that women should breastfeed exclusively for six months, and they encourage women to breastfeed while supplementing with other foods for up to two years and beyond (Canadian Paediatric Association 2005: 1; Health Canada 2004: 1; WHO 2001: 1). Exclusive breastfeeding is defined as feeding an infant only breast milk, excluding water, breast milk substitutes, other liquids, and solid foods (Health Canada 2004:1).

However, few women in Canada exclusively breastfeed for six months as policy recommends. According to Statistic Canada's 2003 Canadian Community Health Survey, 85% of the women surveyed attempted to breastfeed their infant, 47% breastfed for six months or

[2] The terms marginalized and disadvantaged will be used interchangeably throughout this thesis. When using these terms I am referring to the social process where certain groups of people are denied power in society which results in material deprivation and exclusion from various programs or services.

longer but only 17% breastfed exclusively for at least six months (2005: 24-25). A more recent study by the Public Health Agency of Canada determined that 90% of women initiated breastfeeding at birth, 68% reported some breastfeeding at three months, 52% reported exclusive breastfeeding at three months, 54% reported some breastfeeding at six months and only 14% were exclusively breastfeeding at six months (2009: 13).

A number of characteristics are associated with women who breastfeed exclusively for six months or longer. Women are more likely to breastfeed if they have post-secondary education and breastfeeding rates rise with mother's age and household income. Urban women are more likely to breastfeed as opposed to rural women, married women have higher breastfeeding rates than single women, and immigrant women breastfeed more often than non-immigrant women (Statistics Canada 2005: 25-26). According to research conducted by Northern Ontario public health units, Northern Ontario has a breastfeeding initiation rate of 77.2% and at six months 54.6% of women are breastfeeding (Northern Ontario Perinatal and Child Health Survey 2003: vii). However, this data does not separate women who were exclusively breastfeeding from those who mixed breastfeeding with formula, so it is difficult to know if women are exclusively breastfeeding in compliance with the Baby Friendly Initiative.

Aboriginal women have lower rates of breastfeeding than non-Aboriginal women. The Aboriginal Peoples Survey reports that 67% of Aboriginal children in non-reserve areas were breast-fed by their mothers at one time or another when they were young (Statistics Canada 2005: 9). As with the non-Aboriginal population, there is a strong relationship between the parent's level of education and incidence of breastfeeding of children. Eighty-four percent of Aboriginal children who were living in non-reserve areas and whose biological parent had

received a university degree were breastfed during their childhood. This compares with 52% of those whose parents did not continue beyond elementary school (Statistics Canada 2005: 10). No data currently exists on exclusive breastfeeding rates for Aboriginal women.

2. Aboriginal Breastfeeding Research

Minimal research has been conducted on Aboriginal women's infant feeding experiences or on health issues in general. "The unique health needs of Aboriginal women have been under researched and subsumed in the population as a whole. Urban Aboriginal women in particular have been invisible and inaudible within conventional consultation frameworks" (Meadows, L.M., et al. citing Status of Women Canada 2003: 2). Much of the information currently available on breastfeeding in the Aboriginal population is largely demographic and statistical in nature with minimal qualitative research capturing the context or documentation of the everyday experiences of breastfeeding women. Of the reports that do exist (Dodgson and Struthers 2003; Macaulay et al. 1989; Martens 1997, 2001, 2002; Martens & Young 1997; Neander and Morse 1989; Stewart and Steckle 1987; Whelen Banks 2003), none are feminist or sociological in their perspective and their focus is primarily on people living on reserves. However, half of Aboriginal people in Canada are living in urban areas (Statistics Canada 2008). Therefore, there is a gap in published knowledge regarding the experiences of Aboriginal women with infant feeding, especially urban Aboriginal women.

The decisions of Aboriginal women regarding infant feeding need to be understood in the historical context of the colonization that Aboriginal people in Canada have experienced (Dodgson and Struthers 2003: 59). As a result of colonization, Aboriginal people in Canada live in poverty, have lower health status, and experience greater levels of violence (Cull 2006: 150).

The Indian Act which made status Indians wards of the state, assimilation attempts such as the residential school system, the eugenics movement and child protection policies have "all served to nurture and sustain the negative stereotype of Aboriginal mothers" (Cull: 2006: 141). Prior to colonization, Aboriginal women were respected for their role as mothers and this role was perceived to be one of power. Gender relations were more egalitarian and women served as spiritual and political leaders (Lavell-Harvard and Corbiere Lavell 2006: 4). However, colonization has destroyed the social fabric of Aboriginal families (Anderson 2000: 34). Although many Aboriginal people today are in the process of reclaiming their traditional culture, the legacy of colonization continues to negatively affect Aboriginal people.

3. The Baby Friendly Initiative

The Baby Friendly Initiative (BFI) is a global campaign of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). Hospitals and community health facilities can be accredited as a Baby Friendly organization if they implement a series of best practices related to protecting, supporting and promoting breastfeeding. Baby Friendly organizations must have a written breastfeeding policy that is routinely communicated to all staff, that supports mothers to establish and maintain exclusive breastfeeding for six months, and that encourages breastfeeding beyond six months with the introduction of other appropriate foods (Breastfeeding Committee for Canada 2002: viii). BFI policies and practices are based on two documents developed by the WHO and UNICEF; the *Ten Steps to Successful Breastfeeding* and the *International Code of Marketing of Breast-milk Substitutes*. Currently over 15,000 hospitals around the world have been designated as Baby Friendly and in Thunder

Bay, the focal point of this study, the Thunder Bay District Health Unit has received this designation.

BFI practices include the provision of information solely on breastfeeding; formula supplies or information cannot be distributed to families, no advertising of formula is permitted, nor are pictures idealizing or depicting formula feeding such as showing baby bottles. If women express interest in using formula, staff must ensure that women are making an "informed choice" by providing them with information on the benefits of breastfeeding and the risks associated with formula feeding. BFI organizations are directed to support parents through "evidence-based decision making by ensuring that parents are given accurate and unbiased information to allow them to make fully informed decisions" (Breastfeeding Committee for Canada 2002: 7). According to the BFI policy, the information women are required to receive in order to make an informed decision includes the following:

- Benefits of breastfeeding for baby, mother, family, and community
- Health consequences of not breastfeeding for baby and mother
- Risks and cost of breast milk substitutes
- Contraception compatible with breastfeeding
- Ten steps to successful breastfeeding
- Right to be accommodated in the workplace during pregnancy and breastfeeding
- Difficulty of reversing the decision once breastfeeding is stopped

The BFI restricts the provision of formula feeding information in a group or class setting, such as prenatal classes. If women request information on formula in such a setting, this information must be provided outside of the class, on a one-on-one basis in collaboration with information on the risks and cost of breast milk substitutes (Breastfeeding Committee of Canada 2002: 69).

The Baby Friendly Initiative Implementation Guide for Community Health Services states that "all mothers are provided with clear, accurate and impartial information and are thereby enabled and supported to make a fully informed decision as to how to feed their babies" and that "no mother is denied her right to an informed decision" (Breastfeeding Committee of Canada 2002: 69). The guide further states that "women who decide to formula-feed are accepted and cared for within the same standards as a breastfeeding mother" (Breastfeeding Committee of Canada 2002: 1). Barriers to breastfeeding are reviewed in the implementation guide along with strategies for health practitioners to address "perceived difficulties" related to successful breastfeeding (Breastfeeding Committee of Canada 2002: 19). These perceived barriers include embarrassment, inconvenience, father desire to be involved in feeding, fear of failure, previous breastfeeding problems and history of sexual abuse. The guide states that by assisting women in addressing these perceived difficulties, health practitioners will help women build confidence to breastfeed (Breastfeeding Committee of Canada 2002: 20). Interestingly, the use of the word 'perceived' here actually minimizes the real difficulties women may experience related to breastfeeding and suggests they are not real challenges women face. For many women, a history of sexual abuse is not simply a perceived difficulty. In the guide, the complexities of social and cultural factors are ignored and infant feeding is presented as a simple, unidirectional choice. As well, in spite of stated policy goals, breastfeeding is not presented impartially.

The World Health Organization and UNICEF implement a 20-hour required course for staff who will be implementing the BFI. The guide for their course has an appendix of "acceptable medical reasons for the use of breast milk substitutes" (WHO and UNICEF 2009:

249). This document states that "almost all mothers can breastfeed successfully, which includes initiating breastfeeding within the first hour of life, breastfeeding exclusively for the first 6 months and continuing breastfeeding (along with giving appropriate complementary foods) up to 2 years of age or beyond" (WHO and UNICEF 2009: 252). The document continues to outline the rare medical conditions that may be present in an infant or mother which would inhibit breastfeeding. Substance use is the only socially related factor for which breastfeeding is not recommended. Therefore, within BFI policy the only "acceptable" reasons for the use of formula are medical reasons. The social context of women's lives is not addressed.

As a part of its BFI designation, the Thunder Bay District Health Unit distributes a brochure titled "Risks of Infant Formula" to prospective parents and pregnant women. This brochure is provided to women who request information on formula feeding and it is available on their website. The brochure outlines the cost of using formula for one year and informs parents how they could be spending their money if they were not using formula. Some of these suggestions include purchasing groceries for a family, purchasing a high chair, purchasing a stereo, or paying for babysitting services. The brochure has a new addition since its first publication: a statement that informs families to contact their health care provider for information on how to properly prepare, store, and feed formula (Thunder Bay District Health Unit 2008).

Risks for formula-fed infants outlined in this brochure include the following: lung infections, middle ear infections, being overweight, diabetes, diarrhea, infection from contaminated formula, chronic illness, lower intelligence, effects of environmental poisons,

allergies and asthma, childhood cancers, SIDS, and heart disease. As well, the brochure highlights risks for women who do not breastfeed. These risks are: being overweight, higher risk for some types of cancer, reduced child spacing and osteoporosis (Thunder Bay District Health Unit 2008). As will be discussed below, the scientific validity of many of these health claims are contested by some scientists.

4. Medical and Scientific Debates

The BFI is ostensibly an evidence-based initiative, however there is significant debate surrounding the broad health claims made by exclusive breastfeeding advocates and the generalized evidence used to support their message. Wolfe argues that much of the research on breastfeeding comes from observational studies, is inconsistent, lacks strong associations and does not account for possible confounding variables, which makes it difficult to isolate the protective effect of breast milk (2007: 595). According to Law, "many of the most popular cited facts and statistics about infant feeding are not based on medical research at all" (2000: 408). Law argues that the calculations in infant feeding literature, both scientific research and popular advice materials, are often influenced by an assumption of a traditional division of labour and an inherent belief of maternal superiority regarding infant care (2000: 411). In his paper he analyzed breastfeeding research which is commonly referenced in public health promotion and by breastfeeding advocates and he states that "much of what has been written about the relative merits of breastfeeding and formula feeding is misleading at best and false at worst" (Law 2000: 412). For example, he points out that lactation depletes calcium supplies in women, however, the research is divided on the long-term impact this has for women (Law 2000: 420, 421).

Carter argues that much of the research linking breastfeeding with positive health outcomes in developing countries is problematic since it obscures the real causes of infant mortality, which are often rooted in poverty, not in feeding method. In many developing countries breastfeeding rates are high, but so are infant mortality rates. Carter cites Millman in her work, who explains that the "extent to which breastfeeding protects health may have been somewhat overstated in much of this research" (1995: 65). Additionally, Carter argues that pro-breastfeeding messages may be oversimplified, since in developing countries infants who have parents with higher incomes are protected from a host of health problems regardless of infant feeding method (Carter citing Maher 1999: 65).

Additionally, Knaak argues that the research breastfeeding literature is based upon has taken on a manipulative character as a result of biased research (2006: 413). She argues that breastfeeding discourse is based on "scientific selectivity" and does not provide an appropriate contextualization of risks and benefits. Studies that demonstrate little or no benefits associated with breastfeeding are ignored and much of the research used in health promotion literature is based on studies conducted in developing countries with poor sanitation systems and lack of clean water supplies and is not relevant in other contexts (Knaak 2006: 413).

Recent systematic scientific research has demonstrated that breastfeeding may not be the panacea for baby's health that current health policy claims. Renfrew et al. conducted a systematic review of breastfeeding studies used in shaping public health policy (2007). They reviewed eighty studies and found that most were methodically flawed, had inconsistent definitions of breastfeeding and used small sample sizes. Few of the studies examined the psycho-social-biological nature of breastfeeding or the social and cultural context of

breastfeeding, and rarely were women's views and feelings on breastfeeding examined in these studies. As well, few studies examined disadvantaged women and few reflected woman-centred or family-centered philosophies (Renfrew et al. 2007: 729).

A study conducted in hospitals with the Baby Friendly designation reported that in spite of previous claims, breastfeeding does not reduce the incidence of asthma and allergies (Kramer et al., 2007: 815). In fact, one study found that longer duration of breastfeeding favourably influences lung growth in children, however if the mother has asthma, longer breastfeeding was associated with decreased airflows in children (Guilbert 2007: 843). An additional study reported that children did not have fewer allergies when solid foods were introduced after six months of age (Zutavem et al. 2007: 44). A review of recent studies on the relationship between breastfeeding and allergic diseases, atopic dermatitis, and asthma determined that there is no reduction of the aforementioned conditions in infants when breastfed (Duncan and Sears 2008: 398). In this same review Duncan and Sears sight Kramer and Kakuma who conducted a review of the optimal duration of breastfeeding and although the data was inconclusive and conflicting, the World Health Organization recommended that exclusive breastfeeding should continue for six months (2008: 404).

The largest study ever conducted on breastfeeding, which took place in Belarus BFI hospitals, found no risks or benefits of prolonged breastfeeding for children (Kramer et al. 2008: 435) and research from the UK determined that breastfeeding does not increase IQ rates, as previously claimed by numerous health organizations and breastfeeding advocates (Der, Batty and Deary 2006: 5).

A protective effect against obesity as a result of breastfeeding has also been challenged by researchers. Cope and Allison conducted a review of the World Health Organization's report on breastfeeding and obesity (2008). In this report WHO states that breastfeeding may have a small protective effect on obesity. However, Cope and Allison critically assess this research report and conclude that "any statement that a strong, clear or consistent body of evidence shows that breastfeeding reduces the risk of overweight or obesity is unwarranted at this time" (2008: 594). Additionally, data from the Belarus study by Kramer et al., identified previously, found that breastfeeding did not reduce the measures of adiposity, increase stature, or reduce blood pressure. The authors state that "reported beneficial effects of these outcomes may be the result of uncontrolled confounding and selection bias" (Kramer et al. 2007: 171).

There are a number of breastfeeding health benefits that are generally agreed upon. For infants these include a decrease in acute otitis media, diarrhea and pneumonia (Health Canada 2005). However, despite the health benefits that breastfeeding does incur for infants and women, the act of breastfeeding occurs in a social and political world and infant feeding decisions are also shaped by and reflective of the social context in which a woman finds herself. As a result, not all scholars are convinced that breastfeeding is always best for mothers.

5. Is Breast Always Best?

There is a growing body of feminist and sociological literature which argues that infant feeding choices are complex and that breastfeeding policies and promotion may be problematic for women (Bartlett 2006; Blum 1999; Carter 1995; Crossley 2009; Lee 2005, 2007, 2008; Murphy 1999, 2000, 2003; Schmied and Lupton 2001). Current breastfeeding policy assumes that all women should and are able to breastfeed, while failing to recognize the complex social

contexts of women's lives. As a result, women who are unable to breastfeed, or choose not to do so, are often labeled as bad mothers and this has significant consequences regarding how they are viewed in public health terms, as well as by society at large.

Exclusive breastfeeding can be difficult for women who are working outside the home, women in abusive relationships, survivors of sexual abuse, women who experience physical challenges, or those who may simply struggle with exclusive breastfeeding and the demand that it places on their bodies and their time (Avishai 2004: 141, Kelleher 2006: 2730, Kendall-Tackett 2007: 1; Schmied and Lupton 2001; 244). For women living in poverty, life situations are often more complex, which makes exclusive breastfeeding more challenging (Guttman and Zimmerman 2000: 1457). Additionally, exclusive breastfeeding is challenging in a culture that views women's breasts as sexualized objects, thereby rendering public breastfeeding problematic (Carter 1995: 115, Stearns 1999: 309).

Recent studies have also indicated that discourses on good and bad mothering are imbedded within breastfeeding promotion and policy, and women themselves have come to associate good mothering with breastfeeding and bad mothering with formula feeding. Such moralization of infant feeding has led many women to feel guilty if they are unable to or choose not to breastfeed (Blum 1999, Carter 1995, Crossley 2009, Lee 2005, 2007, 2008, Murphy 1999, 2000, 2003, Schmied and Barclay 1999). In BFI policy breastfeeding is referred to as the "normal and optimal" way of feeding infants (World Health Organization 2009: 20). As noted earlier, most women use formula at some point before their infant reaches the age of six months, the recommended period for exclusive breastfeeding (Statistics Canada 2005: 24). If breastfeeding is defined as the normal feeding method, then to feed one's child with formula is

abnormal. Since BFI policy is implemented in hospitals and other health care organizations, this normalized discourse is communicated to women in a medicalized fashion, potentially contributing to thoughts of failure and feelings of inferiority if breastfeeding is not chosen or exclusively implemented.

Issues of race, class, and sexual orientation as well as the manner in which these factors intersect to create diverse realities for women's lives are often ignored in breastfeeding discourse and policy. All health policy, including breastfeeding policy, should be reflective of the diversity of women's lives which requires adopting a deeper understanding of the way in which structural issues impact women and their infant feeding choices (Raphael 2008: xi). Without such an analysis breastfeeding policy will have limited relevance to many women's lives and it will continue to ignore socio-cultural influences on infant feeding choices, promote formula as only a risk to health, assume infant feeding decisions are a result of acquiring the proper education, state that breastfeeding is normative, and ultimately assume that the ability to breastfeed can be controlled through medical intervention.

6. Research Goals

The purpose of this study is to capture the perspectives of urban Aboriginal women in North Western Ontario on their influences and experiences of infant feeding. The infant feeding information urban Aboriginal women are being provided by health organizations will also be explored in order to determine whether or not this information meets their needs. Finally, this study will explore what implications universal breastfeeding policy, has for urban Aboriginal mothers: mothers who are often extremely marginalized as a result of Canada's colonial

history. Therefore, in summary, the goals of this research are to answer the following questions:

- How are urban Aboriginal mothers feeding their infants?
- How do mothers feel about their infant feeding methods?
- What are the influences affecting the decisions of urban Aboriginal mothers regarding infant feeding?
- What kind of information are urban Aboriginal mothers receiving on infant feeding? Does this information meet their needs?
- What are the implications of the Baby Friendly Initiative for urban Aboriginal mothers?

7. Plan of the Thesis

In order to identify key topics for the interviews, a review of literature on breastfeeding from sociological, feminist, and health sciences perspectives was conducted. This literature, which captured numerous social influences on infant feeding decisions, will be presented in Chapter Two. Chapter Three provides an overview of the design and methods of the study which was guided by feminist qualitative methodology. The sample for this study included seven Aboriginal mothers between the ages of 18 and 34, currently residing in Thunder Bay, Ontario and seven key informants who worked with Aboriginal mothers in the region. Open-ended interviews were used to examine the infant feeding experiences of Aboriginal mothers and the factors that influence their infant feeding choices. This chapter provides a synopsis of the development of the interview guides and information on the demographics of the sample, difficulties with recruitment, and challenges with the interviews, as well as methodological strengths.

Chapter Four outlines the main themes that emerged from the interviews. These themes fall under the categories of: infant feeding in everyday life, structural influences, professional influences, and the breastfeeding imperative. In Chapter Five, the final chapter, a summary of the arguments presented in the thesis is provided and connections are drawn between the primary and secondary sources in more detail. The mothers' infant feeding experiences and the factors that influence their choices as well as the implications of the BFI are discussed, while areas for future research are suggested. I argue that the infant feeding decisions of Aboriginal women are influenced by numerous social factors and structural barriers, many of which are a result of the colonial legacy of Aboriginal people in Canada. Additionally, breastfeeding has come to define good mothering, resulting in the alienation of women who chose to formula-feed. I conclude that breastfeeding policy must assume an intersectoral lens in order to ensure that the needs of marginalized women are being met.

Chapter 2 - Literature Review

A review of existing literature on the experiences of women regarding infant feeding experiences in the fields of women's studies, sociology and health sciences was conducted to identify factors that influence women and their infant feeding decisions. Central issues discussed are historical influences on current breastfeeding policy, feminist debates on infant feeding, Aboriginal women's infant feeding experiences, infant feeding in everyday life, structural influences on infant feeding decisions, the construction of risk in infant feeding messaging, breastfeeding as a moral imperative, and breastfeeding policy implications. These issues are analyzed below to provide a framework in which to discuss the complexities Aboriginal women and non-Aboriginal women face when making infant feeding decisions and to determine the implications of current breastfeeding policy.

1. History of Infant Feeding

From ancient times women have sought alternative forms of infant feeding (Barnes 1987: 168). Women supported each other by nursing each others' infants, wealthy women employed low-income women as wet nurses, and infants were fed with cow's milk and a mixture of tea, sugar, and animal milk (Blum 1999: 20). Although this study is not a historical analysis of infant feeding policy it is useful to briefly reflect on the manner in which professional recommendations and infant feeding policy have changed dramatically throughout the last century.

Canadian government recommendations for exclusive breastfeeding have changed over the last century. In the 1920s exclusive breastfeeding was recommended for nine months,

in the 1940s the recommendation was two months, in the 1960s it was recommended for three months and more recently in 2004, Health Canada changed their recommendations from four months to six months (Nathoo and Ostry 2009: 1; Health Canada 2004: 1). Central to infant feeding policy over the past century has been an emphasis on the promotion of breastfeeding through the education of mothers, while ignoring the social and material supports and resources required to breastfeed (Nathoo and Ostry 2009: 198).

In the late nineteenth and early part of the twentieth century, infant mortality rates were extremely high in Canada. During this period people were rapidly moving into cities from the countryside as a result of industrialization, and infant mortality rates spiked, likely due to limited public health infrastructure and a prolonged economic downturn (Ostry 2006: 27). The most vulnerable infants were those who were living in poverty, were artificially fed, and who had mothers who were working and were malnourished (Ostry 2006: 20). Concern mounted over the high infant mortality rates and in 1910 research was commissioned by the Ontario government to further study the issue. Studies determined that there was a relationship between poverty, malnutrition, and ill health, however, the recommendations were not for economic or structural reforms; rather, the recommendations focused on education for the poor and the promotion of breastfeeding. The belief was that infant mortality would be reduced through educating and encouraging mothers to breastfeed (Ostry 2006: 26). However, Arnup points out that this approach to decreasing infant mortality was problematic since breastfeeding was singularly positioned as the solution to infant mortality and other solutions were excluded (1994: 192).

In the 1920s breastfeeding was promoted as the best way to nourish infants. Dr. Helen MacMurchy, the head of the federal government's division of Child Welfare, wrote a publication that was made available to all mothers in Canada. *The Canadian Mother's Book,* first published in 1921, strongly promoted breastfeeding and suggested that mothers were responsible for the future well-being of the country. Breastfeeding was presented as a national duty (Nathoo and Ostry 2009: 1). In this rhetoric, breastfeeding became a moral choice which was aligned with good mothering (Nathoo and Ostry 2009: 198). Educational efforts were targeted almost exclusively at poor women with low levels of education, despite the fact that these women had higher breastfeeding rates than women in higher socioeconomic groups at the time. Infant feeding promotion was based on idealized notions of motherhood, and policy makers believed that women ought to remain in the home despite the fact that a large number of poor women were engaged in paid employment. According to Nathoo and Ostry, the tone of breastfeeding promotion during this time was "singular, dire, patronizing, and imperative" (2009: 199).

During the early part of the twentieth century the scientific revolution greatly influenced ideas surrounding infant feeding (Comacchio 1993: 94). By the 1920s and 1930s scientific motherhood was firmly established and motherhood was elevated as the noblest profession for women. However, in order for women to raise healthy, successful children they needed scientific advice. Women were advised to learn as much as they could about science in order to improve their mothering skills (Apple 1994: 32). Canadian mothers were urged to "embrace scientific methods at a time when there was a pervasive faith in science" (Comacchio 1994: 94). Women were directed to consult experts such as paediatricians, who would oversee

their infant feeding as a way of decreasing infant mortality, rather than relying on the advice from their own mothers or peers (Apple 1987: 404). Apple argues that medicine and physicians constructed the image of the good mother as one who sought out expert advice on childrearing and followed that advice to the exclusion of socialization and experience (1987: 9).

In the 1920s and 1930s hundreds of thousands of mothers across Canada were provided with advice literature on infant feeding and proper hygiene by doctors, nurses, and other governmental health care bodies (Arnup 1994: 193). Notions of scientific management were applied to child rearing practices, which meant that every activity had to be monitored and tightly scheduled (Arnup 1994: 84). Regularity for infants was considered to be essential for the development of good habits in children. *The Baby*, a Toronto publication, offered this advice to mothers: "feed regularly by the clock, even if the baby must be wakened. You will soon train him to awaken at the proper time. Regularity in habits not only makes the baby comfortable and keeps the milk secretion uniform, but lays an early foundation for regularity in other habits" (cited in Arnup 1994: 199). Breastfeeding continued to be the recommended infant feeding practice, however, breastfeeding rates were declining and many health professionals blamed uneducated mothers for the reduction in breastfeeding rates (Arnup 1994: 68).

By the 1940s infant mortality rates had declined, commercial baby formula was widely available, and breastfeeding rates were plummeting. Government publications continued to promote breastfeeding, however, by the 1950s manuals began including information on formula feeding (Arnup 1994: 101). Formula feeding came to be considered more modern and scientific than breastfeeding because it was possible to measure formula and sterilize bottles. In medical school students learned little about breastfeeding and doctors found it easier to

prescribe formula than to teach women about lactation (Apple 1994: 33). The move from home birthing to hospital birthing also reinforced the prescription and use of formula. By the 1960s most Canadian women gave birth in hospitals as opposed to only 35% in 1940 (Nathoo and Ostry 2009: 89). Despite government publications promoting breastfeeding, infants were routinely fed formula in hospitals and women were not supported in establishing breastfeeding. As well, it was believed that infants were particularly susceptible to infections and required protection from their mothers. Hospital practices kept infants away from their mothers, therefore women were unable to breastfeed regularly which inhibited breast milk production (Apple 1994: 34). As a result, few women were breastfeeding by the 1960s.

In the 1960s birth rates declined in North America and infant formula companies began promoting their product in developing countries in order to maintain profits. Many of their promotional efforts were unethical and these companies suggested that formula was good for developing healthy babies, was supported by science, and that women's breast milk was inadequate by comparison (Nathoo and Ostry 2009: 116). In developing countries formula became associated with the rich and breastfeeding with the poor. As a result of substandard water supplies, a lack of sterilization of equipment, and formula instructions that were printed only in English, many infants in developing countries became sick with diarrhea, which led to dehydration and malnutrition, conditions that were often fatal (Nathoo and Ostry 2009: 116). Formula companies also began promoting their product on reserves in Canada in the 1970s which contributed to the increased use of formula amongst Aboriginal women. The use of formula was not without detrimental effects in these communities. Infant mortality rates, infections, and malnutrition were high in the 1960s and 1970s amongst the Aboriginal

population, and contaminated water and unstable formula supplies were contributing factors (2009: 118).

In the late 1960s and 1970s breastfeeding rates in Canada began to climb, particularly amongst women from higher socio-economic groups. The return to breastfeeding was partially influenced by the women's health movement and advocacy efforts against the promotion of formula in developing countries (Nathoo and Ostry 2009: 111, 115). In the late 1980s the WHO and UNICEF developed the *International Code of Marketing of Breast-milk Substitutes* and the *Ten Steps to Successful Breastfeeding* as a response to global declining breastfeeding rates. From this the BFI policy was developed in 1991 as a structured approach for implementing the previously mentioned documents in hospital settings (2009: 154). The Breastfeeding Committee of Canada, a non-profit organization, was identified as the group which would work toward the implementation of the BFI in hospitals and community health organizations across Canada. Since the adoption of the policy, research has demonstrated that exclusive breastfeeding rates increase among women associated with BFI organizations (Nathoo and Ostry 2009: 175). Currently in Canada there are 26 BFI designated facilities (Breastfeeding Committee of Canada 2009: 1).

2. Feminism and Infant Feeding

Van Esterik has conducted a substantial body of work on the issue of breastfeeding from an anthropological and feminist perspective, and addresses the issue in both developing and developed countries. She argues that infant feeding is embedded within issues of poverty, the medicalization of infant feeding, the empowerment of women, and the commoditization of infant foods (1989: 3). As an anthropologist her work focuses primarily on women in

developing countries whose infants were dying due to illnesses contracted through the use of formula mixed with contaminated water. She embraces the health benefits of breastfeeding for mother and child, along with the positive effect on the environment and the minimization of dependency that women have on consumer products. Additionally, Van Esterik writes from a feminist perspective and encourages women to reclaim their bodies through breastfeeding; she views breastfeeding as an empowering experience for women and her goal is to create structural conditions so that every woman has the opportunity to breastfeed if she chooses (1989: 19).

With the exception of Van Esterik's work, Carter argues that there has been a lack of feminist engagement surrounding the politics of infant feeding (1995: 1). However, providing a feminist analysis regarding the politics of breastfeeding is not a straightforward endeavor. Two feminist debates have dominated the literature on infant feeding. The first argument has been tied to the minimization of gender differences as the path to liberation for women. Within this argument some have viewed bottle-feeding as freeing women from the demands of lactation. The other argument aligns formula manufacturing with patriarchy and capitalism, and in taking a maternal feminist perspective, encourages women to embrace the uniqueness of the female body and the 'naturalness' of breastfeeding (Carter 1995: 14). This argument has dominated the feminist and health literature in the later part of the twentieth century and the early part of the twenty-first century. For this group, declining breastfeeding rates have almost exclusively been seen as a result of the assault of formula manufacturers on women's natural capacities. However, Carter believes that these arguments see women as victims and have ignored how women may be using formula to reject health advice, defend their right to make their own

choice, and to avoid the complex body management that breastfeeding requires (1995: 212). She states that the feminist arguments that have informed the pro-breastfeeding movement ultimately essentialize women, as natural mothers, and have ignored the ways in which issues of social location influence women's status, oppression, and opportunities (Carter 1995: 213).

3. Aboriginal Breastfeeding Research

As identified earlier, little research has been conducted with Aboriginal women regarding breastfeeding. Of the studies conducted, few have conducted in-depth interviewing and none have been from a feminist or sociological perspective. Martens has conducted extensive research with a First Nations community in Manitoba regarding the evaluation of initiatives to increase breastfeeding rates. This community received prenatal instruction from a community health nurse and supported breastfeeding women with a postpartum peer counselor. Breastfeeding rates in this community increased from 38% to 60% in a two-year span (Martens 2002: 236). Qualitative interviews confirmed that women who participated in the program were more confident about breastfeeding, had fewer problems with it, and derived greater satisfaction from it.

Dodgson and Struthers argue that it is important to understand the historical context of infant feeding when designing health promotion messages and programs for Aboriginal women (2003: 59). Historically, Indigenous people have been forced by governments to adhere to practices that are misaligned with their traditions. As a result of the cultural atrocities faced by Aboriginal people, many traditional practices have been diminished or lost and breastfeeding is one of these practices. The loss of traditional culture has also impacted the location where many Aboriginal infants were born which has had a negative impact on breastfeeding (Dodgson

and Struthers 2003: 60). Historically, infants were born in their own communities surrounded by family. Birthing attendants and families provided teachings to women, teachings which prepared them for childbirth and caring for an infant, including teachings on breastfeeding. These practices shifted and women were required to leave their communities to birth their children in hospitals away from their support systems, following a Western medical model (Kaufert and O'Neil 1990: 427). Many of these hospital practices undermined breastfeeding initiation and this loss of knowledge transgressed throughout the generations and impacts Aboriginal women today (Dodgson and Struthers 2003: 61).

According to Whelen-Banks, breastfeeding in Mohawk communities is strongly influenced by the infant's grandmother and other women in the extended family (2003: 340). Family members want to participate in infant feeding and support the mother of the newborn child. Since the traditional practice of breastfeeding has greatly diminished among First Nations women as a result of colonization, many mothers and grandmothers do not know how to support younger mothers in initiating breastfeeding. Whelen-Banks also argues that the women in her community value teachings from other women and family members in the community over the teachings of health promotion as delivered by Western professionals (2003: 346).

4. Structural Influences

Women also encounter a number of structural issues that influence infant feeding decisions. A multitude of studies have identified that women living in poverty are less likely to breastfeed (Blum 1999; Carter 1995; Lee 2008; Statistics Canada 2005). Approximately 49% of Aboriginal children in Canada under the age of six are living in low income families (Campaign

2000, 2008: 6). Numerous studies have been conducted to determine the reasons why women living in poverty do not breastfeed and what can be done to influence their infant feeding choices. Many of these studies focus on the assumed educational needs of women living in poverty in order to influence them to choose to breastfeed. In her text on feminism and breastfeeding, Carter states that historically women living in poverty have been the target of research and public policy designed to increase breastfeeding rates (1995:215). She argues that breastfeeding rates have been undermined by formula manufacturers and that mothers who live in poverty, who are young and have low levels of education, are especially susceptible to the pressures of formula corporations. However she points out that low income women have been the target of breastfeeding interventions since well before the rise of large scale formula manufacturers. In fact, she traces these efforts in the UK to the early 1900s (Carter 1995: 44). As demonstrated previously in this thesis, poor women in Canada had also been the target of breastfeeding education prior to the development of commercial formula (Ostry 2006: 26).

Blum argues that women living in poverty have been "treated as if they can be taught to choose the right methods of child-rearing and bodily self-discipline" (1999: 12). However, low income women share the notion that 'breast is best' as identified by women in numerous studies (Blum 1999; Lee 2005, Murphy 2003). Therefore, these women do not lack knowledge or information about breastfeeding. Rather, the reasons for low breastfeeding rates among women living in poverty are complex, and include issues of health status and competing demands on time. For example, women living in poverty are often single, have multiple children, and may be working outside the home in low-paying jobs, among a multitude of other factors (Blum 1999: 110).

In a study on infant feeding practices amongst Ojibway women in Minnesota, the authors found that there was an association between breastfeeding and poverty (Dodgson & Struthers 2003: 50). In First Nation communities, breastfeeding was perceived as a financial necessity and not a choice, resulting in some women choosing formula feeding when they moved to the city as a way to distance themselves from the stigma of poverty. In reference to her life on the reserve, the authors quoted a 65 year old woman who moved to the city as saying "breastfeeding was what poor people did" (Dodgson & Struthers 2003: 56). This woman wanted to leave behind the poverty associated with her community and therefore formula-fed her infants as a result.

In addition to issues of poverty, breastfeeding can be challenging for women experiencing depression. Postpartum depression is a non-psychotic depression that can occur shortly after childbirth and is estimated to affect approximately 13% of women (Ross et al. 2005: 4). A study conducted by Cooke et al. found that women who scored high on The Edinburg Postnatal Depression Scale, a commonly used tool designed to diagnose postpartum depression, were more likely to cease breastfeeding (Ross et al. 2006: 66). Women who scored low on the Maternal Role Attainment (MRA) subscale were more likely to stop breastfeeding. Further, women who scored high on the MRA and were not breastfeeding were more likely to be categorized as distressed than women who had low MRA or women who had high MRA and continued to breastfeed. As well, women who identified strongly with their motherhood role struggled more if they ceased breastfeeding (Ross et al. 2006: 67).

In a study conducted by Shakespeare et al. on breastfeeding difficulties experienced by women with postnatal depression, breastfeeding was also cited as a potential stressor for

women who might be experiencing breastfeeding difficulties which impacted their mental health status. They found that breastfeeding difficulties are common and that they cause emotional distress (Shakespeare et al. 2004: 251). Finally, Pippins et al. conducted a study on the association of breastfeeding with maternal depression (2006). The researchers surveyed ethnically and socioeconomically diverse women and found that breastfeeding initiation was not associated with depressive symptoms during or prior to pregnancy. However, breastfeeding duration of less than one month was associated with persistent depressive symptoms (Pippins et al. 2006: 754).

Another factor influencing women's infant feeding decision is a history of abuse, or current partner abuse which highlights the importance for sensitivity when promoting breastfeeding as a universal public health measure for women. Abuse statistics are staggering in Canada, with about 51% of women experiencing some form of abuse during their lifetime (Statistics Canada 1993: 17). Aboriginal women experience levels of abuse at greater rates than non-Aboriginal women; according to Amnesty International, Indigenous women are five times more likely than non-Aboriginal women to die as a result of violence (2004: 4). According to a study on violence against women during the perinatal period, women involved in abusive relationships are likely to face significant barriers to breastfeeding (Kendall-Tackett 2007: 344). Additionally, women whose partners are not supportive of breastfeeding are more likely to cease breastfeeding. An abusive partner may perceive his partner's breast as existing for his sexual purposes and not for infant feeding. As well, women who are sexual abuse survivors sometimes have difficulties with breastfeeding. Breastfeeding can trigger abuse memories, and

some sexual abuse survivors are uncomfortable with their bodies, which can create challenges regarding breastfeeding (Klingelhafer 2007: 194).

Klingelhafer argues that it is helpful to understand a client's reasoning before challenging them about their breastfeeding choices. The women she interviewed felt that breastfeeding was dirty and disgusting and they struggled with putting a part of their body into their child's mouth (Klingelhafer 2007: 195). One woman felt that her baby could not consent to breastfeeding and since her infant could not make a choice as to how she wanted to be fed she could not breastfeed her. Another woman pumped her breast milk and fed her baby with a bottle because she had received a significant amount of pressure to breastfeed from her husband's family and professionals, but she could not bear to breastfeed her child directly (Klingelhafer 2007: 196).

Bowman argues that breastfeeding may be a threat to adolescent mothers who have a history of sexual abuse. Historical sexual abuse is often a contributing factor to infant feeding decisions amongst adolescent mothers and she argues that nurses need to provide women with neutral information on both breastfeeding and formula feeding and encourage women to choose the method which is best for both them and their infants (Bowman 2007: 97). Not all women who have experienced sexual abuse will be adverse to breastfeeding, but some women will struggle with breastfeeding. These studies suggest that it is important for breastfeeding policy to be reflective of, and sensitive to, such issues and not to pressure or stigmatize women who make the choice not to breastfeed or not to breastfeed exclusively.

Although breastfeeding can be difficult for women who have experienced abuse, studies have found that experiencing sexual abuse does not necessarily inhibit breastfeeding (Kendall-

Tackett citing Benedict et al 2007: 349; Prentice et. al 2008: 219). Prentice et al. conducted a telephone survey with 2,017 parents with children under the age of three and women were asked about childhood sexual abuse and their breastfeeding practices. Of the women surveyed, 7% reported a history of childhood sexual abuse and these women were more than twice as likely to report that they had initiated breastfeeding, as compared to women who did not have a history of abuse. However, this study did not ask women why they chose to breastfeed and it did not explore the psychological aspect of breastfeeding with women who have experienced abuse (Prentice et al. 2008: 225).

Benedict et al. found in their study of 360 women that 12% reported a history of sexual abuse, however, 54% of the women with a history of abuse indicated an intention to breastfeed, as compared to 41% of the non-abused women (Kendall-Tacket citing Benedict et al. 2007: 349). However, as Kendall-Tackett notes, it is unclear whether many of these mothers were actually able to breastfeed and what barriers they may have faced. She points out that high cortisol levels, a hormone produced in response to stress and anxiety, can affect breastfeeding in the early days after birth. Abuse survivors often have disturbed levels of cortisol, a condition which can delay the onset of lactogenesis, causing women to conclude they cannot produce adequate levels of milk (Kendall-Tacket 2007: 349).

Van Esetrik and Wood point out that supporting breastfeeding with women who have been sexually abused requires sensitivity and special attention (2005: 1). Experiencing sexual abuse as a child violates women's body boundaries, and touching breasts or seeing other women breastfeeding may trigger memories of the abuse. For these women, learning to breastfeed may be challenging. According to Van Esterik and Wood it can be easier for hospitals to provide

women who have been sexually abused with formula rather than to support them in establishing breastfeeding. Staff working with women who have been sexually abused need to have specialized counselling and clinical skills in order to properly and effectively support women to breastfeed. They recommend that staff always ask permission before touching a woman's breast since this can trigger the trauma women have experienced. Further they note that breastfeeding can be a healing experience for some women with a history of sexual abuse (Van Esterik and Wood 2005: 2).

5. Infant Feeding In Everyday Life

Breastfeeding in public, the involvement of partners in infant feeding, physical challenges, and work also all impact infant feeding decisions. Breasts have been erotized in Western society which may make breastfeeding difficult for women while performing their maternal role. Stearns argues that the "sexual aspects of women and the maternal aspect of women are expected to be independent of each other" (1999: 309). These contrasting ideas of women's breasts as sexual and maternal have implications regarding the way in which women negotiate breastfeeding in public places and around men. Public breastfeeding is challenging for women in a culture that has sexualized the breast. Breasts are viewed as sexual objects reserved for the use of men. Thus our society is profoundly uncomfortable with public breastfeeding and breastfeeding in front of others. Some have argued that the promotion of exclusive breastfeeding has the danger of relegating women to the private sphere, feeding their infants in their homes, in secluded rooms or in bathrooms out of the public eye (Carter 1995; Stearns 1999; Murphy 2003).

According to Stearns, women must manage their breastfeeding in pubic in certain ways due to societal concepts of breasts as sexual in nature rather than nurturing (1999: 308). Carter believes that the tension between breasts as sexual objects and breasts as sources of nutrition creates difficulties with breastfeeding in public and accounts for the use of formula as a result (1995: 115).

Stearns interviewed women about their experiences breastfeeding in public in her study and she identified that women expressed feelings of irritation and anger with the necessity to be discreet when breastfeeding in front of others (1999: 322). She argues that the work of breastfeeding is increased because women must "constantly negotiate and manage the act of breastfeeding in every sector of society; in public and the home" (Stearns 1999: 322). Women are required to balance competing ideas about what their breasts represent and how they should be used. Breastfeeding occurs with constant vigilance to the observer. Breastfeeding, especially exclusive breastfeeding, is all-encompassing and time-consuming work that can only be accomplished by women. This work becomes invisible when women are required to hide breastfeeding practices (Stearns 1999: 323).

Stories from women who chose to formula-feed suggest that women have used the issue of personal modesty to defend their decision to formula-feed (Murphy 1999: 199). In doing so, Murphy suggests that these women felt the focus was less about fulfilling their maternal "duty" and more about what they considered to be "understandable" or acceptable bodily practices. Women who chose to breastfeed felt that it was their responsibility to ensure that others would not feel uncomfortable when they were breastfeeding in the presence of others (Murphy 1999: 203).

Partners can also have a significant influence on infant feeding decisions. Exclusive breastfeeding requires a mother to be solely responsible for nourishing her infants. Many women choose formula feeding as a way to be supported in sharing the demands of infant feeding with their partners and other family members and friends (Earle 2000: 323; Blum 1999; Murphy 2000). Research has identified that involving fathers in infant feeding is a contributing factor for using formula. Earle found in her research that many women who chose to bottle feed did so because it was perceived as a way to share the work and experience of parenting (2000: 328). Earle also argues that men need to be educated regarding the benefits of breastfeeding since women are influenced by their partners in their infant feeding decisions (2000: 328). In the past few years there has been an increase in health promotion literature on breastfeeding directed specifically at men (Smyth 2008: 93).

Breastfeeding can be physically challenging for some women. A study conducted by Kelleher found that 63% of women experienced pain or discomfort associated with breastfeeding (2006: 2727). Many of the women she interviewed were surprised by the extent and intensity of the pain they experienced and several women reported that the "physical impact of breastfeeding affected their relationship with their baby and sometimes made them hesitant to continue the practice due to feelings of physical vulnerability" (Kelleher 2006: 2730). Huck and Irurita argue that breastfeeding promotion generally focuses on the positive aspects of breastfeeding which results in women feeling poorly if they have experiences that contradict this. They argue that women have a right to be informed of the realities of breastfeeding and the range of variations within individual breastfeeding experiences (2002: 74).

Bartlett claims that breastfeeding is a complex activity that is unpredictable and "cannot be reduced to a set of universal claims that relate to homogenous bodies because lived experiences are fundamental to lactation responses" (2002: 375). Therefore, breastfeeding is not only influenced by cultural and social factors, but also physiological factors. The complexities of individual experiences that affect women's bodies influence their infant feeding choices, capabilities, and experiences.

Some studies have suggested that the act of breastfeeding violates the Western idea of the autonomous body. In their research, Schmied and Lupton, found that women either loved or hated their breastfeeding experiences and that their attitudes did not change much over time. They argue that many of the women's negative feelings were related to the demands of exclusively breastfeeding an infant and to the loss of autonomy related to feelings of encroachment on the body/self (Schmied and Lupton 2001: 244). Some of the women they interviewed were profoundly distressed by their breastfeeding experiences and described breastfeeding as chaotic, distorting and alienating (Schmied and Lupton 2001: 245).

Although Canada does provide women with the option of a twelve month parental leave from paid work, some women chose to return to work early, some share parental leave with their partner and many low income women cannot afford to take six months or a full year off work. Blum notes that working-class women have the lowest breastfeeding rates in the United States and that for many women breastfeeding was a luxury (1999: 176). As noted earlier, single women are less likely to breastfeed than women in relationships (Statistics Canada 2005: 25). Financial security is an important factor in maintaining ongoing or exclusive breastfeeding. The Baby Friendly Initiative encourages the development of legislation that enables women to

continue breastfeeding upon return to paid work (The Breastfeeding Committee for Canada 2002: 3). However, combining work and breastfeeding can be incredibly challenging for women (Gatrell 2007: 394). Low income women are often employed in service-related jobs which render both breastfeeding and the pumping of breast milk virtually impossible. As well, pumping breast milk at work is problematic for many women since many workplaces do not have facilities that accommodate women's ability to do this. Many colleagues do not approve of storing breast milk in the staff fridge, and employers often do not want to provide women the time it takes to pump (Avishi 2002: 140, Gatrell 2007: 396). As Avishi notes, "pumping at the workplace is a viable option only for the most privileged workers" (Avishi 2002: 140). Additionally, some women working in professional roles find managing their leaking, unpredictable bodies challenging in workplaces that are dominated by men and regulated by specific codes of behaviour and dress (Gatrell 2007: 395).

6. The Construction of Risk in Infant Feeding Messaging

As noted in the introduction, formula is presented from a risk perspective in BFI policy. In this section I will review ideas surrounding the construction of risk and its implications for infant feeding. Sociological theorizing argues that contemporary society has become a 'risk society' in which individuals are responsible for managing risks which are identified by experts. Lupton has written extensively on the construction of risk in public health discourse. Historically, risk was a neutral term that referred to the statistical likelihood of an event occurring; risk was neither negative nor positive. Presently, within health discourse, the idea of risk has shifted and assumed a negative connotation that is associated with danger. Lupton states that "a discourse of risk has evolved with particular application to health issues" (1993:

426). In public health discourse, health risks are often presented as a consequence of lifestyle choices made by individuals. There is little consideration of their social context and structural causes of ill-health are frequently ignored. Within this framework health status is subjected to moral judgments. Lupton argues that pregnant women and mothers are subjected to excessive regulation in society because they are perceived to be responsible not only for their own health, but also the health of their child (1996: 41).

According to Law, the risks associated with formula feeding as promoted by breastfeeding advocates are often exaggerated and medical literature does not provide a good picture of the severity of risks or how "particular risks to infant health are constructed and assessed relative to other risks and practices" (2000: 415). A better contextualization of the relative risks and benefits of formula use is needed in public health breastfeeding literature according to Knaak (2006: 413). She feels that it is important to situate the health impacts of formula use within a broader social context which will enable mothers to make infant feeding decisions in relation to other health and mothering considerations (Knaak 2006: 413). This shift would reposition breastfeeding promotion from its current mode of persuasion and influence to an educational tool (Knaak 2006: 414).

Murphy argues that within breastfeeding policies, calculations of risk are translated into expert advice which holds mothers accountable for the future health and intelligence of their children, despite the multiple health, social, economic, structural and cultural factors that influence infant feeding choices and child health outcomes (2000: 297). In her interviews with women she found that mothers were concerned with establishing themselves as knowledgeable about breastfeeding and while in hospital, went along with the desires of

experts and breastfed as a result; nevertheless, many used formula once they left the hospital. Breastfeeding experts believe that women cease breastfeeding once they leave hospitals due to a lack of support. However, Murphy argues that these women were acting out of agency and resisting the public health pressures placed on women to breastfeed (2003: 455).

In a study with women who formula-fed their infants, Lee found that women used formula as a method of managing the pressures of everyday life. However, they perceived formula feeding to be a risky practice and therefore responded to professionals with deceit regarding their choice of feeding method. Women felt a sense of "bewilderment and isolation when they adopted this feeding strategy," according to Lee (2007: 307). She explains that information on formula feeding was largely unavailable to women she interviewed which resulted in uncertainty regarding best practices for formula feeding (Lee 2007: 305).

As noted earlier, the BFI encourages women to make "informed infant feeding decisions" and argues that women are free to choose whatever infant feeding method they desire. However, when formula is presented from a risk perspective, women are informed that using formula puts their infant's health at risk and that it should be used only when medically directed (Lee 2205: 4). In such rhetoric, breastfeeding is associated with safety and formula with risk therefore, as Murphy points out "when mothers are warned of the dangers of formula feeding, the implicit message is that the good mother will breastfeed" (2003: 438). Knaak argues that despite a rhetoric of choice of infant feeding methods in popular infant feeding literature, breastfeeding is ultimately not presented as a choice for women. Breastfeeding represents a medical gold standard, and is therefore presented as a gold standard for mothering, a fact which renders the notion of "choice" problematic in infant feeding decisions

(Knaak 2005: 197). If women choose to formula-feed, they are making a choice which is seen to contrast with contemporary conventional Western ideas of good mothering. Knaak argues that the context of choice in breastfeeding discourse is "morally-based, implicitly judgmental, constraining and contradictory" (2009: 8).

7. Breastfeeding as a Moral Imperative

A moral imperative related to infant feeding has emerged in contemporary society. Lee argues that the use of formula compromises a woman's identity as a good mother, despite the fact that using formula is a common practice (2008: 467). Schmied et al. found that women in their study went to great extremes to maintain breastfeeding when experiencing difficulties, in an attempt to achieve their goal as breastfeeding mothers. If they switched to formula feeding they viewed themselves as failing and felt poorly as a result (2000: 45). Women's feelings of guilt, shame, and failure related to infant feeding have been documented in other studies as well (Blum 1999; Carter 1995; Crossley 2009; Larsen, Hall and Aagaard 2008; Lee 2005, 2007, 2008; Murphy 1999, 2000, 2003; Schmied and Barclay 1999).

Breastfeeding is promoted by medical and health organizations as the gold standard for infant feeding and this "approach conveys, in a medicalized form, powerful messages to women about what 'good mothering' constitutes" (Lee 1997: 297). In a study conducted on breastfeeding women, Murphy argues that infant feeding decisions are a "moral minefield" (1999: 205). She argues that the expressed intention not to breastfeed jeopardizes the moral status of mothers. In her research she found that women were required to defend themselves to health professionals if they did not breastfeed (Murphy 1999: 193). Deciding to formula-feed can lead to the portrayal of a woman as a bad mother, since she is putting her own needs

before her child's, whereas if she decides to breastfeed she is portrayed as a good mother, one who puts her infant's needs ahead of her own. Murphy concludes by suggesting that "feeding decisions are as much about morality as they are about nutrition" (1999: 206).

Current motherhood ideologies contribute to the ideas of good mothering that are imbedded within breastfeeding discourse (Blum 1999: 5). Hayes coined the term 'intensive mothering' to describe present-day motherhood ideologies as presented in her book titled *The Cultural Contradictions of Motherhood* (1996). According to Hayes, intensive mothering is constructed as "child-centered, expert-guided, emotionally absorbing, labour-intensive and financially expensive" (1996: 8). Additionally, O'Reily argues that intensive mothering dictates that only biological mothers can properly care for children. Mothering is a 24 hour a day, 7 day a week commitment. A child's needs come before the mother's, and mothers must be totally satisfied and fulfilled by their mothering role (Gosslin citing O'Reily 2006: 198). Present motherhood ideologies dictate that women invest an enormous amount of time into mothering and women are held solely responsible for raising their children and ensuring their health and well-being; women who fall outside this construct are defined as bad mothers (Gosslin 2006: 199).

However, the ideal of exclusive motherhood is inherently racialized (Blum 1999: 9). Blum states that exclusive motherhood has its origins in the idealized female domesticity of the middle class in the eighteenth century. This domestic ideal relied on women of colour who acted as slaves, servants, or wet nurses (Blum 1999: 9). Blum interviewed African American women who embraced formula feeding as a method to resist sexualized stereotyping and a historical legacy of wet-nursing Caucasian babies (Blum 1999: 165 and 171).

Similarly, exclusive mothering ideals do not always apply to Aboriginal women. Due to cultural differences in parenting practices, Aboriginal women have been framed negatively as mothers in Canada (Lavell-Harvard, M. and Lavell Corbiere, J. 2006:5). Lavell-Harvard and Lavell Corbiere argue that in contemporary society, a good mother is constructed as adhering to expert advice on how to raise her children and she raises her children in isolation from the community at large. However, this philosophy contrasts with traditional Aboriginal parenting practices in which the community as a whole is responsible for child rearing. Contemporary individualistic and expert-oriented Western ideas surrounding mothering conflict with traditional Aboriginal mothering practices. Thus, the intensive mothering ideology has led to many Aboriginal women being labeled as bad mothers in Canadian society (Mzinegiizhigo-kwe Bedard 2006: 69).

8. Breastfeeding Policy Implications

The Baby Friendly Initiative has been criticized for making it difficult for women to access information on formula and for marginalizing women who do use formula (Lee 2005: 5). Lee argues that it is "difficult to separate the provision of factual information and evidence in the crusade against formula" (2005: 5). A systematic review of qualitative and quantitative studies on mothers' experiences with bottle-feeding found that women received little information on formula feeding, mistakes in preparation of formula were common, and women did not feel empowered in their infant feeding decisions (Lakshman, Ogilvie and Ong 2009: 595). The authors of this study conclude that inadequate information and support for women who are using formula may in fact put the health of their infants at risk in the name of promoting exclusive breastfeeding (Lakshman, Ogilvie and Ong 2009: 601).

Meyer and de Oliveira analyze the impact the Baby Friendly Initiative is having on women in Brazil. They argue that breastfeeding is understood to be an intrinsic characteristic of motherhood in Western societies and that this belief has influenced public policies on breastfeeding in Brazil. The use of breast milk has been promoted as a solution to a wide range of social problems such as global malnutrition, poverty, family violence, and ecological problems. As well, breastfeeding has been assumed to be the natural method of feeding infants and weaning has been linked to a host of health problems for children. Meyer and de Oliveira argue that powerful systems of social control are produced through breastfeeding policies and practices (Meyer and de Oliveira 2003: 12).

In another study conducted in Australia, Schmied, Sheehan, and Barclay argue that policies associated with the Baby Friendly Initiative are applied in a coercive and rigid manner. They believe that this policy applies a model of health promotion that fails to consider the social, emotional, and individual nature of infant feeding (Schmied, Sheehan and Barclay 2001: 44). This initiative views breastfeeding from a physiological and medical perspective and assumes that breastfeeding rates will increase if the practice is prescribed by a medical professional. They argue that these practices privilege infant nutrition over the well-being of the mother and do not recognize that maternal health and confidence are as important to the baby as is breastfeeding (Schmied, Sheehan and Barclay 2001: 50).

In a study conducted by Shakespeare et al. on breastfeeding difficulties experienced by women with postnatal depression, women were aware that information on formula feeding was being withheld from them and they resented this practice. Additionally, one woman felt that professionals were unwilling to help her because they were following Baby Friendly

policies. Shakespeare et al. argues that learning how to bottle feed safely is an important public health issue that should not be neglected. They state that "Baby Friendly may need to consider ways in which it can become more mother friendly" (Shakespeare et al. 2004: 259).

Fuber and Thompson reported in their study that midwives have broken hospital breastfeeding policy in order to provide woman-centred care (2006). They conducted research with midwives who were working in hospitals that were either in the process of becoming BFI designated or were already. They found that midwives routinely and knowingly practiced rule-breaking behaviour when working with women regarding infant feeding. The midwives perceived their rule-breaking practices to be woman-centred, however, they concealed their rule-breaking from other colleagues since they felt their behaviour would not be viewed as acceptable to hospital staff members, and they were concerned about being labeled as deviant (Fuber and Thompson 2006: 371). The midwives provided infants with formula when mothers were struggling with breastfeeding or were physically and psychologically exhausted, since the midwives felt that mothers would be more effective at establishing breastfeeding if they had an opportunity to rest (Fuber and Thompson 2006: 369). As well, midwives in this study did not feel it was appropriate to remove women from prenatal classes to provide education on formula if women asked about it in a group setting. The midwives felt that women should not be "closeted away" while receiving this education and that providing information only on breastfeeding was not realistic for many of the women they worked with (Fuber and Thompson 2006: 370). Since the BFI policy does not allow for the distribution of formula unless medically directed, one midwife reported that she hid a supply of formula in her work setting to provide to infants if required (Fuber and Thompson 2006: 370).

Current breastfeeding policy can also be detrimental to marginalized women. A thesis written by Guigne on infant feeding recommendations for women living with AIDS in Saskatoon describes how women are informed not to breastfeed by the local regional health authority (2008: 40). However, the hospital in Saskatoon is a BFI hospital, therefore, women are provided with education on breastfeeding only (Guigne 2008: 71). Professionals in the community report that women living with AIDS often do not seek out information on infant feeding and the responsibility is placed on the women to find out how to feed their infants formula. Although many of the women with AIDS in Saskatoon are living in poverty, poor women face a lack of access to free baby formula (Guigne 2008: 68). The author concludes her thesis by stating that the decision to feed one's baby formula subjects a mother to subject to "bad mothering" discourses within BFI environments, since "breast is best." This is problematic for women living with AIDS because they have been directed to use formula to feed their infants. These women are receiving little information and support regarding infant feeding and the author argues that they are being publicly reminded that their "choice" to feed their infants formula is inferior and unhealthy (Guigne 2008: 63).

Finally, Nelson argues that breastfeeding policies and advocacy need to be repositioned and programs need to provide individualized breastfeeding support rather than standardized breastfeeding approach. She conducted a metasynthesis of qualitative breastfeeding studies and found breastfeeding to be "an engrossing, personal journey" (Nelson 2006: 15). As a result, she recommends that health practitioners support individual mothers' breastfeeding capacity, goals, comfort level with her body, support network, tolerance for breastfeeding difficulties and

willingness to make life adoptions that breastfeeding requires (Nelson 2006: 13). This mode of support will facilitate a satisfactory maternal breastfeeding experience.

9. Conclusion

Infant feeding policies and educational information have changed dramatically over the past century and have always been a political issue. Until recently feminist debate on the issue of infant feeding was dominated by a maternal feminist perspective. A broader, intersectional feminist analysis was scarce. Little evidence exists on the infant feeding experiences of urban Aboriginal women and that which does, is largely from a health sciences perspective. It is evident from the discussion above that infant feeding decisions are complex and influenced by numerous social factors such as poverty, abuse, mental health, work, and infant feeding in public places as well as by partners. However, the positioning of formula from a risk perspective leads to the politicization of infant feeding choices. As a result of policies and messaging which ignores social complexities, women are subjected to a moral breastfeeding imperative which frames the non-breastfeeding mother as a poor mother. BFI policies have been identified as detrimental to women who are unable to breastfeed or choose not to breastfeed. Further, women have little access to educational information on formula, which could be harmful to child health. Drawing on these insights, the next chapter discusses in further detail the methodology shaping this study and the manner in which the research was conducted. The sampling method, the interview questions, the thematic analysis, challenges experienced during the collection of the data, strengths of the research, and the explanation for a qualitative feminist methodology are all reviewed.

Chapter 3 – Methodology

This study is based on both primary and secondary sources of information. Primary sources include in-depth, semi-structured interviews with Aboriginal mothers and health professionals working with Aboriginal mothers, regarding their infant feeding experiences. In particular, I was interested in exploring: the type of infant feeding information health professionals working in the community provide to Aboriginal mothers; the kind of information Aboriginal mothers are looking for; the social and structural influences on Aboriginal mothers which impact their infant feeding decisions; and whether current health policy approaches for breastfeeding are relevant for a marginalized population, specifically Aboriginal mothers.

Secondary sources were drawn from sociological, feminist, public health, nursing, and medical literature on women's breastfeeding experiences, analyses of the health benefits of breastfeeding for women and infants, social and structural influences that impact infant feeding choices, and literature on Aboriginal women's infant feeding experiences. The secondary sources reviewed discuss numerous factors that influence women and their infant feeding choices and decisions such as poverty, abuse, substance use, flexibility of paid employment, family and friends, the sexualization of the breast in popular culture, maternal age at time of birth, physical discomfort with breastfeeding, and reactions to breastfeeding in public places. The literature also fore-grounded issues of social and medical stigmatization and feelings of failure, guilt and judgment experienced by women who chose not to breastfeed or who struggled with breastfeeding. As discussed in Chapter Two, several studies noted that women's lived experiences often clash with public education information on breastfeeding and many women report feeling pressured and conflicted in their infant feeding decisions.

1. Feminist Qualitative Methodology

This study uses feminist qualitative methodology which is valuable in uncovering women's experiences while providing rich detailed information about women's everyday lives. Feminist methodologies celebrate women's ways of knowing; Harding argues that "understanding women's lives from a committed feminist exploration of their experiences of oppression produces more complete and less distorted knowledge" (Maynard citing Harding 2001: 18). Many feminist qualitative researchers prefer to use methods which allow analysis of the way in which multiple realities and experiences are influenced by our social locations and experiences of oppression.

Qualitative methods are valuable for providing insights and meanings regarding social ideas, practices and phenomena. Qualitative research collects detailed data which explores why and how people think and feel the way they do. Green and Britten argue that qualitative research is particularly important in the study of health issues since qualitative research asks questions that cannot be easily answered using experimental methods (1998: 1230). For example, qualitative interviews allow participants to expresses themselves openly and freely in their own words, which can assist in deepening our understanding of social factors and influences on health status and health behaviours.

Feminist research strives for the researcher/research relationship to be as non-hierarchical as possible (Maynard 1994: 15). However, it is important to recognize the privilege and power the researcher brings to the research relationship. As Bryman and Teevan note, "social researchers should reflect on the implications of their methods, values, biases, and decisions on the knowledge of the social world that they generate" (2005: 361). The researcher

should be sensitive to both her own and the research participants' cultural, political and social context. As a result, I have located myself within this research and done my best to understand the manner in which my experiences, biases and privileges have influenced this research process.

Findings from the literature review were used to develop key themes for the interview questions. Participants were asked about how they feed their infants, why they chose that particular feeding method or methods, what types of support systems they have in place to facilitate their feeding methods, their embodied experiences surrounding infant feeding, and their educational experiences with professionals in relation to infant feeding. For the full interview guides see Appendices C and D. These themes were explored with all of the women interviewed, however, each interview was also tailored to the research participant, which allowed for a freer exchange between myself and the participants. Esterberg argues that researchers need to listen carefully to interviewees' responses, which will shape the order and structure of the interview (2002: 10). Following this advice, I designed open-ended questions, however, many questions I asked were based on the responses of the interviewee. Additionally, I collected basic demographic information which will be elaborated on further in this chapter.

Key informant interviews were also conducted with health professionals working with Aboriginal mothers. Key informants are individuals who are knowledgeable about a particular environment and are willing to share information and their expertise with the researcher (Esterberg 2002: 70). Nurses, health promotion specialists, managers, and social workers from various Aboriginal and non-Aboriginal institutions and community-based organizations were

interviewed as key informants for their insights regarding Aboriginal mothers, health policy, and infant feeding choices.

The building of trust was very important for my research since the nature of the interviews was to uncover personal information from marginalized women. Employing feminist principles such as subjectivity and reflexivity assisted in establishing a relationship with the participant, which is vital when discussing personal issues such as breastfeeding and some of the social factors that impact women, such as abuse and substance use (Ardovini-Brooker 2002: 3). I implemented a number of practices in order to establish a comfortable relationship between myself and the participants. I offered to meet the mothers at a time that was convenient for them and at a location they were most comfortable with. As a result my interviews took place at either the mother's home, at a coffee shop, and in one instance at a mall. Since the majority of mothers I interviewed were on social assistance I purchased them a drink and a snack.

One mother met me at a coffee shop because she did not wish to conduct the interview in the presence of her partner. She stated, "He's kinda nosy, he'll be listening and he doesn't need to know everything." In two other scenarios I went to the mothers' homes to conduct the interview as initially agreed upon, however, both mothers wanted to leave and do the interview elsewhere since their partners were going to be home. They did not want to do the interviews in the presence of their partners. One participant informed me that she and her partner were fighting and she didn't want to be around him. Relationship abuse is an important issue when conducting research with women and researchers need to be cognizant of this in order to ensure safety for the woman involved (World Health Organization 2001: 10). Although I do not

know if this was an abusive relationship, since the participant did not disclose this, it was important to note and respect the mother's wishes, so we moved the interview location to increase her comfort level.

In both scenarios noted above I transported the participant and a child to either a coffee shop or a mall. One of the participants had a car seat that she installed in my car, and she sat in the back seat with the infant. The other woman did not have a car seat for her two year old child. I was conflicted as to how I should handle this situation. As someone who has worked in injury prevention for children I was well aware of the statistics regarding injuries and deaths for children in car collisions, in addition to the fact that transporting children in a vehicle without a car seat is illegal. I fully appreciated that this woman did not have a car seat, most likely as a result of living in poverty. Poverty as a determinant of health once again became clear, as it has numerous times throughout my career, and this also reinforced the class differential between the respondent and me. I felt that suggesting a rescheduling of the interview for another time (since I was uncomfortable transporting a child without a car seat) would not be an ideal method for building rapport. Requesting to stay at her home to do the interview would have made the mother very uncomfortable since she asked that we leave because her partner was at home. Therefore, I decided to drive to the mall with the mother and her child. I was extra cautious while driving and grateful that the mall was only a few minutes away.

During the interviews most of the participants asked me personal questions about myself and the research I was conducting. I was asked if I had children of my own, whether I was married, and there were inquiries about my education. A couple of mothers asked about how a Master's program works, how long my thesis had to be, and if I enjoyed my experience at

Lakehead University. A number of interviewees, both Aboriginal mothers and key informants, were interested in how other women interviewed responded to particular questions. Some of the key informants appeared to be insecure about their responses and wanted to know how other people had replied. In some cases I was asked before they provided their answer. I felt that they were seeking to discover how others had answered before they responded so that their own response would be in line with other key informants. I was also asked by some mothers how other women had responded to questions after having given their own response, which I interpreted as an attempt to reassure themselves that their response was similar to others. Many of the mothers I interviewed were keenly interested in how other women had responded to a question about cross-nursing or women breastfeeding other women's infants. They found this topic intriguing and wanted to know what other women thought about it. Additionally, I was asked one question regarding the avoidance of tooth decay which can occur when infants and toddlers are bottle-feeding.

I shared personal information in response to their questions in order to assist the building of a good rapport between myself and the mothers and to minimize the power differential between us. I also shared information I possessed on avoiding rotting teeth in infants and toddlers, however, I also encouraged the mother who asked me about this to consult with her healthcare professional since my knowledge on the topic was limited. When I was questioned about what information other participants were providing, I answered honestly, being careful not to identify respondents. I provided a brief response if I was asked before they had responded themselves, in an effort to minimize the influence this may have had on their own answers. Oakley argues that answering questions interviewees have for the

interviewer is fundamental when conducting research utilizing feminist principles. "The goal of finding out about people through interviewing is best achieved when the relationship of the interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (Oakley 1981: 141).

The interview questions were designed utilizing plain language principles. I shared my interview questions with a friend of mine who is a plain language specialist to ensure that I would not be using any jargon, scientific terminology, or wording that was academically distancing. I also conducted a pilot interview and asked for feedback on the wording and flow to determine if anything should be changed. As a result, I made a few modifications to the questions. Oakley argues that using formal scientific language establishes an atmosphere where the researcher holds more power over those participating in the interviews (Oakley, 1981: 136). Therefore, it was important that I ensure that the language I was using did not alienate any of the interviewees.

The order of the questions I asked the Aboriginal mothers and key informants varied somewhat in each interview I conducted, based on the responses I received. For example, question number fifteen asks about comfort level regarding infant feeding in public places. Many mothers touched on this issue early on in the interview; therefore, I asked them for further details regarding this issue when they brought it up instead of asking them the question later in the interview. As well, some mothers discussed unique personal experiences unrelated to the questions; as a result, I asked further questions related to the topic in order to explore the issue at a deeper level. For example, one mother discussed her experiences when her children were removed from her care by the Child Welfare system. During this difficult time

she continued to pump her breast milk, which she then provided to her child's caregiver. She saw this as a way of staying connected to her child. Since this was an important event in her infant feeding experiences I asked her to elaborate about how she felt and why she felt the way she did. This provided richer detail on her experiences and feelings regarding breastfeeding and parenting.

There were some instances when I did not ask all of the questions I had planned on asking. One of the questions in my interview guide was related to abuse and infant feeding. I did not ask this question in two interviews with mothers since their partners were in the room and I felt it was inappropriate to ask the question. Asking a woman about abuse when her partner is present could put her at risk for further violence if her relationship is abusive (World Health Organization 2001: 11).

After my first interview I added a question about breastfeeding and substance use. In the first interview I conducted I suspected the participant may have struggled with substance use issues, however since I had not planned on asking about this issue and it can be a sensitive topic, I did not feel comfortable exploring this with her. After reflecting on this and discussing it with my supervisor I decided to include this topic for future interviews, phrasing it in a non-threatening manner. I opened the question by stating that some women report struggles with breastfeeding because they are using substances; I then asked if this was something they had heard from other women. By phrasing the question in this manner it allowed women to discuss the issue in general without having to disclose personal experiences if they chose not to. I also included a similar question in the key informant interviews. Through the inclusion of this question I found, as will be discussed in Chapter Four, there is confusion and debate among

mothers as well as health professionals in Thunder Bay regarding breastfeeding protocols for women receiving methadone treatment. As well, some of the mothers interviewed indicated they wished to have more information on how they could balance occasional substance use while continuing to breastfeed.

Finally, I had information available regarding community services for the mothers interviewed, in case any of the participants required information on abuse services, health services, or social services such as food banks or housing.

2. Research with Aboriginal Populations

Research with Aboriginal populations requires special consideration, particularly when the research is conducted by non-Aboriginal researchers such as myself. Historically, when Western researchers have conducted research with Aboriginal peoples they often have not respected cultural values within the communities in which they were working. Research often problematized Aboriginal peoples and this research was used in the creation of policies that contributed to the colonization of Aboriginal peoples (Castellano 2004: 98). When research was conducted with Aboriginal communities, "the western scientific paradigm predominated and, through the research process, Aboriginal people and their cultures became largely the subjects and objects of study" (CIHR 2007: 10). Therefore, in addition to following the research ethics guidelines set out by Lakehead University I also followed the Canadian Institutes of Health Research (CIHR) *Guidelines for Health Research Involving Aboriginal People* (2007). These protocols assist researchers to conduct ethically and culturally competent research that aligns with Aboriginal values and traditions.

Prior to beginning the research for my thesis I had preliminary discussions about my research interests with staff from two Aboriginal organizations. Both organizations expressed an interest in aiding in the study. These organizations assisted in the planning and implementation of the research. As well, an Aboriginal nurse practitioner who has worked for many years in health services and health research agreed to be a member of my MA thesis committee and to aid with the interpretation of the mothers' voices who participated in this research study.

3. Research Design and Sampling

Advertisement for volunteers was conducted through the distribution of a recruitment flyer (see Appendix A) by five local organizations. Staff from some of these organizations identified potential interviewees and made personal contact with the mothers to explain the research and ask if they were interested in volunteering. Due to confidentiality policies implemented by the organizations, the names and contact information of mothers could not be provided directly to me. Staff provided my contact information to mothers and asked women to contact me if they were interested in participating in the study. I also conducted presentations about the study at three community programs in an attempt to directly recruit mothers to interview.

I received ethics approval to interview mothers aged sixteen and above, since Aboriginal women in North-Western Ontario tend to be younger when they give birth than non-Aboriginal women and studies have shown that age is a determining factor for successful breastfeeding

initiation and duration (Statistics Canada 2005: 25).[3] Since older women have higher breastfeeding rates I felt it would be important to examine some of the structural barriers young mothers encounter which might impact their infant feeding decisions. I acquired a letter of support from the Ontario Native Women's Association, which I submitted with my ethics package endorsing my argument for a younger sample. As it turned out, none of the mothers I interviewed were under eighteen at the time of the interview, although a number of the mothers I interviewed had their first child when they were under the age of eighteen.

Potential key informants were contacted by email and telephone. I emailed a recruitment letter (see Appendix B) to key informants and followed up with a phone call to ask if they were interested in participating in the study. I identified people who worked for Aboriginal organizations or organizations that serve a large Aboriginal population. I determined appropriate organizations to contact through prior knowledge I possessed from my community and health sector employment experience. As well, I queried staff from the Aboriginal organizations I was working with to create a list of the most appropriate people to contact for key informant interviews.

Some of the organizations I approached about recruitment had assessment protocols to determine whether they would facilitate the work of outside researchers. As a result, I was required to provide them with my thesis proposal, a copy of my ethics approval, and my recruitment flyer. For some of the organizations I approached this was a relatively quick

[3] Statistics Canada data indicates that teenage mothers accounted for approximately one-quarter of all First Nations births in 1999. According to 1999 data, the largest proportion (33%) of live births occurred in the 20 to 24 age group and 24% of live births occurred within the 15 to 19 age cohort. By contrast, the Canadian rate peaked in the 25 to 29 age group, at 32%, and the 20 to 24 and 15 to 19 cohorts were substantially lower, at 18% and 6%. First Nations females aged 15 to 19, had a birth rate of almost five times higher than non-Aboriginal women (Service Canada citing Statistics Canada 2001: 1).

process and approval to recruit was granted in a timely manner. For other organizations the approval process required significantly more lead time than was feasible for a Master's thesis study, thus, I did not pursue recruitment of mothers through these organizations.

Additionally, two breastfeeding mothers were recruited through a snowball sample. Snowball sampling is useful when trying to recruit a population that may be challenging to engage. With this approach the researcher makes contact with a person or a small group of people who are relevant to the research topic and then uses them to make contact with other people who would be appropriate for the study (Bryman and Teevan 2005: 227). In this case I asked some of the mothers I interviewed if they knew of anyone that might be interested in participating in the research. I gave them copies of my recruitment flyer and asked them to share the information with mothers they knew who met the research criteria. A number of mothers indicated they would share the information with friends and family members. Since snowball sampling relies on participants who interact within the same networks, opinions may be similar and those recruited this way may be influenced by their social network as a whole.

As noted above, in-depth interviews were selected as the research technique for this study since I wanted to capture the infant feeding experiences of Aboriginal mothers in their own words. Reinharz argues that in-depth interviews are particularly effective when researching women because women have been historically silenced and they have not always had the opportunity to tell their stories (Esterberg citing Reinharz 2002: 87). The interviews I conducted with women provided rich details on their infant feeding experiences and what influenced their choices. The in-depth interviews were comprised of open-ended questions,

which afforded an opportunity for in-depth discussion and personal reflections on the experiences of these women.

Stipulations for participating in the study included: the mothers had to be self-defined as Aboriginal, over the age of sixteen, and needed to have given birth in the past three years. Key informants had to work with Aboriginal mothers and provide mothers with information on infant feeding practices.

I began the mother's interviews with the collection of demographic information such as age, education, number of children, age of children, relationship status, annual household income, Aboriginal ancestry, the length of time they had been residing in Thunder Bay, and if they had been employed outside the home before they gave birth to their children. Detailed questions regarding infant feeding experiences included asking how they fed their infant or infants, why they chose that particular feeding method, how they felt about their choices, their involvement with prenatal classes, their birthing experience, who or what may have influenced their infant feeding choices, whether they felt supported in their decision making, where they obtained their information on infant feeding, whether they had received the information they needed on infant feeding, how they felt physically and emotionally about their experiences, whether they had any concerns about how they fed their infant or infants, and their experiences feeding their infants in public places (see Appendix C).

I also had three questions that were of a sensitive nature and I was concerned if I asked the mothers about these issues that they might be uncomfortable responding and provide no information as a result. Therefore, I designed these questions so that mothers could discuss either their own experiences or the experiences of other mothers they knew in relation to the

issue presented. For example, I was interested in exposure to abuse and the impact this may have on infant feeding choices. I phrased the questions as follows: "Some women report feeling uncomfortable breastfeeding their baby because they have experienced abuse in the past or are currently in an abusive relationship. Is this something you have heard of as a concern from other women?" This phrasing allows discussion without personal exposure. Other sensitive questions were related to breastfeeding and substance use and breastfeeding other women's infants. The questions asked in the interviews were developed from the key themes identified in the literature review. The full interview guide with Aboriginal mothers is included as Appendix C.

The interviews with key informants were also in-depth and semi-structured. I began by asking workers about their position and the work they do with Aboriginal mothers. I also asked them about information their organization provides to women on infant feeding, the issues and people that women are dealing with that impact their infant feeding decisions, the kinds of questions their clients ask them about infant feeding, whether they think women struggle with either breastfeeding or formula feeding, whether they feel health promotion information influences women's infant feeding decisions, whether they hear stories of women breastfeeding other women's infants, and whether they think current breastfeeding policy reflects the needs and experiences of Aboriginal women. The full interview guide is included as Appendix D.

Both sets of interviews ranged from 30 minutes to one hour, with the majority of interviews lasting approximately forty-five minutes. With the participants' permission, all of the interviews but one were tape-recorded and transcribed verbatim for further analysis. In

one of the interviews my tape recorder failed which I was unaware at the time. Realizing this upon the completion of the interview, I immediately took notes based on the information discussed during the interview.

I also kept a research diary where I documented my experiences after each interview with both the key informants and the Aboriginal mothers. I wrote about where the interview took place, non-verbal communication such as body language, other people who were present and how this impacted the interview, information that was shared before or after the formal interview occurred, and conversations that took place during the recruitment process. This enabled me to capture information beyond the interview schedule which might otherwise have been lost.

4. The Participants

Participants for this study included seven Aboriginal mothers and seven key informants. All of the interviews with key informants were conducted at their place of work. As noted earlier, the interviews with Aboriginal mothers took place at a location and time which was convenient for them. All but one of the interviews with mothers took place with one of their children present. As indicated earlier, I asked all participants where they would like to do the interviews and the interviews were done at the location that was most suitable for the participant. On the phone I clearly explained the purpose of the study and I provided a time estimate for the length of the interview. Before the interview began, I explained once again the purpose of the study and provided each participant with a letter detailing the study. In both the cover letter and the consent form it was clear that participation was strictly voluntary and that the information provided would be kept confidential. Participants were assured that they

could withdraw from the study at any time and that they did not have to answer any questions they did not feel comfortable answering. The interviews were conducted between the months of September 2008 and January 2009.

The Aboriginal mothers interviewed were between the ages of 18 and 31, with the mean age being 24. The number of children ranged from one to four, with three as the mean number of children the mothers had. All of the mothers were currently in a relationship; one mother did not live with her partner but considered herself to be in a committed relationship. All of the mothers were involved in receiving services from community-based organizations on a voluntary basis. The mothers were currently residing in an urban environment and for the most part had grown up in urban communities. One of the mothers had recently relocated from an isolated northern reserve that does not have road access. All of the mothers but one was a recipient of social assistance and therefore living in poverty. One interviewee had completed college, one had completed high school, and the rest had not completed high school, however, two were in the process of finishing high school. All of the mothers had been employed in various jobs before giving birth, however, none of the mothers interviewed was working outside the home at the time of the interview. All of the mothers had at least one child under the age of three and they were the primary caregiver for their children. Four of the mothers reported that they were Oji-Cree and three reported that they were Ojibway. Two of the mothers had breastfed or were breastfeeding one or more of their infants exclusively. Six had used mixed feeding methods: mixing formula with breast milk. Three used formula exclusively with one or more of their children but had breastfed or used mixed feeding with one or more of their other infants.

The key informants were employed in community-based organizations or institutions. They were all professionals and employed as social workers, nurses, health promoters, home visitors, or managers. All of the key informants worked with Aboriginal mothers in some capacity. Some key informants expressed concern about anonymity since their personal opinions were in conflict with the BFI and organizational policies related to breastfeeding. As well, some organizations expressed concern about participating in the study since their organizational practices related to infant feeding were contrary to dominant messaging regarding the manner in which breastfeeding ought to be supported. As a result, in the discussion below, I have taken great care to protect the identity of individuals and organizations who participated in this study. I have eliminated or changed the names of specific individuals and organizations in the analysis and I do not refer to specific services offered by organizations so that their identity will not be revealed. I do however, give as much context as possible to help the reader interpret the responses.

5. Data Analysis

A thematic analysis was used in coding the data for this research. A "thematic analysis focuses on identifiable themes and patterns of living and/or behaving" (Aronsen 1994: 1). Initially, data from the interviews were narrowed and organized into themes and coded accordingly for further analysis. Transcripts from the interviews were reviewed a number of times to identify these key themes as well as similarities and differences among the participants' responses. Finally, the data from the interviews were connected with literature that has been drawn from social science research.

The interview schedule was organized around key themes that were identified in the literature review. These themes were infant feeding and abuse, the sexualization of the breast, physical and emotional experiences related to infant feeding, poverty, information needs, experiences with health professionals, and the impact other people have on infant feeding decisions. As noted earlier I added a theme on substance use and infant feeding since this emerged in the first interview I conducted. It is common for new themes to emerge when conducting open-ended interviews. Since there is no research from a feminist or sociological perspective on the infant feeding experiences of mothers in relation to substance use, this theme was not reflected in the literature review.

Another theme that emerged during the interviews which was not evident in the literature review was the influence male partners had on mothers in choosing breastfeeding as their infant feeding method. Studies have indicated that partners influence mothers to choose formula however, nothing has been published on whether men are influencing their partners to breastfeed and what the effect of this is. This study revealed that men are persuading their partners to breastfeed, however, it is not always from a supportive perspective. The influence from men may be detrimental to women's needs and act as a controlling factor on women and the use of their bodies. As will be discussed in Chapter Five, more research needs to be conducted identifying the impact breastfeeding promotion targeted at men has on women, from a feminist perspective.

I also compared the interviews from the key informants to the interviews from the Aboriginal mothers. There were many similarities in issues identified by the key informants and the mothers. For example, poverty was discussed at length as a reason for breastfeeding by

both the key informants and the Aboriginal mothers. Many of the mothers indicated they chose to breastfeed because they could not afford to purchase formula. Differences in the interviews were also evident. A number of key informants shared their own experiences with breastfeeding and the struggles they had encountered. A few key informants discussed feelings of guilt and failure if they had difficulties with breastfeeding. This theme has been identified in the literature as a key issue for women (Blum 1999; Carter 1995; Lee 2007, 2008; Murphy 1999, 2000, 2003;Schmied and Lupton 2001). The Aboriginal mothers did not verbalize these feelings if they had struggles with breastfeeding. However, their actions did demonstrate they wished to be viewed as breast-feeders even though they used a combination of breast milk and formula to feed their infants.

6. Challenges and Limitations

I had initial challenges recruiting Aboriginal mothers to interview for this research. It can be difficult building relationships with marginalized women and it requires an investment of time in order to build trust. As a result, my recruitment phase was longer than I had originally planned. Many organizations spend a significant amount of time building trust with marginalized women before they are successful in engaging them in programs and other services.

Through my work in the community I have numerous connections with community and health organizations. These contacts proved to be useful in securing interviews, however, my work history led to some preconceptions about my research. Since I had worked for a health organization that promoted only exclusive breastfeeding, some of the people I contacted about the study initially believed I embraced and was promoting a similar perspective. Some people

assumed I only wanted to explore women's breastfeeding experiences, not breastfeeding and formula feeding. As a result, some organizations were apprehensive about participating in the research since exclusive breastfeeding is not practiced by most of their clients. One organization met with to me to discuss the social realities of their clients before granting me approval to recruit women through their organization. They perceived dominant breastfeeding messaging to be inappropriate for their clients and they explained that for the women they work with breastfeeding was bound up with ideas of mothering. Since their clients are extremely marginalized and struggling with many life challenges, breastfeeding was not always an option for them even if they wanted to breastfeed. As well, some of their clients had had their children removed from their care by the Child Welfare system. The fact that they were unable to breastfeed was emotionally painful for these women. This organization wanted to ensure that I would be sensitive to these issues when interviewing the women.

Two key informants I interviewed were uncomfortable sharing their views related to breastfeeding policy with me since their opinions conflicted with their employer's breastfeeding policies. Their perceptions demonstrate that they view breastfeeding messaging and policy as an imperative of health. The promotion of breastfeeding has become a normalizing moral imperative resulting in staff experiencing difficulties in presenting other options despite the particular context or the person upon whom the policy is being imposed (Crossley 2009: 72; Lupton 1995: 75).

Qualitative research also has inherent limitations. Qualitative research is difficult to replicate in other settings. The researcher is the person who is collecting all of the data in an unstructured format. Interpretation of the data is influenced by the subjective views of the

researcher (Bryman and Teevan 2005: 158). Another researcher may not have reached exactly the same conclusions as I, and may have experienced different interactions with the women interviewed since each person brings their unique self to the interview which results in different dynamics and distinctive information shared.

Small qualitative studies are limited in the generalization of their results. The sample for this study is small and not randomized, therefore it cannot be generalized to the population of Aboriginal women or even the population of North Western Ontario as a whole. However, the purpose of this study was not generalization but rather an in-depth analysis of urban Aboriginal women's infant feeding experiences and as such it makes a valuable contribution to knowledge. In my recruitment efforts I specified that I was interested in interviewing women who had either breastfed or formula-fed their infants. However, all of the women who volunteered for the study had breastfed at least one of their children even though many of the key informants indicated that Aboriginal mothers in general have low breastfeeding rates. This point was also reinforced by the mothers interviewed. The mothers interviewed reported that many of their friends and women they participated in programs with did not breastfeed their infants. Therefore, the study attracted women who were breastfeeding as opposed to women who were only formula feeding, and it may not be reflective of Aboriginal women's infant feeding experiences as whole. Additionally, the experiences of urban Aboriginal women may be different from Aboriginal women living in rural or remote reserves; likewise, the experiences of women residing in Thunder Bay, a small city in North Western Ontario, may be different from those living in other larger urban centres in Canada. An in-depth study would reveal if any differences exist.

7. Strengths

Despite some of the challenges I faced with this study, there were many strengths associated with it that far outweigh the limitations encountered. Qualitative research provides the opportunity to describe, understand, and explain complex phenomena as well as to examine the context in which activities occur. The focus is on understanding a multi-dimensional, dynamic picture of the subject of study. By conducting semi-structured, open-ended interviews I was able to capture information that would have been lost in a quantitative study. For example, I would not have captured information on the impact of child welfare involvement on breastfeeding practices since I would not have been in a position to ask mothers to elaborate further on comments they had made. Through my semi-structured interviews I gathered information about mothers' infant feeding experiences in their own words, a strategy which produces a richer and more descriptive account than if I had employed a structured interview tool. The women would not have shared some of their personal experiences that are nuanced by larger structural influences. As well, a qualitative study allowed me to capture greater details regarding the struggles Aboriginal women experience in relation to breastfeeding and substance use. I was able to tweak my interview questions to capture more information about this issue when it arose in an early interview. This issue turned out to be of great significance.

Additionally, by employing feminist methodological research practices, I developed a strong rapport with the mothers and key informants interviewed and as a result they shared information with me that they may not have shared otherwise. For example, one woman discussed her experiences with postpartum depression and she informed me this was

something she had not told anyone before: "I never told anybody this before, but I know I was having that post-partum depression after her." As well, the discomfort key informants experienced when discussing their feelings that conflicted with organizational policies and practices may not have emerged in a quantitative study where participants could not assess the researchers' intent, reinforcing the value of qualitative research for understanding structural restraints on talk and behaviour.

Finally, I may not have been granted approval to recruit women to interview through some of the organizations I approached since these organizations practice from a woman-centered philosophy and they routinely include the voices of women in their program development. A study that did not allow women's voices to be heard, may not have fit with their organizational mandate.

8. Conclusion

While there are limitations regarding this research, the model was strong, as is evident from the findings which will be reviewed in the following chapter. The discomfort experienced by health professionals who had opinions that deviated from the dominant breastfeeding message clearly demonstrates the powerful force imbedded within breastfeeding policy and promotion. Expert knowledge and BFI policy has been privileged above mothers' experiences and infant feeding knowledge, and health professionals do not feel empowered or validated in sharing the expertise they have gained from working on the ground if it contradicts policy. The mothers interviewed strongly felt that breastfeeding was something positive they could do for their child. They had clearly embraced the message that 'breast is best' and felt the need to adhere to this mantra in order to demonstrate their ability to be good mothers. All of these

women were either recipients of social assistance, involved with Child Welfare, or receiving services from a community organization and as a result were under the scrutiny and surveillance of experts who are in a position to assess the quality of their parenting. It was clear that they felt proud of their breastfeeding accomplishments in a culture that stigmatizes Aboriginal mothers who live in poverty. A review of my results begins in the next chapter, which outlines and analyzes the themes identified above as well as others that emerged during the interviews.

Chapter 4 – Analysis

"I'm a breastfeeding advocate but within means..." : Everyday Breastfeeding Experiences Verses Expert Recommendations

In this chapter I present the summary of my interviews and give detailed accounts from the respondents to illustrate the four key themes that arose in the interviews: infant feeding in everyday life; structural influences; professional influences; and the breastfeeding imperative. In relation to each of these themes, I discuss how Aboriginal mothers' infant feeding decisions are influenced by factors such as interpersonal relationships, mental health, desire for autonomy, bonding and attachment, substance use, poverty, infant feeding in public places, and their experiences with professional involvement such as child welfare. These factors compounded with a breastfeeding imperative have resulted in some mothers expressing ambivalence related to their infant feeding experiences, rationalizing their use of formula, or as key informants reported, being reluctant to ask questions about the correct or safe use of formula even when they wished to do so. Women are receiving little information on formula use from health organizations, a fact which key informants identified as problematic. I explore the perspectives of key informants regarding current breastfeeding policy, and for the most part they reported that they do not feel that the BFI is reflective of the realities of mothering amongst marginalized groups. Before turning to a discussion of the themes, I present demographic information on the Aboriginal mothers interviewed and a descriptive summary of the key informants. As noted earlier, all names have been changed in order to protect the confidentiality of those interviewed.

1. Participant Demographics

A summary of the demographic information on the Aboriginal mothers is provided in Appendix E. The seven women in this study were mobile; they had lived in a number of communities while they were growing up. There was one exception, a mother who had recently moved to Thunder Bay from a northern reserve, where she had resided her entire life. The Aboriginal mothers interviewed were between the ages of 18 and 31, with the mean age being 24. The number of children ranged from one to four, with three as the mean number of children the mothers had. All of the mothers were currently in a relationship; one mother did not live with her partner but considered herself to be in a committed relationship. All of the mothers were involved in receiving services from community-based organizations on a voluntary basis. All of the mothers but one was a recipient of social assistance and therefore living in poverty. One interviewee had completed college, one had completed high school, and the rest had not completed high school, however, two were in the process of finishing high school. All of the mothers had been employed in various jobs before giving birth, however, none of the mothers interviewed was working outside the home at the time of the interview.

All of the mothers had at least one child under the age of three and they were the primary caregiver for their children. Two of the mothers had breastfed or were breastfeeding one or more of their infants exclusively. Six had used mixed feeding methods: mixing formula with breast milk. Three used formula exclusively with one or more of their children but had breastfed or used mixed feeding with one or more of their other infants.

The key informants were all women who worked in a variety of health and social service organizations, providing services to Aboriginal mothers. The key informants were currently

employed as nurses, social workers, home visitors, health promotion workers, and managers. The managers both had a background in social work. Three key informants were Aboriginal and four were non-Aboriginal.

2. Infant Feeding in Everyday Life

Infant feeding in everyday life posed many challenges for the mothers in this study. Although all of the mothers recognized and valued the health benefits associated with breastfeeding, most used a combination of formula and breast milk to feed their infants. Breastfeeding was presented as representing the feeding ideal, however using formula in some circumstances was an acceptable method for all of the women interviewed. The mothers who breastfed enjoyed their breastfeeding experiences, but they also felt that breastfeeding could be a difficult experience at times. Most of mothers appreciated the bonding with their infant that resulted from breastfeeding and many expressed a belief that breastfeeding builds a stronger bond with infants than formula feeding alone. By contrast, key informants did not believe that breastfeeding is imperative to facilitate bonding if mothers engage with their baby when feeding with formula.

The mothers' everyday infant feeding experiences were greatly influenced by their interpersonal relationships. Husbands and boyfriends influenced women to both choose and reject breastfeeding as an infant feeding method. The influence of partners was both positive and negative; some husbands and boyfriends supported breastfeeding and assisted mothers with other infant care beyond feeding, while some insisted their wife or girlfriend breastfeed even if the mother did not wish to do so. The mothers and their husbands or boyfriends struggled with breastfeeding in public places outside of the home. As a result of poverty,

housing conditions did not always allow for women to be living in private dwellings and breastfeeding for many was a public experience even within their home environments. As well, some male family members expressed discomfort about being in the presence of the mothers when they were breastfeeding. Key informants also reported that the mothers they work with are uncomfortable with breastfeeding in public and some work with women to manage this discomfort.

i. Feeding Method

As indicated in Chapter Three, all of the mothers in this study breastfed at least one of their infants for some period of time. Two of the mothers met the definition for exclusive breastfeeding as outlined in current breastfeeding policy. One of these two mothers exclusively breastfed all three of her children for six months and the other mother was exclusively breastfeeding her six month old infant at the time of the interview. With her other two children she both breastfed and used formula. However, the mothers who breastfed exclusively reported they had tried to feed their infants formula, but their infants would not take a bottle. The other mothers interviewed used formula or a combination of breast milk and formula to feed their infants. Those mothers who used a combination of formula and breast milk considered themselves to have breastfed or to be breastfeeding. The use of formula was not always immediately apparent during the interviews. For example, four of the mothers began the interview by stating they were breast-feeders, however at some point in the interview they disclosed that they had or were currently using formula as well. All of the mothers in this study had clearly absorbed public health messaging claiming that breast milk is nutritionally superior to formula, and indicated they wanted to breastfeed their infants because

they believed it was healthier. When asked why they chose to breastfeed, their responses included:

> "I chose to breastfeed because it was more healthier..."(Interview #5)
>
> "I believe it's actually healthier than bottle-feeding...you get everything you need in the mother's milk." (Interview #3)
>
> "...breast milk is the best; it gives them all the nutrients so that's why we choose to breastfeed." (Interview #4)

Breastfeeding was also viewed as a method of keeping children safe and a tangible practice mothers could implement to ensure the health of their infant as demonstrated in the following quote from an eighteen year old mother of one child. "...I guess I just know that breastfeeding is better than bottle-feeding and I just wanted what was healthiest for her... I just wanted to do all that I could for her. I just really, really wanted her to be ok..." (Interview #6)

One mother, a twenty-three year old with three children, felt that she had to breastfeed her youngest infant since she had breastfed her other two children. She felt as though she would be depriving her infant if she did not breastfeed him and would not be treating her children equally. "...Since I breastfed my other kids it wouldn't be fair if I didn't nurse him.... Even his Dad was like well you're going to have to nurse him since you breastfed your other ones..." (Interview #2)

All of the mothers interviewed agreed that breast milk was the healthiest method for feeding infants. However, most of them also used formula to supplement with at least one of their babies. Interestingly, most of the mothers interviewed defined themselves as exclusive breast-feeders which may have meant that they mostly breastfed. However, some of the mothers would not meet the definition of exclusive breastfeeding as outlined in the current BFI

breastfeeding policy, since all but one of the mothers also used formula to feed their infant or infants. Similarly, the key informants working with Aboriginal mothers reported that many of their clients both breastfeed and formula-feed.

The following non-Aboriginal key informant, who currently works in a management position, but worked for many years as a social worker in a health organization, reported. "...I was very surprised at how many people actually mixed, they would do some formula and some breastfeeding..." (Key Informant #5) In spite of recognizing that policy makers are not supportive of such practices, key informants viewed mixed feeding as positive, since mothers were still providing some breast milk to their infants. Key informant #4, a non-Aboriginal nurse who works for a health organization and has worked on a reserve in the past, conceptualizes mixed feeding as a harm reduction strategy. Harm reduction is a term generally used in the addictions field. According to the British Columbia Ministry of Health, "harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behaviour, while recognizing that the behaviour may continue despite the risks" (2002: 4). Harm reduction maintains a neutral view of drug use and the drug user. It focuses on the harms from drug use rather than on the use itself and does not insist on or object to abstinence. As she noted,

> ...we do try the harm reduction strategies around breastfeeding and even though I know it is a dirty word, but mixing feeding. I know it's not acceptable but sometimes women will do both breastfeeding and bottle. It is better than nothing. (Key Informant #4)

In opposition to the BFI recommendations, key informants suggested that it would be beneficial for nursing mothers to receive information and education on how to effectively mix feeding methods so they would be able to maintain their breast milk supply rather than

providing information solely on breastfeeding. An Aboriginal key informant, who was working as a home visitor, noted that mothers tended not to ask for information on how to mix feeding methods. She notes that mothers do not have education on the importance of expressing breast milk between formula-feeds in order to maintain breast milk supply.

> It's generally just not being educated and to know that they should be expressing when they are going to put formula in between the mix. That is a lot of it I think, just not having the information, even though it is readily available in the hospital or through us that they just don't know. I'm not exactly sure what it is that makes them not ask for the help. A lot of people don't want to ask for help when it comes to that so...(Key Informant #1)

Another key informant, a non-Aboriginal social worker, reported that mixed feeding is very common among her clients but that if mothers do not have the education regarding how to manage mixed feeding they are often unable to maintain their breast milk supply.

> They both breastfeed and formula-feed and that is quite common thing but the thing that, it doesn't happen often but they don't have any guidance around how to do that well so what happens is they bottle feed to the point the lose their breast milk and then they say the baby doesn't have enough so it doesn't really work. They just move totally into bottle-feeding. (Key Informant #2)

All but one of the mothers in this study and many of the clients key informants worked with used both formula and breast milk to feed their infants. However, women are receiving little information from health organizations on how to do this effectively. As identified in the introduction, the WHO Baby Friendly Initiative does not support mixed feeding practices and this may be a reason for the information gap. One key informant indicated that mothers are not requesting this information; however, in the interviews I conducted, the mothers stated that they would like information on how to maintain this practice effectively.

ii. Ambivalence and Rationalization

Despite the fact that the mothers reported that they felt breastfeeding was the best way to feed infants, a number of mothers used formula and felt it was an acceptable method for feeding their babies. As a result, a number of mothers expressed ambivalence in their interviews, cycling between endorsing breastfeeding and questioning the health benefits of it, or loving breastfeeding and struggling with aspects of it at the same time. For some this ambivalence seemed to be connected to tension between the breastfeeding ideal and the actual experience.

One mother, a twenty-seven year old on social assistance, mixed breast milk and formula with three of her children and formula-fed one of her children. She expressed support for breastfeeding throughout the interview; however, she questioned whether breastfeeding really did prevent tooth decay as promoted by public health officials.

> I don't think there's much difference between being bottle fed or breastfed because at the end you still have to give them a cup right, a sippy cup, or whatever, but I don't think there's much difference. (Interview #5)

Later in the interview....

> Just there should be more women breastfeeding their child instead of bottle-feeding. Like everyone should try it for at least a couple months and they will notice a big difference in bottle-feeding babies and breastfeeding I think. (Interview #5)

Another mother, a thirty-one year old with a college diploma, expressed support for breastfeeding throughout the interview due to the health benefits it confers and bonding it allows between mother and child. However, she acknowledged that her husband did not have as strong of a bond with their baby as she did. She and her husband attributed this diminished bond to breastfeeding. Since he struggled with his bonding level with his infant, they decided that they would bottle-feed if they had another child so that he could develop a bond with the

infant that was as strong as the mother's bond. She reported she was breastfeeding her infant due to the health benefits, but originally wanted to bottle-feed, "because I knew it's hard to get the babies off." (Interview #4) She later stated that she wanted to bottle-feed with other subsequent children because she wanted to work and felt that breastfeeding and working were incompatible. I asked her if she had any concerns about developing a healthy bond with a future infant if she did not breastfeed and she quickly altered her response and reported that maybe she would breastfeed if she had another baby.

> **Interview #4:** With the first one I knew I was going to breastfeed because it was the more, it's the healthy choice everyone said. Which was more better because everyone else was getting, you see kids with ear aches and getting sick and I saw it as more bonding...
> **Tara:** So you think it builds a stronger bond?
>
> **Interview #4:** Stronger bond, yeah.
>
> **Tara:** Do you worry then if you have another one and you bottle-feed, you won't have as strong of a bond?
>
> **Interview #4:** I don't know we'll have to see. We are thinking of starting a business. That's why we are thinking of bottle-feeding, but I might change my mind and say no! We'll do it this way again. The baby might get all the nutrients and stuff and my kids have never had an ear ache and I hear that other babies have ear aches and stuff.

This mother clearly struggles with providing what she believes to be healthiest for her children while balancing other factors, such as work, which interfere with exclusive breastfeeding. In her interview she also struggled with the time commitment breastfeeding required as well as breastfeeding in public.

The mother quoted below, a twenty-one year old single woman on social assistance, expressed regret for formula feeding one of her children because she wanted more freedom. She feels as though this decision was a mistake.

> I wish I could have fed my son breast milk and I wish could have tried harder to breastfeed him instead of thinking oh I I'll have myself a little bit of freedom this time. Yeah I kinda regret it though...but it's still the fact that I should have breastfed him instead of bottle-feeding him. I was just thinking about my own freedom that's why I wanted to breastfeed [youngest child]. Try to fix the mistake. (Interview #3)

However, later in the interview she explained that she was unable to breastfeed her son because of difficulty with latching. "It was hard with my second son because he wasn't able to latch, it was really, really difficult. I really wanted him to breastfeed but it was too hard." (Interview #3) At another point in the interview she provided another reason she was unable to breastfeed. "My son was gulping a lot of air down, that's what my doctor said." (Interview #3) She also disclosed that she had a substance use problem for which she was currently receiving treatment, and that she had received pressure from her mother to consume substances while she was breastfeeding. Substance use will be explored further in the chapter. The use of multiple explanations for using formula by this woman demonstrate ambivalence about breastfeeding and her perception of the need to rationalize her use of formula.

The mothers in this study had strong support for the idea of breastfeeding but struggled with the everyday realities they feel breastfeeding presents. As a result, they found formula use to be acceptable and rationalized the use of formula despite the belief that 'breast is best'. One mother questioned the health benefits associated with breastfeeding and another mother had multiple reasons for formula feeding one of her children and rationalized this feeding method. Many mothers also expressed ambivalence with regard to loss of autonomy related to breastfeeding as illustrated in the next section.

iii. Loss of Autonomy

Some of the mothers interviewed expressed frustration regarding the time commitment breastfeeding required. Breastfeeding was identified as being stressful since it is a solitary practice that makes mothers solely responsible for the nourishment of their infants. Many of the mothers expressed a desire to pursue activities on their own, away from their infant, however they felt that breastfeeding did not allow for this. Using formula was identified as allowing some mothers to participate in activities on their own.

The woman quoted below is single, twenty-three years old, living on social assistance, and completing her high school diploma. She exclusively breastfed all of her three children for six months and continued to breastfeed two of her children until they reached the age of two, while supplementing with other foods. She reported that she enjoyed her breastfeeding experiences, but at times she also struggled with the level of commitment this required. She was also dependent on public transportation, in common with all of the mothers in this study, which added to the breastfeeding challenge.

> I liked it but then again it does take time to do it so sometimes it can be stressful because you're the only one that can do it. Sometimes it's just me and the kids and I don't want to do it. Like sometimes I'd just like to get away for a couple of hours but I can't. Like he's going to be my shadow until he's like a year old. He's going to be sitting with me everywhere. Like even now I can only be gone for like an hour, 2 hours and by the second hour he's crying. So like where am I going to go for an hour, the bus ride alone takes an hour. (Interview #2)

Interview #4, a thirty-one year old mother of three children, also stated that she enjoys breastfeeding but struggles with the lack of autonomy she has experienced as a result of breastfeeding her infant. She was able to feed her first two children both formula and breast

milk, however she reported that her youngest infant would not consume formula so she exclusively breastfed as a result.

> I feel good when I'm breastfeeding him. There are times though when I just don't want to. *laughs* It just like "oh breastfeeding. He needs breastfeeding!" When I first had him it just flooded back of how many hours I am going to be with him, all the time...Yeah because the majority of the time I'm here, the longest I was away was like 2 hours. I went to a play just to get out of the house at like 3 months; it's a long time to be in the house. He was like always right here (motions to her chest), but you know I knew that what I was getting into. You can't get away at all, the majority of the time I'm nursing. (Interview #4)

By contrast, both of the mothers quoted above also identified the use of formula as stress-inducing and time-consuming, further highlighting the ambivalence expressed by mothers in this study.

> ...I didn't want to worry about the formula and stuff that's like too much. I didn't want to worry about it. I mean everything else is expensive enough and why waste money when I don't need to. (Interview #6)

> Yeah I see everyone doing it like after everyone goes to bed and they are super tired and they have to wake up and all the bottles are gone and then they have to make more and it seems kinda hard. *laughs* (Interview #4)

The mother quoted below is twenty-one years old with three children. She discusses the experiences of her peers who live in an apartment building for young single women. She reported that many of these mothers feed their infants formula in order to increase their autonomy.

> I use to live...at this place called the single mother's building. Most of them were breast-feeders, but half were bottle feeders. It gave them more chance to get away. It gave them less chance to get away if they breastfed. (Interview #3)

Exclusive breastfeeding was also difficult for the mothers' partners who wanted time with their infants. The mother quoted below is eighteen and is breastfeeding with occasional formula use with her infant. Her boyfriend wanted to spend time alone with his infant,

however he felt frustrated since exclusive breastfeeding infringed on the time he could spend with his baby. They decided to purchase some formula once they received some money so that she could participate in some activities without the baby and her boyfriend could increase his involvement with their infant.

> We are going to buy a case of formula this month and try her on both so I can do stuff, like I can go out for coffee. It's getting really hard because I'm the only one that can like do the feeding and it gets frustrating for him [boyfriend] because he wants to take her out and explore the world and show her things she hasn't seen before and that would be good. Like I could go to school one day without my daughter and I could leave her with him and just go. So we are going to try that out, just buy a case of formula but I want to get the stuff that is closest to breast milk I hope." (Interview #6)

Pumping breast milk came up in four of the interviews with the mothers and three reported that they had tried but experienced difficulties with pumping. There was one exception where a mother pumped her milk for three months during a separation from her infant. This particular case will be discussed in greater length later in the chapter. This mother of three who exclusively breastfed her infants explained her challenges with pumping her breast milk as follows: "It took like 2 ounces and then it stopped and then every time I tried pumping it would take like hours just to get like 2 ounces...Yeah like my milk didn't flow as fast as other people when pumping or even hand expressing so I had to give up on that one." (Interview #2)

Interview #5, a twenty-seven year old mother of four reported that she had to drop out of school since she was unable to pump her breast milk with her first child.

> ...I had to drop out of school so I had to breastfeed and people said well buy a breast pump but whenever I tried a breast pump I didn't think they were working. Like they weren't sucking enough milk or something. (Interview #5)

One mother still pumped her milk even though it was uncomfortable at times. Her child is four months old and she reported she is unable to pump as much breast milk as she had in the past. "Yeah we have like 4 or 5 pumps. Sometimes it hurts and sometimes I just don't care and I'm not getting as much as I used to. I used to get full bottles." (Interview #6)

Five of the seven mothers interviewed identified breastfeeding as extremely time consuming and although they enjoyed breastfeeding they struggled with the time investment and constraints on freedom that breastfeeding required of them. The mothers in this study had no difficulty articulating the desire they felt to have some separation from their infants. Using formula was perceived as a way to have some separation from their infant and to include their partners in the work of feeding and child care. Partners also felt that breastfeeding limited the time they were able to spend with their infants.

iv. Bonding/Attachment

Four mothers reported that their infant feeding decisions were influenced by a belief that breastfeeding would facilitate a stronger bond with their child. As noted in chapter One, breastfeeding literature strongly promotes breastfeeding as essential for securing bonding and attachment between mother and child, which has been identified as fundamental for healthy psychological child development.

> I liked the bonding with the child. When I wasn't breastfeeding it didn't seem like, we were still bonding, it didn't seem the same, it seemed different. (Interview #5)
>
> Babies that are bottle-fed, they are more I don't know it seems like they got no connection with their mom." (Interview #4)

However, key informants reported they did not believe that breastfeeding is fundamental to the development of a strong attachment between mother and child and some

felt that mothers could benefit from education on other techniques to facilitate bonding and attachment. The key informant quoted below, a non-Aboriginal nurse, expressed concern that mothers who hear messaging that breastfeeding facilitates bonding may feel as though they will be unable to develop a strong bond with their infant if they do not breastfeed. She believes that strong bonding can also occur through bottle-feeding as long as mothers are interacting with their baby during feeding.

> Women who bottle-feed do feel, there is a feeling that they are not going to be as good a mother because their children won't be as close, that they won't bond with it. It is perfect. You bond extremely well with your baby bottle-feeding because you are holding it. You are still holding it, I have always said to women if you do decide to bottle feed your baby, breast milk or formula, don't prop them up in the corner. You are not going to bond with a baby propped up in the corner with a towel under its chin holding a bottle. That is the difference again with women I have always tried and promote holding your baby to feed it. Don't leave it in the car seat or stroller to feed it. That is where you are losing your bonding, bonding is absolutely possible if you hold your baby to feed it...you can lose a bond with a child if you don't look at it, touching your baby to your breast doesn't mean you are going to bond well. (Key Informant #4)

The same concern was reiterated by a non-Aboriginal social worker. She feels that regardless of what health promotion messaging says, mothers can develop strong bonds with their infants through both breastfeeding and bottle-feeding.

> One of the big things is that health promotion really says that the best way to attach with your baby is though breastfeeding and I think there is ways to do it both ways. So women need education around that so we talk about the bottle propping and not putting cereal in cause they want their babies to sleep through the night. (Key Informant #2)

As noted earlier, one father who was present for part of the interview indicated that if he and his wife had more children in the future they wanted to bottle-feed so he could develop as strong a bond with their infant as his wife had. "Yeah and I can get that bonding feeling too." (Interview #4's Partner)

Four of the mothers interviewed believed breastfeeding was associated with bonding and attachment. Some of the mothers reported that other mothers who did not breastfeed did not seem to have as strong a connection to their infants as mothers who did breastfeed. However, other mothers expressed uncertainty about this concept and the key informants did not subscribe to the idea that breastfeeding is fundamental to securing a strong bond with a child.

v. Interpersonal Influences

Husbands, boyfriends and family members had a significant influence on mothers' infant feeding decisions. Some partners encouraged or pressured mothers to choose breastfeeding because of the health benefits associated with it. Other partners experienced jealousy regarding the close relationship between mother and infant. As well, some partners experienced discomfort with their wives or girlfriends breastfeeding in public places. Male family members were also uncomfortable with mothers' breastfeeding in front of them, which impacted some mothers' infant feeding decisions.

A thirty-one year old mother of three children quoted below, described her husband's feelings of jealousy over the time investment breastfeeding required.

> He doesn't, he got a little bit (motions to partner) like, had some feeling like you are always with him [the baby]. (Interview #4)

Her husband was present during a portion of the interview and he shared his feelings of exclusion:

> Like when I'm not here she's always playing with him so I want to get that because I feel like I've been left out. Like why does he always want her and not me? (Interview #4's Husband)

However, the same mother also reported that her husband's friends liked the fact she was breastfeeding since this tied her to their infant and he was available to go out and socialize.

> His friends think oh you got her breastfeeding, she gets to stay at home and you get to go out. (Interview #4)

Other mothers indicated that breastfeeding was a choice made in collaboration with their partners. Partners were equally aware of the health benefits of breast milk and wanted the healthiest option for their children.

> "Oh yeah we talked about it, me and Steve, and we both agreed it would be good." (Interview #6)

> "My husband. He told me that breastfeeding was better..."(Interview #3)

Some of the mothers' partners encouraged them to breastfeed and one mother reported that she did not want to breastfeed but her husband wanted her to, so she was breastfeeding as a result. Yet this is the same woman whose husband felt jealous about the time she spent breastfeeding.

> With him (motions to baby) I wanted to bottle-feed but he (motions to partner) wanted to have him breastfed because it's more healthier so that's what we are doing right now. (Interview #4)

Interview #6, an eighteen year old with one child, reported that her partner wanted to be a support to his breastfeeding girlfriend but he struggled with how he could do this. "It does cause us some problems because I'm like I need space and I need him to help me but he's like how do I help you? Like do I hold your boob?" (Interview #6)

Other partners assisted in other ways, such as cooking and cleaning, in order to support their partners. "At least I didn't have to do the cooking and cleaning, I just looked after the baby and he did the other things." (Interview #2)

Some husbands and boyfriends were uncomfortable with their partner's breastfeeding in public places and made demands as to how they should be managing their bodies in such settings. Some mothers, such as the one quoted below, resisted these demands, yet she ultimately made accommodations to her breastfeeding practices in public despite the fact that she was comfortable with public breastfeeding. This woman, a twenty-seven year old mother of four, believed breastfeeding to be an aspect of effective mothering which superceded demands placed on her by her partner in relation to breastfeeding in public.

> **Interview #5**: I know my partner, one time we were on the bus and he said "ewww, don't do that here" and I was like "well of course I'm going to feed him what I am suppose to do just let him starve or anything?" But he didn't like the fact that I had to breastfeed in public. He just wanted me to breastfeed at home, but I ain't going to stay home just for other people.
>
> **Tara:** So he didn't mind ultimately that you were out breastfeeding in public?
>
> **Interview #5:** He didn't mind as long as I didn't breastfeed out in public around him. Sometimes, I guess he just told me, "you can't just fling it out in public and start breastfeeding" and I was like "*I know,*" so after that I started to cover myself.
>
> **Tara:** So did you feel comfortable breastfeeding in public?
>
> **Interview #5:** Yeah I didn't care, I just thought it was the right thing to do for your child.

Other mothers felt uncomfortable breastfeeding in public and covered their bodies as a result. This covering brought a sense of empowerment to some mothers and they felt that they could breastfeed anywhere. While some husbands were opposed to public breastfeeding, others provided support to their partners if they breastfed in public and if they were 'appropriately' covering their bodies.

> ...breastfeeding is hard when you are sitting in a crowded room with a bunch of men wanting to look at your tits. But I always use this half blanket that my husband bought me, your head goes in there and your arms and the baby just goes in there. So anywhere I would use this, on the bus, anywhere I would choose to breastfeed. (Interview #3)

A non-Aboriginal nurse working for a health organization reported that mothers she deals with struggle with breastfeeding as a result of the sexualization of breasts and notions of male ownership of women's bodies.

> A lot of them feel their breasts are sexual objects, same thing for the spouse, so sometimes the spouse don't like them sharing their breasts...(Key Informant #4)

Some partners wanted to be involved in the feeding of their infants. This point was brought forward by this Aboriginal health promotion worker, who reported: "...there's even some people [partners] who want to do the feeding themselves." (Key Informant #5) Partner involvement related to the use of formula was reiterated by this non-Aboriginal social worker working in a social service organization.

> I think that the other piece that is really important too is they also want to involve their partners and the best way they can involve the partners is by bottle-feeding and feeding their babies formula and having their partners participate more in the actual feeding. (Key Informant #2)

Breastfeeding was sometimes identified as inhibiting relationships between mothers and their partners, as described by this non-Aboriginal key informant working as a manager with a background in social work.

> ...it [breastfeeding] takes them away from being available for their partners. Again go to the young teen moms. They have the teen dads that might not have the understanding or they might not have the father around and they want the time to establish new relationships. (Key Informant #3)

Although I did not ask women if male family members, other than their partners, influenced their infant feeding decisions, this issue arose in two interviews. One mother, an eighteen year old student living on social assistance, was comfortable breastfeeding in front of male family members, but they were uncomfortable with her breastfeeding. She was aware of

the pressures mothers feel to be discrete and the need to be cognizant of how other people feel about breastfeeding but resisted it anyway. She defined herself as a 'bitch' for not succumbing to this standard.

> The one I find the most trouble with is my Dad, step Dad and uncle they have more trouble with it than anyone else. They'll be like "I'm sorry, I'm so, so sorry" (turning head) and they'll be like "I'm sorry I have to wait until you're done" and I'm just like "whatever." They are uncomfortable because they don't want to make it seem like they are looking at me. My step Dad will be like "whoa!" But I don't care, "I'm like whatever." I try and respect others, but I can still be a bitch about it. (Interview #6)

Breastfeeding in front of male family members was also identified as a concern by an Aboriginal key informant working as a community support worker. She reported that a friend of hers who was living with her parents had difficulties when breastfeeding around her father. Although her father did not ask her to cease breastfeeding, his reactions influenced her to stop the practice. This mother was living with her parents due to financial reasons.

> I had a friend that just had a baby and she was breastfeeding, she only nursed for maybe 6 weeks because she was living at home and her father was very uncomfortable every time he walked in. So he was always kind of at her like "Oh god you're feeding that baby again!" She herself said that the thought of it kind of grossed her out, but she wanted to do it for the health reasons, so she only did it for a couple of weeks. When you go back to depending on their living situations in a not so direct manner, other people may affect it. (Key Informant #1)

All of the mothers were asked about the influence extended family members, such as their mothers and grandmothers, had had on their infant feeding decisions. Only one mother reported a strong support system within her family. Both her mother and grandmother influenced her decision to have a natural birth and to breastfeed. "My grandma she was into that [breastfeeding] too..." (Interview #6). Other women simply stated that their mother had no influence on their infant feeding decisions and two women reported difficult relationships

with their mothers. "My mom could have done better, she should have done better. But...." (Interview #2)

Interview #3, a twenty-one year old single mother of three on social assistance, talked about her relationship with her mother throughout the interview. She indicated that her mother encouraged her to breastfeed, however she did not discuss breastfeeding at length with her mother because they had a challenging relationship. "My mom didn't breastfeed but she said that it's good to breastfeed but I didn't know exactly what she meant...but we didn't really get along." (Interview #3) She also identified that her mother did not breastfeed and although she did not elaborate on this point, I feel this may have contributed to the lack of breastfeeding support her mother was able to provide her. Additionally, she disclosed that her mother had a substance use problem and would pressure her to drink when she was breastfeeding so she chose to distance herself from her mother. However, she shared a positive story of when her mother was able to support her.

> Me and my mom patched things up after I had my daughter. We weren't talking when I was pregnant she was mad because I hadn't finished school right away and I had a baby so she was pretty pissed off. But we patched things up and she helped me, she helped me. My daughter was screaming one night, I didn't know what to do. It was only the third day that she was born so I was running around and freaking out. So I took a cab... and my mom just grabbed her and she was sleeping within a couple of minutes. She just held her. It was her stomach. I didn't even know anything and I was freaking out and she said that the baby can sense when you're freaking out. (Interview #3)

The same mother, Interview #3, continued to share the difficulties she experienced that resulted from a lack of extended family support. Her father lived in a different community and her mother had recently passed away.

> My mom was really sick, some people have their parents to depend on and I didn't have my parents to depend on. My Dad lives in Winnipeg and my Mom was sick, she helped

> me with little things but not much. Yeah it was pretty difficult. I'm glad I'm out of it. My Mom passed away last year. (Interview #3)

All of the key informants indicated that support from partners, families and friends, is vital for establishing and maintaining breastfeeding. However, many of the Aboriginal mothers they work with do not have strong support networks in their lives. One key informant, an Aboriginal health promotion worker, shared that many of the mothers she works with are living in Thunder Bay, away from their families who live on distant reserves. The mothers she works with come to Thunder Bay to upgrade their education or to access housing since there is little housing available in some reserves.

> A lot of women that we have they are all from the different places out of town like the reserves and they don't have family here to support them in their breastfeeding... Yeah like the grandmothers are not here, their mothers are not here to help them. (Key Informant #6)

Lack of extended family support was an issue identified by another key informant who works as a manager for a social service organization. She indicated that many of the mothers involved in her organization have strained relationships with their own mothers.

> Yeah I don't hear a lot stories of their mother's involvement or just that it isn't there so that's saying a lot they don't have that support and when I've heard about mothers' situations it's been more negative that the mother just isn't involved doesn't support them, hasn't been there for them or has issues themselves. (Key Informant #3)

As these examples indicate, male partners are influencing women's choices about breastfeeding as an infant feeding method. While sometimes this influence provides positive encouragement to promote infant health, at other times it is detrimental to women's needs, particularly when used as a manner of controlling of women and the use of their bodies. Family support was identified as important for the establishment and maintenance of breastfeeding,

however only one mother in this study indicated that she had family support and that her mother and grandmother positively influenced her decision to breastfeed.

vi. Infant Feeding in Public Places

Six of the mothers interviewed struggled with breastfeeding in public places and found they had to manage their bodies as a result of the expectations of other people. As noted in the previous section, one mother made accommodations regarding how she breastfed in public as the request of her husband, despite her personal comfort with breastfeeding in public. As a result of the sexualized breast many mothers struggled with public breastfeeding.

A mother from a northern reserve reported that she did not observe mothers breastfeeding in public in her community. However, an Aboriginal key informant shared that many of the clients she works with are comfortable with public breastfeeding in their First Nations community, but not as comfortable breastfeeding in public in Thunder Bay.

> ...there was one woman who said that she doesn't have any problems breastfeeding on the reserve where she is from because everything is ok there, but here she says they look at me. She wants to breastfeed anywhere but she can't do it here. (Key Informant #6)

Some key informants reported they work with their clients to help them manage public breastfeeding. The professionals interviewed were well aware of the pressures mothers are under when breastfeeding in public and seek to empower mothers to feel confident about it. However, this key informant, an Aboriginal nurse, reinforced the concept of breasts as a sexual object by emphasizing the importance of covering the breasts when feeding in public and celebrating the skill mothers have acquired in discretion.

> I've been told they get some odd looks from people in public and I say you go and tell that old guy to have his lunch in the bathroom. It was an issue locally, when people were breastfeeding in the Mall and people would say that's disgusting. I would say how

> can anybody say that's disgusting? It's the best nutrition for your child and why do they have to look? It's none of their business. I remember a few years ago someone made a comment to one of my clients and she felt terrible and I said don't ever go in the corner and breastfeed your baby. Because I know how they breastfeed. They are discreet and they are good at it. Once their baby's latched on they are covered. You don't even notice it so if someone has a problem, I say *they* have the problem. I try to give them some self esteem because I'll tell you it doesn't take much to rob the little bit they have away and people don't seem to understand that. (Key Informant #7)

One interviewee, a twenty-three year old mother with three children, reiterated messages health nurses share with mothers about how to manage breastfeeding in public. She breastfed her infant in public despite the fact she did not always enjoy this experience. While explaining why she is uncomfortable with breastfeeding in public, she tried to reframe the practice using the language of the health nurse.

> I don't understand why people think it's so weird. Like you need to eat too. Like I was told [by health nurse] like just sit there. If they look at you, they look at you. You have to feed your baby. Like you're not forcing someone else like a grown up to sit in the corner and eat their meal right? So it's just like a regular baby. He has to eat. Sometimes I don't like it but I know I have to do it. (Interview #2)

Some mothers reported feeling that they are judged if they are unable to feed their baby in public places and their baby cries as a result of being hungry. The same mother quoted above reported:

> Yeah like sometimes on the bus people will say "why is your baby crying?" I say "well I can't just sit down and pull it out and feed him here." I've got the stroller and I have to hold on to the stroller and they are just like wondering what kind of parent are you letting him cry and I like just can't pull him out and feed him. (Interview #2)

She continued to explain that when breastfeeding in public, being stared at was a common experience, this was reported by other mothers as well. Mothers reported that it was older women who tended to stare more and shake their heads, rather than men. This gaze to which mothers are subjected creates great discomfort and even anxiety for some mothers.

> ...I just don't like being in public I guess you could say. People staring at you or you are sorta. Well I feel comfortable sometimes, I just feel, I don't know, I just don't like to sit there...(Interview #2)

The thirty-one year old mother of three who is quoted below related a time she considered staying home instead of going to a party because she would have had to breastfeed her infant in front of others. She also explained how she managed breastfeeding when accessing public transportation.

> I have my doubts sometimes. Like I was freaked about going to the party and I thought well maybe I'll just stay home. I just felt like staying home. But then, what I used to do with the kids when they were crying if I was on the bus or something, I would just give them the breast because I was sitting down anyways and it wasn't like I was out in the open. I felt better if I was sitting in the seats, not the long seats but in the other ones. I would breastfeed. (Interview #4)

As a result of the emphasis placed on the importance of breastfeeding by health professionals, some mothers felt judged if they were bottle-feeding in public places. This key informant, a non-Aboriginal nurse, shares her thoughts:

> ...when they are in public it can go both ways. They are judged for breastfeeding in public, I have heard that several times. But I have also heard judgment around if they are bottle-feeding...Not necessarily people come up to them, but that they feel judged. (Key Informant #2)

A thirty-one year old mother of three, reported that she has received public support when breastfeeding in the community, which she appreciated. However, such support for breastfeeding in public was expressed only by this woman.

> I've had women come up to me and say they should have this and this here at the mall, like ummm more seating for breastfeeding. They say those comments and I'm like "yeah!" (Interview #4)

Although this comment is one of support it also speaks to the way in which breastfeeding bodies should be presented in public. Special seating for breastfeeding requires

that breastfeeding be removed from the public eye; reinforcing the idea that breastfeeding is not an activity that should be conducted in public places. Another mother, a twenty-three year old mother of three, reported that she appreciates businesses that advertise they are breastfeeding friendly. She also shared that she would breastfeed her infant anywhere if necessary; however she wasn't always comfortable with this.

> I like going to places that like advertise that you can breastfeed, they have those breastfeeding symbols but not really if he were to cry in Intercity mall say, I would sit there and feed him you know, I'm not going to go into the corner and feed him. (Interview #2)

Breastfeeding in public was a concern for many of the mothers interviewed and the mothers felt a requirement to cover their bodies when breastfeeding in public. Some were so uncomfortable it limited the activities they participated in outside of the home. Being stared at while breastfeeding in public was a common experience, although one mother reported a supportive comment she received for breastfeeding in public. Professionals tried to empower mothers to breastfeed in public, however one key informant reported some of her clients feel negatively judged when bottle-feeding in public places.

3. Structural Influences

A number of structural influences on infant feeding choices were evident in the interviews. Poverty, mental health, abuse, and substance use were themes that emerged as influencing or impacting infant feeding decisions in the interviews with both the mothers and the key informants. Some women chose to breastfeed as a means of saving money, while other women, as a result of poverty, struggled to afford the formula they required. Poverty increases the complexity of mothers' lives, therefore, increasing the complexity of maintaining breastfeeding.

Additionally, mental health, childhood trauma, and relationship abuse were described as inhibiting breastfeeding for some mothers. Engaging in substance use was reported as a rationale for some mothers' interest in mixed feeding practices or using formula. A few of the mothers shared that other women they knew used substances while breastfeeding, despite the health consequences of this. Confusion and debate was also evident among key informants regarding whether it was appropriate for mothers to breastfeed while receiving methadone treatment.

i. Poverty

The key informants strongly believed in the benefits of breastfeeding, but they also possessed a complex understanding of the social factors mothers faced that limit their infant feeding choices. They felt the need to explain to me why mothers might not be breastfeeding, and to defend the mothers they worked with who were not breastfeeding. All but one of the mothers interviewed were living in poverty and the Aboriginal women the key informants worked with were also, for the most part, living in poverty. The mothers interviewed reported that they chose to breastfeed for financial reasons, demonstrated by comments such as, "...it saved me a lot of money so I had money for diapers..."(Interview #5)

In some reserves formula resources are sometimes scarce. The mother quoted below is a twenty-five year old woman with four children, living on social assistance, who recently moved to Thunder Bay from a First Nations community. She used formula to feed her children and she discussed some of the concerns she experienced regarding access to formula in her community.

> **Interview #7:** Yeah sometimes the formula would run out and mothers would have to order it from other communities or Thunder Bay because the formula was all gone.

Tara: So what happened if people ran out and had nothing to use?

Interview #7: They would change milk.

Tara: They would give them regular milk?

Interview #7: Yeah or there is one lady and she can't even afford formula or milk so she uses that Carnation [condensed] milk and adds sugar to it. I asked if that was good for the baby and she said "oh yeah it's cheaper. It's only a buck or two bucks."

Formula can be expensive to purchase for women living on social assistance. The same woman quoted above shared the stress she felt as a young mother about purchasing formula and how she was able to access formula from the hospital when her children were born.

Interview #7: I didn't think about it at first. Just when they were about to be born. I just thought, how am I going to buy this, how am I going to pay for this!

Tara: You mean if you were going to use formula?

Interview #7: Yeah and because like it was always hard for me because I left home when I was 15 and it was really hard because I couldn't really afford to buy formula... I was always struggling with milk and I didn't want to breastfeed you know...One time I was getting out of the hospital and I just grabbed as much as I could from the hospital.

Tara: Formula?

Interview #7: Yeah and then right away I put him on powder because I didn't have enough [money] for the liquid kind. So basically I just made him the powder milk. Actually all of my kids.

Key informants also cited poverty as a reason mothers chose to breastfeed, as reported by this Aboriginal health promotion worker. "We try to encourage them to breastfeed because it's economical so they don't have to go and buy formula, because formula is so expensive." (Key Informant #6) However, sometimes mothers chose to breastfeed for this reason even if they did not want to breastfeed, as shared by this non-Aboriginal manager who had previously worked as a social worker for a health organization. "...they can't afford the formula so they

are breastfeeding, not because they want to, but because it is the most economical decision." (Key Informant #2)

Yet there is a financial cost associated with breastfeeding which is often not acknowledged. The mothers that key informants work with struggle to purchase cream if their nipples crack, special clothing for nursing in public, and other breastfeeding supplies as explained by an Aboriginal nurse. "One of the hardships of breastfeeding 100% is that the cost of milk is ok, but then you need the cream, the pads, the pump, the different clothing for breastfeeding..."(Key Informant Interview #7)

The mothers in this study, however, struggled to simply meet their increased nutritional requirements associated with breastfeeding as explained by this twenty-one year old mother of three. "If I ran out of money I would get food from Haven House[4]... so I found myself turning to organizations, other place, food banks..." (Interview #3) This point was restated by a non-Aboriginal key informant working in a management position.

> ...we try to promote breastfeeding being the better choice because then they don't have the cost of the formula, but then they have the cost of increased food requirements and eating healthy. (Key Informant #3)

For the most part, key informants reported low breastfeeding rates amongst their clients and many mothers who were formula feeding struggled financially due to the cost of formula. As a result, key informants noted that some mothers watered down formula since they did not always have the resources required to purchase what they needed. As well, the mothers had little education about proper formula use, they were unaware that this was problematic.

[4] Haven House was a youth shelter operating in Thunder Bay which has since closed.

> It's [formula] very foreign to people. It's not talked about so a lot of Aboriginal people would water down the formula. They weren't doing that to deprive their child of nutrition, but a: they weren't educated about it, b: they didn't know how to make it, the practicality of it and c: financially up north formula is very expensive and so if there's a way they can stretch their dollar they were, without knowing what that was doing. (Key Informant #5)

One key informant, an Aboriginal home visitor, noted that formula was extremely costly in reserves. "Most of them have just left their reserves because of the issues that are up in the northern communities. And the cost...if they need to buy formula up there, the price would be just astronomical" (Key Informant #1). For example, in 2006 the Northwestern Health Unit in partnership with the Sioux Lookout First Nations Health Authority participated in a food costing exercise. They compared the cost of food in three northern First Nations communities with Ministry of Health and Long Term Care's study on the cost of food in municipalities in other parts of Ontario. They found that a container of formula powder was over $30 in First Nations communities as compared to an average of $20 in other municipalities (2006: 2).

Another key informant was very passionate about the importance of breastfeeding mothers providing Vitamin D supplements to their infants. Health Canada currently recommends breastfed infants receive a daily vitamin D supplement (2004: 3). However, for mothers living in poverty, this may be an unaffordable expense.

> Our babies are being inadequately nourished because we are in the north. You know that we are pretty north and these babies need to be supplemented with vitamin D and the girls worry and it's another stress because they don't have the money to buy the drops and so we are doing half a job but not all of it. I'm always saying if we are going to do something let's do it right, so if we are going to promote breastfeeding let's provide those women with vitamin D drops for their infants... I say do you remember all the little native kids that use to walk around bow legged? That was from poverty and lack of education. Somebody, the government, wasn't doing their job in getting across to those poor Indian women to give those kids vitamin D... If we want policies on breastfeeding then we have to include that vitamin D... The NPs [nurse practitioners] don't want to prescribe it because the woman can't afford it. These women are living in poverty and

> we've got to provide. If we're providing food and shelter for the kids we are missing something there and I think it's a big miss. If I see that child walking around 6 years from now bow legged and I know that mother breastfed it would mortify me. (Key Informant #7)

Poverty clearly impacted the lives and choices of the mothers in this study. Breastfeeding is an economical infant feeding method, however there are still financial costs associated with breastfeeding which are not addressed or acknowledged in BFI literature. The recommendation to supplement breastfed infants with Vitamin D further complicates the issue for mothers living in poverty. Mothers also experienced increased nutritional requirements when breastfeeding and some struggled to continually meet these needs. Formula is more costly in remote First Nations communities than in urban communities, and at times unavailable altogether. For women living in poverty it may be tempting to feed infants condensed milk or to water down formula in order to extend resources.

ii. Mental Health

Mental health was cited as influencing infant feeding choices by both mothers and key informants. Other studies have demonstrated that mothers who struggle with postpartum depression find breastfeeding difficult (Cooke et al. 2006; Pippins et al. 2006; Ross et al. 2005; Shakespeare et al. 2004;). Depression was reported by two of the mothers interviewed as negatively impacting their infant feeding experiences. A woman from a remote reserve shared her struggles with postpartum depression after the birth of her first child. She was 15 years old at the time.

> **Interview #7:** Yeah plus umm, I never told anybody this before, but I know I was having that postpartum depression after her (motions to daughter).
>
> **Tara:** Oh yeah?

Interview #7: Yeah, I never told anybody, I controlled it.

Tara: Oh really. That must have been difficult.

Interview #7: It was. Like I controlled it outside in the public but inside the home I was always mad or angry. I would always throw things. I was reading a pamphlet and I thought oh that's what I'm having is the postpartum depression.

Tara: So you didn't feel like that before you had her?

Interview #7: No.

Tara: So how did you control that when you were out in public?

Interview #7: I would just I don't know, my mind would be racing. Sometimes I just wouldn't go out, but sometimes I would want to and I would be laughing that pretend laugh you know. I would be *mimics fake laugh* and that just wasn't me you know because I know when I'm pretending to laugh. There was one birthday party I went to and I was trying to be happy. I was trying to keep myself busy at the party but I went into the bathroom and I remember I was looking into the mirror and I just said "oh fuck" and I wanted to hit the mirror. When I came back out I was just pretending to be happy.

She also noted that breastfeeding was emotionally difficult for her. "Yeah like when I sat down and did it [breastfeed] I felt like crying" (Interview #7). For this woman, feeding her children, whether it was breastfeeding or by formula, caused her to reflect on difficult life situations. When I asked her about her feelings related to infant feeding she stated she would think about people who triggered angry feelings when she fed her children. "Like when someone gets me mad or my spouse gets me mad or something." (Interview #7)

Another mother, a twenty-one year old woman on social assistance with three children, shared her experiences with depression and its impact on her ability to breastfeed. She indicated the seriousness of her depression by stating that child welfare might have become involved in her life if she did not have support. Changing to formula feeding was important for

her ability to maintain a healthy mental state. She also notes that if she had lacked support she might have been unable to purchase the supplies she required to formula-feed.

> **Interview #3:** I went into a depression after a while. I went through depression after Alison was born because I was a single mother. I had broken up with my boyfriend. Alison's Dad is from another country. He got in trouble with the cops and got sent back, so Alison didn't have a Dad. It's really difficult being on your own and do everything yourself. My mom was really sick, some people have their parents to depend on and I didn't have my parents to depend on.
>
> **Tara:** So did the depression affect your ability to breastfeed? You were breastfeeding at that time?
>
> **Interview #3:** Yeah it was 8 to 9 months after she was born. After a while there was too much pressure on me. She was getting up all through the night and she would eat and eat and eat and not get full. It was overwhelming. So my boyfriend helped me and got me the nipples and helped me with the bottles and he spent like $300 on baby stuff. He went all out just to help me because I'd be breastfeeding and crying and the guy was just like, he started helping me even though it wasn't his baby. He was very supportive. My kids would probably be in care or something if I was alone.

Key informants also reported that some mothers they have worked with chose not to breastfeed because they struggled with mental health issues such as childhood trauma or depression. Postpartum depression was also identified as a concern by three of the three key informants. This non-Aboriginal manager working for a social service organization reported:

> And some people if they are choosing breastfeeding they struggle because they have these other complications, umm a lot of our girls they fall into the post-partum depression stuff and that complicates the breastfeeding too because everything is so overwhelming, so that can impact it. (Key Informant #3)

Another key informant, an Aboriginal nurse working for an Aboriginal organization, stated that difficulties with breastfeeding can impact a woman's mental health.

> I remember being at this one house day after day after day and she really wanted to breastfeed and that baby did not want to breastfeed. We tried every trick on him and when I seen that it was stressing her out so much...I gave her the ok...She was so upset with herself. Breastfeeding is right but post-partum depression can be drastic. So there

always has to be a balance, like I'm a breastfeeding advocate but within means...(Key Informant #7)

The same key informant also reported that it is important for mothers to be supported in their infant feeding choices in order to encourage healthy mental states for both mothers and their infants. She discussed how children's mental health can be impacted by how the mother is feeling.

> We have some women [who] for whatever reason cannot breastfeed, or they will say "I don't want to." The way I see it, the child senses and the child's mental health is often affected by the way a mom feels, so hold the baby close and bottle feed if that's what you have to do.(Key Informant #7)

This point was reiterated by another key informant, a social worker working in a health organization. She believes that if breastfeeding difficulties are excessive then a woman's psychological health may be at risk.

> ...sometimes people's psychological health, mental health is more of a risk factor, you know if you're not sleeping and you're bordering on depression and you're not coping well and you can't get the baby to latch and you're constantly feeling like a failure and you can't get out of that rut, is it worth it? If you want to give a bottle is it worth trying to breastfeeding, I don't know. People have to decide that for themselves. (Key Informant #5)

As such statements indicate mental health issues play a significant role in the infant feeding choices of Aboriginal mothers. Two women in this study experienced either depression or postpartum depression, which impacted their ability to breastfeed. Key informants indicated that breastfeeding difficulties can impact a woman's mental health status and that infant mental health is partially reliant on a healthy mother.

iii. Abuse

Experiencing abuse in a relationship or abuse as a child was not an issue identified by the Aboriginal mothers in this study as impacting their infant feeding choices. When queried

about experience with abuse and how this could impact infant feeding decisions, the mothers were visibly uncomfortable with the question. Some of the mothers looked away from me, lowered their head, began shifting their body or stopped smiling. I therefore concluded that this was an issue they did not want to discuss with me. However, abuse was an issue raised by four of the key informants as affecting their clients and infant feeding decisions. Key informants reported observing increased levels of abuse associated with breastfeeding and key informants have worked with mothers who have experienced breastfeeding difficulties as a result of childhood abuse. One key informant reported that breastfeeding can be empowering for some women who have experienced abuse and another key informant works to increase the level of comfort women with a history of abuse have with their bodies.

Key informant #3, a non-Aboriginal woman who previously worked in a home visiting program, reports that relationship abuse did impact some of her clients and their breastfeeding decisions.

> I know of a couple, years ago when I was home visiting I recall a few cases where because she was breastfeeding she wasn't available for her partner and that increased the abuse and so then she didn't want to do it anymore. She thought that would save things. (Key Informant #3)

As explained earlier, an abusive partner may perceive his partner's breast as existing for his sexual pleasure and not for infant feeding. Another key informant, a non-Aboriginal woman working in a management position in a health organization, observed the difficulties mothers with a history of sexual abuse have regarding their bodies and breastfeeding.

> I've seen in my practice that there were women who have experienced abuse or sexual abuse and their bodies have been really sexualized and so to feed a baby from your breast for some women it's very uncomfortable. For some women it's empowering, but I have heard those reasons. (Key Informant #5)

This key informant, an Aboriginal nurse, works with a large number of mothers who have experienced trauma. She tries to empower the mothers she works with to reclaim their bodies and move beyond the abuse they have experienced.

> So we talk about a woman's breasts and giving birth. Like that's a part of our body and if was violated at one time in our life, we have to somehow move beyond that and it may not be as easy as some of us think it is, but somewhere along the line they have to make that move to prevent their children from experiencing that same cycle. So I like to go back in history. The clients they are complex, and at every end of the spectrum, mental health and addictions and it's all a result usually of childhood...(Key Informant #7)

Breastfeeding, as identified in the literature review, can be incredibly difficult if mothers have experienced abuse (Bowman 2007; Kendall-Tackett 2007; Klingelhafer 2007). Breastfeeding can be complicated by an abusive relationship and breastfeeding may not be an option for some women. Historical or current abuse often results in the misuse of substances as a coping mechanism which further complicates feeding choices. This will be discussed further in the next section.

iii. Substance Use

Issues related to substance use and abuse were identified as a major theme in the interviews conducted with both key informants and Aboriginal mothers. A couple of mothers shared their personal struggles with substance use and the support they were receiving with methadone treatment. The mothers interviewed recognized the health consequences of mixing substances with breastfeeding, however some reported they knew other women who breastfed while using substances. Debate exists among professionals regarding whether women should be breastfeeding if they are receiving methadone treatment, and women in this

community are receive mixed messages as a result. Mothers reported that they would like information on how they could combine breastfeeding with occasional substance use.

This twenty-one year old mother of three shares her experiences with methadone treatment.

> Well to tell you the truth I'm on the methadone program right now. After my second son was born I started taking percs [percocet], you know after I couldn't breastfeed. My cousin would come over and I'd take a quarter of one just to help me sleep and then it started to be half and then I started needing them more and more so I said "screw it" and I wanted to cut it off. So then I got pregnant with my second son and my doctor she said she would help me get on the methadone program. (Interview #3)

The same mother reported that she sometimes felt pressure from family members to consume substances:

> Well my mom she like um, she drank a lot and stuff and I didn't like going around there when I was breastfeeding and she would always try to push me into drinking so I stayed away from her for awhile. (Interview #3)

A thirty-one year old mother of three explains how she and her partner decided to cease using substances when she became pregnant. Her partner attended a treatment facility to access help for his substance abuse problem.

> We knew we were going to have him, so we knew it was time to quit everything... But he (motions to partner) went to treatment and I said "ok if you're going to do that," and we both quit and we knew what the long haul was going to be. (Informant #4)

Some of the mothers shared stories about other mothers they knew who were breastfeeding and using substances. These mothers wanted to breastfeed their infants for the health benefits and were unaware that some substances can be absorbed into breast milk and will be passed on to the baby.

> I know this one girl she was using and she still breastfed and then this other girl she was smoking pot and she still breastfed and people were like "what are you doing, why are

you doing that, like it's not healthy," but they thought they were doing the right thing. (Interview #5)

This one lady got out of the hospital, she had the baby last month same time as her sister and one stopped breastfeeding. "So that's good" I told her because "you know the baby will take what you're taking," so she stopped and put her on formula, but the other one is still breastfeeding and using. (Interview #7)

When mothers were asked if they had received the information they required on breastfeeding, some indicated that they would like more information on how they could balance breastfeeding with occasional, recreational alcohol and drug consumption as explained by the following twenty-three year old mother of four.

They always do that thing like if you want to go out like how long you can wait until you feed your baby and like that. But someone who is like me because like my body mass or weight is different from someone else and they give like the time thing or how many drinks or how many hours to wait for. Maybe someone like that who could do one on one... Yeah because maybe you're a small woman, or a big woman, and you have to wait like 2 to 3 hours for 2 drinks and it's like well ok *laughs* that's not going to go very far. (Interview #2)

This eighteen year old mother of one was interested in learning more about what substances are safe to use when breastfeeding and how the body filters them.

Except I've always been interested in how the breasts, like say, I see mothers who have done drugs, like other mothers, and I always wondered how that works, the filtering of it. Can they still smoke a joint and still be ok or what's up? That's the only thing I've never found out about like if it's filtered out, or it's all in there and the baby getting it too. That's the only thing I've ever wondered, even prescribed drugs, I've always wanted to know if that will affect the baby. (Interview #6)

The same woman reported that she and other mothers she knew who were breastfeeding would use formula if they were going to use alcohol or drugs.

Yeah some girls, like I know a few moms who do breastfeed, but when they use drugs they use formula. Like my 19th birthday is coming up and I do want to go out, so I want to get her use to the formula, like let's be honest here it's my 19th! Like I haven't been able to go out for a while. I do want to go out. I have a few other friends who will formula-feed to go out that night. (Interview #2)

One mother, a twenty-three year old mother of three, said she felt health professionals infringed on her sister's right to breastfeed since the nurse was concerned about substance use and the impact breastfeeding might have on the infant.

> Yeah like I know one of my younger sisters. She's the baby of us, she's using and I would think it would be ok for her to breastfeed even though she's using because they say like if you smoke, it's still better to breastfeed because they I guess, if you look in the formula there is some stuff that could hurt your baby but they don't know specifically what it is. I don't know. I got information that if you breastfeed you can still smoke and if you drink, wait a couple of hours to feed your baby. Like if someone was to use, I don't know. I know when my sister was using, her nurse told her not to breastfeed because too much was going to the baby. So she was told and she didn't breastfeed and they took away her right to breastfeed I guess, but then again you don't want to be putting that into your baby because it will go into your breast milk. (Interview #2)

Concerns about misinformation about substance use and breastfeeding and judgment regarding mothers who use substances were reflected in the interviews conducted for this research. It was also clear that there is significant confusion in the social service and medical community regarding the combining of breastfeeding with methadone treatment. A few key informants indicated that they did not have much knowledge on the issue and that they would like further education. They noted that some health professionals in the community are informing mothers they should not be breastfeeding if they are receiving methadone treatment and others are being told it is unproblematic to breastfeed while receiving methadone treatment. This conflicting information is causing significant confusion among mothers and many are choosing to formula-feed as a result. Additionally, many front-line professionals are confused or unclear about medical recommendations regarding breastfeeding and methadone treatment, as shared by this Aboriginal health promotion worker:

> ...some of them tell us that they are on methadone. They planned to breastfeed and when they baby is born they aren't able to and it's mixed messages on that because, methadone is such a new thing and some say it's ok to breastfeed and some say no it's not advisable that's where a lot of them, the ones that come here anyways, they don't breastfeed because of the message....With me I'm still confused, I need to get educated on that, if you can breastfeed or not breastfeed on methadone....that methadone, we have to be educated in that because there is mixed messages. (Key Informant #6)

This nurse admits her bias against methadone treatment.

> ...women come in this room on the methadone and they still want to breastfeed and it's still not cut and dry whether they could, should. And some will do it without advice... Personally I just don't know what to say about that I'm very biased when it comes to methadone, it's so new and I didn't see it make an improvement in this city. (Key Informant Interview #7)

The mixed information women are receiving was reiterated by this non-Aboriginal social worker. She noted that many mothers receiving methadone treatment are negatively judged by professionals in the health system.

> ...they get really mixed messages around whether they should be breastfeeding or not. So lots of nurses say you don't breastfeed and some nurses say "yes, breastfeed." They are getting lots of mixed messages and often there is a lot of judgment around that from their doctors too. That can be really confusing for them so they just bottle feed.(Key Informant #2)

Key informants also reported that they had been asked questions by the mothers they work with regarding balancing breastfeeding and substance use, as shared by this Aboriginal health promotion worker:

> ...there was a question a couple of years ago, this one woman asked me in an elevator she said can I extract my breast milk in the evening and she wanted to go out drinking and can I then feed her in the morning. Well my answer was its best not to drink. If you want your baby to be healthy, just abstain from it. (Key Informant #6)

Some key informants expressed frustration about their inability to provide information on formula feeding to substance using mothers due to organizational breastfeeding policies which do not allow for the provision of information on formula use. This key informant, a non-

Aboriginal nurse, perceives this practice as particularly unsupportive to mothers who are using substances.

> We weren't even allowed to give out booklets, in fact in the prenatal clinic, I had a fight with the Obstetrician because she wanted me to not give out these really, really good Child and Baby Care Encyclopedias. They are free. It's got excellent information, but it does have formula making information and information on how to feed a baby a bottle, hold them, bottle teeth, decay etc. She didn't want me to give them out because they promoted bottle-feeding, which goes against the hospital policy. I said to her that there are so many women who have to bottle feed because they have addiction issues that why are we not supporting them as well? We want to make sure these babies, all babies get nutrition and not just those that are breastfed. (Key Informant #4)

A number of key informants indicated that utilizing harm reduction strategies was an effective approach for mothers who used substances intermittently. For these mothers mixing formula use with breastfeeding was an effective strategy, as reported by the same nurse quoted above:

> ...many of our women have addiction issues and they should not be breastfeeding. So we do provide support to the women who need to bottle feed as well. We also support harm reduction strategies around breastfeeding; if they do know that the weekend is when they drink, but they don't drink or use during the week, we try to do some education with pumping, preparing for a night's bender if they know it is coming up. (Key Informant #4)

The non-Aboriginal social worker quoted below explains that using formula is the responsible and healthy choice for mothers using substances; however, since many women do not disclose their substance use, their health care provider may be unaware of this behaviour and continue to promote breastfeeding. As well, two key informants reported that many mothers fear being reported to child welfare if they disclose to their health care provider that they are using substances.

> ...they might still be using and so that they don't want to breastfeed as they are still using and that it goes though their breast milk so they choose to formula-feed. Which is the most responsible decision and which might not be looked at that way from other

> organizations because they haven't told them the whole picture...Sometimes their lifestyle doesn't allow them to breastfeed 100% of the time so they will use formula...(Key Informant #2)

This non-Aboriginal nurse feels that women who are using substances and choose not to breastfeed should be celebrated for making a positive choice that is in the best interest of their child.

> A lot of them do choose not to breastfeed because they do have substance abuse issues and I always applaud them when they make that decision because they know they are trying to practice harm reduction. They already know they have done some damage to their children and don't want to continue it by breastfeeding. There seems to be such a mental block around breast is best, but if a mother chooses not to because she can't give up smoking or she knows that she has substance abuse issues why can't we say good job, well done, you've made a good decision. Why can't we do that? (Key Informant #4)

Substance use was the strongest challenge to breastfeeding to emerge from these interviews and it represents an issue that many Aboriginal mothers are struggling with. As a result, women who are using substances need to be supported in using formula to feed their infants. Key informants reported that mixing breastfeeding with formula use was an effective harm reduction strategy for women who might be binging or using substances occasionally. As well, the mothers reported they would like more information on how to mange breastfeeding with occasional substance use. The mothers interviewed recognized the health consequences of mixing substances with breastfeeding, however some reported that they knew other women who breastfed while using substances. Finally, significant debate exists among professionals regarding whether or not women should be breastfeeding if they are receiving methadone treatment; as a result, women are receiving mixed messages from health professionals on this issue.

4. Professional Influences

A number of professional influences on mothers, with regard to infant feeding decisions, were identified in the interviews. Child Welfare was reported as an inhibiting factor for breastfeeding and, as noted earlier, a number of mothers in this study were involved with Child Welfare in some capacity. Health professionals influenced women in both negative and positive ways. The social assistance system was reported as pressuring women to quickly return to work or school, which impacted the ability of some women to breastfeed. As well, a number of key informants felt the need to impress upon me that their clients were good mothers and to defend their infant feeding decisions.

i. Child Welfare and The Social Assistance System

A number of the Aboriginal mothers were involved with child welfare services or were aware of the potential for this involvement in their lives. Many of the mothers the key informants worked with were under pressure to please child welfare workers and demonstrate their capacity to be good mothers. As well, one key informant reported that many of her clients struggled to breastfeed since the social assistance system pressures women to return to school or work soon after giving birth.

A twenty-one year old mother with three children interviewed for this study, was under surveillance by the child welfare system. She explained that child welfare became involved in her life as a result of a substance use problem she had had. In the quote below she stated that child welfare threatened to remove her children once she began methadone treatment. I questioned her further about this and she stated that child welfare has not removed her children from her care, however she is being closely monitored by them.

Interview #3: If I wasn't on the methadone they would have taken my kids. I guess after I went on the methadone that's when Dilico[5] called and they said we can take your kids.

Tara: Even though you're on the methadone program?

Interview #3: Well no they said now that you are on a methadone program we can't touch you but if you fall off it. They watch everything I do now and the people I hang around with. I learned the hard way.

One mother, a twenty-seven year old woman with four children, shared her story of the measures she took to provide her infant with breast milk after he had been removed from her care. She continued to pump her breast milk for a period of three months and provided that breast milk to her sister-in-law, who was caring for her infant. However, her sister-in-law chose not to feed the breast milk to the infant and disposed of it. This mother felt violated and struggled during her separation from her child, since she felt she was supposed to be breastfeeding him. During a visit with her baby she was able to feed her infant from her breast, which brought her great joy. This mother perceived breast milk to act as a facilitating measure in maintaining a connection with her infant.

Interview #5: Well with him, (motions to child) because of my involvement with Dilico, and I was just getting my kids back at that time when I had him. My sister-in-law said she would take him, and she said I could still breastfeed and see him, like all this and that. I breastfed him right until he was 3, 4 months and then finally she took him for like 2 months and she didn't let me see him for 2 months. Every time I gave her breast milk to give him through a bottle, she'd chuck my breast milk and so I was like sad. I was really upset, like she took something from me, I felt really depressed I guess, like my sister would try to comfort me but she didn't know what to say I guess. I don't know, I guess a part of you is gone, she took that feeling away from me. I just hated it, I just hated her actually. When I got him, when I finally got a visit it was like a month after me calling Dilico and me saying I want to see my baby, like I seen my kids but I want to see him too because he's a part of me. And so finally I think it was like 3 weeks after and so

[5] Dilico Anishinabek Family Care is an organization that provides child welfare services to Aboriginal people in Thunder Bay, Northwestern Ontario and thirteen First Nations communities in the District of Thunder Bay and the District of Algoma.

finally they said ok you can see your baby. We finally got a hold of her and my sister she's like go ahead and try feeding him. Like I was just overwhelmed I was so happy to see him, but I wasn't too sure if he remembered me. So my sister's like just go ahead, feed him, because I still had my milk or whatever because I was pumping.

Tara: So you continued to pump the whole time he was...

Interview #5: Well because I thought she was giving him the milk, because she was taking the milk from her mother's, and I just thought she was still giving him the milk and then I found out. So I tried breastfeeding him and he took it....Yeah I was happy, I was so happy and then he was gone again so I went back to my family and I tried talking to my counselor about it. Like what she did wasn't right, like she took a part of him away from me and so finally when I got him back I had already dried out the milk or whatever so it didn't feel the same. I don't know, but I had him but it didn't feel the same, like the way I wanted it to be. Maybe that's why we're so close, like I can't even leave him with his Dad, he won't even stay with his Dad. Maybe that's why, I don't know, but we are like really, really close now. Like those 2 or 3 months that I lost him, and the father was ok about it but I freaked out on him all day. I was like, I'm suppose to be breastfeeding him, I wanted to breastfeed him...

For some mothers under surveillance by child welfare, formula feeding can be a method of demonstrating effective parenting skills. With breastfeeding it is impossible to measure the amount of milk the child receives. However, with formula mothers can measure and report to child welfare that they are feeding their children appropriately. The key informant quoted below, a non-Aboriginal manager, provided her thoughts on the matter.

> Also, it's hard to judge if your baby is getting enough food, nourishment [with breastfeeding]. So I think that's what they struggle with as well. So then they worry if the baby's crying so they assume that the baby is not getting enough food and they aren't producing enough breast milk. They don't understand that it's just the other reasons that a baby might cry, so we try to support them and encourage them as well. A lot of our families are involved with child protection so they would worry so if their baby is crying or they have to worry about failure to thrive, those kinds of things. So then yeah, they want to make sure their babies are perfect when those workers are around. (Key Informant #3)

Breastfeeding was cited as a human right in a couple of interviews, a right that was violated by professionals; child welfare and nurses. One organization that works with mothers

who have used substances reported that many of their clients, who are now substance-free, wanted to breastfeed their infants and saw this as a way of performing the role of a good mother. Even though these mothers were attempting to make positive changes, they were not supported by child welfare in their infant feeding choices. This non-Aboriginal social worker shared her perspective on the issue:

> The other thing is what I have found is that when a woman really wants to breastfeed and their child is apprehended and they really want to breastfeed, it's not supported by Child Welfare. Which I am a little confused by because I'm thinking if it's almost like it should almost be a right. I know a few women who have really tried and they have pumped you know done the whole thing but haven't been able to sustain it because their baby's in care. (Key Informant #2)

An Aboriginal health promotion worker reported that some of her clients are pressured by the social assistance system to return to work or school shortly after giving birth. She shared that for some women attending the community high school program for young mothers, this was not a problem since the program is set up to support breastfeeding mothers. However, for mothers attending college or university this was more difficult. As well, working and breastfeeding would be difficult for the mothers she works with since they would be employed in low-paying service related jobs.

> **Interview #6:** The big one I hear them say is sometimes if they are on Ontario Works within certain months after the baby is born they have to go back to work or they have to go back to school. They are pushed from that side.
>
> **Tara:** How soon is Ontario Works pushing them to go back to school or work?
>
> **Interview #6:** Some say right away. I've tried to tell them, you know, tell them that you want to breastfeed your baby for as long as you can.

As indicated in the quotes in this section, Child Welfare was involved in the lives of a number of these women which, in most cases, had an impact on infant feeding decisions. The

mothers felt pressure to demonstrate that their children were properly nourished, and breastfeeding made it difficult for mothers to judge this. Using formula enables mothers to measure the food provided to their infants, which allows them to know precisely what their infants are consuming. Finally, the social assistance system might also be impacting infant feeding decisions by pressuring women to return to school or work soon after giving birth.

ii. Health Professionals

Health professionals have significant positive and negative influences on mothers' infant feeding choices. The mothers shared both stories in which they were supported in breastfeeding and stories in which they were pressured to breastfeed when they did not want to do so. Some women may be breastfeeding to reduce pressure from professionals to breastfeed, as reported by key informants, however this was not the experience of the mothers in this study. One key informant reported an observed lack of support for Aboriginal mothers in the establishment of breastfeeding in hospital environments.

The key informant quoted below, a non-Aboriginal manager, felt that some mothers might breastfeed to appease health professionals.

> On the health professional side who are pushing breastfeeding, it can go in the opposite effect. So if you are really feeling like I need to stop breastfeeding because I can't do this anymore and a health professional makes you feel like you are a bad mother if you do, then you may continue breastfeeding to appease other people... (Key Informant #5)

However, another key informant, an Aboriginal nurse, did not share the same opinion. "I'm seeing more women breastfeeding and breastfeeding for longer periods and so because they want to not because they have to or felt they were made to." (Key Informant #7)

According to one key informant, a non-Aboriginal nurse who worked in a hospital maternity setting in the past, reported that Aboriginal mothers may not be supported in

establishing breastfeeding. She stated that nurses often do not put effort into supporting Aboriginal mothers to breastfeed. There was an assumption that Aboriginal mothers would not continue breastfeeding and so nurses did not want to invest time in supporting mothers to establish breastfeeding.

> ...one thing I have heard is that First Nations girls felt that the nurses presumed that they would not even keep up. They would start bottle-feeding as soon as they go home. I can attest to that as I do know a lot of them will say that especially with the younger girls "they are not going to bother to do it when they get home so we're not going to put the effort in." (Key Informant #4)

A twenty-seven year old mother of four reported a negative experience in relation to a nurse touching her without her consent. The nurse was trying to assist with establishing breastfeeding, however the mother was uncomfortable with the approach implemented by the nurse. This mother, who wanted to formula-feed due to physical pain she was experiencing, was confused about why she was not provided with formula upon her initial request: "Why? You guys have formula there?" She eventually was provided with formula, but only when she became angry.

> **Interview #5:** ...I didn't like when they were grabbing my breast and showing me how to breastfeed. I don't like people coming in my space, I just don't like it.
>
> **Tara:** Did they ask you before they would touch you?
>
> **Interview #5:** No, they would be like, this is how you do it and they just grab you. And I'm like, excuse me, that's my body and then they'd like, oh you have to do it this way so you can latch them. With Sarah they were showing me and they were really pushing it on me to breastfeed and I was like its sore, I can't, I can't. They showed me what to do if it got to that point, if it was too sore, like put a tea bag there or a cloth. But it was still too painful, so I don't think those things work. It was just really, like the whole time I was in the hospital they just wanted me to breastfeed and I was like "why, why you guys have bottles there?" But I guess ummm, with Sarah I got to the point where I was just getting frustrated I guess and I must have looked mad or something because they went and got a formula bottle and they fed her. I guess they want the baby eating at a certain

time, but ummm yeah that's what they did with her and I was glad that they let my breasts heal for a few minutes.

Other mothers reported positive experiences with health professionals, both in the hospital and in the community. They felt they were supported in their infant feeding choices. "But yeah the nurses at the hospital were really awesome and they helped me out and stuff." (Interview #6)

The mother quoted below, a twenty-five year old mother of four from a First Nations community, explained how the nurses encouraged her to breastfeed when she gave birth but she did not feel pressured to do so.

> They [hospital nurses] asked me "what are your plans?" And I said I was going try breastfeeding but my nipple was like, I don't know, it's just me I guess, I didn't like it. But they did ask me if I was going to breastfeed and they told me it would be good for the baby you know. And I said I want to use formula and the nurse tried [get me to breastfeed] but they didn't force me. (Interview #7)

Another mother, a twenty-three year old woman with three children, was supported with some difficulties she experienced with breastfeeding by a nurse, which helped her to maintain her breastfeeding practices.

> Like with him I wanted to stop but my nurse, she's a registered nurse, I got her to help me and she said even if it hurts like you're gonna have to, like you should get him on one side and express on the other but you should just get him on anyways. Like it will feel better if you just let him nurse, because it will just get engorged and then like just dry up or whatever. It's just going to get a lot better she said because when you are engorged your breasts just get like really hard. That's what I noticed with him so with that one I learned to prepare myself I guess. *laughs* It got better after that, it got easier. (Interview #2)

However, a different mother, a twenty-seven year old mother of four, reported an experience she had had in a post-natal class. She explained that the group facilitator would ask

the women in the group who was breastfeeding, and for how long they had been doing so. She felt it was implied that the longer a mother was breastfeeding, the better.

> Like when I went to program they would go around and say who's going to breastfeed and they'd talk about why you should breastfeed and so I don't know basically so you would know what to do. They would say who breastfeeds more, they would say this person breastfed for 2 years and like it was better or something I don't know. (Interview #5)

As evident from the information presented above, the mothers in this study are being encouraged and supported by health professionals to initiate and sustain breastfeeding. Some of the mothers indicated they appreciated this support, although one mother had to insist upon her desire to use formula. A competitive breastfeeding environment was reported by one mother in her post-natal class.

iii. The Good Mother

Three of the key informants felt the need to stress to me that their clients were good mothers. For key informants, breastfeeding was synonymous with good mothering and some felt the need to defend their clients who might not be breastfeeding.

This Aboriginal health promotion worker explained to me why some of her clients may use substances"...a lot of them are good mothers, it's just they get side tracked or they are here alone and a family member comes into town and they ask them out, that's a lot of it." (Key Informant #6)

A non-Aboriginal nurse explained that the mothers she works with really want to breastfeed and do what is best.

> A lot of these moms are excellent moms, they really want to do this and do what is best for their baby and because they have grown up in a society where breast is best. That is what they want to do, that is the first thing they want to do. (Key Informant #4)

One Aboriginal nurse in particular felt the need to present her clients as good breastfeeding mothers. She explained that since her clients breastfed there would be no reason for other nurses to judge them. "The majority breastfeed so I can't see why any nurses would look down on them..." (Key Informant #7) She also separated herself from her clients and associated herself with me. This key informant clearly saw me as a privileged woman and therefore as being different from her clients. "Like in our homes it's a disaster if you're low; gotta get some milk! These people do not have milk in their cupboards..." (Key Informant #7) When discussing the impact of childhood trauma, the same woman stated, "I would see some people who loved their kids as much as you and I love ours but they hardly touched them. You know how kissy and smoochy we are with our kids..."(Key Informant #7) She also compared the mothering practices of her clients to the practices of privileged mothers, which are understood to be the practices of good mothers.

> They can be very picky about their babies, they're as picky as us. Even though they are high risk and have a lot of complex issues in their lives, more than any of us could handle. But about their babies they are like "no, I only use this and not that"... (Key Informant #7)

Despite the fact that the Aboriginal mothers and the key informants all reported that few Aboriginal mothers they knew breastfed, this key informant stressed that most of her clients did breastfeed. This nurse clearly believes that other people associate breastfeeding with good mothering and as a strong client advocate she was committed to ensuring I understood the complex lives her clients led. However, she also viewed herself and me as being different from the mothers she worked with and spoke in distanced terms from her clients. Key informants were concerned I would perceive the Aboriginal mothers they were working with as poor mothers.

5. The Breastfeeding Imperative

A moral imperative related to breastfeeding was evident in these interviews. Key Informants felt that formula use was not considered an acceptable infant feeding method by the health system and many clients do not have access to information on formula other than the risks associated with its use. Key Informants felt constrained in expressing their opinions if they were in opposition to dominant breastfeeding messaging.

i. Formula Use

Many of the key informants reported that formula feeding has become stigmatized in society, in particular within the health field. They argue that because of this stigmatization, some bottle-feeding mothers do not disclose their infant feeding choices to health professionals, or, they feel as though they need to justify their infant feeding method. One key informant stated that she introduces the subject of formula feeding since many clients do not ask questions about this feeding method due to what she perceives as judgment related to formula use.

This non-Aboriginal manager feels that breastfeeding is currently being promoted strongly by health organizations and some mothers are feeling poorly if they are using formula. She explains that formula is now becoming stigmatized, which adds to a lack of confidence in some mothers who may already be struggling in many other ways. She feels that mothers are often required to justify their infant feeding method to professionals.

> Well I think there is a very strong push on breastfeeding and as you know with the Health Unit being totally "breastfeeding friendly" now, that certainly makes it a strong push. So I think a lot of people are feeling less than if they can't. So it's almost getting to if you're not breastfeeding you don't even want to admit that. So that's almost becoming the stigma as opposed to breastfeeding and so then it adds to their lack of

> confidence I think...I think the girls that do infant formula are going to get that negative response from other professionals that are breastfeeding friendly. It's almost like it's getting to be you have to have a good excuse or a justification to why you are choosing to use formula instead. (Key Informant #3)

One key informant, a non-Aboriginal nurse, ensures that she broaches the subject of formula use with clients since many mothers will not even ask about it for fear of judgment. She believes that the infant feeding climate has changed dramatically over the past twenty years and that many women may experience negative responses from health professionals if they disclose formula as their infant feeding method.

> Unless I bring it up they don't tend to ask about it because they think I am going to judge them for it [using formula]. I ran a prenatal clinic for 6 years. A lot of women, I would talk to the women about their feeding choices, because I was trained as a midwife and I didn't have to but I did, because I knew what would happen when got to the hospital and the push for breastfeeding. If you mention the word bottle you may have the nurse go up one side and down the other...over the last 20 years it has changed dramatically because the awareness is so much there. Many years ago when I was training as a midwife lots of people were bottle-feeding and it was okay. Whereas now, it is a dirty word. (Key Informant #4)

Accessing free formula was a covert activity for some mothers using services from organizations who follow BFI policies, as described by this Aboriginal health promoter: "...they go around, there are some places that give formula, I don't know who they are, and they don't tell me." (Key Informant #6) In the recent past some organizations in the community provided free milk to breastfeeding mothers, in order to ensure the mothers met their personal nutritional requirements. However, milk was not provided to formula feeding mothers. This practice has recently been changed since it was identified as a punitive practice for non-breastfeeding mothers (Health Canada 2002: 11).

None of the Aboriginal women articulated feeling stigmatized if they used formula to feed their infants, however their actions demonstrated the need to be identified as breast-

feeders. As well, even though most of the women used a combination of formula and breast milk to feed their infants, they viewed themselves as breast-feeders. As noted earlier in the chapter, one mother provided a number of justifications for feeding her infant formula. Additionally, the endorsement for breastfeeding combined with the ambivalence expressed by virtually all the mothers indicates that mothers feel stigmatized by using formula or that formula is not an approved choice by professionals working in the health sector. The mothers who did breastfeed clearly felt proud of their infant feeding method stemming from a connection to the current value placed on breastfeeding in society.

ii. Provision of Information on Infant Feeding

Information on formula from health organizations was largely unavailable to mothers in this study. The mothers interviewed reported receiving plenty of information on breastfeeding and little information on formula-feeding. For the most part, the information they did receive relayed only negative aspects of formula use. When I asked the mothers if they received the information they required on formula preparation, five responded by indicating that they had read the instructions on the formula packaging and that they felt this was sufficient information. Two mothers reported that they found information on the internet about how to prepare formula. As well, two mothers indicated they would have appreciated information on substitutions to use if an infant had a reaction to a specific type of formula. As indicated earlier in the chapter, two key informants reported that mothers often do not ask about formula since they feel they will be negatively judged for using it. As well, for mothers living in poverty who do not have education on how to properly prepare formula, it may be tempting to dilute it in order to extend resources. This finding was reported by four key informants.

The following twenty-five year old mother from a First Nations community stated that the only information she received on formula was in relation to the negative consequences of its use. She indicated that she figured out how to prepare formula, however she did not report if she knew how to sterilize bottles. "No to be honest they only gave information on what the bottle can do, like tooth decay and stuff...They didn't show me how to make milk. I just read the label on the can and it said to mix it half and half so that's what I did." (Interview #7)

For the majority of mothers interviewed, the information they did receive on infant feeding was on breastfeeding. However, as this mother, a twenty-three year old woman with three children, indicates, there may be an unstated but implied privileging of breastfeeding mothers over non-breastfeeding mothers in pre-natal and post-natal groups. "I guess in pre-natal classes they sorta, well they don't look down on you if you don't breastfeed but they do give you information to breastfeed. Like they say it's more better, the more they say its better." (Interview #2)

A twenty-seven year old mother living on social assistance with four children, shared the kind of information she would have liked to receive on formula use. She was interested in learning about the kind of formula should she give her baby and alternative formulas to feed infants who may be lactose intolerant.

> Like if you're baby couldn't latch what kind of milk should you give your baby? Like I didn't understand that part, like what kind of milk should you give your baby if they are lactose [intolerant]? Or like my sister would always come over and her baby would always spit up, and she would come to me and ask me what to do. I guess she thought I would know because I have like 4 kids and I was like I don't know. I don't know that much about bottle-feeding. Like if the baby spits up so much what you should do, what other kind of milk should you give. She was always questioning me and I was like ask Mom she must know. Like they figured I would know but I don't know that much about bottle-feeding. (Interview #5)

A twenty-three year old mother of three who exclusively breastfed her infants reported that she did receive information from an organization on how to prepare formula properly and how to sterilize bottle-feeding equipment.

> Yeah I got it from [name of organization], they gave me this book about feeding and it tells you to boil the bottles, how to clean then, feeding time and what to do with the bottles later and how long the formula can be in the fridge for and stuff. (Interview #3)

Similarly, key informants reported mothers are not asking questions about formula because they fear judgment from health professionals about their infant feeding method as shared by this a non-Aboriginal manager.

> The only thing I can say that I recall is, a lot of people didn't know how to mix formula. Because of the whole campaign breast is best it's a part of the whole philosophy in our community. I think people sometimes were afraid to ask the question: "how I mix formula? I don't even know what to do with formula?" (Key Informant #5)

A non-Aboriginal social worker, reported that some of her clients who are living in poverty are watering down their formula because they do not have information on how to prepare it. Although this key informant is a self-reported breastfeeding advocate who exclusively breastfed her four children, she believes in supporting women's infant feeding choices because of the multiple social influences on women that impact their infant feeding decisions.

> ...when the women choose to bottle feed there is not a whole lot of support around how you do that properly. Often these women are living in poverty so what they are doing is they are diluting their formula so the babies are not getting the nutrients they really need. Or they [mothers] are not being supplied with formula, we will supply formula if a woman doesn't have any money for it, but I don't think that say the Health Unit is able to do that...I think you can still give the educational pieces but I think that is, we know that breast milk is really good but we have to really support women's choices. Sometimes we just don't have all the information so we don't know what women are going through in terms of why they are making the choices they are and I think that they need to be supported in what they are doing...I think that we need to have things in place where you are told how to store your bottles, how to mix your formula, all that

sort of stuff we need more information around that sort of stuff. Women are not sure if they are doing things right. (Key Informant #2)

It is apparent that mothers are receiving information about infant feeding that conforms to BFI policy. Other than in one scenario, mothers only received information on the negative health consequences related to formula use. However, both key informants and mothers shared that they felt receiving information on formula use from health organizations was important, although key informants reported that many mothers are apprehensive about requesting this information.

iii. Pressure and Guilt

Key informants reported that they feel there is a lot of pressure placed on mothers to breastfeed and this pressure is not balanced within a framework that identifies the various social challenges mothers are experiencing when making their infant feeding choices. As a result, a number of key informants reported that mothers are feeling guilty if they are formula feeding or struggling with breastfeeding. Although none of the Aboriginal mothers I interviewed shared stories of feeling guilty, their actions demonstrated that they wanted to be perceived as breast-feeders. The mothers took pride in the fact that they did breastfeed and they wanted me to view them as breast-feeders. They had internalized the importance of being labeled as breast-feeders as an indication of being a good mother, regardless of whether or not they were practicing mixed feeding methods. Three key informants shared their personal stories related to infant feeding and they reported feeling poorly as a result of using formula.

The quote below is from a non-Aboriginal manager working for a health organization. Although she recognizes the importance of promoting breastfeeding, she feels that campaigns and books may be unbalanced and may result in inducing guilt in women.

> Pressure; you know there's a lot of campaigns out there for breastfeeding and I completely understand the campaigns and think they have absolute merit. They are grounded in research but I do think it might be slightly unbalanced and it may make people feel guilty. The books people are reading about, you know, have sections in them on breastfeeding that are huge and then a section on formula feeding that is one page you know. (Key Informant #5)

A non-Aboriginal nurse explained that there are many reasons women may not breastfeed but these women are being judged and feeling negatively as a result.

> There is a huge judgment for women who are not breastfeeding. They feel incredibly guilty, they feel like their babies are not going to do as well, not going to be as intelligent. ..not going to do as well in life, and it is their fault because they are not breastfeeding! There are so many, many reasons why women choose not to breastfeed and they all have to be taken into account I think. (Key Informant #4)

Key informants who were non-Aboriginal had many stories to share regarding their feelings of guilt related to their personal infant feeding experiences. The following manager, who worked previously as a social worker, reported that she had felt pressured and guilty because she had struggled with breastfeeding. She also felt conflicted about the subject since she promotes breastfeeding as part of her job.

> I think people are feeling a little bit of pressure and I was one of them....I formula-fed and I felt guilty for it. It's just another mother guilt that is put on us. Something that I struggle with is because I work for an organization that for good reason promotes breast is best and baby friendly, but for me it's a bit conflictual for me as a social worker and you know just knowing that there are women out there who just choose not to. (Key Informant #5)

This nurse shared a story of a negative comment she received about bottle-feeding her infant in a public place.

> I think there is a judgment call that you are not doing what is best for your baby. This means you are not as good a mother as you could be. Or you know "It's a shame you are not breastfeeding!" I mean this comes from a failed breast feeder, I could not breastfeed. I had no milk, and I remember someone coming up to me in a doctor's office when I was bottle-feeding my son, he was about 6 weeks old after I had been told

> to stop trying as he was losing weight. "It's such a shame you are not breastfeeding dear." (Key Informant #4)

Similarly, this social worker shares the struggles she experienced while exclusively breastfeeding her children and explains how using formula on occasion would have benefited her mental health.

> I know because I have 4 children and breastfed all my children, but it was not easy. I think that the whole piece around it's natural, it's hard and needs to be done with a whole lot of support and especially the first month is brutal. You feel like a cow and you are hurting because you nipples are cracked and all sorts of things and I know that I wouldn't have been able to do it without a lot of support. It's not the easiest thing and really does require a whole lot of support and then when you say I can't do this anymore you are met with the "Oh my god you can't stop." Many times there are many times that I am thinking that it would have been very helpful for my well being if I would have given the baby a bottle. It would have been a whole lot easier in taking care of myself. I just think that we need to give women a break. (Key Informant #2)

These key informants have associated breastfeeding with good mothering and attempted to breastfeed their own children but some experienced difficulties as a result. None of the Aboriginal mothers I interviewed reported feeling guilty if they did not breastfeed one of their children, ceased breastfeeding before the recommended six months, or had breastfeeding difficulties. One mother who did cease breastfeeding early with one of her infants expressed regret for doing so, but quickly stated that her children are still healthy despite receiving formula. "I kind of regret it now, I think I should have tried more but they are all good now." (Interview #3) As identified earlier, most of the mothers I interviewed considered themselves to be exclusive breast-feeders and were not initially transparent about their formula use. They also expressed ambivalence about their infant feeding and some rationalized their use of formula, demonstrating a desire to play the role of the good mother. They did not speak negatively of other mothers who did not breastfeed and the mothers indicated their infant

feeding method was in the minority amongst friends and family; most other Aboriginal mothers they knew did not breastfeed. I asked one woman directly if she thought mothers felt guilty if they formula-fed their infants and she said no. When I asked one key informant, an Aboriginal home visitor, if any of her clients who were not breastfeeding felt guilty, she responded:

> None of them have. If they have already made their decision on it they are not going to feel guilty about it and if you don't like it too bad, that is how I am going to feed my child. (Key Informant #1)

The above response could be interpreted as a defense mechanism in response to the pressures mothers feel to breastfeed, compounded with the judgment and racism many Aboriginal mothers experience in their parenting practices.

As demonstrated from these interviews, breastfeeding has become a measure of motherhood and women are feeling guilty if they are formula feeding or struggle with breastfeeding as a result. Although none of the Aboriginal mothers shared stories of feeling guilty, their actions demonstrated that they wished to play or be perceived as playing the role of the good mother through breastfeeding.

iv. Constrained Deviance

During the interviews three key Informants expressed anxiety with how their opinions and practices deviate from the current BFI breastfeeding policy. One key informant required extra assurance that her identity would not be revealed in this study while another key informant dropped her voice and asked how other people responded before she would respond to a question about current breastfeeding policy meeting the needs of Aboriginal women.

When I asked one key informant, a non-Aboriginal manager who formerly worked as a social worker for a health organization, if mothers shared their experiences with her regarding other health professionals she responded with the following:

> ....so this is where I want to make sure my name and title and organization is not attached to this. But absolutely, all the time I heard "the nurses are forcing me to breastfeed and I don't want to." Big tears, so of course I would support them the other way and say, "you have to do what right for you and no one can tell you what you need to do. You need to balance it and look at all the information and decide what's best for you." (Key Informant #5)

An Aboriginal health promotion worker clearly stated to me at the outset of the interview that her organization is a breastfeeding friendly organization. "We are told to encourage breastfeeding only. We aren't supposed to give them formula... Our goal is for every baby to be breastfed. We are supposed to encourage them, prepare them to feed their babies as long as they can. I mean breastfeed their babies as long as they can." (Key Informant #6) Later in the interview she revealed that her organization does provide information to mothers on formula feeding and formula samples.

> Yeah but if the mother can't give you have to do the next best, which is give them all the information on formula feeding. And see, I don't even know what the best one is. The doctors upstairs give free things, free formula...they bring it down sometimes. We just give it to whoever wants it because she might need it, because we don't know her situation. If she asks for it we give it to her...Policies are made to be broken eh? *laughter* (Key Informant #6)

The key informant quoted below, a non-Aboriginal manager, reported that her organization supports mothers in whatever infant feeding choice they make. However, during the interview she questioned whether her organization should be stronger in their promotion of breastfeeding. Throughout the interview she expressed an understanding of the complexities of the lives of her clients and how those complexities influence infant feeding

choices. However, in this exchange she conceptualizes her clients' infant feeding choices as individually perceived limitations, rather than structural barriers.

> I would have to say there are as many girls that bottle-feed as breastfeed, so I do think they struggle with those decisions. So that becomes the question, is that because we support both ways and make them feel ok about it? So they don't, you know, they're ok and they're open. Or so should we be stronger in our emphasis in the breastfeeding? It's such a delicate balance on how to balance that. So I think they do they struggle with what's required. Even if it's in their mind and that they want to do it, it's the limitations that they see around breastfeeding. (Key Informant #3)

When I later asked the same key informant if she thought current breastfeeding policy meets the needs of Aboriginal mothers, she responded with hesitation, lowered the volume of her voice, and asked me how other people were responding to the same question.

> Ummm....do I think it reflects their needs and experiences? Maybe not *laughs*. (said in a quiet voice) Ummm...probably not because I mean...that's interesting to figure out Tara. What have you been hearing? (Key Informant #3)

Key informants had an abundance of negative opinions to share about BFI practices, however not all of these key informants felt comfortable sharing their views openly. Current breastfeeding messaging is strong and powerful within the health sector and these professionals felt discomfort sharing opinions that deviated from the current breastfeeding messaging that exists within the health sector.

v. Policy

All but one of the key informants interviewed do not believe that current exclusive breastfeeding policy is reflective of the complexities of Aboriginal mothers' lives. When asked if current breastfeeding policy is reflective of Aboriginal mothers' needs, an Aboriginal home visiting key informant responded, "I think they need to start opening up a little bit about

formula feeding because it's going to hurt the mothers in the long run, mentally, if they don't." (Key Informant #1)

The following key informant, a non-Aboriginal social worker, believed that policy should allow for the provision of information that mothers need and mothers need to be supported in their choices. She had concerns that current policy may alienate mothers who are not breastfeeding:

> I again think that we need to provide information that they need and on what they are asking for and supporting women's choices. I think that is really important because not all women can breastfeed, for whatever reason so what are you saying to them? What is the message there? That you are lower, not as good and that is not fair. Some things are just beyond our control sometimes and I don't think that it is right. (Key Informant #2)

This non-Aboriginal manager feels that mothers need more support in order to be able to breastfeed:

> I think that if Aboriginal women are going to be breastfeeding this needs to be approached at a community level. I think the more support people have at a community level for choice. I'm never about one end or the other, I'd rather people make an educated choice. If you educate the community about the different choices and allow them to educate the women within their circles they will be more successful. If they don't have that support they probably won't do as well. (Interview #5)

This Aboriginal nurse feels that people developing policy need to consult with those who are working with women.

> I've read all these policies over and over and they are well meaning but they are missing someone who is doing the work like us down here. (Interview #7)

One key informant, a non-Aboriginal manager for a social service organization, viewed her organizational programs as beneficial to mothers since they were not bound by BFI parameters. Other organizations tied to BFI policies benefited through a partnership with her organization since they could still work with mothers who were using formula.

Most key informants felt that current breastfeeding policy does not reflect the experiences of marginalized women. Key informants felt women need support at a community level to maintain breastfeeding and policy makers should be consulting with professionals working with marginalized women. At a local level, some organizations that implement BFI policy benefit from partnerships with other organizations that do not follow this policy.

6. Conclusion

In this chapter I summarize the key themes from the qualitative research interviews. The findings fall under four main themes, which are: infant feeding in everyday life, structural influences on infant feeding, professional influences on infant feeding, and the breastfeeding imperative. In the section on infant feeding in everyday life I discuss how mothers are aware of the health benefits of breastfeeding and how most chose to breastfeed as a result of this. However, most of the mothers used both formula and breast milk to feed their infant and as a result they expressed ambivalence regarding infant feeding throughout the interviews. Most of the mothers expressed struggles they encountered pertaining to a loss of autonomy from breastfeeding and breastfeeding in public places. As well, the mothers were influenced by their interpersonal relationships in both negative and positive ways. The theme of structural influences discusses how poverty, mental health, abuse, and substance use impacted and influenced the mothers in this study. The third theme, professional influences, I cover the influence Child Welfare had in the lives of many of the mothers interviewed. Health professionals influenced mothers in both positive and negative ways regarding their infant feeding decisions, and a number of key informants felt compelled to position their clients as good mothers. In the final theme I discuss the breastfeeding imperative and the impact of

privileging of breastfeeding mothers over non-breastfeeding mothers. Infant feeding has become a measure of motherhood, with the breastfeeding mother identified as a good mother. Formula use is stigmatized within health organizational culture and mothers who use formula feel the need to hide their infant feeding practices.

The major conclusion from this chapter is that the infant feeding decisions of Aboriginal women are complex and influenced by numerous social factors and structural barriers. Some of the mothers felt the need to define themselves as breast-feeders even though they did not meet the definition of exclusive breastfeeding since many used a mixed feeding approach to nourishing their infants. Despite the fact that formula use is common, mothers reported receiving little information from health organizations on formula. The information they did receive was related to the risks associated with formula use. As well, none of the women reported receiving information on how to manage mixed feeding practices, information which key informants identified as being vital for maintaining breast milk supply. Since mothers are not receiving information on how to mix feed, breast milk supply diminishes and mothers often move fully into formula feeding. Key informants reported that many mothers feel pressure to breastfeed and feel guilty if they choose not to. As well, key informants did not feel that current breastfeeding policy meets the needs of a marginalized population, however some conveyed anxiety regarding expressing opinions that deviated from this policy. Finally, few professionals seemed concerned about the impact that infant feeding method has on fathers and their relationship to their children.

In the next chapter I compare my data with the findings from the literature review. I outline commonalities and differences between my research and that of the secondary sources and I conclude with recommendations for future research.

Chapter 5 - Discussion

"We have to really support women's choices...": Moving Towards an Intersectoral Lens in Breastfeeding Policy

In this chapter I compare the findings from my research with those of the literature reviewed in Chapter Two. In general, my study found that a host of social factors influence mothers' infant feeding decisions. Additionally, only two of the mothers in my study had or were breastfeeding at least one of their infants exclusively as per BFI recommendations. Despite the fact that formula use was common amongst the women interviewed, mothers generally did not receive information from health organizations on how to prepare formula properly. The mothers in this study enjoyed their breastfeeding experiences but found exclusive breastfeeding to be challenging. Key Informants also reinforced that the BFI is not reflective of the complexities of Aboriginal mothers' lives or the various social factors which impact Aboriginal mothers and their infant feeding decisions and is problematic for them to operationalize if they are going to meet this group of women's needs.

Some of the results from this study concur with the current literature while others challenge or add to present understandings. One unexplored area in the literature identified here pertains to the influence partners have on mothers' choices about breastfeeding, particularly when the mothers may not wish to breastfeed. Another under-studied issue which was prominent in this study was the experiences of mothers' who either wished to breastfeed or are breastfeeding while using substances. Numerous studies have found that mothers who do not breastfeed often feel guilty or feel the need to justify their use of formula. In my study, only one mother rationalized her use of formula and the mothers did not report feeling poorly

if they used formula, although their actions did demonstrate that they had a desire to be perceived as breast-feeders. Non-Aboriginal key informants shared their personal infant feeding experiences and some reported feeling poorly as a result of their infant feeding method or their struggles with breastfeeding. As well, since many women use formula in some capacity to nourish their infants, it is important to further explore if there are any negative health consequences as a result of limited information provided to women on formula by health organizations. Finally, the possibility that violence may increase for women in an abusive relationship when breastfeeding should also be explored further.

Areas in the literature supported by my study include difficulties with breastfeeding in public places, the fact that poverty can make breastfeeding more complex for some mothers, mental health issues can render breastfeeding difficult, and although none of the mothers in this study reported experiences of abuse, this was reported by the key informants who stated that either historical abuse or a current abusive relationships can impact the ability to breastfeed. The evaluation of current breastfeeding policy reported by the key informants was in line with published literature on policy critiques. Finally, I conclude the discussion with suggestions for future research based on the results from this study.

1. Summary of Major Research Findings

The purpose of this study was to capture the infant feeding experiences of urban Aboriginal mothers in Northwestern Ontario, to determine what factors influenced their infant feeding decisions and to analyze the implications that a universal breastfeeding policy, the BFI, has for Aboriginal mothers. The research goals stated at the outset of this thesis were to answer the following questions:

- How are urban Aboriginal mothers feeding their infants?
- How do mothers feel about their infant feeding method?
- What are the influences affecting the decisions of urban Aboriginal mothers regarding infant feeding?
- What kind of information are urban Aboriginal mothers receiving on infant feeding? Does this information meet their needs?
- What are the implications of the Baby Friendly Initiative for urban Aboriginal mothers?

The Aboriginal mothers interviewed for this study, for the most part, fed their infants both breast milk and formula. One mother exclusively breastfed all three of her babies for 6 months and beyond, and one other mother breastfed one of her babies exclusively for 6 months. However, both of these women attempted to feed their infants formula but they reported that the babies would not consume it. One mother strictly formula-fed two of her infants. Key informants reported that few of their clients breastfed which was confirmed by the mothers I interviewed. They reported that few of their family members or friends breastfed.

All but one of the mothers reported that they had enjoyed their breastfeeding experiences, however their responses were complex and the mothers expressed ambivalence regarding their experiences throughout the interviews. The mothers greatly struggled with the commitment exclusive breastfeeding requires and the loss of autonomy as a result. They reported difficulties with pumping their breast milk and most did not choose to pump if they were going to be separated from their infant; they used formula instead.

Influences on infant feeding choices were numerous, diverse, and complex. Partners influenced mothers to choose breastfeeding, however this wasn't always positive. One woman

reported that she breastfed because her partner wanted her to do so, not because this was her desire. As well, partners were not always supportive of their wives or girlfriends breastfeeding in public places. Infant feeding in public places was a great concern for many of the mothers interviewed, since breastfeeding in public required special clothing and constant vigilance regarding the way in which other people would respond to it. As a result of poverty some of the women did not have access to privacy in their homes which also impacted the practicalities of exclusive breastfeeding. All but one of the mothers in this study was living in poverty and this was cited as a reason for choosing to breastfeed. However, the mothers who used formula struggled financially to access the formula her infants required. Two of the mothers reported experiences with depression which made breastfeeding difficult. None of the women reported experiences with abuse, but this was reported by key informants as being a factor which inhibited breastfeeding among clients. Substance use was a major issue for the mothers in this study, which caused them to use formula on occasion.

The mothers in this study reported that they received a sufficient amount of educational information on breastfeeding from health organizations, but little to no information on formula feeding, other than the risk factors associated with formula use. As a result the mothers figured out how to prepare the formula themselves by reading the formula labels and seeking out information on the internet. Key informants reported that mothers often do not ask questions about formula use since formula has become stigmatized and many women feel judged for using it. Key informants also indicated that some women were unaware of how to prepare formula, and formula was used inappropriately as a result. Therefore, the information

women are receiving on infant feeding is not meeting their needs, a conclusion which relates to the final research goal: to determine the implication of the BFI.

Since the BFI does not allow for the provision of information on formula other than from a risk based perspective, mothers are not receiving the information they require and formula is potentially being used inappropriately. As well, it is a reality that mothers in this study, in common with mothers across Canada, are not exclusively breastfeeding for six months and therefore information on how to used mixed feeding methods is important, as identified by key informants. The BFI has also contributed to a moral breastfeeding imperative which has privileged breastfeeding mothers over non-breastfeeding mothers. The mothers in this study clearly wanted to be perceived as breast-feeders even though they used both breast milk and formula to feed their infants. Although they did not articulate personal feelings of guilt if they used formula, they did not disclose their use of formula to me at the start of the interview. This was disclosed much later, once a strong rapport was established. However, key informants who shared their personal infant feeding experiences reported intense feelings of guilt if they used formula and they conveyed an immense pressure to breastfeed.

As well, key informants felt discomfort in sharing their opinions of BFI policy if their views were in contradiction to the policy. Others implemented practices that violated current policy in an attempt to provide woman-centered services. Most key informants did not feel that current breastfeeding policy is reflective of the social and structural influences on mothers' infant feeding decisions, which has resulted in women feeling poorly if they use formula. As identified in the introduction, the Breastfeeding Committee of Canada identifies that women who use formula will be supported within the same standards as the breastfeeding mother.

However, the actions of the BFI, such as promoting formula from a risk perspective, the prohibition of providing formula education in a group setting, and the prevention of the provision of formula to women who are in financial need, contradicts this statement. Clearly ideas of what constitutes good mothering have become imbedded within breastfeeding policy, which has implication for all women but in particular those who face additional social and structural barriers to breastfeeding.

2. Infant Feeding In Everyday Life

There were a number of everyday experiences which influenced mothers' infant feeding choices and breastfeeding experiences. These include the loss of autonomy associated with exclusive breast-feeding, difficulties with pumping, and one mother reported a conflict with breastfeeding and paid employment. Mothers' infant feeding decisions were influenced by ideas related to bonding and attachment, their interpersonal relationships, and breastfeeding in public places.

In common with other studies, the mothers in this study were aware that breastfeeding is the healthiest infant feeding method (Blum 1999; Carter 1995; Lee 2005, 2007, 2007, 2008; Murphy 1999, 2000, 2003). However, most of the mothers in this study used both breast milk and formula to feed their babies and one of the mothers used strictly formula to feed two of her children. As indicated in Chapter One, most women in Canada do not exclusively breastfeed their infants for the recommended six months. Therefore, the mothers in this study do not differ from other women in Canada with regard to their infant feeding practices.

As a result of using formula to feed their babies, the mothers in this study expressed ambivalence about breastfeeding and one felt compelled to rationalize her use of formula. This was also the finding of a study by Lee on the experiences of mothers who use formula to feed their infants (2005). Lee found that women who used formula felt that breastfeeding was healthiest but they found formula to be an acceptable but unequal alternative (2005: 11). Lee also found that women defended their use of formula, which was also documented in a study by Murphy where women felt the need to defend their decision to use formula to health professionals (1999: 194).

The mothers in my study struggled with the loss of autonomy which results from exclusive breastfeeding. This finding is supported by literature which demonstrates that some mothers struggle with the time commitment exclusive breastfeeding requires. Murphy identified the belief that breastfeeding limits freedom in her research (1999: 199). She refers to a teenage mother who defended her decision to bottle feed for the sake of freedom by suggesting that while it's okay for a "regular" mother to be "tied down" at home, for someone her age, this [formula-feeding] should be a "reasonable compromise between the demands of motherhood and youth" (1999: 199).

Consistent with the literature, loss of autonomy was a significant theme that emerged in most of the interviews in my study. Breastfeeding was identified as stressful since it is a solitary practice and mothers were solely responsible for the nourishment of their infants. Many of the women expressed a desire to pursue activities on their own away from their infant, in order to have a break from parenting, however they felt that breastfeeding did not allow for this. Using formula was identified as a reason by some mothers to be able to participate in activities on

their own. Although all of the mothers reported they enjoyed their breastfeeding experiences, they struggled with the demand that exclusive breastfeeding presented.

A number of women in this study found pumping to be either time consuming, painful, or ineffective for producing the amount of breast milk required to feed their infants. Avishai echoed these sentiments in her study. She found that the women she interviewed spent between 15 to 45 minutes pumping per session and some women were unable to pump the amount of breast milk they needed to feed their infants. Most women in her study felt that pumping was physically demanding (2004: 143). Additionally, Boswell-Penc and Boyer interviewed twelve women who were pumping in the workplace and none of the mothers described pumping as an enjoyable experience (2007: 561).

Combining breastfeeding with work was identified as problematic for many women in the literature (Avishi 2002: 140; Gatrell 2007: 396). In this study paid employment was identified as a non-issue for all of the mothers but one. Most of the mothers in this study were on social assistance and therefore not engaged in paid employment. One woman identified that she had the opportunity to return to a job she had before giving birth when her son was six months old. However, she felt she was unable to accept the offer since she was exclusively breastfeeding. The same woman also reported that if she had any children in the future she wanted to formula-feed since she wanted to start a business. She perceived combining exclusive breastfeeding and work to be incompatible.

Another factor that is influential on infant feeding decisions is the alignment of bonding with breastfeeding. The mothers in my study clearly had absorbed the public health message that breastfeeding facilitates a stronger bond between mother and child. However,

ambivalence was also expressed regarding breastfeeding and bonding. One woman indicated that if she had another child she would formula-feed the child so that her partner could develop as strong a bond with the baby as she had, however she valued the bonding experience she had had through breastfeeding. By contrast, the key informants interviewed did not believe that breastfeeding was fundamental for developing a strong attachment between mother and child. They felt that women should be educated on how to interact with their baby when bottle-feeding in order to establish a strong bond.

Wall analyzed breastfeeding promotion developed by the Canadian government and she argued that breastfeeding discourse promotes breastfeeding as a form of developing a healthy attachment with infants. Parents are routinely informed that children's early attachments impact the way a child's brain develops, which has led to increasing pressure on women to ensure their children's physical, emotional, and psychological development (Wall 2001: 594). Knaak points out in her research that statements regarding breastfeeding and bonding are often not accompanied by citations in breastfeeding promotional literature and therefore these suggestions may be driven more by ideology than research (Knaak 2006: 413).

Consistent with the literature identified in Chapter Two, my study found that partners did influence mothers regarding the use of formula, some partners wanted to spend time with their infants and increase their bonding. However this study also supports the success of breastfeeding promotion targeted at men since husbands and boyfriends influenced mothers to breastfeed. This influence was not always positive for women; one woman, who reported she wanted to formula-feed, was breastfeeding because her partner wanted her to do so. The

same woman reported that her husband's friends supported exclusive breastfeeding since it allowed her husband greater freedom to go out, not for the health benefits of the child.

This issue has not been identified in other breastfeeding research. However, Reed identified in his study on men as birthing coaches that men are expected to assert their masculine authority over some birthing mothers. Historically birth has been viewed as a natural event, more recently though, as birth was taken over by physicians and moved into hospital settings, birth was viewed as a strictly biological process to be controlled by medical experts. With the introduction of male partners into the hospital birthing process, Reed argues that men are expected to control the birthing process and their partners (2005: 117). This research on male participation in the birthing experience may be a suitable lens through which to explore the issue of male involvement in breastfeeding decisions.

According to Whalen Banks, grandmothers are an important influence on breastfeeding within Mohawk communities and family members wish to share in infant feeding practices which leads to the use of formula by some mothers. As well, since the traditional practice of breastfeeding was lost in First Nations communities, many mothers and grandmothers do not know how to support younger mothers in initiating breastfeeding (Whalen Banks 2003: 341). In my study, one of the mothers spoke highly of her grandmother and reported that she breastfed because the women in her family did, which included her mother and her grandmother. The other mothers interviewed did not speak of grandmothers as an influence on them and their infant feeding choices. Some of the women spoke of their mothers as influencing their infant feeding experiences, however relationships with their mothers were not always supportive and the influence was sometimes negative. This finding was supported in the key informant

interviews. One key informant reported that many of her clients had difficult relationships with their mothers and they were not a part of their support network. The legacy of Residential Schools has left many Aboriginal families devastated (Ing 2006: 157). Mothering skills were greatly impacted by the experience women faced in these schools. Children grew up without affection, often experiencing violence or other traumas, no parenting role models and little guidance on how to be a parent themselves (Ing 2006: 170). These experiences have had multi-generational implications which continue to impact some Aboriginal people today.

The sexualization of women's breasts creates challenges for women when breastfeeding in public. Stearns argues that women must manage their breastfeeding in pubic in certain ways due to societal concepts of breasts as sexual rather than nurturing (1999: 308). Carter believes the tension between breasts as sexual and breasts as a source of nutrition creates difficulties with breastfeeding in public and accounts for the use of formula as a result (1995: 115). Additionally, breastfeeding is not always a neutral activity in the private world; women must negotiate how they will breastfeed, where it will be done, within whose presence it will occur, and with whose approval (Carter 1995: 107). Carter interviewed low income women in her study and she found that women often did not live in their own homes, which created difficulties with breastfeeding in the home (1995: 108).

Discomfort with public breastfeeding was a central theme in this study. Both Aboriginal mothers and key informants reported that many of their clients are uncomfortable breastfeeding in public. The mothers in this study felt the need to cover themselves when breastfeeding in public which was stressful and hid the work they were engaged in. Many partners were also uncomfortable with their wives or girlfriend breastfeeding in public and

made demands as to how women were to engage in this practice in public. For example, mothers had to cover their bodies to ensure that other people would not see their breasts. Class issues created additional pressures for mothers in this study when breastfeeding in public. Many of the women I interviewed discussed how they managed breastfeeding while using the bus as their means of transportation. Stories were shared about how they were stared at on the bus when they were breastfeeding. As well, breastfeeding on the bus was not practical for these women when they had strollers and other children to manage. The mothers also felt pressure to ensure their baby did not cry on the bus and disturb other people, however exposing their breasts in such a public venue with little personal space was challenging. Class is clearly highlighted in this scenario; breastfeeding becomes more complicated when the act of transportation is a public activity, as it was for the low-income mothers in this study.

In common with Carter's research noted above, some of the mothers reported they found breastfeeding in their homes uncomfortable at times further highlighting issues related to class. Women who had to share housing with other people did not have privacy in their homes to breastfeed. The boundary between the private and public spheres was not always clear cut. One Key informant shared a story of a friend who had returned to her parent's home to live after the birth of her child due to financial constraints. Both she and her father were so uncomfortable with her breastfeeding in his presence that she ceased the practice. Another woman interviewed shared her experiences of breastfeeding in front of male family members and although she was comfortable doing so, her father, step-father, and uncle were not comfortable with her breastfeeding in their presence. This mother refer to herself as a "bitch" for being unsympathetic to the comfort level of others when she breastfed in front of them.

The need to be cognizant of the comfort level of others when breastfeeding has been supported in other studies.

A number of studies have indicated that women are responsible for ensuring modesty and discretion when breastfeeding in front of others (Carter 1995; Murphy 1999; Stearns 1999). Stearns identified that women in her study expressed feelings of irritation and anger with the necessity to be discreet when breastfeeding around other people. Women also felt the need for a "tricky public performance" which causes women to be constantly vigilant to their breastfeeding location, situation, and observer (1999: 322).

One of the key informants discussed how the women she works with are discrete when breastfeeding in public and she educates her clients on how to do this successfully. However, this key informant spoke about discretion when breastfeeding in public as a requirement and a reason for other people to find the practice acceptable but only under the requisite of covering one's body. According to Hausman, breastfeeding under the requirement of hiding one's breasts, as prescribed by health professionals and the government, is problematic since this is difficult to achieve and denies the embodied requirements of breastfeeding (2007: 490).

3. Structural Influences

In this section I will discuss the way in which issues of poverty, mental health, abuse, and substance use influence infant feeding decisions. A multitude of studies have identified that women living in poverty are less likely to initiate breastfeeding and for those that do initiate breastfeeding, they are less likely to sustain the practice (Blum 1999; Carter 1995; Guttman and Zimmerman 2000; Kukla 2006; Lee 2008; Public Health Agency of Canada 2009:

14; Statistics Canada 2005). However, absent within public policy is an analysis of the way in which poverty increases the complexities of infant feeding decisions.

Dodgson and Struthers argue that in First Nations communities, breastfeeding was perceived as a financial necessity and not a choice, resulting in some women choosing formula feeding when they moved to the city as a way to distance themselves from the poverty (2003: 63). Conversely, the Aboriginal women in this study, as well as the key informants, indicated that the choice to breastfeed was often financially motivated. The distribution of free formula was perceived by those interviewed to meet food security needs for women living in poverty, who for whatever reason are unable to breastfeed.

One key informant noted that there are additional costs associated with breastfeeding as well. She strongly believed that the government should be subsidizing women who are living in poverty to supply their infants with vitamin D supplements as recommended by Health Canada and the BFI. She also stated that women had greater costs due to increased nutritional requirements, special clothing for public breastfeeding, nipple cream, breast pads, and pumps. Avishai points out that the simplicity of breastfeeding is complicated by a growing commercialization of breastfeeding; a broader parenting trend in general for the privileged. The women she interviewed were immersed in breastfeeding-related consumption (Avishai 2007: 147). Conversely, for some families breastfeeding is not more cost effective than bottle-feeding; purchasing formula at a single point of purchase is less expensive than purchasing a breast pump (Boswell-Penc and Boyer 2007: 552).

Mental health issues also impact infant feeding decisions. Cooke et al. found that women who were diagnosed with postpartum depression were more likely to cease

breastfeeding (2006: 66). According to Shakespeare et al., breastfeeding was cited as a potential stressor for women who may be experiencing breastfeeding difficulties and could therefore impact their mental health status. They found that breastfeeding difficulties were common and caused emotional distress among the women they interviewed (Shakespeare et al. 2004: 251). These findings were supported in my research; two mothers disclosed that they struggled with depression, which caused them to stop breastfeeding. The mothers in this study who experienced breastfeeding difficulties did not continue with the practice therefore no mothers reported that difficulties with breastfeeding impacted upon their mental health.

As identified in Chapter Two, according to a study on violence against women during the perinatal period, women involved in abusive relationships are likely to face significant barriers to breastfeeding (Kendall-Tackett 2007: 344). As well, women who are sexual abuse survivors sometimes have difficulties with breastfeeding. Breastfeeding can trigger abuse memories, and some sexual abuse survivors are uncomfortable with their bodies, which can create challenges pertaining to breastfeeding (Klingelhafer 2007: 194). None of the women in this study reported that experiences with violence directly impacted their breastfeeding experiences, although some tensions were reported with partners and other family members. However, three key informants indicated they had observed clients who chose not to breastfeed as a result of either historical abuse or a current abusive relationship. As well, breastfeeding may increase violence for some women in abusive relationships, although this finding was not reported in the literature.

Health professionals were cited among the mothers in this study as being supportive and helpful in establishing breastfeeding. There was one exception, where a mother shared a

story in which a nurse touched her breasts without her consent, causing her to feel uncomfortable and angry. Although this mother did not disclose a history of abuse, touching a woman without requesting permission is not advised when working with women who have a history of abuse (Van Esetrik and Wood 2005: 1).

Colonization has had a negative impact on the mental, physical, and spiritual health of Aboriginal people in Canada. Many Aboriginal people experienced abuse in Residential Schools, which led to the destruction of countless families and subsequent generations. This historical trauma led to substance abuse as a coping mechanism for some Aboriginal people. Substance use was a significant theme that emerged in the interviews I conducted for this study. Some mothers indicated they used formula occasionally in order to partake in recreational alcohol and drug use, while others indicated they would like more information on how to manage breastfeeding and occasional substance use. Some mothers reported they knew of other women who used substances and breastfed. Key informants also reported that substance use inhibited breastfeeding among their clients. However, this was a sensitive issue for some of their clients since they wished to play the good mothering role by breastfeeding their infants. No literature exists on the infant feeding experiences of mothers who use substances, however much has been written about women who struggle with addiction issues and the perception of them as mothers.

As noted in the literature review, girls and women suffer high rates of physical and sexual abuse and Aboriginal women experience even higher rates of abuse in Canada. Research has demonstrated that many women use substances as a method of coping with past and current traumas. According to the Women's Health Surveillance Report, 85.7% of women

surveyed in nine treatment centres across Ontario had experienced violence (Cormier et al. 2003: 7). A study which looked at childhood sexual abuse and intimate partner violence among women in methadone treatment discovered that 57.9% of women had experienced childhood sexual abuse, 89.7% had experienced intimate partner violence at some point in their life, and 78.4% had experienced violence at the hands of their partner in the past six months (Engstrom et al. 2008: 605).

Women, especially pregnant women and mothers, experience significant societal stigmatization if they are using substances, which makes it difficult for women to discuss these issues openly. "The public discourse on women as users of alcohol, drugs and tobacco has been fundamentally judgmental, blaming and unsympathetic" (Poole and Dell 2003: 6). Cormier et al. argue that this stigma causes women to feel guilt and shame and that it creates barriers to accessing help. In their report on women and substance use problems, the authors identify that the stigma women experience affects service providers and as a result women often encounter misinformation, denial, inaction, and judgmental attitudes (Cormier et al. 2003: 7). Women who breastfeed and use substances are increasingly experiencing judgment and surveillance, as evidenced by a woman in North Dakota who was recently arrested for breastfeeding her infant while she was intoxicated. She was charged with child neglect and faces a five year prison term (CTV News 2009).

Methadone treatment was a controversial issue among the key informants interviewed. Mothers receiving this treatment are receiving mixed messages about breastfeeding while receiving methadone treatment from health professionals in Thunder Bay. Some health professionals recommend women to continue breastfeeding while receiving methadone

treatment, while others advise against it. Currently Motherisk advises physicians that the amount of methadone to which infants are exposed in breast milk is minimal and that women should not be discouraged from breastfeeding (Glatstein et al. 2008: 1689). Another study states the small amounts of methadone transmitted via breast milk in developing infants is unknown, but it is likely that the benefits of breastfeeding outweigh any risks associated with the methadone found in breast milk (Jansson et al. 2008: 106). The authors of that study also report that the incidence of breastfeeding amongst methadone-maintained women is low and they suggest that this may result from a lack of clear and consistent guidelines on the issue (Jansson et al. 2008: 107). However, according to the Centre for Addiction and Mental Health, once a baby is three to six months old and is consuming large amounts of breast milk, he or she is also receiving larger amounts of methadone (2009). They recommend that women either cease breastfeeding or methadone treatment at this time (Centre for Addiction and Mental Health 2009). This is clearly an area for further research and policy clarification.

4. Professional Influences

As explained in Chapter Four, a number of the Aboriginal mothers interviewed were involved with the child welfare system. Additionally, key informants reported that many of the women they work with are under the surveillance of child welfare and these women feel the need to demonstrate positive mothering skills. Mothers felt pressure to demonstrate that their children were properly nourished and breastfeeding makes it difficult for mothers to judge this. Using formula allows mothers to measure the food provided to their infants, which enables them to know precisely what their infants are consuming. Paradoxically, if mothers water down their formula in order to extend resources due to poverty, they may be at risk of loosing

their children as well. Although none of the mothers spoke about this in relation to infant feeding it points to the surveillance marginalized women face in their mothering practices.

Blum found that many of the women she interviewed were under surveillance by the state in some capacity (1999: 154). Most had used some form of social assistance and many were under the threat of having their children "snatched" away from them by the state (Blum 1999: 159). No literature exists specifically on breastfeeding and child welfare involvement, however a significant amount of literature exists on the child welfare system and Aboriginal families. Cull argues that Aboriginal women are constructed as bad mothers in Canada, requiring regulation of the state. "The state has been instrumental in creating a negative stereotype of Aboriginal women as being inherently "inferior" people and "unfit" parents" (Cull 2006: 141). This stereotype justifies the state's scrutiny of Aboriginal women and the notion that Aboriginal mothers require state observation, guidance, and intervention. The number of Aboriginal children in the child welfare system today has not decreased since the sixties scoop; in fact, the number of children in care increased between 1995 and 2001 by 71.5% (Cull quoting Blackstock et al. 2004).

In my study, one of the women interviewed shared a story about her separation from her infant and how she used her breast milk to try to maintain a bond with her child when he was in the care of Child Welfare. Other women have viewed breastfeeding as a method for facilitating a connection with infants. In her research, Blum interviewed a woman who worked as an obstetrician and spent long hours working away from her children. She feared that her infant would forget her and therefore she saw breastfeeding as a method for maintaining a connection with her infant and as a way for her child to remember who she was (Blum 1999: 5).

5. The Breastfeeding Imperative

Key informants reported in this study that the use of formula has become stigmatized and those who use formula need to justify their infant feeding method. As noted earlier, one mother in this study rationalized her use of formula, and for the most part the mothers interviewed did not disclose their use of formula immediately. When asked if they felt mothers who used formula felt poorly for doing so, they did not agree.

Interestingly, Blum found in her research that some women purposely reject breastfeeding and embrace the use of formula. She interviewed both African-American women and white working-class women in her study and she discovered that both groups had challenging life situations but they differed in how they perceived their infant feeding experiences. The white working class women spoke of "failed bodies" when they struggled with breastfeeding, however this discourse was absent among the African-American women interviewed (Blum 1999: 147). She argues that the African-American women she interviewed rejected breastfeeding as a result of black women's history of oppression, racism, and sexual exploitation. She states that many African-American women in the United States opt to use formula as a method to feed their infants as a result of difficult life circumstances, a lack of time, a lack of private space, and lower health status; all factors required to make breastfeeding a positive experience (Blum 1999: 161). The women she interviewed perceived breastfeeding to be burdensome, while formula feeding allowed other people to assist with child care (1999: 163).

Mothers in this study reported receiving information on breastfeeding, but little on formula feeding. The Public Health Agency of Canada found that 92% of mothers reported

receiving enough information on breastfeeding; further, 81% reported their health care providers offered them enough support to breastfeed, and 86% reported receiving information on community breastfeeding resources (2009: 13). Lee found that women in her study also received little information on formula feeding, which resulted in uncertainty about it (Lee 2007: 305).

Lakshman, Ogilvie and Ong also noted that women received little information on formula feeding, which resulted in mistakes in the preparation of formula and women who did not feel empowered in their infant feeding decisions (2009: 596). The authors conclude that inadequate information and support for women who are using formula may put the health of their infants at risk (Lakshman, Ogilvie and Ong 2009: 601). In my study, key informants noted that due to a lack of information, some of their clients used formula inappropriately.

As identified in Chapter Two, breastfeeding has become a moral imperative. In a study on breastfeeding women by Murphy, the author argues that infant feeding decisions are a "moral minefield", stating that "breast feeding was treated as not only compatible with, but indeed indicative of, maternal morality" (2001: 125). In her research she found that women were required to defend themselves if they did not breastfeed (Murphy 1999: 187). She goes on to say that deciding to formula-feed can portray the woman as a "poor mother", putting her own needs before her child's, whereas if she decides to breastfeed she is portrayed as a "good mother", one who puts her infant's needs ahead of her own. Murphy concludes by suggesting that feeding decisions are as much about morality as they are about nutrition.

The non-Aboriginal key informants shared their personal stories regarding the struggles they had had with breastfeeding their infants. These women did feel guilty and felt poorly as a

result of feeding their infants formula. Conversely, the Aboriginal mothers interviewed in this study did not see themselves as poor mothers if they struggled with breastfeeding or did not breastfeed. However, they did present themselves as breast-feeders, even though most used a combination of breast milk and formula.

Schmied et al. argue that policies associated with the Baby Friendly Initiative apply a model of health promotion that fails to consider the social, emotional and individual nature of infant feeding (2001: 44). Key informants interviewed in my study did not believe current breastfeeding policy is reflective of the complexities of Aboriginal women's lives. However, during the interviews three key Informants expressed anxiety with some of their opinions and practices that deviate from current breastfeeding policy. One key informant required extra assurance that her identity would not be revealed in this study. Another key informant dropped her voice and asked how other people had responded before she would respond to a question about current breastfeeding policy meeting the needs of Aboriginal women.

As identified in Chapter Two, Fuber and Thompson found that midwives often broke rules associated with BFI policy in order to provide woman-centered services (2006: 365). Key informants in my study also practiced rule-breaking by providing formula to women even if they had organizational policies in place indicating that formula was not to be distributed to mothers, or else they found ways around BFI policies to support mothers in their use of formula. For example, one social worker provided emotional support to mothers she encountered who felt pressured to breastfeed by nurses. Another key informant who was bound by BFI policies through a partnership with a health organization navigated this constraint by funneling support to mothers using formula under a different program.

6. Suggestions for Further Research

I have a number of suggestions for future research based on the results of this study. First, a study with a larger sample would have been useful in order to have a larger group of women to compare and contrast personal experiences. A study comparing the experiences between urban Aboriginal mothers and Aboriginal mothers living on reserves would shed light on the differences these mothers experience. As well, a study comparing Aboriginal and non-Aboriginal mothers would assist in identifying cultural differences related to breastfeeding. Further research is needed to determine the way in which Aboriginal mothers associate their motherhood identity with infant feeding, and if there are differences between how they feel and how non-Aboriginal mothers feel regarding this issue. If there are differences, contributing factors need to be explored.

Second, there is a need to explore the influences men have on mothers regarding infant feeding decisions as well as the control men have regarding the use of women's bodies. As identified earlier, health promotion professionals may be influencing men to support their partners with breastfeeding, however this may be translating into the control of women's bodies. Additionally, health professionals may also be promoting successful parenting as an exclusive female role.

Third, there is a need for further research on the experiences of mothers using substances and breastfeeding. Much has been published from a medical perspective on the diffusion of substances into breast milk and the resulting negative health effects on infants. However, women in this study clearly indicated that they wanted more information on how to balance occasional substance use while maintaining breastfeeding. As well, women who have

substance use problems, and who fall under state or public scrutiny, are extremely marginalized and stigmatized in society. Research needs to be conducted to explore what their experiences are with professionals regarding breastfeeding. How have these women interpreted the message 'breast is best', and what are the impacts of this message on themselves and their motherhood identity? Many professionals provide conflicting information to women regarding breastfeeding and methadone treatment and the impact of this should be explored further.

Fourth, for women in an abusive relationship, breastfeeding may increase exposure to violence as identified in this study. Since this finding has not been reflected in other studies, this issues needs to be explored further to ensure that women's safety is not being put at risk through universal breastfeeding recommendations.

Finally, it would be interesting to explore whether infants are being put at risk for health problems associated with improper formula use as a result of the lack of information on formula provided to mothers from health organizations.

As a result of the lack of research examining Aboriginal mothers' infant feeding experiences from a feminist and sociological perspective, this area holds great potential for extensive future exploration.

7. Conclusion

Although numerous studies have been conducted on the health benefits of breastfeeding, reasons why women do not breastfeed, and methods for increasing breastfeeding rates, little qualitative research has been conducted on urban Aboriginal mothers' infant feeding experiences and no studies with Aboriginal mothers have been

sociological or feminist in their perspective. The findings from this study provide important insights into the infant feeding experiences of urban Aboriginal mothers and the impact of an exclusive breastfeeding policy that is enacted for the control of mothers, rather than to give mothers the best options for infant feeding in their context. Therefore, its results are significant and contribute to our knowledge on factors influencing infant feeding decisions and the implications of a universal breastfeeding policy.

With mounting public health efforts to increase breastfeeding rates, it is important for breastfeeding policy to adopt a multidisciplinary and intersectional lens in order to ensure that the social and structural factors influencing women as well as the way in which these factors intersect are well understood. A deep understanding of the social influences marginalized women experience when making their infant feeding decisions is required to ascertain that the needs of both women and children are being met. As well, in order to ensure that women feel empowered in their infant feeding decisions and to assist in detaching mothers' sense of self worth from infant feeding method, formula needs to be presented from a neutral perspective. Finally, health policy needs to move beyond breastfeeding education and the assumption that breastfeeding rates are associated with exposure to information on formula and address the structural barriers and material resources of women in order to increase the breastfeeding duration.

References

Amnesty International. 2004. *"Stolen Sisters: A Human Rights Response to Discrimination and Violence towards Indigenous Women in Canada."* Amnesty International.

Anderson, Kim. 2000. *A Recognition of Being: Reconstructing Native Womanhood.* Toronto: Sumach Press.

Apple, Rima D. 1994. "The Medicalization of Infant Feeding in the United States and New Zealand: Two Countries, One Experience." *International Lactation Consultant Association* 10(1): 31-17.

Ardovini-Brooker, Joanne. 2002. "Feminist Epistemology: The Foundation of Feminist Research and its Distinction from Traditional Research." *Advancing Women in Leadership.* Retrieved May 6, 2009, from the Advancing Women Website (http://www.advancingwomen.com/awl/spring2002/ARDOV~CG.HTM)

Arnup, Katherine. 1994. *Education for Motherhood: Advice for Mothers in the Twentieth Century.* Toronto: Toronto Press.

Aronson, Jodi. 1994. "A Pragmatic View of Thematic Analysis." *The Qualitative Report* 2(1): 1-2.

Avishai, Orit. 2004. "At the Pump." *Journal of the Association for Research on Mothering* 6(2): 139 – 149.

Avishai, Orit. 2002. *"Family-Friendly as a Double Edged Sword: Lessons from the "Lactation-Friendly" Workplaces."* Centre for Working Families, University of California, Berkeley: Working Paper No. 46.

Avishai, Orit. 2007. "Managing The Lactating Body: The Breastfeeding Project and Priviledged Motherhood." *Qualitative Sociology* 30: 135-152.

Barnes, Lewis A. 1987. "History of Infant Feeding Practices." *American Journal of Clinical Nutrition* 46: 168–170.

Bartlett, Alison. 2000. "Thinking Through Breasts: Writing Maternity." *Feminist Theory* 1(2):173-188.

Bartlett, Alison. 2006. *Breastwork: Rethinking Breastfeeding.* University of New South Wales Press.

Bartlett, Alison. 2000 "Breastfeeding as headwork: Corporeal feminism and meanings for breastfeeding." *Women's Studies International Forum* 25(3): 373-382.

Blum, Linda M. 1999. *At The Breast Ideologies of Breastfeeding and Motherhood In The Contemporary United States.* Boston: Beacon Press.

Boswell-Penc, Maia and Boyer, Kate. 2007. "Expressing Anxiety? Breast Pump Usage in American Workplaces." *Gender, Place and Culture* 14(5): 551-567.

Bowman, Katherine G. 2007. "When Breastfeeding May Be A Threat To Adolescent Mothers." *Issues in Mental Health Nursing* 28:89-99.

Breastfeeding Committee for Canada. 2002 *"The Baby Friendly Initiative in Community Health Services: A Canadian Implementation Guide."* Breastfeeding Committee of Canada, Canada.

Breastfeeding Committee for Canada. 2009. *"Annual Report February 2008-09."* Retrieved on July 17, 2009 from (http://www.clca-accl.ca/english/Documents/BCC_Annua_%20Report_2008_2009.pdf)

British Columbia Ministry of Health. 2002. *"Harm Reduction: A British Columbia Community Guide."* Retrieved on July 17, 2009 from (http://www.housing.gov.bc.ca/ptf/hrcommunityguide.pdf)

Bryman, Alan and Teevan, James J. 2005. *Social Research Methods.* Toronto: Oxford University Press.

CTV. 2009. "Arrest in drunken breastfeeding case starts debate." Accessed July 9, 2009 from (http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20090706/drunk_breastfreeding_090706/20090706?hub=Health)

Campaign 2008. *"2008 Report Card on Child and Family Poverty in Canada."* Toronto.

Carter, Pam. 1995. *Feminism, Breasts and Breastfeeding.* New York: St. Martin Press.

Canadian Paediatric Association. 2005. "Exclusive Breastfeeding Should Continue to Six Months." *Paediatrics and Child Health* 10(3): 148.

Castellano, Marlene Brant. 2004. Ethics of Aboriginal Research. *Journal of Aboriginal Health* 1(1): 98-114.

Centre for Addiction and Mental Health. 2009. *"Methadone Maintenance Treatment."* Retrieved July 17, 2009 from (http://www.camh.net/Care_Treatment/Resources_clients_families_friends/Methadone_Maintenance_Treatment/mmt_clienthndbk_ch7.html#breastfeeding)

Comacchio, Cynthia R. 1993. *"Nations Are Built on Babies" Saving Ontario's Mothers and Children 1900-1940.* Montreal and Kingston: McGill-Queen's University Press.

Cooke, Margaret, Schmied, Virginia and Sheehan, Athena. 2007. "An exploration of the relationship between postnatal distress and maternal role attainment, breast feeding problems and breast feeding cessation in Australia." *Midwifery* 23: 66-76.

Cope, M.B. and Allison, D.B. 2008. "Critical review of the World Health Organization's (WHO) 2007 report on 'evidence of the long-term effects of breastfeeding: systematic reviews and meta-analysis' with respect to obesity." *Obesity Reviews* 9: 594-605.

Cormier, Renee A., Poole, Nancy. 2003. *Women and Substance Use Problems.* Women's Health Surveillance Report.

Crossley, Michele L. 2009. "Breastfeeding as a Moral Imperative: An Autoethnographic Study." *Feminism and Psychology* 19(1): 71-87.

Cull, Randi. 2006. *"Aboriginal Mothering Under The State's Gaze."* Pp. 141-156 in *Until Our Hearts Are On The Ground: Aboriginal Mothering, Oppression, Resistance and Rebirth,* edited by Lavell-Harvard, Memee and Lavell Corbiere, Jeannette. Toronto: Demeter Press.

Der, G., Batty, D., and Deary, I. 2006. "Effect of breast feeding on intelligence in children: prospective study, sibling pairs analysis, and meta-analysis." *BMJ* 333(945): 1-6.

Dodgson, Joan E. and Struthers, Roxanne. 2003. "Traditional Breastfeeding Practices of the Ojibwe of Northern Minnesota." *Health Care for Women International* 24: 49-61.

Duncan, Joanne M. and Sears, Malcolm R. 2008. Breastfeeding and allergies: time for a change in paradigm? *Allergy and Clinical Immunology* 8: 398-405.

Earle, Sarah. 2002. "Factors affecting the initiation of breastfeeding: implications for breastfeeding promotion." *Health Promotion International* 17(3): 205-214.

Earle, Sarah. 2000. "Why some women do not breastfeed: bottle feeding and fathers' role." *Midwifery* 16: 323-330.

Engstrom, Malitta, El-Bassel, Go, Hyun and Gilbert, Louisa. 2008. "Childhood Sexual Abuse and Intimate Partner Violence among Women in Methadone Treatment: A Direct or Mediated Relationship?" *Journal of Family Violence* 23: 605-617.

Esterberg, Kristin G. 2002. *Qualitative Methods in Social Research.* Boston: McGraw Hill.

Fowler, Catherine and Lee, Alison. 2007. "Knowing how to know: questioning 'knowledge transfer' as a model for knowing and learning in health." *Studies in Continuing Education* 29(2): 181-193.

Fuber, Christine, Thomson, Ann. 2006. "Breaking the rules in baby-feeding practice in the UK: deviance and good practice?" *Midwifery* 22: 365-376.

Galtry, Judith. 2000. "Extending the "bright line" Feminism, Breastfeeding and the Workplace in the United States." *Gender and Society* 14 (2): 295-317.

Gatrell, Caroline Jane. 2007. "Secrets and Lies: Breastfeeding and professional paid work." *Social Science and Medicine* 65: 393-404.

Glatstein, Marcelo, Garcia-Bournissen, Facundo, Finkelstein, Yaron and Koren, Gideon. 2008. "Methadone exposure during lactation." *Canadian Family Physician.* 54: 1689-1690.

Gosselin, Cheryl. 2006. *"They Let Their Kids Run Wild: The Policing of Aboriginal Mothering in Quebec."* Pp. 196-208 in *Until Our Hearts Are On The Ground: Aboriginal Mothering, Oppression, Resistance and Rebirth*, edited by Lavell-Harvard, Memee and Lavell Corbiere, Jeannette. Toronto: Demeter Press.

Greaves, Lorraine, Varcoe, Colleen, Poole, Nancy, Morrow, Marina, Johnson, Joy, Pederson, Ann, Irwin, Lori 2002. *"A Motherhood Issue: Discourses on Mothering Under Duress."* Status of Women Canada.

Green, Judith and Britten, Nicky. 1998. "Qualitative Research and Evidence Based Medicine." *British Medical Journal* 316(7139): 1230-1232.

Guilbert, Theresa W., Stern, Debra A., Morgan, Wayne J., Martinez, Fernando, D., and Wright, Anne L. 2007. "Effect of Breastfeeding on Lung Function in Childhood and Modulation by Maternal Asthma and Atopy." *American Journal of Respiratory and Critical Care Medicine 176: 843-848.*

Guigne, Francoise Clair. 2008. "To Breastfeed or Not to Breastfeed: An Ethnographic Exploration of Knowledge Circulation, Medical Recommendations on HIV and Infant Feeding, and Related 'Good Mothering' Discourses in Saskatoon, Saskatchewan." MA Thesis, Department of Sociology and Anthropology.

Guttman, Nurit and Zimmerman, Deena. 2000. "Low-income mothers' views on breastfeeding." *Social Science and Medicine* 50: 1457-1473.

Hauck, Yvonne L. and Iruita, Vera F. 2002. "Incompatible Expectations: The Dilemma of Breastfeeding Mothers." *Health care for Women International* 24:62-78.

Hayes, S. 1996. *The Cultural Contradictions of Motherhood.* New Haven and London: Yale University Press.

Hauk, Yvonne L. and Irutia, Vera F. (2002). "Incompatible expectations: The Dilemma of Breastfeeding Mothers." *Health Care for Women International* 24: 62-78

Hausman, Bernice L. 2003 *Mother's Milk Breastfeeding Controversies in American Culture.* London: Routledge.

Hausman, Bernice L. 2004. "The Feminist Politics of Breastfeeding." *Australian Feminist Studies* 19(45): 273-285.

Hausman, Bernice L. 2007. "Things (Not) to Do with Breasts in Public: Maternal Embodiment and the Biocultural Politics of Infant Feeding." *New Literary History* 38: 479-504.

Health Canada. 2002. *A Practical Workbook to Protect, Promote and Support Breastfeeding in Community Based Projects.* Canada: Health Canada.

Health Canada. 2004. *Exclusive Breastfeeding Duration 2004 Health Canada Recommendation.* Canada: Health Canada.

Health Canada. 2005. *"Nutrition for Healthy Term Infants – Statement of the Joint Working Group: Canadian Paediatric Society, Dieticians of Canada and Health Canada."* Retrieved July 15, 2009 from (http://www.hc-sc.gc.ca/fn-an/pubs/infant-nourrisson/nut_infant_nourrisson_term-eng.php)

Human Resources and Social Development Canada, the Public Health Agency of Canada and Indian and Northern Affairs Canada. 2007. *The Well-being of Canada's Young Children: Government of Canada Report 2006.* Canada.

Ing, Rosalyn. 2006. *"Canada's Residential Schools and Their Impacts on Mothering."* Pp. 157-172 in *Until Our Hearts Are On The Ground: Aboriginal Mothering, Oppression, Resistance and Rebirth*, edited by Lavell-Harvard, Memee and Lavell Corbiere, Jeannette. Toronto: Demeter Press.

Jansson, Lauren M., Choo, Robin, Velez, Martha L., Harrow, Cheryl, Schroeder, Jennifer R., Shakleya, Diaa M., and Huestis, Marilyn A. 2008. "Methadone Maintenance and Breastfeeding in the Neonatal Period." *Pediatrics* 21(1): 106-114.

Kaufert, Patricia A., O'Neil, John D. "Cooptation and Control: The Reconstruction of Inuit Birth." *Medical Anthropology Quarterly* 4(4): 427-442.

Knaak, Stephanie. 2005 "Breast-feeding, Bottle-feeding and Dr. Spock: The Shifting Context of Choice." *Canadian Review of Sociology and Anthropology* 42: 197-216.

Knaak, Stephanie. 2006. "The Problem with Breastfeeding Discourse." *Canadian Journal of Public Health* 97(5): 412-414.

Kelleher, Christina M. 2006. "The physical challenges of early breastfeeding." *Social Science and Medicine* 63: 2727-2738.

Kendall-Tackett, Kathleen. 2007. "Violence Against Women and the Perinatal Period: The Impact of Lifetime Violence and Abuse on Pregnancy, Postpartum, and Breastfeeding." *Trauma, Violence and Abuse* 8(3): 344-353.

Klingelhafer, K. 2007. "Sexual Abuse and Breastfeeding." *Journal of Human Lactation* 23(2): 194-197.

Kramer, M., McGill, J., Matush, L., Vanilovich, I., Platt, R., Bogdanovich, P. et al. 2007. "Effect of prolonged and exclusive breast feeding on risk of allergy and asthma: cluster and randomized trail." *BMJ* 335(7624): 815-823.

Kramer, M., Fombonne, E., Igumnov, S., Vanilovich, I., Matush, L., Mironova, E. et al. 2008. "Effects of Prolonged and Exclusive Breastfeeding on Child Behaviour and Maternal Adjustment: Evidence From a Large, Randomized Trial." *Pediatrics* 121(3): 435-440.

Kramer, M., Matush, L., Vanilovich, I., Platt, R., Bogdanovich, N., Sevkovskaya, Z., et al. 2007. Effects of prolonged and exclusive breastfeeding on child height, weight, adiposity, and blood pressure at age 6.5 y: evidence from a large randomized trial." *American Journal of Clinical Nutrition* 86(6): 1717-21.

Kukla, Rebecca. 2006. Ethics and Ideology in Breastfeeding Advocacy Campaigns. *Hypatia* 21(1): 158-180.

Lakshman, Rajalakshmi, Ogilvie, David and Ong, Ken. (2009). "Mothers' experiences of bottle feeding: a systematic review of qualitative and quantitative studies." Archives of Disease in Childhood 95: 595-601.

Larsen Schilling, Jette, Hall, Elisabeth O.C. and Aagaard, Hanne. 2008. "Shattered expectations: when mothers' confidence in breastfeeding is undermined – a metasynthesis." Scandinavian Journal of Caring Science 22: 653-661.

Lavell-Harvard, M. and Lavell Corbiere, J. eds. 2006. *Until our Hearts are on the Ground: Aboriginal Mothering, Oppression, Resistance and Rebirth.* Toronto: Demeter Press.

Law, Jules. 2000. "The Politics of Breastfeeding: Assessing Risk, Dividing Labour." *Journal of Women and Culture in Society* 25(2): 407-450.

Lee, Ellie and Furedi, Frank. (2005) *Mothers' Experience of, and attitudes to, using infant formula in the early months.* Unpublished report, University of Kent.

Lee, Ellie. 2007. "Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks." *Sociology of Health and Illness* 29 (7): 1-16.

Lee, Ellie. 2007. "Infant feeding in risk society." *Health, Risk and Society* 9(3): 295-309.

Lee, Ellie. 2008. "Living with Risk in the age of 'intensive motherhood': Maternal identity and infant feeding." *Health, Risk and Society* 10(5): 467-477.

Lupton, Debroah. 1999. *Risk.* London: Routledge.

Lupton, Debroah. 1999. *Risk and Sociocultural Theory.* New York: Cambridge University Press.

Lupton, Deborah. 1995. *The Imperative of Health.* London: Sage.

Ostry, Aleck. 2006. *Nutrition Policy in Canada 1870-1939.* Vancouver: University of British Columbia Press.

Macaulay, A.C., Hausaik, N. and Beauvais, J.E. 1989. "Breastfeeding in the Mohawk community of Kahnawake: Revisited and redefined." *Canadian Journal of Public Health*, 80(3): 177-181.

Martens, P.J. 1997. "Prenatal infant feeding intent and perceived social support for breastfeeding in Manitoba First Nations communities: A role for the health care providers." *International Journal of Circumpolar Health* 56(4), 104-120.

Martens, P.J. and Young, T.K. 1997. "Determinants of breastfeeding in four Canadian Ojibwa communities: A decision making model." *American Journal of Human Biology* 9: 579-593.

Martens, P.J. 2001. "The effect of breastfeeding education on adolescent beliefs and attitudes: A randomized school intervention in the Canadian Ojiwba community of Sagkeeng." *Journal of Human Lactation* 17(3): 245-255.

Martens, Patricia J. 2002. "Increasing Breastfeeding Initiation and Duration at a Community level: An Evaluation of Sagkeeng First Nation's Community Health Nurse and Peer Counselor Programs." *Journal of Human Lactation* 18(3): 236-246.

Meadows, L.M., Lagendyk, L.E., Thurston, W.E. and Eisener, A.C. 2003. "Balancing Culture, Ethics, and Methods in Qualitative Health Research with Aboriginal Peoples." *International Journal of Qualitative Methods* 2(4): 1-25.

Meyer Estermann, D. and de Oliveira Lucia, D. 2003. "Breastfeeding Policies and the production of motherhood: a historical-cultural approach." *Nursing Inquiry* 10(1): 11-18.

Motherisk. 2007. "*Breastfeeding and Drugs.*" Retrieved January 4, 2008 from (http://www.motherisk.org/prof/breastfeeding.jsp)

Murphy, Elizabeth. 1999. "Breast is Best: Infant feeding decisions and maternal deviance." *Sociology of Health and Illness* 21(2): 187-208.

Murphy, E. 2000. "Risk, Responsibility and Rhetoric in Infant Feeding." *Journal of Contemporary Ethnography* 29(3): 291-325.

Murphy, Elizabeth. 2003. "Expertise and forms of knowledge in the government of families." *The Sociological* Review 51 (4): 433-462.

Nathoo, Tasnim and Ostry, Aleck. 2009. *The One Best Way? Breastfeeding History, Politics and Policy in Canada.* Waterloo: Wilfrid Laurier University Press.

Neander, Wendy L. and Morse, Janice M. 1989. "Tradition and Change in the Northern Alberta Woodlands Cree: Implications for Infant Feeding Practices." *Canadian Journal of Public Health* 80: 190-194.

Nelson, Antonia M. 2006. "A Metasynthesis of Quantitative Breastfeeding Studies." *Journal of Midwifery and Women's Health* 51: 13-20.

Northern Ontario Perinatal and Child Health Survey Consortium. 2003. "*Breastfeeding Practices in Northern Ontario.*" Sudbury: Public Health Research, Education and Development Program, Sudbury and District Health Unit.

Oakley, Ann. 1981. "*Interviewing Women: A Contradiction in Terms.*" In H. Roberts, ed. Doing Feminist Research. London: Routledge and Kegan Paul 30-61.

Pippins, Jennifer R., Brawarsky, Phyllis, Jackson, Rebecca A., Fuentes-Afflick and Hass, Jennifer S. 2006. Association of Breastfeeding with Maternal Depressive Symptoms. *Journal of Women's Health* 15(6): 754-761.

Poole, Nancy and Dell, Colleen Anne. 2003. *"Girls, Women and Substance Use."* British Columbia Centre of Excellence for Women's Health and Canadian Centre on Substance Use.

Public Health Agency of Canada. 2009. *"What Mothers Say: The Canadian Maternity Experiences Survey."* Ottawa.

Public Health Agency of Canada. 2009. *"Mothers Voices: What Women Say About Pregnancy, Child Birth and Early Motherhood."* Ottawa.

Prentice, Julia C., Lu, Michael C., Lange, Linda and Halfon, Neal. 2008. "The Association Between Reported Childhood Sexual Abuse and Breastfeeding Initiation." *Journal of Human Lactation* 18(3): 219-226.

Raphael, Denis. 2008. *"Social Determinants of Health."* Toronto: Canadian Scholars Press.

Reed, Richard. 2005. *"Birthing Fathers: The Transformation of Men in American Rites of Birth."* New Brunswick, New Jersey and London: Rutgers University Press.

Renfrew, MJ., Spiby, H., D'Souza, L., Wallace, LM, Dyson, L and McCormick, F. 2007. "Rethinking research in breast-feeding: a critique of the evidence base identified in a systematic review of interventions to promote and support breast-feeding." *Public Health Nutrition: 10(7): 726-732.*

Ross, Lori E., Dennis, Cindy-Lee, Robertson Blackmore, Emma and Stewart, Donna E. 2005. "Postpartum Depression: A Guide for Front-Line Health and Social Service Providers." *Centre for Addiction and Mental Health.*

Schmied, Virgina and Lupton, Deborah. 2001. "Blurring the boundaries: breastfeeding and maternal subjectivity." *Sociology of Health and Illness* 23 (2): 234-250.

Schmied, V. and Barclay, L. 1999. "Connection and Pleasure, Disruption and Distress: Women's Experience of Breastfeeding." *Journal of Human Lactation* 15(4): 325-334.

Schmied, V., Sheehan, A. and Barclay, L. 2001. "Contemporary breast-feeding policy and practice: implications for midwives." *Midwifery* 17, 44-54.

Service Canada. 2008. *"Canadian Youth: Who are they and what do they want?"* Retrieved April 10, 2008 from (http://www.jeunesse.gc.ca/yoaux.jsp?&lang=en&flash=0&ta=1&auxpageid=857)

Sioux Lookout First Nations Health Authority and Northwestern Health Unit. 2006. *"Northern Food Basket Survey."* Retrieved July 2, 2009 from (http://knet.ca/documents/FN-FOOD-COSTS-SUMMARY.pdf)

Shakespeare, Judy, Blake, Fiona, Garcia, Jo. 2003. "Breast-feeding difficulties experienced by women taking part in a qualitative interview study of postnatal depression." *Midwifery* 20: 251-260.

Smyth, Lisa. 2008. "Gendered Spaces and Intimate Citizenship." *European Journal of Women's Studies* 15(2): 83-99.

Statistics Canada. 2005. *"Health Reports, Breastfeeding Practices."* 16 (2).

Statistics Canada. 2004. *"A Portrait of Aboriginal Children Living in Non-Reserve Areas: Results from the 2001 Aboriginal Peoples Survey."* Catalogue no. 89-597-XIE.

Statistics Canada. 2008. *"Aboriginal peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census."* Catalogue no. 97-558-XIE.

Statistics Canada. 1993. "The Violence Against Women Survey." *The Daily*. Ottawa: Statistics Canada.

Stearns, Cindy A. 1999. "Breastfeeding and the Good Maternal Body." *Gender and Society* 13 (3): 308-325.

Stewart, Paula J. and Steckle, Jean. 1987. "Breastfeeding among Canadian Indians On-Reserve and Women in the Yukon and N.W.T." *Canadian Journal of Public Health* 78: 255-261.

Thunder Bay District Health Unit. 2008. *"Risks of Infant Formula: A Guide to the Risks and Cost."* Thunder Bay District Health Unit.

Van Esterik, Penny. 1989. *Beyond the Breast-Bottle Controversy*. New Brunswick and New Jersey: Rutgers University Press.

Van Esterik, Penny and Wood, Karen. 2005. "Assisting Adult Survivors of Childhood Sexual Abuse (CSA) through Breastfeeding." *National Network on Environments and Women's Health.*

Van Esterik, Penny and Wood, Karen. 2005. "Infant Feeding For Women Who Were Sexually Abused During Childhood." *National Network on Environments and Women's Health.*

Wall, Glenda. 2001. "Moral Constructions of Motherhood in Breastfeeding Discourse." *Gender and Society* 15 (4): 592-610.

Whelen Banks, Jane. 2003. "Ka'nistenhsenra: A Native Community Rekindles the Tradition of Breastfeeding." *AWHONN Lifelines* 7(4): 340-347.

Wolf, Joan B. 2007. "Is Breast Really Best? Risk and Total Motherhood in the National Breastfeeding Awareness Campaign." *Journal of Health Politics, Policy and Law* 32 (4): 595-636.

World Health Organization. 1981. *"The International Code of Marketing of Breastmilk Substitutes."* WHO, Geneva.

World Health Organization. 2001. *"Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women."* WHO, Geneva.

World Health Organization. 2001. *"The Optimal Duration of Exclusive Breastfeeding: Report of an Expert Consultation."* WHO, Geneva.

World Health Organization. 2007. *"Breastfeeding."* Retrieved October 10, 2007, from (http://www.who.int/topics/breastfeeding/en/)

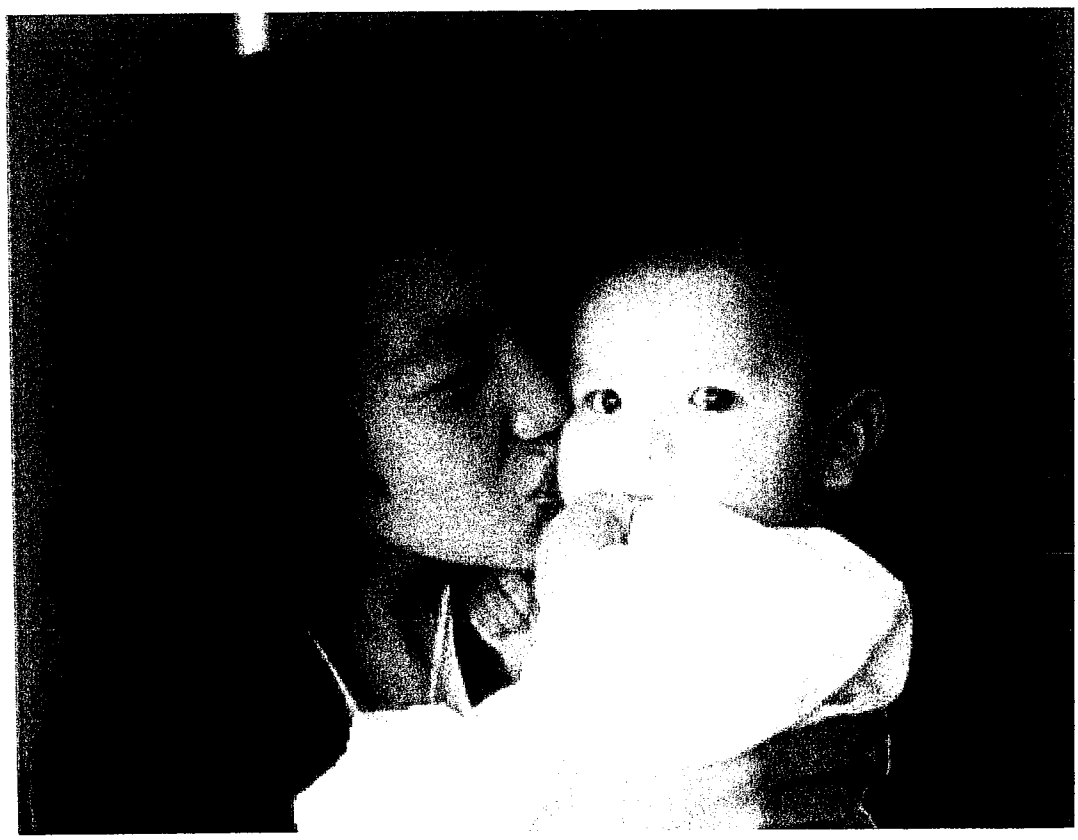
World Health Organization and UNICEF. 2009. *"Breastfeeding Promotion and Support in a Baby Friendly Hospital: A 20-Hour Course for Maternity Staff."* WHO and UNICEF, Geneva.

Share your story.....

on your experiences and attitudes around feeding your baby.

- I am a student in the Masters of Sociology program at Lakehead University conducting research on the infant feeding experiences of Aboriginal women in Thunder Bay.

- I am interested in interviewing women age 16 years and older who have had a child in the past 3 years. Interviews will take approximately one hour.



Appendix B

Information Letter

Dear Potential Research Participant:

You are invited to participate in a study about the infant feeding experiences of Aboriginal women and the development of culturally competent breastfeeding policy. Your insight and experiences will be extremely valuable for this research. Results from this study will be used towards the completion of my thesis which is a partial requirement for my Masters degree in Sociology and Women's Studies.

Interviews for this research will take approximately 60 minutes. Your participation in this study is completely voluntary, you are free to answer questions in any way that you choose, decline any questions you do not wish to answer and withdraw from the interview at any time. There is no anticipated risk of physical or psychological harm by participating in this research other than any emotional distress that may occur as a result of sharing personal information. If you do experience any emotional distress or require any social service, attached is a list of support services available in Thunder Bay for you to contact.

To ensure that information is gathered accurately, I am requesting to audio tape the interview, however, I can also take notes if you prefer. Audio tapes will be transcribed following the interview for further analysis. All audio tapes and notes will be secured in locked cabinets at Lakehead University for a period of five years after the study, after which time they will be destroyed. All data will be kept confidential and you will not be identified in any written reports.

If you have any questions or concerns about the study please contact my thesis supervisor, Dr. Pam Wakewich at (807) 343-8353 or pam.wakewich@lakeheadu.ca. For further information about procedures for maintaining consent and confidentially, you may contact the Research Ethic Board at (807) 343-8235. If you wish to receive a summary of the project after its completion please contact me at (807) 621-1700 or tgauld@shaw.ca.

Thank you for your time and interest!

Sincerely,

Tara Gauld

Consent Form

Consent

By signing this sheet it indicates that I agree to participate in a study on the Infant Feeding Experiences of Aboriginal Women. It also indicates that I understand the following:

1. I am a volunteer and I can withdraw from this research at any time.
2. There is no apparent risk of physical or psychological harm.
3. I will be asked questions of a personal nature, but I am under no obligation to answer questions that I am uncomfortable with.
4. The data I provide will be kept confidential.
5. The interview will be tape recorded and no one except Tara gauld and Dr. Pam Wakewich will have access to the tape recordings, and that the tape recording will be stored in a secure a secure location for 5 years accessible only to Ms. Gauld and Dr. Wakewich.
6. I will receive a summary of the project, upon request, following the completion of the project.

I have received an explanation of the nature of the research, its purpose, and procedures.

_____ _____

Signature of Participant Date

☐ Yes, I would like to receive a copy of the project report.

☐ No, I would not like to receive a copy of the project report.

Tara Gauld
Graduate Student at Lakehead University
Department of Sociology
(807) 621-1700
tgauld@shaw.ca

Appendix C

Interview Guide for Aboriginal Mothers

Demographic Questions

1. How old are you?
2. How many children do you have?
3. How old is your child/children?
4. What is your level of education?
5. Are you married or in a common-law relationship?
6. What is your household income?
7. What is your Aboriginal ancestry?
8. How long have you lived in Thunder Bay?
9. Before you gave birth were you working outside the home? If so what was your job?

Interview Questions

1. When did you fist start to think about how you would feed your child/children?
    - Before you were pregnant
    - During beginning stages of pregnancy
    - At the end stage of pregnancy
    - Once you gave birth

2. How did you feed your child/children in the first 6 months of his/her life?
    - Formula
    - Exclusive breastfeed
    - Combination breastfeeding/formula feeding
    - Mostly breastfeeding and some formula
    - Mostly formula feeding and some breastfeeding
    - Cross feeding (sharing breastfeeding with family member or friend)
    - Other

3. Why did you choose that feeding method?

4. How did you/do you feel about your feeding method?

5. Were there any differences in how you planned to feed you child and how you actually fed your child?

6. Did you attend prenatal classes before you gave birth? If so where did you take the classes? What was your experience with the classes?

7. Where did you give birth?
    - Home
    - Hospital

- Other

8. Who or what influenced your decisions around feeding your baby?
    - Husband/partner
    - Mother
    - Mother-in-law
    - Grandmother
    - Aunts
    - Sibling
    - Friends
    - Doctor
    - Midwife
    - Nurse
    - Other professional
    - Educational information
    - Other

9. Do you feel you were supported in your infant feeding decision by other people in your life such as your husband/partner, mother, mother-in-law, friends etc?

10. If you gave birth in a hospital what were your experiences with hospital staff in relation to breastfeeding or formula feeding? Were you supported in your infant feeding decision?
    - Some women report that hospital staff influence women to use formula
    - Some women report that hospital staff influence women to breastfeed
    - Some women report that hospital staff support them in whatever decision they have made.

11. Where did you receive your information on infant feeding?
    - Health organization
    - Family
    - Friends
    - Doctor
    - Midwife
    - Nurse
    - Magazine
    - Books
    - School

12. Do you feel you received the information you needed on breastfeeding? Please explain.

13. Do you feel you received the information you needed on formula feeding? Please explain.

14. Is there any information you didn't receive about infant feeding that you wish you had received? Please explain.

15. What information you received did you find useful? Please explain.

16. If you breastfed, how did you feel physically about the experience? How did you feel emotionally? Please explain.

17. Did you have any concerns about the way you fed your baby?
    - What were these concerns?
    - Why did you have these concerns?

18. Are you comfortable feeding your baby in public place; either bottlefeeding or breastfeeding? Please explain.

19. Some women report they do not breastfeed because they have either experienced abuse in the past or are currently in an abusive relationship. Have you heard this from other women?

20. Some women report they do not breastfeed because they are using substances. Is this something you have heard from other women?

21. Some women report that they breastfeed other women's infants or their infants have been breastfed by other women; this is called cross-nursing. Do you have any experiences with cross-nursing or have you heard of other women participating in cross-nursing?

22. Do you have anything else you would like to add about your infant feeding experiences?

Appendix D

Key Informant Interview Guide

1. Please tell me a little bit about your position and the work you do with Aboriginal women.

2. What kind of information does your organization provide women on infant feeding?

3. What do you think are some of the issues that women are dealing with that impact their infant feeding decisions?

4. Do you think other people in women's lives affect their infant feeding decisions?

    - Husband/partner
    - Mother
    - Mother-in-law
    - Grandmother
    - Aunts
    - Siblings
    - Friends
    - Health professionals

5. Do you think health promotional information influences women around their infant feeding decisions?

6. What kinds of questions do women ask you in relation to infant feeding?

7. Have women shared with you their experiences with other professionals around infant feeding? If so what are their experiences?

8. Do women struggle with breastfeeding?

9. Do women struggle with formula feeding?

10. Do you ever hear stories of women breastfeeding other women's infants?

11. Do you think current breastfeeding policy is reflective of the needs and experiences of Aboriginal women?

12. Do you have anything else you would like to add about women and infant feeding?

Appendix E

Demographics

Interview #1 is 24 years old and is Ojibway. She has two children aged 3 and 10 months. She is currently not in a relationship and is living on social assistance. She completed grade eleven and worked various jobs before giving birth. She was born in Armstrong but has lived in Thunder Bay for a number of years. She primarily breastfed her 10 moth old until he was about 8 months, however, she used formula on occasion. She was unable to breastfed her 3 year old due to medical reasons, however, she pumped her breast milk and fed this child breast milk and formula.

Interview #2 is 23 years old and is Oji-Cree. She has three children aged 4, 2 and 2 months. She is currently not married or in a common-law relationship, however, she does have a boyfriend. She is living on social assistance and is working on completing her grade 12 education. As a young child she lived in a number of communities but has lived in Thunder Bay since she has been about four years old. She was not employed before giving birth to her children. She breastfed all her children exclusively and breastfed her first child until the age of 3 and she is nursing her second child while nursing her infant.

Interview #3 is 21 years old and is Ojibway. She has three children aged 3, 2 and 8 months. She is in a common-law relationship and she is on social assistance. She completed high school and is preparing to attend college in the up coming year. She has lived in Thunder Bay for three years and lived in Winnipeg previously. She had various jobs before giving birth to her children. She breastfed and used formula with her first child for eight months, she did not breastfeed her second child and she breastfed her 8 month old for three weeks.

Interview #4 is 31 years old and has three children aged 10, 8 and 6 months. She is Ojibway and Odawa and has lived in Thunder Bay for 12 years, previously she lived in Toronto. She has a college diploma and is married. Her annual income is $22,000. She was employed before giving birth to her 6 month old and she was in college when she had her other two children. She breastfed all her children, the first for two years, the second for one year and she is still breastfeeding her 6 month old. However, she used formula on occasion with her first two children and exclusively breastfed her third child.

Interview #5 is 27 years old and has four children aged eight, six, four and two. She is Ojiway and has lived in Thunder Bay for about 10 years; she lived in North Bay and a number of other communities previously. She is on social assistance and in a common-law relationship. She has completed grade 11 and worked in the service industry in between giving birth to her children. She breastfed her first child for eight months, with occasional formula use, she did not breastfeed her second child, her third she breastfed for two weeks and then switched to formula and with her last child she breastfed for four months with occasional formula use.

Interview #6 is 18 years old and is Oji-Cree. She has one child aged 4 months. She is in a common-law relationship and is currently completing her high school diploma. She is on social

assistance and has lived between Thunder Bay and Sault Ste. Marie for most of her life. She is currently breastfeeding her infant with occasional formula use.

Interview #7 is 25 years old and has four children aged eight, five, twins who are three. She is from a remote First Nation community and has recently relocated to Thunder Bay. She is married and her annual household income is less than $20,000. She is Ojibway and has completed grade 10. She had various jobs before giving birth to her children. She breastfed her twins for a few months and then switched to formula. She used formula to feed her other children.

Key Informant #1 is an Aboriginal woman working for an Aboriginal organization. She provides support to women with children under the age of six.

Key Informant #2 is a non-Aboriginal woman employed as a social worker. She works for a non-Aboriginal organization, however, approximately 90% of her clients are Aboriginal. Her organization provides support to women using substances.

Key Informant #3 is a non-Aboriginal woman employed in a management position. She works for a non-Aboriginal organization, however, approximately 50% of her clients are Aboriginal. Her organization provides support to women with children under the age of six.

Key Informant #4 is a non-Aboriginal woman employed as a nurse for a health organization. A large percentage of her clients are Aboriginal. She has worked in First Nations communities in the past and in Labour and Delivery at a hospital.

Key Informant #5 is non-Aboriginal, employed in a management position and has worked as a social worker in the past for a health organization. A large percentage of their clients are Aboriginal and their organization employs a cultural liaison worker.

Key Informant #6 is an Aboriginal woman employed by an Aboriginal organization. She provides parenting support, nutrition information and pre and post natal education to Aboriginal women.

Key Informant #7 is an Aboriginal woman employed by an Aboriginal organization as a nurse. She works with Aboriginal women with children under the age of six.