

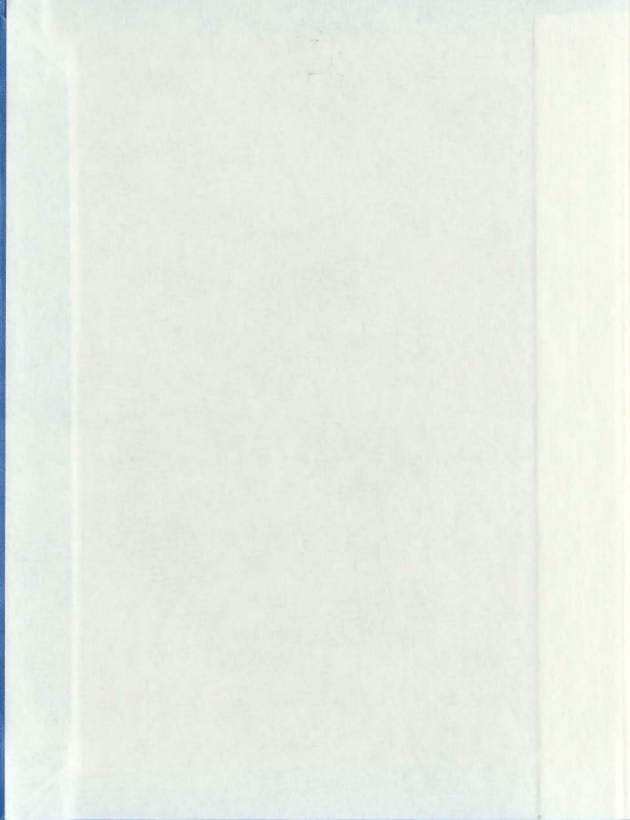
FEEDING BABIES, MAKING MOTHERS:
INFANT FEEDING PRACTICES IN
ST. JOHN'S NEWFOUNDLAND

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FEEDING BABIES, MAKING MOTHERS:
INFANT FEEDING PRACTICES IN ST. JOHN'S, NEWFOUNDLAND

by

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School of Graduate Studies
in partial fulfillment of the
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Abstract

Breast feeding is promoted as the optimum infant feeding method for numerous reasons. How do we explain why not all new mothers in St. John's breast feed? Using examples collected during fieldwork in St. John's, Newfoundland in 1999, I argue that the historical, social, and cultural contexts of infant feeding must be examined in order to understand the experience of infant feeding in St. John's within the context of what has become a pro-breast feeding, anti formula feeding social environment. As well, I demonstrate connections between the promotion of a "breast feeding culture" and ideas about 'good' mothering and 'good' parenting. In examining infant feeding practices from these perspectives, I argue that infant feeding is work that is accomplished alongside other day-to-day responsibilities.

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Table of Contents

	<u>Page</u>
<i>Abstract</i>	ii
<i>Acknowledgements</i>	iii
<u>Chapter One</u>	
<u>Introduction</u>	1
Anthropology, Feminism, and Infant Feeding	5
<i>The Women's Movement</i>	6
<i>Patriarchy and Reproductive Politics</i>	9
<i>"Women's Work"</i>	11
<i>Infant Feeding Practices</i>	13
The Benefits of Breast Feeding	16
Infant Feeding in Newfoundland: Existing Research	18
The Research Setting	27
Methodological Considerations	31
Overview of Thesis Chapters	35
<u>Chapter Two</u>	
<u>A Mother's Duty: Infant Feeding Practices in Historical Perspective</u>	38
Infant Feeding Alternatives in History	39
The Child Welfare Association and Infant Feeding Practices in St. John's, 1921-1965	47
<i>The Child Welfare Association and Infant Feeding</i>	54
<i>The Child Welfare Association in Post-Confederation St. John's</i>	56
The 'Return' of Breast Feeding	58
Chapter Summary	60

<u>Chapter Three</u>	
<u>The Promotion of Infant Feeding and the Creation of a “Big Deal”</u>	62
Steve, Emily, and Faye	65
The Influence of Commercial Formula Marketing	67
Campaigns to Promote Breast Feeding	74
<i>The World Health Organization and Infant Feeding</i>	74
<i>The Baby Friendly Hospital Initiative in Canada</i>	76
<i>Early Canadian Initiatives</i>	78
<i>Breast Feeding Promotion Activities in Newfoundland</i>	80
Promoting a Breast Feeding Image	83
Breast Feeding Promotion in Everyday Encounters	87
The Creation of a Pro-Breast Feeding Environment	93
Chapter Summary	96
<u>Chapter Four</u>	
<u>Infant Feeding and Good Parenting in St. John’s</u>	98
Faye	100
“I knew I was going to breast feed ...”: The Effects of Promotion	103
<i>Joan and Peter</i>	106
My “Breast Feeling” Research: Sexualized Breasts and the “Male Gaze”	108
“Carnation Babies”: Evaporated Milk Formulas and “Bad” Mothers	115
Infant Feeding, Bonding and “Good” Fathers	119
Chapter Summary	121

<u>Chapter Five</u>	
<u>"You just get up in the morning and do it": Infant Feeding and the Work of Everyday Life</u>	123
Beth	126
Women Working Outside of the Home	130
<i>Childcare in St. John's</i>	132
<i>Work and Infant Feeding</i>	132
Full Time Parents	134
Gendered Divisions of Labour	136
Chapter Summary	141
<u>Chapter Six</u>	
<u>By Way of Conclusion</u>	143
<u>Appendix A: Interview Parameters</u>	147
<u>References Cited</u>	149
<i>Archival Sources</i>	149
<i>Secondary Sources</i>	152

Chapter One

Introduction

At 55%, the breast feeding initiation rate in St. John's Newfoundland is among the lowest rates in Canada. International, national, and local health promotion campaigns promote breast feeding as the optimal infant feeding method. Despite these initiatives, not all mothers breast feed and those who do often do not breast feed for as long as recommended by health professionals. Based on fieldwork in St. John's in 1999, and a review of relevant primary and secondary sources, I argue that the practice of infant feeding must be examined in terms of the historical, social and cultural contexts in St. John's. Within these contexts, I demonstrate a connection between the promotion of infant feeding and ideas about 'good' mothering and 'good' parenting. Moreover, I argue that parents make infant feeding decisions within the context of a pro-breast feeding, anti-formula feeding environment. Further, I argue that infant feeding practices are work and must be accomplished in terms of other, often conflicting, day-to-day responsibilities of parents. In approaching infant feeding practices in St. John's from this perspective, I explore what factors some parents take into consideration when making infant feeding decisions, how they view these decisions, and what these decisions might say about the experience of being a parent of young children in St. John's, Newfoundland.

Why would a young unmarried woman with no children be interested in infant feeding? Like most research, the topic found me. Being young, about to begin a professional career and hoping to start a family one day, I think about my future prospects and the dichotomy that seems to channel my choices -- career or family. While

I recognize that many women have both, managing a career and a family seems a daunting task. What employment can I pursue that will provide food, shelter and pay the student loan, give me a sense of accomplishment and worth, and still allow me to devote myself to my children? Will I have the social and economic resources to raise my children the way I hope to? If I have both a career and a family, how will I manage and succeed at both? What will be my partner's role in our family and household? How do other women do it, not in theory or according to unrealistic media images, but in their everyday, day-to-day living?

Feminist and anthropological methods and theories have always appealed to me because they address lived experiences in the context of wider social and cultural understandings. In an egocentric sense, they help me to understand the social and cultural world and my place in it. The choice of infant feeding practices as a thesis topic is not surprising given that an ethnographic examination of infant feeding practices is also an examination of the daily, lived experiences of women.

Anthropologists such as Vanessa Maher (1992a), Nancy Scheper-Hughes (1992), and Penny Van Esterik (1995, 1988), have demonstrated that ideas surrounding infant feeding practices are culturally constructed. Moreover, almost two decades ago, anthropologists Dana Raphael and Flora Davis argued that a woman's decision to breast feed:

Is influenced by a multitude of factors including: the family's economic status, the mother's work outside the home, her anticipation of work, her access to substitute caretakers, her health, her energy level, the strength of her motivation, the health and personality of the baby -- in other words, a myriad of factors, most of which are beyond her control. (Raphael and Davis 1985:116)

In this thesis, I examine social and cultural influences on infant feeding and recognize the ways in which parents', especially mothers', decisions and experiences of infant feeding methods are constituted by social, cultural, political, and economic contexts of parenthood in the 1990s in St. John's.

In contrasting the ways women describe their infant feeding choices in my own and other social science research, I would suggest that the practice of being a 'good' mother is variable among women in a society. Assuming this starting point has validity, what must be questioned is where do ideas about what it means to be a 'good mother' come from? How are different conceptions of motherhood imagined and displayed? How are ideas about 'good' mothering behaviour and 'good' womanly behaviour played out in the everyday lives of mothers? Finally, how are these conceptions reinforced and embodied in the practice of infant feeding? This thesis addresses these and related questions through my analysis of the fieldwork data I compiled in St. John's in 1999.

Over the course of my fieldwork in 1999 in St. John's, Newfoundland, I heard many infant feeding stories. Some were positive, some were negative, some were disturbing, and some were outright funny. In her feminist examination of breast feeding¹, sociologist Pamela Carter (1995:200) suggests that women tell their infant feeding stories, in part, as a means to justify their decisions about infant care to others. I was not

¹ In the same way that 'formula feeding' is two words, I purposefully separate the words 'breast' and 'feeding' in an attempt to differentiate between infant feeding options. For example, infants can be breast fed, fed breast milk from a bottle (breast milk feeding), or formula fed or fed combinations of each. Further, I use the term 'formula feeding' rather than 'bottle feeding' to emphasize that bottles can contain a variety of infant milks, juices and water. However, I maintain original spellings when referencing other authors.

the first, or the only, one to hear the stories told to me by parents in St. John's for they had been told many times to other people. As an anthropologist I also recognize that these women, and in some instances these men, were telling me their stories through a particular cultural script. This script includes the idea that breast feeding is the ideal infant feeding method. To apply the metaphor, within these scripts actors follow the general plot but are forced to improvise as the scenes unfold.

The experiences of mothers are, perhaps, over-represented in this thesis. I frequently switch back and forth from "women," "mothers," and "parents" when discussing infant feeding decisions not out of confusion but rather as a means to acknowledge the multiple perspectives from which these decisions occur. The decision to breast feed (or not to) is primarily made by *mothers*. Infant feeding patterns are frequently influenced before *women* become mothers. Further, some infant feeding decisions are made by *parents* who are also considering their other responsibilities and desires. Unfortunately, I did not have many opportunities to speak with fathers in this research and they are under-represented in this thesis. I do not mean to suggest that they do not make decisions or that they are not influential participants in infant feeding practices.

Acknowledging that infant feeding practices are influenced by social, cultural, political, and economic environments, I continue this chapter with an overview of some of the theories that have influenced the writing of this thesis -- namely those of anthropology and feminism. I follow with a brief description of the suggested benefits of breast milk and breast feeding and how researchers have addressed the 'problem' of why

women do not breast feed. Recognizing that breast feeding initiation rates in Newfoundland are among the lowest in Canada and that St. John's has the highest initiation rate in the province, it is important to describe some of the unique features of the city. This brief discussion is followed with an overview of my methodological considerations. Then, I outline the characteristics of the people I interviewed. I conclude with an overview of the chapters of this thesis

Anthropology, Feminism, and Infant Feeding

While not necessarily abundant, studies of infant feeding practices and how they are experienced in women's lives are not new to anthropology. As anthropologist and infant feeding researcher Dana Raphael writes:

Margaret Mead was there first. Her field studies on infant/child rearing practices are the touchstones on which we build today. No one had to convince her that breast feeding is more than women feeding babies. She knew firsthand, in many different cultures, how mothers struggle daily against incredible odds to feed their children and to hold their world together against explosive modernization. She reported to us how they were experimenting, winning, and losing with new and difficult lifestyles. She showed how breast-feeding fits within all these levels of experience. (Raphael 1973:i)

Anthropologists such as Katherine Dettwyler (1995, 1998), Vanessa Maher (1992a,b), Penny Van Esterik (1995, 1989a,b, 1988, 1985), continue to show how infant feeding practices are part of culturally specific constructions of what it means to be a woman.

Infant feeding practices may be viewed with a Foucaultian (1978) twist as "a discursive field, not contained within one discourse rather as a 'multiplicity of discourses produced by a whole series of mechanisms operating in different institutions'" (Carter

1995:28). Theories concerning the politics of reproduction, body politics, and feminism are particularly useful in examining infant feeding practices.

Infant feeding practices are one element within a broad definition of reproduction. This definition encompasses "events throughout the human and especially female life-cycle related to ideas and practices surrounding fertility, birth, and childcare, including the ways in which these figure into understandings of social and cultural renewal" (Ginsburg and Rapp 1991:311, see also Jordanova 1995). Within this definition, anthropologists add a grounded perspective of reproduction "by studying not only the larger systems in which reproductive policies are enacted but also the struggles, social processes, and constituencies through which they are realized" (Ginsburg and Rapp 1991:317). An examination of infant feeding, then, is also an examination of the larger social and cultural mediums in which reproduction takes place.

The Women's Movement:

Social anthropologists argue that "reproduction is systematically organized, sensitive to changes in domestic economies and therefore always an aspect of the distribution of power in any society" (Ginsburg and Rapp 1991:313). In her overview of the ideological and socio-economic contexts of reproductive labour, Shellee Colen (1995:86-89) provides a useful summary of how meanings of motherhood and wage labour have changed over the years. In the 1950s, and continuing throughout the 1970s and 1980s women were the primary, if not sole, providers of reproductive labour in most societies and situations. Moreover, motherhood and reproductive labour were often devalued, trivialized and viewed as unskilled, unwaged women's work in homes (Colen

1995:86). The 'Second Wave' feminists of this time fought for a change in ideology, one in which women's intellectual and biological capacities would be viewed as equal to those of men. These feminists argued that women should have the same access to, and equal wages for, jobs as their male counterparts. In many countries such as Canada and the United States, the goals of the Second Wave feminists came to be achieved in part. However, motherhood and wage work were still viewed in opposition to each other. Despite the contradiction, as Colen describes, "economic realities, social behaviours, and changing beliefs and expectations increasingly contradicted this ideology" (Colen 1995:86). Women entered the workforce, and stayed there even after they became mothers, out of economic necessity, for the pursuit of economic security, and for the personal fulfillment of a career outside of reproductive labour, the latter idea influenced by the feminist movement. Regardless of these changes, reproductive labour remained women's 'nonwork' to be fulfilled in addition to their wage work responsibilities.

The increase of women in the workforce did not come without ideological consequences. Balsamo et al. affirm that "the figure of the 'bad mother,' of the 'unnatural mother,' seems to re-emerge every time deep social changes are taking place, particularly with regard to women and their role in society" (Balsamo et al. 1992:86). As more women joined the workforce, child centred discourses surrounding the definition of a 'good' mother gained momentum (Carter 1995:59, Blum 1999:42). The discursive contradiction lay in how women could be 'good' *mothers* by keeping their children's (and husbands') interests central to their decisions while at the same time being 'good'

women who have a career outside of the home – something feminist discourse encouraged.

Towards the end of the 1970s, so called Third Wave feminists began to assert that improvements to the lives of women could only be made with wide-sweeping social changes that acknowledged not only women's equality to men, but also promoted women's unique biological and psychological capacities (Weitz 1998b:8). There are numerous feminist examinations of the medicalization of women's bodies and experiences of their biological processes: menarche, birth, postpartum depression, motherhood, menopause (Ginsburg and Rapp 1991:312, see also Davis 1988; Lee and Sasser-Coen 1996; Maclean 1990; Martin 1987; Oakley 1993; among others). In part, these examinations reflect an emphasis on the uniqueness of the female body and how this uniqueness should be valued and not scorned, one aspect of the feminist movement.

In North American public culture in the early 1980s, mothering and reproductive labour continued to be devalued while a woman with a career was valorized (Colen 1995:88). By the mid-1980s, babies became symbols of high status, the message being "that children were a valuable commodity and could fill a void that work and other activities could not" (Colen 1995:89). By the late 1980s, "the focus had shifted from women as workers to women as mothers and secondarily as jugglers of family and work" (ibid.). In the 1990s, children are sometimes idealistically portrayed as giving 'true' meaning to women's lives while the mundane tasks of childcare remain unglorified (ibid.).

Beyond issues addressed by feminists, the breast feeding movement itself may be viewed as a complex negotiation over the extent of social control over women's bodies and their own autonomy. In this light, infant feeding choices present a unique problem for feminism. On the one hand, feminist discourse may be used to support formula feeding as it minimizes gender differences and offers women mobility and freedom from the confinement of the home and infant care (Carter 1995:14). On the other hand, feminist discourse can be used to enhance gender differences allowing women to claim their unique biological right to feed their children through breast milk (ibid.).

Patriarchy and Reproductive Politics:

Many feminist activists, anthropologists, and other scholars view women's reproductive experiences as examples of the power of the patriarchal system in determining the social positions and practices of mothers and of the subordination of women to meet these roles (Ginsburg and Rapp 1991:312; among others). Alluding to feminist discourses surrounding motherhood, Maher defines 'patriarchy' in reproductive politics as meaning:

That the relationship between mother and child is defined or even controlled by the cultural emphasis on social institutionalism accorded to relationships involving adult men in dominant positions. This may have implications for the way breast feeding is regarded in symbolic terms and for women's practice. (Maher 1992a:32; see also Carter 1995)

Politics can be defined as "the ways that power is both structured and enacted in everyday activities" (Maher 1992a:32). It can be argued, then, that choices surrounding infant feeding practices are played out in the political arena of the power over, and the subordination of, women in patriarchal societies. The outward subordination of women

by men is not directly observable as women are regulated by bureaucratic processes and by public health initiatives. Further, if productivist and industrial conceptions of reality have come to pervade social life, as Maher (1992a:33; see also Ewen 1988 and Martin 1987) suggests, then it follows that to reproduce is to produce people in the same way that things are produced. As Maher states, "in this picture, the active figures are the clock, the scales and the doctor who reduce the mother and the baby to mechanisms in a productive process" (Maher 1992a:33; also Martin 1987:54-67). Viewing reproduction in this way, women and children become resources to be optimally manipulated for productive ends (Maher 1992a:32)

Whether a mother in a context such as urban North America makes decisions to pursue wage work outside of the home and/or to be the primary caregiver of her child(ren), her decisions are influenced by the existence of a market driven economy. Vanessa Maher (1992a) presents some mothers expressing the desire to stay at home with their children in order to provide the labour and emotionally intensive mothering that they need to protect them from the market driven society. At the same time, some women have the opportunity to escape this economy when they stay home with their children. Similarly, in her research on partners becoming parents Fox observed:

... for women who held jobs for years, pregnancy and even motherhood presented the opportunity to take "time out" to give up anxieties about appearances and weight, and temporarily abandon the need to accomplish things (in market terms). (Fox 1997: 147)

Further, di Leonardo (1987: 451) states that, "the domestic domain is not only an arena in which much unpaid labour must be undertaken, but also a realm in which one may

attempt to gain human satisfaction – and power – not available in the labour market.” For some women, staying at *home* provides a life’s occupation and identity (Fox 1997). “*Women’s Work*”:

To conceptualize a definition of ‘women’s work’ in this thesis, I draw upon anthropologist Micaela di Leonardo’s (1987) article on the work involved in maintaining kinship ties. In this article, di Leonardo explores a definition of “kin work”² in terms of one form of unpaid labour frequently assumed by women. In her argument, di Leonardo recognizes women as participants in three types of work: the work of kinship, work in the labour market, and the work involved in household and childcare. Following di Leonardo, women’s work “takes place in an arena characterized simultaneously by cooperation and competition, by guilt and gratification” (di Leonardo 1987: 446). Further, women’s work responsibilities frequently conflict with one another considering that paid labour is mostly undertaken outside of the home while within the home sphere childcare, family, and household responsibilities compete for a woman’s limited time (di Leonardo 1987:446; see also Hirsch 1989; Lamphere et al. 1993). Within this conceptual definition of women’s work, infant feeding is one aspect of childcare and must also be considered work. As Stearns emphasizes, “breastfeeding is work; work that is not shared and work that is rendered invisible by the way it is required to be hidden” (Stearns 1999: 323). Regardless of choices made, di Leonardo reminds us that “all

² Michaela di Leonardo defines kin work as the “conception, maintenance, and ritual celebration of cross-household kin ties” (1987:442).

women, are ultimately responsible, and subject to both guilt and blame, as the administrators of home, children, and kin networks" (di Leonardo 1987: 449).

Frequently, by being the primary caregivers of children and elderly dependents, women also play a primary role in the delivery of a broad definition of health care and accomplish this role in a variety of ways. According to the Working Group on Women's Health, when women have access to money and time, "they are the providers of health through the maintenance of clean, safe homes and the production of nutritious meals" (WGWH 1994:5). Women teach future generations healthy behaviours through role modeling and mediate contact with the formal health system. Further, women frequently provide this care often at the expense of being attentive to their own health concerns (ibid.).

Within this framework of 'women's work', feeding the family, specifically making nutritional choices for the family, is most often a woman's responsibility. According to sociologist Majorie De Vault (1991; see also Murcott 1993), feeding the family is gendered work assumed by women and falls under the work of caring. Even though men may participate in feeding the family on some levels (cooking a meal or grocery shopping for example), the responsibility of planning, organizing, and ensuring that family members are adequately fed according to social standards lies mainly with women in most societies. The women I spoke with in St. John's saw feeding infants and other members of their family as their responsibility even when other members of the family 'help out' or assume some of the duties. As women do the work of feeding, the effort and skills involved go relatively unseen and the work devalued (ibid.).

Despite being 'devalued work', mothers I spoke with were proud to tell me how they feed their families. In our conversation Ellen, a married mother of three young, breast fed children proudly remarked, "I make my own meals and my own muffins and I'm really particular on what I feed them. I also made all of my children's baby foods. I feel I did my part, as much as I could for giving them a good healthy start and by making their own food." Susan, a married mother of two children, remarked as I tried to close our long conversation about her breast feeding experiences and work schedules, "you didn't even ask me about my baby food!" and proceeded to tell me about her refusal to buy jarred baby food.

Infant Feeding Practices:

It is difficult to 'classify' infant feeding practices into distinct statistical categories. Most people's infant feeding practices do not follow distinct breast feeding or formula feeding guidelines as mothers, fathers, and caregivers introduce a variety of foods and methods at different times. This variety is rarely acknowledged in infant feeding statistics; some patterns do emerge, however. An understanding of infant feeding patterns may be better classified according to *rationalizations* of infant feeding choices.

The clearest example of these patterns was told to me by one of the lactation consultants in St. John's who identifies five groups of mothers based on their infant feeding rationalizations. There are mothers who formula feed from birth and believe that

even if breast milk is the 'best,' formula is almost as good as breast milk³. There are mothers who "do their time" and breast feed their infants for as little time they feel necessary and then switch to commercial formula. Third, there are those mothers who embrace the breast feeding ideology and truly want to breast feed their babies but for whatever reason can not breast feed for as long as they had hoped. Another group of mothers have only positive, 'problem' free breast feeding experiences.

Finally, the lactation consultant recognizes mothers who describe themselves as 'militant breast feeders.' Not only do these mothers breast feed, they do so for much longer than the recommended six months many breast feeding each of their children for over two years. Further, they actively encourage, support, and promote breast feeding in their communities, and they are acutely aware of violations of the World Health Organization's International Code of Marketing Breastmilk Substitutes.

In my conversations with breast feeding activists I heard distinct evaluations of motherhood: good mothers breast feed their children for at least six months; mothers with good intentions breast feed their children for as long as possible even if they do not meet the six month preference; mothers who 'choose' not to breast feed are bad mothers for seemingly prioritizing their own needs over the health of their children. As one advocate said to me, "it's not a mother's *choice*, it is a baby's *right*"⁴ (emphasis hers). Parents who

³ As Murphy points out, "unlike those who initiate breast feeding but then change to formula feeding, these women cannot claim that their good intentions have been overwhelmed by events" (Murphy 1999: 194) and are therefore subject to more criticism.

⁴ This phrase is also used by INFACT Canada in recent breast feeding promotion media.

formula fed their infants recognized the 'breast is breast' mantra but emphasized to me that there are many other ways to be a 'good' parent.

The existence of breast pumps in breast feeding, and especially breast feeding in working mothers' lives, redefines the value of breast feeding and mother's milk. What is promoted by breast feeding advocates as an intimate act that can only occur between mother and child can now occur without the mother actually being there (Blum 1999:52). The act of breast feeding becomes the provision of a substance rather than an activity. As Allison contends, Japanese *obentos* (lunchboxes prepared by mothers) are, "intended to ease a child's discomfort and to allow a child's mother to manufacture something of herself and the home to accompany the child as s/he moves into the potentially threatening outside world." (Allison 1991:199). Pumped breast milk may be seen in the same way. Blum argues, using the ideas of psychoanalyst Michelle Freedman, breast milk is fetishized as milk comes to replace the presence of the mother (Blum 1999:52). In other words, exclusive motherhood can be achieved through the *presence of breast milk itself* whether or not the mother is there. As a result of the emphasis on breast milk as a mother's important contribution to her infant's development, "the mother in her body, her pleasures and needs, satisfactions and pains, have been largely erased" (Blum 1999:55). Infant feeding is one aspect of women's work in a market driven economy. Within this framework, breast milk is promoted as the optimum infant food and the act of breast feeding becomes another way to demonstrate 'good' mothering practices.

The Benefits of Breast Feeding

There is a vast amount of research on the beneficial aspects of breast feeding. This research is heavily represented by medical approaches to breasts and lactation. Numerous scholarly publications, medical research, and advocacy literature present breast feeding as a natural, immunologically and nutritionally superior infant feeding practice. Moreover, breast feeding is primarily presented in terms of optimum benefits for the infant, with some attention to women's health, but rarely from mothers' point of view (Balsamo et. al. 1992:60-61; Law 2000; Schmied and Lupton 2001)⁵.

Recent medical research asserts that breast milk is the optimum method of infant feeding for the first year or more of life and is optimum for multiple reasons (CICH 1996; Lawrence 2000; among others). Using the summary given by the Canadian Institute of Child Health (CICH 1996:7-9), reasons for this superiority include such nutritional factors as the ease with which breast milk is digested; the easy absorption of its minerals into the body; and the tendency of breast milk to change in composition to meet the needs of the particular feeding, time of day, and age of the baby. Breast milk provides infants with increased immunological protection from various acute and chronic illnesses as well as helping to prevent allergies. Suckling provides exercises that promote the proper development of jaw and facial structures. Cited health benefits for the mother include the promotion of involution of the uterus after birth, less postpartum bleeding, fewer incidences of ovarian and breast cancers, and the promotion of child spacing for the first

⁵ Some research on infant feeding has been focused on women's experiences, for example Carter 1995, Maclean 1990, Maher 1992, Van Esterik 1998.

six months after birth (lactational amenorrhoea). Further, breast feeding increases the production of oxytocin and prolactin, hormones which are attributed to the emotional well being of mothers⁶. Despite the numerous benefits:

Health care professionals cannot guarantee mothers that continued breastfeeding will result in noticeable improvements in lifelong health or longevity for their children. What is more significant, and clear, is that health care professionals have no basis for claiming that the health benefits of breastfeeding ever cease or become insignificant, nor for claiming that extended breastfeeding ever harms a child or is contraindicated after a certain age. (Dettwyler 1998:24)

In other words, while studies show improved outcomes the longer a child is breast fed, this does not guarantee a healthier child (Dettwyler 1998; Maher 1992a,b). Stearns further points out that, "while breastfeeding has become the medical gold standard for infant feeding, it is still not the typical form of feeding" (Stearns 1999:309). Moreover, Law (2000) questions 'breast is best' presentations illustrating how some advocates selectively cite the research of others. In so doing, only the positive aspects of breast feeding are cited while research, or parts of research that do not support a pro-breast feeding stance are ignored. For example, while breast feeding advocates such as La Leche League members argue that breast feeding "prevents" breast cancer, they fail to cite research that suggests that incidences of ovarian cancer are higher among breast

⁶ For a more detailed overview of the health benefits of breast feeding for the mother, see Labbok 1999.

feeding women⁷ (Law 2000). Women are, therefore, encouraged to breast feed without being made aware of the potential health risks of doing so.

Infant Feeding in Newfoundland: Existing Research

Even though breast feeding is widely recognized as the optimum infant feeding method, not all women breast feed nor do many women who choose to initiate breast feeding do so for as long as recommended by health experts. According to Health Canada analyses of the National Population Health Survey collected in 1994, the Canadian initiation rate (the attempt to establish breast feeding regardless of duration or exclusivity) of breast feeding is 73% (CPSS 1998). According to 1996-1997 data collected for the National Longitudinal Survey of Children and Youth (NLSCY) this rate has increased slightly to 76.7% (Health Canada 2000). These figures represent an increase from 38% in 1963 and are similar to rates recorded during the early 1980s. According to statistics gathered in 1996 (Health Canada 2000), breast feeding initiation rates are distributed across the country from a high of 89% in British Columbia to a low of 57.7% in Quebec, a west-east trend reflected in both the National Population Health Survey (CPSS 1998) and the National Longitudinal Survey of Children and Youth (Health Canada 2000). Prior to the NLSCY survey, the Atlantic provinces (including Newfoundland and Labrador) were reported to collectively have the lowest breast feeding initiation rate of 53% in 1994 (CPSS 1998). However, in the 1996-1997 survey, the four

⁷ In a keynote address given at a Women's Health Forum in 1999, environmentalist Elizabeth May (1999) suggested that even though incidences of breast cancer are lower among women who breast fed, this may be because the toxins stored in breast tissue are expelled in the breast milk fed the baby (see also Hogue 2001).

Atlantic provinces had an initiation rate of 65.3% (Health Canada 2000). Overall, the data continues to show an east to west gradient of initiation rates that has been present since the 1960s (*ibid.*).

In Newfoundland and Labrador, the breast feeding initiation rate has continually increased from 17% in 1978, to 33.7% in 1984, reaching 42.9% in 1994 (Matthews et al. 1994). The percentage of mothers who breast feed falls to 32.4% after one month, to 22.9% after infants are four months, and 17.4% of mothers in the province continue to breast feed beyond the first six months (Matthews et al. 1994: 78)⁸.

Comparatively, the city of St. John's has the highest provincial initiation rate of 51.3% in 1994. Despite this, according to one study, only 34.8% of mothers in St. John's continue to breast feed after one month, 22.6% after four months, and only 17.9% breast feed for longer than six months (Matthews et al.: 1994: 78). In other words, while in St. John's more mothers overall initiate breast feeding than elsewhere in the province, their numbers fall to match those of other breast feeding mothers in the province after the first month. Moreover, these percentages are consistently lower than national averages⁹.

During the 1980s and 1990s, students and faculty members largely of the School of Nursing at Memorial University of Newfoundland extensively investigated infant feeding practices in Newfoundland (for example Goodridge 1989; Hudson 1986; Matthews et al. 1994; Olsson 1988; Warren 1998). Most notable of these is the 1994 report submitted to the Toronto Hospital for Sick Children by Kay Matthews and others

⁸ According to the most recent collection of data (2000), breast feeding initiation rates have increased to 55% provincially (personal communication, Health Care Corporation of St. John's, March 6th, 2001).

⁹ Nationally, 61% of all mothers continue to breast feed at one month and 40% at four (CPSS 1998).

entitled Infant Feeding Practices in Newfoundland and Labrador: A Study of the First Six Months of Life¹⁰. In the report, the authors link social and economic conditions, the potential significance of health care institutions, and distinct cultural conceptions of motherhood with infant feeding practices in St. John's.

Matthews et al. (1994: 73-75) conclude that, in Newfoundland and Labrador, women who decide to formula feed their infants from birth are more likely to have lower family incomes, lower educational levels, to be younger, and that more single mothers choose formula feeding over breast feeding. These characteristics are the same for nearly all Canadian women who choose to formula feed (see for example CPSS 1998; Sage Research Corporation 1995; CICH 1996). In Newfoundland, the most common reasons given for choosing not to breast feed were distaste, embarrassment, and discomfort with the idea and act of breast feeding (Matthews et al. 1994). Matthews et al. recognize that:

These attitudes which reflect the views of some members of society that the breasts are purely sexual objects clearly must be addressed if the breastfeeding rates of the province are to be increased. Mothers who find breastfeeding distasteful are not going to be successful breastfeeders and are likely to negatively influence their family and friends and pass these negative attitudes on to their own children, reinforcing the pattern of artificial feeding or breastfeeding failure. (Matthews et al. 1994: 78)

Other reasons given for not breast feeding included: breast feeding was inconvenient; that it was too demanding or time-consuming; because women had medical conditions which

¹⁰ This regionally divided study consisted of a random sample of 912 Newfoundland and Labrador mothers who had given birth to healthy full term babies. Interviewers administered questionnaires during the early postpartum period and by telephone at one, four, and six months following birth. The data for the study were collected between January 1992 and June 1993 and the results analyzed using the Statistical Package for the Social Sciences (SPSS). Warren's (1998) Master of Nursing thesis is based on her research as part of the Matthews et al. (1994) study.

inhibited breast feeding; because of the health of the infant; because mothers were returning to work; because they smoked; and/or based on previous negative breast feeding experiences (Matthews et al. 1994:78).

The percentage of mothers who breast feed significantly decreases by the end of first month. Matthews et al. (1994) report that this dramatic decrease in breast feeding rates suggests that mothers experience difficulties shortly after they leave the hospital. Reasons given by mothers for ending breast feeding by the first month include the mother's perception that her baby was not getting enough milk and that breast feeding proved to be too difficult (ibid.: 79). In contrast to mothers who never breast fed, mothers who stop breast feeding after four to six months generally have higher education levels, are older, and have a higher family income. Matthews et al. (1994) suggest that it seems likely that this group of women were employed and switched to formula when they returned to work.

Federal and provincial funding has been used to encourage research that identifies the reasons why women do not breast feed and how to encourage more women to breast feed. Under the auspices of Health Canada, the Sage Research Corporation (1995) organized twelve discussion groups that were centred on topics designed to explore attitudes toward infant feeding options. In the resulting report, using information gathered from various Canadian regions including St. John's, the Sage Research Corporation presents reasons given by mothers (and a few fathers) for both breast feeding and formula feeding decisions.

The Sage Research Corporation (1995: 22) presents women who choose to initiate breast feeding as seemingly giving only one reason for doing so -- they do so because it is the best thing for the baby. By contrast, women who chose to formula feed their infants from birth gave a range of distinct explanations for their decision (Sage Research Corporation 1995: 7-8). Among some of the most common responses, these women mentioned that formula feeding would give them more freedom allowing them to return to their normal routine, to leave their children in the care of others, and to continue to smoke or consume alcohol. Women who used formulas said that they have fewer nutritional concerns than they feel others have with respect to breast milk. Some women said that since they had been fed formula as infants, they saw no harm in using it for their children. Others wanted to be able to include their partners in the feeding process.

Regardless of the research focus, almost all of the researchers cited in this section openly advocated the promotion of breast feeding. Although these research projects were designed to explore the possible reasons for infant feeding patterns, they frequently presented their findings in terms of cultural barriers that needed to be overcome in order to establish breast feeding as the normal and right thing for all mothers. With over half of mothers formula feeding from birth and three quarters of all mothers formula feeding by four months, infant feeding research in Newfoundland and elsewhere tends to focus on why women do not breast feed rather than how they experience infant feeding in general. It is important to note that the Sage Research Corporation (1995) discussion groups were composed of those women (or partners of these women) who had either stopped breast feeding soon after birth or had chosen not to breast feed at all. Existing research on

infant feeding methods, such as those of Sage Research Corporation (1995), are corroborated by other survey and statistical research in Canada, including that of Matthews et al. (1994). The opinions of those women who chose to breast feed for longer durations were not a part of the research by the Sage Research Corporation. Similarly, researchers in the Matthews et al. study (1994) asked women who chose to formula feed to give reasons for their choice but did not ask the same of breast feeding mothers.

There is a larger health promotion movement that underlies the increased promotion of breast feeding. Beginning in the 1970s, health care models in North America shifted from a focus on the *treatment* of illness to an emphasis as well on *prevention* of illness and disease. This emphasis on “health promotion and prevention through self-care, mutual aid, and healthy environments” (WGWH 1994:5) has been reaffirmed in documents produced for Health Canada such as New Perspectives on the Health of Canadians (Lalonde 1974), the Ottawa Charter for Health Promotion (WHO 1986), and Achieving Health for All: A Framework for Health Promotion (Health & Welfare Canada 1986)¹¹. These reports emphasize that improvements to population health are more likely to be influenced by changes to lifestyle, environments, and biology than through increased health care funding. In this de-institutionalizing approach, individuals take responsibility for their own health while the basic health care and social service needs, once provided by medical institutions, are assumed by the community (Peterson and Lupton 1996; see also Badgley 1994; O'Neill and Pederson 1994).

¹¹ As cited in “A Profile of Women’s Health in Newfoundland and Labrador” (WGWH: 1994:5).

Using Foucault's concept of "biopower" (1978:25) to describe how individuals 'govern' their own behaviour, health promotion begins when scientific and medical disciplines are employed to evaluate and assess biological processes. Risk is mathematically calculated and formulated (epidemiology), and policy is enacted based on these calculations to govern the behaviour of individuals (rather than control individuals directly). Policy becomes morality as people voluntarily conform to goals of the state and other agencies (Peterson and Lupton 1996:12-13) ¹², thus creating and enforcing ideologies of health. Viewing health promotion in this way, the biological process of lactation is a reproductive phenomenon that takes place in a woman's body (Law 2000:442). In turn, the processes of infant feeding are social activities in which "the bodies, prerogatives, obligations and interests of multiple citizens converge" (ibid.).

Stephens (1995:286) recognizes that, "people reproduce worlds of social divisions, understandings, and modes of experience even when -- especially when -- they are least aware of doing so." Further, anthropologist Ann Allison, in her analysis of Japanese *obentos* (lunch-boxes prepared for pre-school children), describes how state ideologies and gendered meanings of work are represented through a "properly prepared lunch-box" (Allison 1991:195). In this context, "motherhood ... is institutionalized through the child's school and such routines as making the *obento* as a full-time, kept-at-home job" (Allison 1991:203). Further, the lunch-boxes become who the mother is -- a reflection of who they are through the products that they produce:

¹² These ideas were discussed during the "Seminar in the Sociology of Medicine Course" I completed with Dr. Barry Edginton at the University of Winnipeg, September 1997 to April 1998.

[The mother] is alienated in the sense that others will dictate, inspect, and manage her work. On the reverse side, however, it is precisely through this work that the woman expresses, identifies, and constitutes herself. (Allison 1991:203)

Tasks defined by gender such as infant feeding are instilled with cultural ideology and the expectations of women and men as mothers and fathers.

Within the context of health promotion and the creation of ideologies of health, the vast majority of research on infant feeding practices seems to focus on the goal of educating mothers about breast feeding and assumes that women would choose to breast feed if only they knew how beneficial it really is for them, and more importantly, for their babies. This goal is formulated under the apparent assumption that women are free to make decisions based on personal knowledge and preference and that most, if not all, women would succeed at breast feeding if only the social support was there. However, as Schmied and Lupton (2001) among others point out, in determining an infant feeding method, social contexts are often more important than knowledge and attitudes. The question then becomes: how much of a choice do women really have when it comes to feeding their children (Balsalmo et al. 1992:62; Caplan et al. 1998:172; Law 2000; Murphy, Parker and Phipps 1998:262)?

As Murphy, Parker and Phipps argue, "the risk of defining [infant feeding] decisions as choices is that we camouflage the constraints under which women deliberate and act" (1998:263). Using their discussion, 'choice' implies that women have the power to implement their own preferences for how their children will be fed, emphasizing mothers' responsibility for the outcome of such practices. It follows that if women know what is 'best' and they feed their infants differently, they are then placing their infants'

interests second to their own. This presumption, however, fails to acknowledge the economic, social, and cultural restraints surrounding this decision. In the words of Murphy, Parker, and Phipps:

Culture is internalized by individuals and literally limits what actions are thinkable. Individuals conform to cultural norms not because they are forced to, but because it does not occur to them to think otherwise ... Even where individuals challenge such predefinitions and redefine experience, they may be dissuaded from acting on such redefinitions by negative reactions which they anticipate from others. (Murphy, Parker, and Phipps 1998:23)

Similarly, in her examination of infant feeding practices in colonial Malaya, anthropologist Lenore Manderson (1982) recognizes that the marketing of breast milk substitutes plays a role in their increased use while social and cultural factors influence overall infant feeding patterns. As Manderson argues, the marketing of these substitutes must also coincide with ideological shifts making it acceptable for a woman to choose from new infant feeding alternatives (Manderson 1982:615). Similarly, in her discussion of motherhood in colonial and post-colonial Asian and Pacific countries, Margaret Jolly (1998) emphasizes that attempts to change practices of mothering are rarely completely successful as the messages are altered in accordance with existing beliefs and practices (see also Comaroff and Comaroff 1989, 1991). In this sense, some ideas are adopted, some rejected, others still are redefined within the contexts of dominant ideologies at play in particular cultures during specific historical periods.

It seems as though there is plenty of research that addresses that question of why women do not breast feed. Perhaps, what is needed are examinations of why women *do* choose to breast feed (Maher 1992a) as well as how infant feeding choices and practices

are experienced regardless of what type of method is chosen. As well, Maher (1992a) argues that, when interpreting infant feeding practices, we need to question how methods are determined, to what purpose, and to whose advantage (see also Carter 1995:12; Law 2000; Morse 1989). In turn, instead of producing research that is based on solving the problem of mothers who do not breast feed, my aim has been to consider the many contexts in which infant feeding practices are experienced in one place and time through anthropological theory and methods.

The Research Setting

The city of St. John's is distinct from other areas of the province. As the main urban centre and political capital of the province of Newfoundland and Labrador, St. John's is the "commercial, governmental, administrative, financial, judicial, religious, educational, and communications centre of Newfoundland society, and the site in which approximately a fifth of the population live" (House 1988:125; Matthews 1988:166). Despite the number of ethnographies describing various areas of Newfoundland, ethnographic descriptions of the city of St. John's are limited¹³. In this section, I use sources drawn from a variety of disciplines and recent statistical information to describe the city of St. John's.

According to House (1988:166-9; see also Rusted 1995), during the early days of the fishing industry, St. John's stood out as a communications centre because of its

¹³ A few studies stand out among the few: Nigel Rapport's (1987) anthropological study of talk of violence in the city, and Vince Walsh's (1985) ethnographic documentation of the experiences of boarding house life in St. John's.

location on the island and its secure natural harbour. Many battles were fought in and around St. John's over the centuries because of its commercial, administrative, geographically strategic, and communications importance to the rest of the Island and to Europe. The increase in the importance of St. John's in global trading networks and the resulting power of city trades people over outport merchants led to the town's rise both in population and in influence over the rest of the Island as early as the eighteenth century. Because of these factors, St. John's became known as a place of leadership in social and political reform. As historian Keith Matthews summarizes:

As the importance and wealth of St. John's grew, it gradually acquired social and cultural advantages. St. John's had newspapers, health services, superior educational and charitable facilities and -- as the only town in Newfoundland with a large, educated and moderately wealthy middle class -- it increasingly attracted the outport middle classes, who found life more varied and exciting there¹⁴. (Matthews 1988:169)

St. John's officially became the political centre of the island in 1832, electing its first town council in 1888. With the passage of the City of St. John's Act by the Newfoundland Government, St. John's was incorporated as a city in 1921. Newfoundland became a Canadian province in 1949.

The city of St. John's is located on the eastern coast of the Avalon Peninsula and currently occupies 431.75 square kilometres (Statistics Canada 1998: electronic document). At the time of the 1996 Canadian census, the population was approximately

¹⁴ Hanrahan (1993:31) suggests that the city of St. John's has been settled in 'clusters' of people from certain parts of the province.

101,936, a decrease of 2.6% since 1991¹⁵ (ibid.). The city is predominantly English speaking, has less than 4% immigrant population, and less than 3% of the population identify themselves as members of visible minorities (ibid.). These percentages illustrate the relatively homogenous population of St. John's.

Until 1997, education in Newfoundland was based on a denominational school system run primarily by Roman Catholic or Protestant denominations. In addition, 37% of Newfoundlanders identified themselves as Roman Catholic, 61% Protestant, and less than 1% claimed no religious affiliation in the 1991 Census¹⁶ (Statistics Canada 1998: electronic document).

According to Statistics Canada (1998: electronic document), 69.5% of the population of St. John's 25 years or older (55.1% provincially) has a high school certificate or higher, while 11% have less than grade nine (21.2% provincially). As well, 22.3% of this population has completed university compared with 11.1% provincially. These statistics suggest that a higher proportion of adults living in St. John's are more educated than the provincial population as a whole.

In 1996, the capital city had a lower unemployment rate, 14% compared with the provincial rate of 25.1% (Statistics Canada 1998: electronic document). Employed persons in St. John's have an average income rate of \$23,409, higher than the provincial

¹⁵ The province of Newfoundland and Labrador as a whole was reported to have a population of 551,792 in 1996 (Statistics Canada 1998: electronic document).

¹⁶ In her discussion of women's wage labour in St. John's during the 1920s and 1930s, historian Nancy Forestell describes St. John's as being "a city where religion created divisions and tensions amongst its inhabitants. For example, employment with certain companies was often known to be based on religious affiliation" (Forestell 1995:84).

average of \$19,710. The majority (89%) of those employed are employed in the service industry compared with an average of 74% employed in service jobs provincially.

According to statistics released by the Women's Policy Office (1996:2.1), the majority of births in the province are to women who are either married or living common law. There are, however, an increasing number of young, single mothers in the province. Statistics Canada (1998: electronic document) reported that the average number of persons in a married or common-law family was 3.2, with 2.5 individuals living in a lone parent family. These numbers are the same provincially.

The social and economic setting of St. John's as described above influences feeding practices in ways that the characteristics of particularly smaller communities around the province may not. Because it is the centre of health care provision in the province, mothers in St. John's have access to specialized care through a choice of health clinics and hospitals. As the capital and largest city in Newfoundland and Labrador, mothers are exposed to commercial and governmental advertisements, have increased opportunities to participate in support groups and drop in clinics, and may more frequently find themselves at public venues in which they may have to feed their infant than their counterparts living elsewhere in the province. As well, living in a medium-sized city increases the likelihood that women will encounter formal organizations such as La Leche league, INFACT (Infant Feeding Action Coalition) Canada, and the Breastfeeding Committee for Canada (BCC).

Methodological Considerations

I gathered information on infant feeding from various sources over four months of fieldwork in 1999 in St. John's, Newfoundland. These sources included: semi-structured, informal interviews; observations in the home, in shopping malls, and in other public contexts; attending public forums on breast feeding and women's health; and through conversations and observations at social gatherings with friends and research participants who knew of my role as a researcher and openly shared their ideas with me. In addition, I reviewed existing published research on infant feeding in Newfoundland and did archival research on the promotion of infant feeding methods and childcare in St. John's between the 1920s and the 1960s.

Following Emily Martin's (1987) example, the people who participated in this research were self-selected rather than randomly sampled. For the most part, I contacted research participants through a snowball technique whereby people who knew of my research or those I interviewed asked others if they would be willing to participate. During casual conversations I frequently found myself describing the research project and asking people if they knew of anyone who might be interested in participating. As well, I posted notices at daycare centres on and off campus and through student organizations. In these postings I briefly described the research and invited interested research participants to contact me. I met one couple through the postings.

I designed interview parameters to guide the interviews and to try to ensure that basic information was gathered from all participants (see Appendix A). In these parameters, I framed important research questions around such aspects as: the socio-

economic description of the family; household dynamics; experiences of pregnancy, birth, and the early post-partum period; exposure to infant feeding methods; experiences with infant feeding; and experiences with health care professionals and advocacy groups. Researchers have identified these issues as important influences on infant feeding decisions and practices (see, for example, Maclean 1990, Matthews et al. 1994, Sage Research Corporation 1995).

I was flexible when using research parameters and treated each interview situation as unique from others while at the same time recognizing shared discourses. As with much feminist qualitative research, my goal was not to have a set of pre-formulated questions answered, but to understand the research participants' perspectives (Stearns 1999:310). The parameters ensured that various research topics were addressed but on only one occasion were the questions asked word for word. Ultimately, I let those I interviewed decide not only what information they chose to share with me but also how they chose to share it.

Following the initial interview, some research participants were asked if they would be willing to participate in more extensive conversations with me. These participants were chosen according to how well we interacted, the ease of our conversation, their willingness to share information, and the informant's expressed interest to meet with me again. I used these additional conversations to gather more information on what day-to-day living with children may entail in these families.

In all, I initially interviewed fourteen mothers and three fathers representing fifteen households in St. John's. Of these households, I conducted a series of extended conversations with four mothers and one father.

For the most part, the interviews took place in the research participants' homes. Many of the interviews were scheduled by the participants when their child/ren were either not in the home or were expected to be sleeping. Fathers were not usually home during my interviews with mothers. However, in some cases I made specific attempts to schedule future interviews for a time when both parents would be available.

On more than one occasion, participants were referred to me not only because they were parents but, more often, because they were identified as articulate, easy to talk with, and familiar with the research process in general. Others still had permitted their own children to be a part of other research projects varying from testing infant formulas to others testing physiological movements. Some participants had been interviewed many times by infant feeding researchers because of their unique life experiences and their willingness to share their lives with strangers in order to promote breast feeding. In other words, the research process was not unfamiliar to these mothers.

Since my initial contact source was the lactation consultant in St. John's, I was referred to mothers from a variety of backgrounds who, for the most part, had a variety of views about infant feeding. Among others, I interviewed mothers who were nurses who had published articles on their research on infant feeding in Newfoundland. I interviewed mothers who had had their experiences published in breast feeding advocacy journals. I also interviewed mothers who would publish in the future and expressed an interest in

what my research had to say about infant feeding. Of course, I also interviewed other mothers and fathers who had not been exposed to research, did not advocate breast feeding to others, and who were exclusive formula feeders. Because of my conversations with breast feeding advocates and researchers, however, I encountered not only situations that would lead to “when they read what you write” (Brettell 1993) but also situations of ‘when you read what they write,’ ‘when they want you to write,’ and ‘when they might write about what you wrote.’

Maclean (1990:17) notes that in her research on breast feeding attitudes, and other examples in the literature, women who choose to breast feed are more likely to volunteer their participation in infant feeding research. Similarly, in their examination of the characteristics of responders and non-responders in an infant feeding study, Shepherd et. al. (1998:275) report that non-responders to their pre-birth survey were more likely to be from a lower socio-economic class, to smoke, and to formula feed their infants from birth. This might suggest that women who believe that they are engaging in behaviour that contravenes dominant social norms do not choose to participate in infant feeding research. It is not surprising, then, that the research participants I interviewed were generally well educated, belonged to a higher socio-economic position, and the majority breast fed for some length of time. Thinking that I was looking for experiences of breast feeding difficulties, one mother apologized, “Look, I’m really healthy, I’m sorry if I’m not going to be much help to your project.” Of course, there were those who did not fit into these ‘typical’ categories of experienced research participants, researchers or breast feeders. In order to protect the identity of the parents’ who shared their experiences with

me, throughout this thesis I have changed names and altered information that may identify the participants in this research.

All of the parents in this research had their high school diplomas. Seven mothers had post-secondary education and three mothers had or were pursuing graduate degrees in various fields. For the most part, fathers had the same level of education or slightly higher.

Of the mothers, eleven were raised in St. John's, one in rural Newfoundland, and two moved to St. John's from other provinces but their infants were born in St. John's. The average age of the mothers was 37 years old although I interviewed one mother under the age of 25 and one mother over 60 years old.

Eight of the fifteen families had three or more children. Nine of the families were currently feeding a child under the age of two. Two families were expecting a baby within six months. Out of all of the households, eight of the families exclusively breast fed all of their children for at least six months. Three families used a combination of breast milk and formula to feed their infants. Four families (with twelve children in total) can be considered to have been exclusive formula feeders and the parents identify themselves as such. Altogether, the interviewees had breast fed twenty-five children.

Overview of Thesis Chapters

Infant feeding practices are not 'natural' phenomena but are influenced by specific historical and socio-economic factors and are surrounded by such discourses as those relating to science, medicine, and motherhood. In the next chapter, I describe

infant feeding options over history. An overview of the services provided by the Child Welfare Association in St. John's reflects the concern over, monitoring of, and intervention in infant and child health through campaigns targeted to mothers earlier in the 20th century. Further, while breast feeding has always been promoted as the optimum infant food, infant formula grew increasingly available and acceptable within the changing social, economic, and political contexts of St. John's.

The 'return' of breast feeding, beginning in the 1970s, was not easy or immediate but relied on a social movement supported by international, national and local breast feeding promotion campaigns. In Chapter Three, I discuss the influence of commercial formula marketing on infant feeding practices and also the international, national, and local campaigns to promote breast feeding. While current health initiatives encourage women to breast feed as well as encourage the acceptance of breast feeding in the larger society, the socio-economic conditions and viewpoints of the women themselves are often ignored. As feminist Pamela Carter states, "it is important to examine not simply how many women breast and formula feed, and what makes them do it, but the meaning of the experience of both forms of feeding within their daily lives" (Carter 1995: 199). Further, I argue that infant feeding in current contexts exists in a pro-breast feeding, anti-formula feeding environment in which decisions, at once private in the sense that they are made by the individual, remain a public concern.

Regardless of the infant feeding method chosen, infant feeding practices are social indicators of 'good' parenting. Infant feeding is one aspect of parenting that is focused on the actions of women. Moreover, it can be argued that ideas of 'good' motherhood,

and indeed, 'good' womanly behaviour, are reflected in infant feeding decisions. I discuss in Chapter Four some of the social and cultural influences on infant feeding decisions. The sexualization of breasts creates a potential conflict between being a 'good' mother and a 'good' women. If being a 'good' mother means breast feeding, mothers (and fathers to some degree) who formula feed often face negative evaluations of their behaviour. Moreover, if breast feeding is the "best", and infant formula is inferior to breast milk, the use of evaporated milk formulas in Newfoundland can be met with a heightened level of judgement and scrutiny. Within these contexts, fathers must find their place in their infants' lives in a culture that focuses infant care on the actions of the mother.

When parents describe their infant feeding experiences, they are also describing other aspects of their everyday lives in terms of their responsibilities as parents and adult members of their society, an aspect of infant feeding practices that I describe in Chapter Five. When the parents I interviewed discussed how they feed their young children interesting things were said about how work, both paid and unpaid, outside and inside of the home is negotiated vis-à-vis childcare responsibilities, how unpaid labour is divided among members of the household, and about how parents continually make choices among these frequently competing aspects of their everyday lives. I conclude with an overview of the arguments presented in the thesis.

Chapter Two
A Mother's Duty: Infant Feeding Practices in Historical Perspective

Parents and other caregivers make choices about feeding infant children in relation to a multitude of factors including historical circumstances, economic variables, the influence of medical models, and discourses surrounding motherhood. Across different historical periods, in diverse societies, caregivers of children have always had a variety of infant feeding methods to choose from. Options such as the availability of wet nurses, animal milk, and infant formulas as well as the introduction of supplemental feedings into an infant's diet are influenced by cultural approaches to nutrition and by socio-economic conditions. As I discuss in the previous chapter, these conditions may include occupational opportunities for women, government initiatives, medical discourses, and attitudes towards the female body. Further, there exist as many different infant feeding methods within societies as there are between societies.

Infant feeding options have always been available to mothers and breast feeding has always been recognized as the "best" infant food source when. Because of their role in reproducing physically and socially 'healthy' future generations, women have been the target of many promotions and recommendations thought to improve the health of populations. The other, often conflicting, responsibilities that women are expected to fulfill influence the degree to which these recommendations are followed.

Infant Feeding Alternatives in History

Until the late 19th century, most mothers would either breast feed or, if they could afford to, hire a wet nurse to feed their infants. As a last resort, animal milk or home-made formulas would be used to feed infants¹⁷ (Apple 1987; among others). Manufactured cow-milk based formulas were not introduced until the late 19th century and did not become popular until the mid 20th century. Until this time, breast milk was acknowledged as essential to infant survival but not all mothers breast feed their own children.

Women have long heard conflicting messages about their and their biological and social roles. In the case of infant feeding in Early Modern Europe, for example, women of the higher socio-economic classes were expected to produce many heirs, to plan and attend social functions, to be sexually available to their husbands, and to maintain the appearance of unused breasts (Blum 1999: 21). Many of these social expectations conflicted with the establishment of breast feeding because the latter meant that the mother had to be there when her infant needed to be fed, that the natural contraceptive effect of lactation reduced the number of heirs she could conceive, that social taboos dictated that her husband would not have conjugal rights to her while she was lactating, and that her lactating breasts would not be considered attractive (*ibid.*). Because of the dictums surrounding their social roles, mothers of the upper socio-economic classes would often hire poorer mothers to wet nurse their infants even though “medical men”

¹⁷ For a more detailed historical overview of infant feeding options see especially Rima Apple (1987), Mary-Margaret Costes (1993), and Valerie Fildes (1986).

(Donnison 1977) of the time of the time felt that breast feeding one's own infant was the best way to ensure infant survival. This point was made even more marked by the fact that children of the lower classes who breast fed their own children had a greater survival rate than their wealthier counterparts (Apple 1987, among others).

According to Linda Blum (1999:23), the practice of wet nursing was less predominant in North America because there were fewer women who had the financial resources to employ a wet nurse. Even though wet nursing was not as prominent in North American contexts, the profession still became an occupation for some women of the lower classes and, in turn, these women were evaluated according to their breast feeding 'suitability' (Blum 1999:23; Wolf 1999). Based on historian Jacqueline Wolf's (1999:110) discussion of infant feeding in Chicago from 1871 to 1961, the practice of wet nursing remained one of the few occupational opportunities for women who sometimes had to sell their milk in order to survive. At the same time, "the women who hired wet nurses steadfastly refused to acknowledge even what little they did share with their employee – motherhood" (ibid.). As well as reinforcing class distinctions, the practice of employing wet nurses impacted on cultural interpretations of human milk. As Wolf notes, "the mothers who could afford to hire wet nurses were beginning to deem maternal nursing less an activity of biological necessity and mother-love and more of a pastime of the vulgar lower class" (Wolf 1999:110). It is possible that the association between breast feeding and the lower classes may have contributed to the decline of breast feeding in some parts of the world.

In addition to my previous discussion of the early 19th to early 20th centuries, it can be argued that the Industrial Revolution had a profound impact on infant feeding methods. The Industrial Revolution complicated infant feeding choices for, among other consequences such as rapid urbanization and resulting poor sanitary conditions, the expansion of manufacturing and other jobs provided wage labour to women outside of the home. This reduced not only the number of women who stayed home to nurse their infants but also the number of women available to wet nurse the infants of wealthier mothers. Although animal milk and/or home made formulas were available for those mothers who did not breast feed their infants, these substitutions often led to serious illness or death because of inadequate nutrition and exposure to contaminated milk or formula (Apple 1987:4; Crellin 1994:168; Valquist 1981:2; among others). Before the Industrial Revolution, infant mortality was high among the children of wealthier mothers who did not breast feed their children. Following the late 19th century, infant mortality was highest among the lower and working classes.

Beyond its effect on socio-economic conditions, the Industrial Revolution profoundly influenced infant feeding *ideologies*. As a researcher of global infant feeding policies Jelliffe describes it, the near global decline of breast feeding was the result of "linear westernism" or:

The cultural changes that arose as a result of the dramatic scientific discoveries and ways of thought which occurred with the Industrial Revolution and with the parallel medical revolution of the last century. This we term linear to emphasize the *man-made, the technological, the mathematical, the provable and the new*. (Jelliffe 1976:233, emphasis added).

Even without adopting his characteristics of linearity, it is clear that technological changes in the late 19th century did affect infant feeding practices. After the turn of the century, infant feeding practices were influenced by both the increase in use of breast milk substitutes and the development and marketing of commercial infant foods.

Ideas about scheduling and the uses of scientific knowledge that stemmed from the impact of industrialization on conceptions of everyday life (see Ewen 1988) influenced infant feeding practices. Breast feeding was viewed as a natural process but the ideas and advancements of 'science' made natural processes seem 'primitive.' During this time, the lower classes were perceived to be 'closer to nature' and therefore breast feeding was characterized as an easy and natural task for such women to achieve. It was thought that because women of higher social status had more social duties and responsibilities, these demands would conflict with breast feeding. Women of higher classes, therefore, were thought to need medical advice and management if breast feeding was to be successful (Blum 1999:29; Carter 1995:39; Oakley 1993:131). However, as Blum adds, the advantages that upper class mothers' held "made it easier to adhere to breast feeding advice and to 'regulate' their babies' and their own bodies. They rarely faced financial pressures to seek paid work and usually lived in more comfortable, cleaner neighbourhoods" (Blum 1999:29). Despite these advantages, this group of mothers turned to commercial formula instead of breast milk to feed their infants because, as Blum suggests, of the "prestige and authoritative weight of modern science, the growing confidence in artificial products, and the declining confidence in breast milk" (Blum 1999:29).

By the late 19th century, concerns over high infant mortality rates led to increased scientific research comparing the composition of breast milk and infant feeding alternatives including animal milks, homemade food mixtures, and the new commercial formulas. This research led to the acknowledgment of the importance of sanitation in the preparation of all infant formulas and the development of the pasteurization process for animal milk. As a result, when mothers did not breast feed homemade food mixtures, animal milks, and wet nursing were replaced with consistently reformulated and improved commercially manufactured infant formulas¹⁸.

As scientists continually attempted to replicate the qualities of breast milk, specialized and sophisticated formulas were developed and marketed to mothers and medical practitioners by manufacturers¹⁹, as a means to meet the specific nutritional needs of infants (Apple 1987:11; Valquist 1981:3-4). The scientifically researched formulas were sanitary and perceived to be better than what was often characterized by manufacturers and medical professionals as 'weak' and 'insufficient' breast milk (Cunningham 1988:17). Formulas were presented as a suitable and justifiable replacement for breast milk. Two important themes in commercial formula advertising were propagated: fear for the health of the child and a faith in science (Apple 1986:9). Influenced by the convincing messages of infant formula manufacturers, many began to

¹⁸ Based on medical historian John Crellin's (1994:16) discussion, it seems that the rise in availability and use of commercial remedies, the increasing number of commercial outlets, and the skillful advertising of pharmaceutical companies may have promoted the sale of manufactured infant formulas in Newfoundland. Food product companies and tinned milk manufacturers used similar strategies to sell their product in Newfoundland.

¹⁹ For a historical discussion of pharmaceutical companies and their development and marketing of infant formula, see Apple (1986).

doubt the quality of breast milk when compared with scientifically developed formulas (Apple 1987:4; see also Carter 1995; Fildes 1986; Maclean 1990; Scheper-Hughes 1992:325; Van Esterik 1989). Science, therefore, was not only used to develop commercial formulas but also employed by formula manufacturers in their marketing strategies.

As Fomon (2001) discusses, from the 1930s to the 1960s, the increasing availability of safe, commercial infant formulas meant that more mothers used formula to feed their infants instead of breast feeding. Over the same time period, infants were introduced to cow's milk and *beikost*²⁰ at earlier ages than before. By the 1960s, most infants, whether breast or formula fed, were weaned onto solid food by four to six months, much earlier than previous generations. However, as Fomon (2001) notes, the 'return to breast feeding' in the 1970s coincided with longer periods of formula feeding (*ibid.*). In other words, even though the number of women who exclusively formula fed decreased after the 1970s in countries such as Canada and the United States, those who did formula feed delayed introducing other foods in their child's diet until a later age. This meant that many older infants continued to be fed commercial infant formulas instead of being introduced to cow's milk as their breast fed peers were (*ibid.*). The development of formulas designed and marketed for older babies is a likely reason for the longer use of infant formula²¹.

²⁰ Supplementary infant foods other than breast milk but including infant formula and solid foods.

²¹ I discuss infant formula marketing in more detail in the next chapter.

Acknowledging that women's bodies are regulated in modern states in response to social concerns over reproduction as well as national priorities (Ginsburg and Rapp 1991:316), the history of medical, commercial, and state influences on infant feeding practices runs concurrent with trends in the development and increased use of breast milk substitutions. The period of time between the two World Wars exemplifies this point.

With a falling population growth rate in Britain and North America after each of the World Wars, the governments of these nations turned to medical and scientific authorities to create initiatives to improve the 'health' of their nations (Arnup 1990; Carter 1995)²². The state's heightened interest in family, reproduction, and population growth led to the establishment of voluntary health clinics in various parts of the world including Newfoundland. These clinics offered mothers a place where their infants' health could be monitored through an emphasis on their weight gain.

While these 'free' health clinics were established to curb high mortality rates and did encourage breast feeding, they frequently gave out free sterilized, powdered, or tinned milks to ensure adequate infant nutrition (Cunningham 1988:16; see also Carter 1995 and Valquist 1981:3)²³. Milk, especially since it could now be pasteurized and safely stored over periods of time, was seen as a cure for many social ills when used to

²² Although other European nations such as France and Germany were also developing similar public health services and initiatives (see Fildes; Carter 1995; WHO 1981 for example), I focus on British and North American examples, as they would have been the primary influences on Newfoundland policy makers (as Godfrey 1985 recognizes).

²³ Commercially manufactured infant formulas were not generally provided at these clinics until the later half of the 20th century.

feed infants and small children. Therefore, while nations still held the official policy of encouraging mothers to breast feed, Pamela Carter notes:

... we can see bottle feeding, subsidized by the state, as a payment in kind over which women had control in the family setting, and which left them less exhausted than did breast feeding. This, combined with its supposed 'medicinal qualities', must have brought at least apparent benefits even though breast feeding was still seen as cheaper. (Carter 1995:51)

As Ann Oakley comments, the early (British) depots represent "both the collectivism of the public health movement and the individualism of weighing, advice and home visits" (as cited in Carter 1995:45). Through their charitable actions, health clinics established a history of medical standardization, monitoring of infants, and prescribed solutions to the risk of infant starvation.

Arnup argues that the development of 'scientific' childcare in the 1920s and 30s shifted what was seen as the 'traditional' mother-child relationship into a "scientifically controlled and managed experiment" (Arnup 1990:196; see also Apple 1987:97; Hays 1996). This trend was further supported by the encouragement of women to put themselves under medical supervision from the moment of 'diagnosed' pregnancy (Arnup 1990:195, see also Martin 1987). Similar to the shift from home midwife-attended births to physician-attended and medically managed hospital births over the same time period²⁴, the processes by which women mothered their infants were regulated and supervised by medical authorities and sanctioned by social norms. Women of the

²⁴ There is enormous literature addressing the shift from home to hospital birth. For a detailed description of these shifts see for example Donnison (1977), Benoit (1991) for a Newfoundland perspective, and Martin (1987) for an analysis of reproduction in a recent context.

time supported this medicalization because it was presented as freeing them from the control that biology had over their lives (Blum 1999:31). Mothers were told that breast feeding was still the best for their infants but that their bodies were unreliable and that formula was very nearly as good (ibid.), a belief that continues to exist in current contexts.

Using the medical profession's standards, the growth and development of an infant became the primary standard by which women measured their ability to nurse (Maclean 1990:60). Since physicians are the ones who weigh and evaluate an infant's progress, these health professionals became essential in the evaluation of motherhood. As motherhood was perceived to be 'the greatest duty' (Arnup 1990:200) mothers were therefore ideologically pressured to be the main individuals responsible for childrearing but still as needing the expertise of medical professionals to develop proper childcare techniques (Apple 1987:97, Oakley 1993: 82). Women were still expected to be 'good' mothers but could do so either by formula or breast feeding their infants (Carter 1995). By the "Baby Boom Era" following World War Two, commercial infant formula use was the social norm in North America.

The Child Welfare Association and Infant Feeding Practices, St. John's 1921-1965²⁵

In early 20th century Newfoundland, respected physicians, clergy, and magistrates of the time reported, as Godfrey notes, there was ample evidence of "high infant and

²⁵ There is a lack of published historical information about infant feeding in Newfoundland and Labrador contexts. The information that is presented in this section has been collected from existing publications and archival records of the Child Welfare Association (COLL-002 ARCH) and is meant to be read within the general history of infant feeding patterns discussed above.

maternal mortality, of malnutrition and other pernicious conditions among children, as well as ignorance of child rearing knowledge and skills among mothers” (Godfrey 1985:150).

Prompted by the urban reform movement, and in response to malnutrition among many members of the population of St. John’s and surrounding areas, the Child Welfare Association (CWA) was established in 1921 as a result of actions by St. John’s Mayor Gosling and the Women’s Patriotic Association²⁶ (Godfrey 1985: 151). The St. John’s Municipal Council, the Government of Newfoundland, membership fees, gifts, and donations were all financial contributors to the Association. Originally a charitable organization providing services to the needy, the CWA became a provider of constant medical supervision and attempted to ensure that mothers adhered to officially prescribed childrearing practices (Gibbons 1996:31, 56). This was accomplished through home visits in St. John’s and surrounding areas and the establishment of community clinics. Beyond its mandate for improved housing, sanitary and medical conditions, the Association employed a community nurse to visit mothers and newborn infants to give advice and to help new mothers.

From the beginning, the founders of the CWA recognized the need to reduce the extent of infant mortality and to ensure the health of surviving infants (Gibbons 1996:46). This was to be accomplished “with the intelligent co-operation of the mother, ... [through] training in practical motherhood. This was always the basis of true Child Welfare activities” (Gibbons 1996:46).

²⁶ Linda Cullum (1995) further explores the work of women’s voluntary organizations in Newfoundland.

In the 1920s, the mandate of the CWA was “mostly concerned with Infant Welfare Work, and propaganda in urging and trying to work out schemes that would benefit ‘Child Life’ in the city”²⁷. Under this mandate, the executive of the CWA sponsored “Baby Week” from June 21-26th, 1926²⁸. “Baby Week”, received support through editorials and articles published in the daily newspaper. Invitations to attend the various events were extended to all “prominent citizens” and the week long event was under the patronage of Lady Horwood and Mrs. Monroe, wives of prominent political figures in St. John’s. It seems almost ironic, though, that invitations to attend an event that was supposed to serve to educate the public about childcare were only extended to “prominent citizens”.

An exhibition in Star Hall (St. John’s) was held as part of “Baby Week.” The exhibition included a milk stall where properly bottled fresh milk was sold and given out, the sterilization of milk was demonstrated, food made from milk was displayed, and the ice-box and its uses were demonstrated. While pasteurized fresh milk (a relatively new product to Newfoundland in the early 1920s) was promoted as a source of nutrition for children of all ages, breast feeding continued to be supported. One might question what impact this stall may have had on the feeding of infants. As well, the “Well Baby Center” stall provided forms, literature, and a scale where babies could be weighed.

²⁷ As cited in an unidentified article in the “Baby Week” scrapbook, 1926.

²⁸ All information concerning “Baby Week, June 21-26th, 1926” was collected from an anonymous scrapbook of newspaper clippings. This scrapbook is archived in the Child Welfare Association (COLL-002 ARCH) collection at the Centre for Newfoundland Studies, Memorial University of Newfoundland. Newspaper articles and the authors of this material are sourced when known. I cite the “Scrapbook of St. John’s Baby Week” as “Scrapbook 1926” throughout this chapter.

During the festivities, a prize was awarded to the baby who had the most frequent attendance at the Special Welfare Centre²⁹.

The events described in the "Mother Craft" competition illustrate the types of duties mothers in St. John's were expected to perform in the 1920s (Scrapbook 1926:11-24). For example, various competitions included garment making, knitting, "theoretical cooking," and record keeping of "the healthy progress of the child." There was also a competition in which mothers were asked questions in "Mother Craft" such as: "Breast milk is best milk for baby. How many feeds, at what time, and at what ages should babies be fed?"

The events and messages promoted during "Baby Week" illustrate childcare attitudes during the 1920s. As discussed earlier, this particular time was influenced by the consequences of the First World War. The health of populations and the need to replenish a reduced population heightened health promotion campaigns. As well, science and technology seemed to offer new and improved products and an ideology of efficiency. As Miss M. MacDonald of the Y.W.C.A. wrote in an article published during "Baby Week", "the war has taught us many things and through bitter experience we have come to learn the value of human life and the need for giving all the youth of the nation every possible chance to make good" (MacDonald 1926). She adds that mothers are responsible to use "the newest scientific education" to raise "the babies of their Race" (ibid.).

²⁹ While I could not locate a description of this centre, I presume that it provided care for infants and children of mothers who faced economic challenges.

The idea that mothers are solely responsible for properly raising the “babies of their race” is a theme echoed in other articles published during “Baby Week.” In another example, J. L. Paton, President of the Memorial College, wrote:

The most important person in education is not the Deputy Minister, or the Superintendent, or the President of the University. ... the most important person is the mother. The real ultimate questions about anyone is ‘what sort of mother had he? What sort of sound did he hear as he lay as a helpless infant in his home? What food had he? What neatness and order was there around him? What sort of things did he see? Did his mother smile on him or scowl? Did she sing or curse? What sort of pictures did he see on the wall? What sort of conduct between man and men? And as he grew up and began to understand, what sort of things were the people around him talking about and in what tone of voice?’ ... *mould conditions right and the children will grow good to fit them* (Paton 1926, emphasis in original).

This quotation suggests that it is the social environment in which a child grows up which determines healthy outcomes. Further, it is the responsibility of the mother to provide the optimum environment for her child.

According to physicians, many residents of St. John’s during this time were in poor health attributed to “conditions of the city slums, the smoke overhanging the city, the small tightly spaced houses with small dirty windows, the dirt and sewer on the roads, poor light and poor sanitation” (Fallon 1926). Under these conditions, mothers carried the burden of raising healthy, well-adjusted children, a task that proved even more burdensome for mothers with reduced economic means. As if to emphasize this point, Miss Pressley-Smith writes:

The important factors in the life of a child are many, but they may be summed up in the one essential of a good home, with all that implies. ... poverty and ignorance are the greatest handicap, ...

[but] the darkness of ignorance is being rapidly dispelled by the light of scientific knowledge. (Pressley-Smith 1926)

These authors, while acknowledging the present living conditions of many of the residents of St. John's, suggest that the solution to poor health is in terms of educating mothers through "scientific knowledge".

World War Two impacted on the activities of the CWA. As Jessie L. Edgar, Acting Superintendent wrote in 1939: "The attendances at our Welfare Clinics have been affected by the improvement in working conditions and the consequent change in home routines" (CWA 1939). In other words, women employed in war-relief efforts had other responsibilities to care for as well as their children and attendance at clinics may not have been as high of a priority. As well, perhaps the additional income to many households reduced the need to attend such clinics. Nurses still encouraged and instructed their clients about "the importance of natural feeding of infants, and when this [was] impossible, from unavoidable causes, the care of feeding bottles and the correct preparation of formulas"(CWA 1942). After World War Two, the need for CWA services and the number of CWA volunteers continued to decrease (Gibbons 1996:58).

An important function of the CWA continued to be home visits with new mothers and their families. During these visits, nurses asked questions concerning the health of the newborn, evaluated how the mother was coping in the household, and offered medical and household advice where needed. As an anonymous author of the 1945 Annual Report wrote:

Now we come to a very essential and interesting part of our work, visiting the homes, with the problems and difficulties of family life, and where many a disgruntled mother after airing her troubles

to (as she hopes a sympathetic and understanding listener) feels a sense of relief and finds more courage to face this future. (CWA 1945)

In order to carry out these duties, the nurse had to be sensitive, ensuring the trust of the mothers, while observing of the health of the children and the living conditions of the household. Another anonymous author wrote in 1948:

The first visit is possibly the most important and certainly the most difficult. The Nurse, very likely a complete stranger to the family, must use tact and understanding in order to gain the confidence of the mother. (CWA 1948)

Some of the observations made by CWA nurses during this time included overcrowding, the general health of the family, and the lack of fresh air and cleanliness in some homes and areas of the city.

Despite improvements to the standard of living during and after World War Two (Encyclopaedia of Newfoundland and Labrador 1998, electronic document), members of the Child Welfare Association were aware of the continual poor living conditions of the mothers they visited. In 1945, one member of the executive reported:

The housing problem is still a great menace to the general health of St. John's. When visiting those miserable shacks in slum areas, and seeing the conditions that these people exist under. It seems rather futile to talk health to already over-taxed mothers, knowing that, under such existing circumstances they are, in many cases, carrying on as best they can. (CWA Annual Report 1945)

The nurses who visited people's homes would have realized that the task of promoting health was a multi-faceted one and one which home visits alone might not achieve. As Kathleen McCoone, Superintendent of the CWA, wrote:

We go on from year to year, trying, by home visits, clinics, and talks to educate the mothers, seeing sometimes very little

improvement, and we do realize that without their co-operation and interest our work is futile indeed. (CWA Annual 1947)

These two examples from contemporary commentators indicate a difference of opinion. The anonymous member of the executive of the CWA recognizes the living conditions and the responsibilities of the mothers whereas McCoone emphasizes that it is the ignorance and reluctance of mothers that inhibit the health of their children.

During the 1940s, the CWA established a "Mother's Club" which met at the Child Welfare Centre and was suggested to be well attended. At these meetings, mothers knit, sew, read, or had "little social get-togethers." A series of talks on nutrition, simplified first aid, and home nursing were also given (CWA Annual Report 1948, no author).

Despite the efforts of the CWA, the infant mortality rate increased from 17% above the Canadian rate in 1922 to 55% above this rate in 1932, and 65% higher infant mortality rate than Canada by 1945 (Encyclopaedia of Newfoundland and Labrador 1998: electronic document).

The Child Welfare Association and Infant Feeding:

Based on information gathered from archival records³⁰, the Child Welfare Association (CWA) always endorsed and promoted breast milk as a superior infant food source. When breast feeding was found to be impossible for the mother, the proper preparation of bottles, the care of feeding bottles, and the importance of cod-liver oil were emphasized.

³⁰ Archival information gathered from the "Records of the Child Welfare Association". Centre for Newfoundland Studies Archives, COLL-002 ARCH, file 1.01.

During this time the emphasis was not so much that a mother should breast feed her infant as it was that a mother should prevent the onset of diseases in her child. Although reasons for not breast feeding were not recorded, the CWA paid attention to how evaporated milk formulas were used. From 1932 until its disbanding in 1977, the CWA acted as a distributing depot for tinned, evaporated milk on behalf of the Newfoundland Government. This milk was paid for from government provisions, private donations, and commercial donations of “free” samples. When deemed necessary, the infant’s physician would prescribe tinned milk and the necessary slip would be signed by the City Welfare Office. According to CWA records, over 500,000 tins of evaporated milk were distributed between 1945 and 1950 alone. The percentage of women who were noted to be breast feeding during the first nurse visit decreased from approximately 40% to 27% over the same five years. Further, nurses observed that many women had switched to evaporated milk by the second visit despite their continued mandate to promote breast feeding. As Ms. Edgar noted in the 1943 CWA Annual Report:

The problem of obtaining the necessary amount of Evaporated and cow’s milk for young infants, has caused many mothers to switch to the sweetened milks, which caused digestive upsets to many, and is not a satisfactory substitute and unless babies that are fed on these milks are given the necessary Cod Liver Oil and fruit juices, to make up for the vitamin deficiency, more cases of rickets and scurvy will develop. (CWA Annual Report 1943, see also Murray 1979:98)

Unfortunately, I could find no documentation that describes why mothers increasingly began to use evaporated and sweetened milk formulas instead of breast feeding to such a dramatic extent over such a short period of time.

The Child Welfare Association in Post-Confederation St. John's:

According to Stevens, Williams and Davies (writing in 1961), breast feeding and the use of fresh animal milk (usually goat's milk) had been common infant feeding methods prior to Confederation with Canada in 1949 (as cited in Encyclopaedia of Newfoundland and Labrador 1998: electronic document; see also Crellin 1994:168; Murray 1979:98). From 1949 to 1959 a switch from breast milk to evaporated milk occurred and there emerged "an undue dependence upon food from cans, packets, cereals and other commercial preparations" (Encyclopaedia of Newfoundland and Labrador 1998: electronic document). In fact, CWA records indicate a dramatic decrease in the number of women who were breast feeding when nurses made their first visits to the homes of newborn infants. These rates steadily declined from 66% in 1943 to 50% in 1944, 42% in 1946, 39% in 1947, 27% in 1948, and by 1955 the breast feeding rate had fallen to less than 5% among the mothers of infants being visited.

Confederation of Newfoundland to Canada in 1949 brought many economic advantages to the citizens of Newfoundland. These advantages also changed the activities of the CWA. After Confederation, the standard of living for most residents of St. John's improved through Acts of Legislation, federal social security programmes and other services, through increased federal funding for infrastructure, and through the distribution of the "Baby Bonus" -- a monthly allowance to families with children.

After Confederation, the CWA continued to promote breast feeding and, when that was considered impossible, taught proper bottle preparation (CWA 1952). In the 1952 CWA Annual Report, the author mentions the support of pharmaceutical companies

“who keep us supplied with Infantol, Maltevol, Radiomulsion,” (CWA 1952), popular commercial formula brands of the time. According to a newspaper article on the activities of a Baby Clinic in St. John’s, the clinic distributed hundreds of bottles of Infantol through the generosity of Horner Brothers and their agent Mr. Gus Stafford, at an average cost of one dollar each (Drodge 1954).

The anonymous author of the 1955 CWA Annual Reports notes “we have noticed in our home visiting, that the mothers are becoming much more health conscious, and listen with interest to the advice which we are able to give them” (CWA 1955). But what advice were these public nurses giving mothers? In the 1961 CWA Annual Report, the author states:

The whole subject of infant feeding is, perhaps, one of the most difficult about which to write definite directions since what suits one baby is altogether unsuitable for another. But considering the normal, healthy infant it is possible, within certain limits, to arrive at some conclusion as to what is best for it in the way of diet *whether it is breast or artificially fed.* (CWA 1961, emphasis added)

In these reports, some of the last ones to be written before the disbandment of the CWA in 1977, we see the change from the promotion of breast feeding to the gradual acceptance of commercial formula and, as shown in the next quotation, the idea of the importance of both parents in providing a healthy environment in which their infant might reach his or her full potential:

Child care is a great art. It is an important task, perhaps, the most important task the parents undertake. The parents have a responsibility, not only to their children, but also to the community to see that the child grows into an adult who can use fully all the talents and capabilities that he had with him when he was born. The father shares this responsibility with the mother, and from the

baby's birth they will want to work together to see this most important job well done. (opening lines of the CWA Annual Report, 1962)

In an interview for a newspaper article, retired nurse Phyllis Godden recounted her experiences as a child welfare supervisor from 1942 to 1974 noting the changes to the services provided by the CWA and to living conditions in St. John's (Evening Telegram 1974). Ms. Godden states that in the early days, the CWA's function was to hand out milk, orange juice and cod-liver oil to newborn babies. Since Confederation, the "mother's allowance" ("Baby Bonus") made this function no longer necessary. The CWA would be notified of a baby's birth by the maternity hospital. A nurse would visit the home, see the baby in its home environment, weigh and measure it, inoculate it against disease, and discuss formulas and general safety precautions. Ms. Godden felt that by the 1970s, mothers were more informed about diseases that may affect their children and that babies were healthier than in the past. As well, some of the poor residential areas of St. John's which had contributed to the high incidence of many diseases, had been cleared away thus improving the health of many residents.

The 'Return' of Breast Feeding

As Cunningham (1988:19) discusses, social movements in Canada and the United States beginning in the late 1960s forced a questioning of the assumption that formula feeding was a "fact of modern life" (Vahlquist 1981:7). These movements included: the 'back to nature' movement of the 1970s; a "mother's rebellion" represented by such

organizations as La Leche League³¹, the recognition that the introduction of commercial formulas to Third World countries had detrimental effects among those populations (Van Esterik 1989a,b, 1995); and continuing biomedical research that forced the acknowledgement that many features of human milk cannot be replicated (ibid.).

As a result of publicly circulated scientific findings espousing the 'proven' benefits of breast feeding, in addition to the related broad ideological shifts, in 1978 the Canadian Paediatric Society (among other medical organizations) modified its official statement on infant feeding in order to recognize breast milk as a superior infant food and stating that it should ideally be the sole source of nutrition for the first four to six months of life (Nutrition Committee, Canadian Paediatric Society 1979). This modification negated the long promoted belief that babies fed with formula were just as happy and well nourished as breast fed babies. This change also marked the beginning of federal breast feeding promotion campaigns by Health Canada and other government agencies in North America. In turn, other health organizations such as the World Health Organization have since made the promotion of breast feeding a primary goal (CICH 1996:5). As I discuss in the chapter to follow, this shift has had a significant cultural impact in St. John's.

³¹ For a more detailed description of the history and work of La Leche League see an edition of their publication, *The Art of Breastfeeding* (1991). I have also used information posted on the website <http://www.lalecheleague.org> for current information on the group. Also, Jule DeJager Ward (2000) provides an interesting history of the organization highlighting the League's religious foundations.

Chapter Summary

The material presented in this chapter demonstrates that changes in women's social and work responsibilities, the influence of social class, and the development and resulting prominence of scientific discourse have long impacted infant feeding practices.

What may be more important to recognize, as Penny Van Esterik does, is that:

... [T]oday is not the first time in history that women have found substitutes for maternal breastfeeding. This is, however, the first time in history when infants lived through these experiences long enough for others to measure the impacts on their health. This is also the first time that huge industries have promoted certain options for women, and profited from mothers' decisions not to breastfeed or to supplement milk with a commercial product. (Van Esterik 1995:148)

As I illustrate in this chapter, infant feeding practices are not natural phenomena but are influenced by specific historical and socio-economic factors and are construed by such discourses as those relating to science, medicine, and motherhood. An overview of the services provided by the Child Welfare Association in St. John's reflects the concern over, monitoring of, and intervention in infant and child health through campaigns targeted to the mother. Further, while breast feeding was always promoted, infant formula grew increasingly available and acceptable as nutritious infant food.

The 'return' to breast feeding in North American contexts after a generation of near absolute commercial infant feeding was not an easy one. Feminist authors such as Anne Oakley (1993) and Pamela Carter (1995), among others, argue that the loss of confidence in the ability to feed, the lack of an experienced support network, as well as the perception of women's bodies as sexual objects had to be overcome before breast feeding as a social practice can be re-established. Researchers of infant feeding practices

point out that while various professional medical organizations have formally acknowledged the superiority of breast milk, medical practitioners frequently give conflicting advice to their patients (see for example Carter 1995; Maclean 1990; Maher 1992a). Despite these apparent obstacles, breast feeding rates increased gradually in countries such as Canada throughout the 1970s, 1980s, and 1990s.

Chapter Three
The Promotion of Infant Feeding and the Creation of a “Big Deal”

Early into my research I noticed the relative lack of academic and other materials describing infant feeding practices from the late 1950s to the late 1970s. This time period is important to this thesis because it marks the period during which formula feeding became the most prominent form of infant feeding in St. John's and other locales. I had been searching for documents and materials that described infant feeding practices during this important period but was having a difficult time finding much. I was, therefore, quite excited about the prospect of interviewing Martha. I hoped that Martha, who had her children in the 1950s and 1960s and is now a grandmother, could illustrate aspects of infant feeding practices during that time.

Shortly after I arrived at her home, Martha and I were easily chatting about our families, life in St. John's, and her infant feeding experiences over a cup of tea at her kitchen table. She told me that when her first child was born in 1957, he was fed on a 'new' powdered commercial infant formula in the hospital. This formula was said to be "next to mother's milk," to be lighter, and have less fat than tinned milk preparations. She describes: "All he did was throw it up and it was terrible. You could smell it on everything." Martha, concerned about her baby, called her physician and was told to replace the commercially prepared with the more common formula made with tinned evaporated milk. The baby did so well on the evaporated milk that she fed the next three children with the same formula.

When I asked what factors she took into consideration when choosing among her options she answered:

You just didn't think about it then, you just fed them and that was it. Out of my circle of friends, which was a rather large one, no one breast fed. Not even the ones who didn't go back to work. Breast feeding by that time was really out. I mean nobody breast fed. It didn't even occur to us.

Even though Martha listened to her physician's recommendations, formula feeding was considered so normal that it was not even a decision to be made.

Shortly after I completed my fieldwork, a friend of mine introduced me to a colleague of hers, an older gentleman who had grown children. We began to chat about our lives and I told him that I was finishing my Master of Arts degree in Anthropology. After the usual, "What culture do you do," I explained to him that my thesis deals with infant feeding in Newfoundland. We talked for about an hour, discussing different aspects of breast and formula feeding. Drawing on the reading I had done as well as my fieldwork, I presented to him alternative ways of thinking about infant feeding choices. At the end of our interesting conversation, my friend turned to me and said, "Wow. I never realized it was such a big deal."

How has infant feeding changed from being something you "just didn't think about" to "such a big deal"? As demonstrated in the previous chapter, how parents, namely mothers, feed their infants has increasingly become a national and international concern for health professionals, policy makers and infant health advocates. Changing approaches to public health and profound ideological shifts in notions of womanhood, motherhood, and childcare are reflected in the establishment of formalized, state and

internationally-supported breast feeding promotional campaigns. Moreover, in their attempt to change what they perceive to be a formula feeding culture to a breast feeding culture, advocates, health policy makers, and some medical professionals present the “breast is best” message in both formal promotional efforts and in everyday, informal encounters. I argue, contrary to what many breast feeding advocates would, that infant feeding choices and decisions exist in a pro-breast feeding and anti-formula feeding environment. Even though a “breast feeding culture” (as opposed to the existing “formula feeding culture”) is not yet a reality, a ‘big deal’ is created as infant feeding decisions, while at once being private acts, remain a public concern situated and contested in public domains.

The purpose of this chapter is to examine how infant feeding practices have become “such a big deal” through an exploration of the impact of commercial formula marketing strategies and how breast feeding is being promoted internationally, nationally, and locally in St. John’s through both formal and informal means. I begin this chapter by briefly describing how commercial manufacturers have established infant feeding marketing strategies since the late 19th century. In order to demonstrate the impact the aggressive marketing strategies have had on infant feeding promotions in general, I follow with a description of breast feeding promotions in Canada and Newfoundland as they have been influenced by the actions of the World Health Organization (WHO) and implemented through Health Canada. Since ideas about infant feeding are promoted through a variety of means, I also present a brief analysis of the role that the popular and mass media (mainly books and magazines) play in terms of promoting a particular image

of infant feeding. I conclude by describing infant feeding promotion beyond institutional and ideological influences and in terms of larger social movements.

Steve, Emily, and Faye

I was almost surprised that Steve, one of the few fathers I spoke with about infant feeding, had such strong and clear opinions about infant feeding. When we spoke, Steve and his wife had a son who was ten months old and they were expecting another baby in less than four months.

As I drove Steve and some other friends to their homes, the topic of my “breast feeling”³² research came up in conversation. Steve began telling everyone in the car what he thought about infant feeding. I remained quiet, not wanting to interrupt the flow of his thinking with questions. Almost without pause, he said:

When they ask me if my wife is breast feeding, I say, “That’s a personal question.” [laughs] Then I say, “Yes, she is, but the baby is on the bottle!” I mean if a woman doesn’t want to breast feed then why should she? She wouldn’t get any sleep if she did. They feed for forty-five minutes every two hours! I don’t see what the big deal is, we were all fed that carnation crap but now they’ve made formula just as good as breast milk. And now there’s soymilk formula. Have you ever tasted it? It’s really gross. Sure some babies need it but now it’s just the hype. But basically formulas are all the same, except the hospitals get babies hooked on the expensive ready-to-feed formula. After two months of spending twenty-five dollars for a two day supply, we switched [our first baby] to the less expensive stuff. I mean I really don’t know how single mothers manage to afford the stuff, I really don’t.

³² I discuss the sexualization of breast feeding in the next chapter.

Steve recognizes that his wife is the one who ultimately decides what to feed their children even though he was about to leave his job to become the primary caregiver. Steve acknowledges that while infant formulas were not very good in the past, now commercial formulas are “just as good as breast milk.” To him, infant feeding options are influenced more by ‘trends’ and ‘fashion’ than nutritional quality and there is not really a difference between infant feeding choices.

Emily and I talked about why some mothers choose to use formula to feed their infants instead of breast feeding them. As a self-described ‘militant’ breast feeder, Emily blames formula marketing strategies on some women’s reluctance to initiate breast feeding:

If I were to say to someone who bottle feeds and doesn’t want to know anything about breast feeding. I’ll say to them, “You know something, I know you can feed your kid this stuff and it’s really, really good and it guarantees to do this, this, and this” and they probably don’t know anything about breast feeding but you tell them. “And you know it’s free, absolutely free,” or even tell them it’s thirty bucks a case. I’ll tell them, “Look it outweighs Similac [a brand of formula] any day. It’s wicked. Wicked. There’s nothing like it on the face of the earth.” And they will be the first ones in line to buy it. And here it is free and they don’t want to use it. It’s almost like if it’s going to be better it’s got to cost more.

Breast feeding advocates, such as Emily, recognize that by doing what is ‘best’, mothers may be influenced by claims made in promotional materials and suggest that, in the same way that infant formulas are, breast feeding should be marketed and “sold”. Further, Emily recognizes that some people equate the higher cost of a product with its superiority, ‘if it costs more, it must be good’.

Like Emily, Faye is a self-described 'militant' breast feeder. Faye, a married mother of three children, told me in our conversation:

I think about some of the women I know where there's a lot of allergies in their families and yet they still choose to bottle feed, I can't figure it out and I'll go so far as to say it's selfish. I'll go so far as to say it's a lack of knowledge. I won't say that they don't care about their children, I wouldn't go that far but I do believe that knowledge is power and if you read all of the information, even formulas will tell you breast feeding is best for your baby.

Faye, whose story I describe in more detail later in this chapter, argues that while all mothers care for their children, some do not breast feed because they have not heard, or accepted or, perhaps, they do not believe the message that breast feeding advocates have been promoting: breast feeding is the 'best' infant feeding method.

The formula feeding opinions of Steve, Emily, and Faye illustrate a history of infant feeding practices as influenced by breast milk substitute marketing, the existence of consumer culture, and breast feeding promotion activities.

The Influence of Commercial Formula Marketing

Scientific and medical discourses play a crucial role in the commercial manufacturing and marketing of breast milk substitutes. Even though food companies such as Nestlé had been producing infant foods since before the turn of the century, (Van Esterik 1995:149), pharmaceutical companies introduced infant 'formulas' in the early 20th century. It was thought that the 'scientifically formulated' breast milk substitute made by pharmaceutical companies could only be prepared in the home using complicated ratios and, therefore, could only be correctly explained by physicians

(Greiner 1996). As these commercial formulas became more sophisticated in their composition and came 'ready made' by 1910, the products could be prepared according to the instructions on the labels. This was considered by physicians to be "physically unhealthy for the infant and economically harmful to the physician" (Greer and Apple 1991:284) as mothers no longer turned to physicians for instruction.

According to Ted Greiner (1996), a prominent breast feeding advocate and researcher, the pharmaceutical industry and medical professionals have had a symbiotic relationship since the late 19th century. Recognizing this profitable relationship, formula manufacturers soon recognized the value of physician cooperation and made attempt to re-establish the link between infant formula and professional advice. The manufacturers could use the research and diagnostic skills of the physicians to improve their product. In addition, physicians' perceived authority could be used to market formula more profitably through the medical establishment (Greiner 1996, see also Carter 1995:48). In order to obtain the American Medical Association Committee on Foods' "Seal of Approval" in 1932, formula manufacturers such as Abbott (Ross), Bristol-Myers (Mead-Johnson), and American Home Products (Wyeth) readily agreed not to market directly to the public since "every infant should be in the care of a physician who is skilled in the care and feeding of infants" (AMA as cited in Greiner 1996: electronic document, Greer and Apple 1991)^{33,34}. The 1930s also marks a steady increase of breast milk substitute

³³ Two food companies, Nestlé and Gerber, entered the infant formula (as opposed to infant food) market over fifty years after their more established counterparts. Greiner (1996, electronic document) notes that these two companies, lacking the marketing contacts with the health care sector, began to market their product through the mass media. Despite continued complaints from professional medical organizations, Nestlé and Gerber continue to advertise in the mass media.

promotion in part as a result of “Baby Boom” following World War Two³⁵ (Van Esterik 1995:149).

In this context, physicians have assured their authoritative position over infant foods while formula manufacturers had an effective and pervasive means of marketing their product. With advertisements in medical journals and with medical professionals prescribing these products, infant formula manufacturers began the practice of sponsoring scientific meetings and providing significant funding for medical research thereby further establishing the relationship between manufacturer and professional. Therefore, infant food manufacturers are not only constantly present in the medical professions but also have access to, and some degree of control over, infant feeding research (Greer and Apple 1991).

Physicians promote infant formula to their patients in different ways. Beyond direct prescriptions and recommendations of formula brands, Jelliffe argues that physicians “endorse by association” (as cited in Greiner 1996: electronic document). This endorsement is achieved when health care professionals use the promotional products given to them by infant formula manufacturers. As Greiner notes:

The pen in the shirt, the notebook in the hand, the growth chart, all may bear the name of the company that conveys a clear message to the mother, whether or not this is the health professional's intention. (Greiner 1996: electronic document)

³⁴ Although I could not locate similar information about the Canadian and Newfoundland context, it can be assumed that similar processes were occurring.

³⁵ Van Esterik (1995:149, among others) argues that when sales dropped off as the “Baby Boom” lessened, infant formula marketing campaigns were directed at foreign countries.

Breast feeding advocates attribute both the historical decline in breast feeding rates and the difficulties in promoting breast milk as the optimal infant food to the persistent message that infant formula must be “okay” if health care professionals tolerate its presence even in the form of new products:

... many parents simply cannot believe that their own doctor or hospital would take a neutral or even pro-formula stance if it posed such a threat to their babies’ health. (Granju 1998: electronic document)

While physicians have always recommended breast feeding, the presence of infant formula marketing in their profession amounts to contradictory messages.

Commercial formula manufacturers employ marketing strategies to promote their product and spend significant sums of money in the development and subsequent marketing of these new products³⁶. As Greiner points out, “effective promotion involves market segmentation and product positioning” (Greiner 1996: electronic document).

Using his examples, “You tell a mother that toothpaste stops cavities; you tell a teenager that it gives you fresh breath; and you tell smokers that it gets rid of yellow stains”

(ibid.). Breast milk substitutes are marketed to different segments of the population in much the same way. Further, as Greiner describes:

[Formula marketing] includes the use of mass media, billboards, and pamphlets and is complemented by other types of promotion such as baby contests, temporary price reductions, and point of purchase promotion (an attractive display, lots of shelf space devoted to it, and labels idealizing their product). (Greiner 1996: electronic document)

³⁶ For a more detailed overview of the how images are used and manipulated to market commodities see, for example, Ewen (1988).

While marketing *strategies* of infant formula have become more pervasive, one marketing *message* has remained very similar since the turn of the century – “Our product is new and improved and even closer to breastmilk than ever before” (Greiner 1996: electronic document). As products are constantly developed to address particular infant needs and over different developmental stages, formula manufacturers ensure that their products will be used to feed more babies for longer periods of time.

Beyond modifying existing products, infant formula manufacturers develop new infant formulas that are designed to treat what breast feeding advocates recognize as simply part of the infant feeding process. For example, Mead Johnson, one of the largest formula companies, markets one of its infant formulas as an “anti-regurgitation cure.” An article in a recent INFACT (Infant Feeding Action Coalition) Canada newsletter points out:

Regurgitation (or “simple reflux”) is present in about 40 percent of infants... Even this is made to be a “problem.” Mead Johnson has come up with the instant fix of AR formula clinched with the medicalized jargon of “anti-reflux” or “anti-regurgitation.” (INFACT Canada. 2000a)

Breast feeding advocates criticize the cycle of developing new products which are marketed using phrases such as “new”, “improved” and “better than ever” only to be replaced by another product “proven” to be even better.

The apparent symbiotic relationship between formula manufacturers and the medical profession is not without criticism. In a 1980 interview with the Wall Street Journal, the late Dr. Derrick Jelliffe characterized the history of formula production as “a succession of errors ... each stumble is dealt with and heralded as yet another

breakthrough, leading to further imbalances and then more modifications” (as cited in Brinson 1980: electronic document, and in Granju 1998; electronic document).

Increasingly, and after decades of attempts, researchers are finally acknowledging that breast milk will never be replicated in infant formula. With this recognition, infant formula manufacturers have modified their statements from the “superior to breastmilk” campaigns of the early 20th century to the “as close to breastmilk” phrases of the 1990s (Greiner 1996: electronic document).

But what effect do these infant formula marketing strategies have on infant feeding choices and practices? In one randomized study including over five hundred women in New York, Howard et al. (2000) compared the effects of exposure to two types of infant feeding guides on the mothers of newborn babies: materials produced by infant formula companies and materials without formula advertising. Both sets of materials promoted breast feeding as the optimal infant feeding method but the study was designed to assess whether they differentially impacted breast feeding initiation and duration. Although there was no significant effect on initiation and long-term duration breast feeding rates, there was an effect on the cessation rate at two weeks postpartum among the women who were exposed to formula promotion materials. Further, breast feeding duration rates were shortened among those women who did not plan to breast feed for any particular length of time.

As a result of the baby food industry's need for expanding markets³⁷, commercial infant formulas were introduced to developing nations after their initial marketing to regions such as Europe and North America. This introduction has created a potentially lethal situation. As researchers and activists such as anthropologist Penny Van Esterik (1995, 1988, 1989a,b, 1985), Naomi Baumslag and Dia L. Michels (1995) and others have illustrated, the aggressive marketing strategies implemented by commercial formula manufacturers focuses on women who may not have the resources necessary to use their products safely. This has resulted in initiatives introduced by the World Health Organization to encourage breast feeding and to enact legislation regulating the introduction of formulas both in developing countries and around the world (see also Ginsburg and Rapp 1991:325; Scheper-Hughes 1992:316-26; WHO 1981; among others). These initiatives mark a distinctive shift in infant feeding promotion, namely, the beginning of a national and international strategy to promote breast feeding.

Recognizing that aggressive strategies may influence breast feeding practices in a negative way, the formula industry is regulated the same way that the tobacco industry is in countries such as the U. S. A. and Canada – through limitations on what they can say, to whom, and in what contexts. Consumer advertising is one of the most familiar forms of marketing of infant formula and one that is frequently targeted by the World Health Organization, a topic I discuss next.

³⁷ For a more detailed overview of the formula industry's expansion into foreign markets, see Van Esterik 1989, 1995.

Campaigns to Promote Breast Feeding

There are a number of strategies used to promote the act of breast feeding among new mothers and the acceptance of breast feeding in society in general. On an international scale, in 1981 the World Health Organization issued an International Code of Marketing Breastmilk Substitutes as an instrument for human rights providing "governments with a very specific set of policies to benefit a particular target population; in this case pregnant women and new mothers" (INFACT Canada 1997b: electronic document). The Code is endorsed by Health Canada and implemented by the Breastfeeding Committee for Canada (BCC). Organized breast feeding advocacy groups such as INFACT (Infant Feeding Action Coalition) Canada and La Leche League have been established to promote breast feeding, to serve as sources for breast feeding support and information, to monitor the actions of infant formula companies, and to lobby government bodies to establish legislative sanctions that ensure a woman's right to breast feed. On the individual level, breast feeding is promoted through one-to-one encouragement and information provided by other mothers; the establishment of pro-breast feeding policy statements by professionals in hospital maternity wards; and popular articles and books which discuss the benefits of breast feeding (INFACT Canada 1997b: electronic document). I discuss these forms of breast feeding promotion in this section.

The World Health Organization and Infant Feeding:

In 1981, the World Health Assembly (WHA) adopted the WHO/UNICEF International Code of Marketing Breastmilk Substitutes, commonly known as "the Code"

(WHO/UNICEF 1981). The WHA, recognizing that the Code would need clarification and revision, adopted Resolutions having equal status every two years. The Code is an internationally adopted and endorsed public health recommendation designed to protect and promote breast feeding and to ensure that breast milk substitutes and supplies are appropriately marketed (IBFAN 2001b: electronic document). Further, the Innocenti Declaration (WHO 1990) was enacted in 1990 urging national governments to adopt and implement the recommendations described in the Code and its Resolutions by 1995.

The Code was drafted in response to the World Health Assembly's recognition that breast feeding is undermined on an international scale by the marketing strategies employed by the baby food industry¹⁸, and it therefore provides guidelines for the marketing and promotion of bottles, teats, and all breast milk substitutes, not just infant formula. As Van Esterik summarizes, the Code includes these provisions:

- No advertising of any of these products to the public.
- No free samples to mothers.
- No promotion of products in health care facilities, including the distribution of free or low-cost supplies.
- No company sales representatives to advise mothers.
- No gifts or personal samples to health workers.
- No words or pictures idealizing artificial feeding, or pictures of infants on labels of infant milk containers.
- Information to health workers should be scientific and factual.
- All information on artificial infant feeding, including that on labels, should explain the benefits of breastfeeding, and the costs and hazards associated with artificial feeding.
- Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.

¹⁸ Specifically, international breast feeding advocacy groups such as INFANT and IBFAN state that breast feeding is undermined by the use of: "promotion using free samples; inappropriate language; using 'humanitarian aid' to create products; labels which undermine breast feeding; promotion to mothers and pregnant women; and promotion to health professionals" (IBFAN 2001a: electronic document).

- Manufacturers and distributors should comply with the Code's provisions even if countries have not adopted laws or other measures. (Van Esterik 1995:155-56)

Although these recommendations are not binding, they “carry moral or political weight, as they constitute the judgment on a health issue of the collective membership of the highest international body in the field of health” (Shubber 1985 as cited in IBFAN 2001b: electronic document). Further, countries are expected to implement the Code and its Resolutions as one measure for governments to fulfill their obligations under the Convention of the Rights of the Child³⁹ (IBFAN 2001b: electronic document). Although Health Canada endorses and provides the means to implement the Code, legislative acts to implement and enforce the Code have not been established nor are there penalties for violations (INFACT Canada 1997b).

The Baby Friendly Hospital Initiative in Canada:

With the birth of a baby, the hospital maternity ward becomes the first place where infant feeding practices are put into practice. To encourage the initiation of breast feeding during this influential time, the Code contains recommended guidelines for policies that should be implemented by health professionals in health care institutions. I highlight the Baby Friendly Hospital Initiative in this section to illustrate how the Code is specifically being implemented, and with a certain degree of success, in Canada and in Newfoundland.

³⁹ The UN General Assembly adopted the Convention of the Rights of the Child (CRC) in 1989. The CRC was ratified by Canada and was signed but not ratified by the U.S.A..

As the appointed National Authority of the Baby Friendly Initiative by Health Canada, the Breastfeeding Committee for Canada created an action plan to implement the WHO/UNICEF Baby-Friendly™ Hospital Initiative (BFHI), known in Canada as the "Baby-Friendly Initiative (BFI)"⁴⁰, in November 1997. According to a statement released by the BCC, the BFHI "is a primary strategy for the protection, promotion and support of breastfeeding" (BCC 2001, electronic document)

The goal of the Baby Friendly Initiative is to establish a breast feeding-friendly environment in Canadian maternity wards. This environment includes, among other practices recommended by the World Health Organization: the presence of health care professionals providing effective and useful breast feeding assistance; extensive mother and child contact while in the hospital; the elimination of the presence of commercial infant formula including items bearing formula logos and formula samples distributed to mothers when discharged⁴¹.

In order to assess the status of breast feeding activities and to determine future needs, a survey on routine maternity care and practices in Canadian hospitals was completed in 1994. In this survey, Levitt et al. (1995:75) found that 57% of hospitals in Newfoundland have a policy concerning sample packs written according to the

⁴⁰ The Breastfeeding Committee for Canada altered the name of the initiative to "reflect the continuum of care for breastfeeding babies outside the hospital environment" (BCC 2001: electronic document).

⁴¹ The distribution of sample packages to mothers when leaving the hospital is a common practice used by manufacturers to promote their products. These packages contain, among other items such as disposable diapers and diaper creams, free samples of formula. It has been suggested that this practice has a negative impact on breast feeding rates, especially among first time mothers (Levitt et al. 1995:72). Matthews et al. (1994:48) report that most mothers who choose to formula feed and mothers who switched to formula from breast feeding, choose to use the brand of formula introduced in the hospital or given as a free sample.

recommendations made by WHO/UNICEF. As well, 86% of Newfoundland hospitals never give sample formulas to mothers compared to the national average of 58%. The results presented by Levitt et al. (1995) suggest that Newfoundland hospitals follow the guidelines set by WHO/UNICEF more closely than other Canadian provinces. Despite these measures, however, the province of Newfoundland continues to have the lowest breast feeding rates in Canada.

Early Canadian Initiatives:

As discussed in the previous chapter, since 1978 health organizations such as the World Health Organization and Health Canada have made the promotion of breast feeding a primary goal (CICH 1996:5). According to Myers (1988:101-110), general concerns over low incidences of breast feeding in the early 1970s led to the creation of the Canadian "National Task Force to Promote Breast feeding" in 1978. This task force was responsible for developing the following by 1979: the implementation of a national awareness programme aimed at health professionals; the initial development of a national breast feeding policy; and the organization of strategies and projects to complement these initiatives. Health professionals were targeted in these programmes because of their perceived roles as providers of critical information, motivation, and support⁴².

⁴² Some research, however, suggests that the decision to breast or formula feed exclusively is often made during, if not prior to pregnancy (Hudson 1986, Mackey and Fried 1981, Matthews et. al. 1994, Olsson 1988, Sage Research Corporation 1995, among others). As well, Matthews et al. (1994) found that a woman will make infant feeding choices according to her own feelings towards breast feeding first, then those of her partner, and with the influence of her friends and/or her mother third (Matthews et. al. 1994:81). Therefore, while physicians and health care professionals may play an active role in providing information to mothers before and after birth, Matthews et al. (1994:42) suggest that this information may not always influence a mother's decision over whether or not to breast feed.

Beginning with “a strong, authoritative position paper from within the medical profession” (ibid.:101), it was hoped that the importance of breast feeding, would cascade top-down through the medical system. This strategy was designed to have its greatest impact in the short-term while setting the trend for long-term and widespread attitudinal changes towards breast feeding. Taking from Myers, strategies in this initiative included:

- 1) Improving the quality, timing, and targeting information and educational resources about breast feeding, both to health-care professionals and the public.
- 2) Stimulating professional support for breastfeeding within the healthcare system.
- 3) Formation of national alliances from government, professional, and voluntary sectors to provide a national emphasis on breast feeding.
- 4) Supporting mothers’ groups and citizen coalitions whose aim is to promote breast feeding.
- 5) Developing a national advocacy position leading to a national policy position on breast feeding.
- 6) Monitoring breast feeding patterns in Canada as well as policies and practices influencing them. (Myers 1988:102)

The promotion of breast feeding through health care professionals has been successful to some degree. When I asked one mother who breast fed her four children who had influenced her ideas about infant feeding, she replied:

It wasn’t my mother or my mother-in-law or my friends who told me, just two wonderful women who were there for me in the hospital. I think I was really lucky to have them there.

In many of my conversations, I heard stories of wonderful and supportive nurses and lactation consultants who helped mothers establish and maintain breast feeding in the hospital, in clinics, and, in some instances, in the home. Some breast feeding mothers described incidences in which physicians were the sources of negative breast feeding advice. Sarah, a paediatric nurse whose baby was born with a terminal medical

condition, knew the immunological and psychological benefits of breast feeding her sick child. She told me how one physician told her to stop breast feeding and “give the baby something decent to eat.”

As described elsewhere in this thesis, pro-breast feeding messages have historically been conveyed through medical professionals. However, as the above examples show, breast feeding support is more likely to be given by nurses and lactation consultants than the medical physicians from whom breast feeding messages were supposed to “filter down.”

Breast Feeding Promotion Activities in Newfoundland:

The Breastfeeding Coalition of Newfoundland and Labrador (BCNL), supported by the Provincial Perinatal Program and the Department of Health and Community Services, was established in 1991 to “promote, protect, and support breastfeeding” (BCNL 1999: electronic document)⁴³. The Coalition recommends actions based on WHO, Health Canada and other prominent breast feeding advocacy groups’ guidelines in order to “establish breastfeeding as the cultural norm” (ibid.).

The La Leche League is a breast feeding advocacy and support group that endorses “good mothering through breast feeding” and has been “empowering mothers to

⁴³ The Breastfeeding Committee for Canada was established in 1991 as a Health Canada initiative following the World Summit for Children. The BCC has a broad membership including representatives from various health care professions, breast feeding advocacy groups such as La Leche League, Government bodies, and individual breast feeding experts. Information on the Breastfeeding Committee for Canada is taken from their web-site: <http://www.geocities.com/HotSprings/Falls/1136/>, last accessed on March 5, 2001.

breastfeed” since the 1970s⁴⁴. Given their prominence in federal breast feeding promotion campaigns, I was surprised that the La Leche League was not frequently mentioned during fieldwork. The activities of La Leche League are frequently referenced and researched in infant feeding literature but only a handful of mothers, usually the mothers who were active in the breast feeding movement, mentioned their influence to me during my fieldwork in St. John’s. Mothers did, however, acknowledge the Healthy Baby Clubs (HBC) as sources of breast feeding and child care support.

The Healthy Baby Clubs were originally established in 1994 through federal funds to target “high-risk” mothers⁴⁵. “High risk” pregnant women (defined by standards such as age, income, and access to services), thought to pose a high risk to the health of their infants, are provided with dietary supplements such as milk and oranges, and are offered pre-natal classes, nutrition counselling and a place to discuss parenting strategies including basic childcare and coping skills. Breast feeding is actively promoted in the HBC and regular breast feeding support group meetings are organized. As one mother in St. John’s describes:

The Healthy Baby Club was really very good because all of my family was really against it [breast feeding]. My family was like, “Oh, you’re not going to be able to do that,” “That’s gross,” “You can only do it for so long” and stuff like that. They [HBC] were really good because they let me know if I needed help that I could phone them or whatever. ... I ended up keeping it up because of really good support.

⁴⁴ Examples of La Leche League statements found on many of their promotional, educational, and electronic materials.

⁴⁵ The HBC model was expanded to the St. John’s region in April, 1995. In 1999, there were nine Healthy Baby Clubs throughout Newfoundland and Labrador.

'Good mothers' as defined by the discourses in the Healthy Baby Clubs are concerned with their child's nutrition from pregnancy until early adulthood, but especially during the first few years of life for these are the years in which the future development of the child is determined (BCC 1999; among sources). Breast feeding is promoted as one way of ensuring optimum infant development and a healthy child and adult.

What is interesting about the Healthy Baby Clubs in St. John's and elsewhere in the province of Newfoundland and Labrador is that, although they were designed to target 'high risk' mothers, mothers from a variety of socio-economic positions, including those who may not be considered "high risk", voluntarily attend these clinics. During my interviews with them, a few such mothers said they attend the clinics for the opportunity to communicate with other mothers, to seek advice, and to have their babies weighed⁴⁶.

The Healthy Baby Clubs were the most frequently mentioned sources of infant feeding promotion during my research with mothers in St. John's. The communal aspect of these groups may be credited with successful breast feeding practices as women "learn how to mother" (Merrill 1987). For example, in Gander Bay, a rural community in Newfoundland, breast feeding rates increased from 4% to 67%, a percentage attributed to the establishment of a Healthy Baby Club in the area (INFACT Canada 1997a). As the

⁴⁶ Women described in research based in Newfoundland find support and understanding, a source to disseminate and receive information, and even basic lay medical care through their informal networks of production and friendship orientated female networks (Benoit 1990: 173; Davis 1985: 8). Women often 'band' together, creating a significant force of power in some social arenas (a point illustrated by Benoit 1990; Davis 1988; George 1995; and Porter 1993).

Breastfeeding Coordinator of the St. John's Healthy Baby Club, Janet Murphy Goodridge states:

Several women who have made the decision to bottle feed at the outset have changed their mind throughout their participation in the HBC. The emphasis is not on overwhelming the women with breastfeeding information, but on helping them to identify and work through the many perceived barriers to breastfeeding in their communities. (INFACT Canada 1997a)

Unfortunately, as Van Esterik (1996:79) points out, promotion campaigns run the danger of becoming too prescriptive by providing rules and techniques from authority figures, losing sight of the goal of empowering women to breast feed.

Promoting a Breast Feeding Image

In an attempt to change the cultural perception of breast feeding, Health Canada's 1992 breast feeding promotion initiative included a series of posters (1994-1996) and transit boards (1994) designed to promote the acceptance of breast feeding in public areas such as parks, malls, and restaurants. The transit boards are currently displayed in almost every city bus in St. John's. The transit board is made up of an image of a mother breast feeding her child sitting with a group of women and printed messages such as "Anytime, anywhere," "A normal part of life," and "The natural thing to do." These themes are prevalent in other forms of promotional media including those produced by La Leche League and INFACT Canada.

The promotional video Breastfeeding: Go With the Flow, (BCNL 1997) sponsored by the Breastfeeding Coalition of Newfoundland and Labrador and with funding from Health Canada, was created using stories and images of young breast feeding families living

in rural Newfoundland. This video was produced in the hopes that viewers would see how breast feeding is experienced and, perhaps more importantly, that breast feeding does not have to involve displaying one's breast.

At a public breast feeding forum held in St. John in October 1999⁴⁷, a resource mother from a Healthy Baby Club in rural Newfoundland described how breast feeding is promoted to future generations of parents. These promotional efforts include children's books with breast feeding images (rather than bottles) supplied to libraries and parents, Grade 9 classes being visited by breast feeding mothers "to show them what breast feeding really looks like," and young adults being provided with opportunities for discussion.

As part of a larger study on the effect of a promotion campaign on adolescent breast feeding attitudes (Friel et al. 1989), and for her Bachelor of Science (Dietetics) Dissertation, Nancy Hudson (1986) examined teenagers' attitudes towards breast feeding before and after a public breast feeding campaign in St. John's. This campaign ran for five weeks and included a television commercial and advertisements in local newspapers. Friel et al. (1989) and Hudson (1986) report that the television commercial was the more influential of the two media in positively affecting female adolescents' attitudes towards breast feeding⁴⁸. The authors attribute the frequent sight of breast feeding as making females more comfortable and less embarrassed by the thought of breast feeding. What is

⁴⁷ "Promoting a Breastfeeding Culture: Building Community Support." Public Forum presented by the Health Care Corporation of St. John's on October 15, 1999.

⁴⁸ Recognizing that women's attitudes towards infant feeding practices are formed early into, if not prior to, pregnancy, the researchers only sample females in their study (Friel et al. 1989). Unfortunately, infant feeding attitudes of adolescent males were not measured even though they would have also seen the advertisements and would have a future influence on their partners' infant feeding decisions (as Matthews et al. 1994 argue).

important to consider in these specific campaigns is the promotion of a breast feeding *image* rather than a breast feeding *message* to mothers.

Images in the popular media, such as those found in magazines, on television, and advertisements, can be viewed as both reflecting and reinforcing prevalent infant feeding norms. In these images, infants are usually seen with a bottle. Both myself, and the parents I spoke with, frequently saw television shows and commercials where, if a baby was shown, that baby was usually shown with a bottle even if infant feeding had nothing to do with the scene, advertisement, or television show. Bottles, therefore, have come to represent infancy. 'Baby = bottle' representations are one aspect of the "formula feeding" culture that breast feeding advocates aggressively target, many of whom pointed out to me the number of letters protesting these images, waiting to be signed and sent off to editors, publishers, television executives, and government representatives.

It appears that when images of mothers breast feeding are shown, or positive breast feeding messages are spoken, they are done so purposefully, with thought, and are usually intended to specifically promote breast feeding. Some television characters talk of breast feeding even though they never show the actual practice. For example, on a recent episode of "ER", a popular American television series situated in the emergency room of a large hospital, one of the characters who is a nurse brought her twins into work. An actor playing one of her colleagues remarked, "They look so happy," and the nurse character replied, "They're always happy after they nurse." Positive breast feeding messages such as these are, however, infrequent.

While many advocates see the effectiveness of positive breast feeding images, visually-based promotions may have an unintended effect on women's infant feeding choices. The issue of the appropriateness of explicit images of breast feeding in promotional posters, specifically those distributed by INFACT, was raised at a recent public forum in St. John's⁴⁹. These posters show bare breasts and infants breast feeding with captions such as "Will work for food" and "For a healthy baby please see attached." In an attempt to promote breast feeding as a cultural norm, many other breast feeding advocacy groups, such as the Baby Milk Action Group and the International Baby Food Action Network (IBFAN), use similar images in their posters, books, and magazines.

There exists an idea that frequently seeing breasts used for breast feeding will make women more comfortable with their own possible exposure during breast feeding. According to lactation consultants and health workers, however, some women in Newfoundland are offended by the sight of exposed breasts and are reluctant to breast feed because of these images. A lactation consultant working in rural Newfoundland told forum participants that she feels that she must tell mothers that the images of breast feeding found in these materials do not represent what breast feeding needs to look like. In counselling women, she emphasizes that there are discreet ways to breast feed so that one's breasts are not so openly exposed.

⁴⁹ "Promoting a Breastfeeding Culture: Building Community Support." Public Forum presented by the Health Care Corporation of St. John's on October 15, 1999.

Breast Feeding Promotion in Everyday Encounters

This chapter has been focused on an overview of formal breast feeding promotion campaigns. Recognizing the pervasiveness of these, I also ask how breast feeding is promoted in everyday encounters. What might these everyday encounters mean in terms of conceptions of 'good' mothers and their decision making practices?:

I was at the mall the other day and a woman was standing there and it was obvious she was breast feeding. I patted her on the back and I said, "I think it's wonderful what you're doing." She said, "That was so nice of you to say that when you were not forced to say it." I replied, "To me this is the ultimate. This is not a convenience. This is not a formula. This [pointing to her breast] is the convenience right here." (Faye)

If you're more public, to me, you'll influence more people. ... Around here [her neighbourhood], there are not many breast feeders but a couple of them have come around. My neighbour didn't breast feed her first one but she's breast feeding this time and I had another friend who said to me, "If it hadn't been for you at the other end of the phone I would never have breast fed for so long." (Emily)

I think they [the in-laws] were shocked that I did it [breast feed] for so long and that I enjoyed it. ... You almost change their ideas as well. I think so because they had never been around it. I think maybe there's been more awareness of it, knowing how important it is for the baby therefore they support it. (Ellen)

As I have discussed previously, decisions about infant feeding are influenced by a myriad of cultural, social, political, and economic factors. Infant feeding choices are subject to, among other things, the variable impact of the explicit promotion of breast feeding in various contexts and the existence of what is viewed by some breast feeding advocates as a 'formula feeding culture'. Further, as Julia Grant articulates:

Mothers often have a degree of private power but very little public power. Thus their ability to affect the dominant discourse has been minimal, yet women's communal network, conversations, and experiences with children have had an impact on mothers' thinking and practices that is for the most part undocumented in the mass media or in the historical literature. (Grant 1998:11)

Further, many Newfoundland women's identities are presented as essentially tied to the home and the family⁵⁰. Women's kin networks provide not only sources of support, but also play a role in defining and evaluating what a woman should or should not do.

Women can enhance their own power or authority outside of their home and family realms if and when they meet the cultural ideals defined and reinforced in kin networks. Within this environment, advocates of breast feeding play a key role in influencing ideas about infant feeding through their formal and informal breast feeding promotion activities.

Emily describes herself as a member of the 0.3% of women who are not statistically supposed to be breast feeding. In other words, she is unmarried, gave birth at 19, and comes from a low socio-economic position. I have introduced Emily many times in this thesis as she not only chose to breast feed but also identifies herself as a 'militant' breast feeder. During our conversation, Emily had a very clear idea about how breast feeding should be promoted in Newfoundland. She described the reactions to her breast feeding that she heard from friends and family and tells me:

But now I just get to the point when they say, "Eugh, gross breast feeding," I say "Eugh, gross bottle feeding," right. I turn it right

⁵⁰ Researchers such as Cecelia Benoit (1990, 1995), Linda Cullum (1995), Dona Davis (1988, 1995, 1997), Glynnis George (1995, 2000), and Marilyn Porter (1993, 1995) serve as important contributors to understandings of what it may mean to be a woman in Newfoundland.

around because I'm just so tired of it. And I know in Newfoundland, they want us to be like, ease it [breast feeding promotion] in, just come on in through the back door. I think we should come in through the front door, guns blazing. People say you can't stuff it down their throat and I say, "Why not? They're stuffing it down ours." It's forced on us to bottle feed, and yet they [some breast feeding advocates] want to sneak in the back door and be really quiet about it. And I say, "No, you got to go in the front door with all of your guns blazing."

Emily feels as though formula feeding is "stuffed down our throats," and her solution is to actively and relentlessly advocate breast feeding to everyone. While not every breast feeding advocate would agree with her, breast feeding advocates like Emily argue that aggressive infant formula strategies should be met with equally aggressive breast feeding promotion strategies.

Breast feeding activists, like Emily, seem to agree with Baumsdag and Michels that, even if formula manufacturers do not directly endorse all formula feeding messages, implicit or explicit, "there doesn't need to be a finger pointing at formula makers every time because *their influence is everywhere*" (Baumsdag and Michels 1995:171, emphasis added). Beyond anti-formula activities, militants make it a habit to commend women they see breast feeding in public, to participate in various public forums and to readily volunteer in various ways to help other mothers establish and maintain breast feeding. As one mother said to me, "I would leave my children to go and help another woman breast feed." In a very real sense, these women are not only advocates, but are also *activists* who promote the pro-breast feeding message in their everyday interactions.

'Militants' are extremely offended by the sight of commercial formula being used to feed babies in magazines, on television, in advertising, and in other public images.

Ofentimes, these women argue with store managers to remove formula promotion materials from their shelves⁵¹. Many 'militants' I met showed me a stack of letters they were in the process of writing to either condemn formula messages or, less frequently, to commend a positive breast feeding message.

One Newfoundland daily newspaper, The Telegram, publishes an annual "Newcomers" supplement, reprinting all of the birth announcements from the previous year. The 1999 version of the supplement⁵² was published with images of bottles as a border and anonymously authored write ups that could be interpreted as suggesting formula as an alternative to breast feeding. When this edition was distributed, three of the self identified 'militants' I spoke with wrote to the newspaper's editor noting that The Telegram was in violation of the WHO Code and that they were offended by the presentation.

During the same time period, a television advertisement for the "Canadian Legal Will Kit," was being aired that portrays a young couple presenting arguments for planning their own will. At the end of the commercial, the man, holding a small infant states, "I feel better knowing my future is planned for," and puts a bottle into the infant's mouth. I spoke with four different mothers who were outraged at the commercial and its clear violation of WHO codes. All of the mothers had either written or called the toll free number to express their concern and disapproval of the commercial. One mother went so

⁵¹ INFACT. 2000b. "Similac displays get the boot in St. John's." INFACT Canada Newsletter, Summer/Fall 2000.

⁵² The Telegram (2000), "Newcomers: Babies Born in 1999." The Telegram/The Weekly Extra, January 30: supplement.

far as to call the toll free number and tell the telephone operator that, "You might as well write that baby a will if you feed it that poison [formula]." The 'bottle feeding ending' had been cut when I saw the advertisement on television a few weeks later and I assume that these St. John's militants may not have been the only ones to call or write.

Beyond addressing public images presented in various forms of popular media, breast feeding 'militants' do not hesitate to approach women in their daily encounters. Emily's account of an encounter she had with a stranger in a department store in St. John's illustrates her breast feeding militancy. Emily was standing beside another woman who appeared to be shopping for pablum. The other woman was trying to decide between different types of baby cereal. She told Emily that she wanted something "good" for her baby's first cereal. Emily told me that, as they talked casually, the other woman said, "I wanted this stuff because my friends said it's really good, it's really expensive but it's supposed to be really, really good." Recognizing the mother's desire to feed her child the 'best,' Emily asked, "You must be breast feeding, are you?" to which the other mother said, "Oh no, I'd never do that." Emily admonished, "You'll pay \$2 more for a box of cereal that's supposed to be really good but you won't breast feed. That just blows my mind." She then abruptly turned around and walked away from the other woman.

Similarly, referring to class differences, marital status, and Newfoundland identity in one breath, Faye told me:

If I saw women who weren't breast feeding I could be very judgmental. I didn't care what their status was there was just no excuse. I mean here we are the poorest province in Canada and I

knew these women were single mothers but yet they were going out to buy formula and I just couldn't believe it.

These two 'militant' breast feeding mothers, who both live in St. John's, view the promotion of breast feeding in very similar ways.

Incidents of the informal promotion of breast feeding in everyday encounters are numerous and are not specific to St. John's or any particular region. For example, as I scanned through television channels one day, a British documentary on women and their reproductive lives quickly caught my attention. Women representing a wide range of backgrounds and age groups were talking about their experiences of menstruation, pregnancy, childbirth, and childrearing. During a presentation of vignettes of women's infant caregiving experiences, one mother recounted how her decision to formula feed was met with less than an enthusiastic response. She said, "I might as well have said that I'm going to throw my baby out of a twenty-storey building." We could ask the question, as John Hoffman does:

We've worked so hard to make breastfeeding the norm that we seem to have created a social underclass of mothers who bottle-feed. Have we gone too far in our efforts to promote breastfeeding?

There's a tricky question of balance here. It's not wrong to give women information about the well-documented benefits of breastfeeding. But it's easy to tell somebody to do something. What's hard is helping people to do it. (Hoffman 2001:57)

In promoting breast feeding as the optimum infant feeding method and as an indicator of good parenting, how are other aspects of being a mother and a woman addressed?

The Creation of a Pro-Breast Feeding Environment

The efforts of advocates have been successful on many levels. Beyond the slight increase in initiation and duration rates, the “breast is best” message is getting through. In this research, *all* of the people I spoke with, breast and formula feeders alike, acknowledged not only that breast milk is the best but also the reasons why it is the best.

Advocates argue that women must make infant feeding decisions in a pro-formula feeding – hostile breast feeding culture. In the Innocenti Declaration of 1990, the WHO itself recognizes that:

Attainment of this goal requires, in many countries, the reinforcement of a “*breastfeeding culture*” and its vigorous defense against incursions of a “*bottle-feeding culture*”. This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life. (WHO 1990, emphasis in original)

To combat the formula feeding culture, federal and provincial funds are allocated for research that addresses low breast feeding rates and which offers possible strategies to get more women to breast feed for longer periods of time as well as funding for promotional advertisements in the mass media. Recently the World Health Organization has extended the recommended length of exclusive breast feeding to six months (from four). The resulting increased breast feeding duration combined with more countries adopting and reinforcing the WHO recommendations for the marketing of breast milk substitutes, may translate into millions of dollars in lost revenue for formula manufacturers⁵³. In contrast, and in view of the current emphasis on preventative health measures, Judith Galtry

⁵³ “Feed only breastmilk for first 6 months, UN says.” André Picard. The Globe and Mail, May 24, 2001.

(1997:5-6) argues that breast feeding not only reduces health care costs but that these savings extend to all socio-economic levels⁵⁴ (see also Ball and Wright 1999). As Marilyn Waring contends, “an inadequately fed infant is a cost to the health system ..., to the education system (because of brain development), and to society generally” (Waring 1988:207 as cited in Galtry 1997:6).

A concern over the health of infants and in effect, over the health of the population, have resulted in international, national, and local campaigns to promote breast feeding as the optimum infant feeding method. Among those I spoke with and in much of the popular literature, breast feeding is acknowledged as the optimal feeding method and formula thought to be a close second (a conception which breast feeding advocates are attempting to change as well). Breast feeding promotion and advocacy is actively encouraged and financially supported by the Government of Canada and its provincial governments while formula marketing campaigns are regulated by international codes. Further, parents who ‘choose’ to formula feed do so in an environment in which their decision will undoubtedly be scrutinized.

In other words, and contrary to what the advocates describe, I argue that rather than a formula feeding environment, infant feeding decisions are made in a pro-breast feeding – hostile formula feeding environment. In this situation, infant feeding decisions,

⁵⁴ The U. S. Department of Health and Human Services (2000:11) estimates that the total medical care expenditures were 20% lower for fully breast fed infants than for never breast fed infants. The Department also suggests that because breast fed infants are sick less often, maternal absenteeism from work is lower, overall medical costs are lower, and employee productivity is higher in companies with “lactation programs” (ibid.).

regardless of method, are always contested, frequently a site of resistance, and seldom ignored. Seen in this light, the creation and experience of a “big deal” seems inevitable.

The ‘big deal’ is that infant feeding decisions, while being private, remain a public concern situated and contested in public domains. As Pam Carter emphasizes, “even their [women’s] place in the private sphere is problematic in that they have to negotiate with others what they do there”⁵⁵ (Carter 1995:190). She continues:

I have suggested that although infant feeding is deemed as ‘private’ in the sense of an unpaid domestic responsibility, it nevertheless remains a public issue. Infant feeding practices disrupt the whole notion of separate public and private domains. (Carter 1995:190)

Further, and as Jules Law (2000) and other feminists (see also Blum 1995:260) ask, what are we really promoting when we promote breast feeding?

As we will see in the next chapter, women themselves assess the risks and benefits involved in their choice of infant feeding methods. As Guttman and Zimmerman’s research among low-income mothers illustrates:

Regardless of their feeding method, mothers tended to attribute higher health benefits of breastfeeding and perceived community norms as pro-breast feeding. They differed in their rating and perception of logistics and the extent to which benefits mattered in their infant feeding decision. (Guttman and Zimmerman 2000:1457)

While every one of the women I spoke with acknowledged the benefits of breast milk and breast feeding, not all women breast fed nor did all of the mothers who breast fed do so

⁵⁵ Based on her research in Stephenville, Newfoundland in the early 1990s, Glynnis George (1995: 320) argues that women feel that home is their social space of autonomy and control. At the same time, ‘home’, or the family, is “rarely an exclusively private domain; nor do women have the privacy of personal choice. Rather, they are constrained by the social pressures and cultural norms that bridge the domains of family and community” (ibid.).

according to Health Canada's recommendations. The fact that many women in St. John's and in Newfoundland do not follow all of the recommendations suggests that other priorities may be involved when making infant feeding decisions.

Chapter Summary

According to one report on women's health submitted to Health Canada (Walters, Lenton, and McKeary 1995:24), health promotion is focused on the individual and her decisions rather than on the social constraints on the individual. Although specifically referring to smoking habits, alcohol, and weight concerns of Canadian women, the authors do acknowledge the constraining social pressures that influence choices. One can see connections here to women's infant feeding decisions:

... It is important to see how women's lifestyles represent something more than individual choice, ignorance or neglect. Their lives are shaped and constrained by the broader culture, the economic interest of companies in promoting unhealthy lifestyles and the challenges of their roles as wives and mothers. (Walters, Lenton, and McKeary 1995:31)

Over the past few decades, government funds were allocated for researching healthy infant feeding practices and developing effective promotional techniques in an attempt to "pin down the recalcitrant mothers who still have not heard the message," an idea that I described in the previous chapter. As the stories of Ellen, Carol, Steve and other parents reveal, I argue that Newfoundland mothers (and fathers and grandparents, and peers) have heard the 'breast is best' message, and have heard it over and over again, but that for a variety of reasons many women do not make the decision to breast feed.

Have promotions been successful? Perhaps. There is no question that they have had an impact on infant feeding choices and no denying that breast feeding initiation rates have increased. But it is important to remember that infant feeding choices are part of larger social contexts. A mother will not choose to breast or formula feed simply because she is told to do so. To suggest such is to seriously undermine the agency of women. Indeed, as we will see in the following chapters, the decision to breast feed is contingent on a multitude of sometimes conflicting social, economic, psychological and physiological considerations.

Chapter Four

Infant Feeding and Good Parenting in St. John's

Ideas about infant feeding practices have developed over time and are influenced by larger social concerns about the health of infants and, moreover, about the health of the 'state.' Having the main biological burden as reproducers of new life, women as mothers are the targets of state driven health promotions. In this chapter, I explore how the larger pro-breast feeding, anti-formula feeding social environment is experienced at the individual level. In doing so, I argue as Pamela Carter does, that "a concern with infant feeding is also a concern with the behaviour of women" (1995:7).

Research on women in Newfoundland suggests that women's social identities are "tied – socially, morally, and economically – to a household, a family, and in some cases, a community" (George 1995:317). In turn, ideas of 'womanly behaviour' are formed and evaluated by the community's ideals of family, church, gender, and their 'culture' (ibid.:318). While extensive women's networks may provide avenues of support, they also serve to establish and reinforce standards for 'appropriate womanly' behaviour. Based on her research in Stephenville, Newfoundland in the early 1990s, Glynis George (1995:320) argues that women today feel that home is their social space of autonomy and control. At the same time, 'home' or the family is "rarely an exclusively private domain; nor do women have the privacy of personal choice. Rather, they are constrained by the social pressures and cultural norms that bridge the domains of family and community" (George 1995:320).

It can be argued that there exists a dialectic between cultural and social standards of behaviour and individuals' personal experiences. Similar to other anthropologists (see especially Lock 1994), Dona Davis draws on her rich fieldwork material from the Newfoundland context to argue that, even though all women experience menopause, the biological process cannot be explained without examining the cultural and social circumstances that influence experience (Davis 1988). Davis (1988) argues that biological processes are influenced by lived experience, the dynamics of daily interactions, conceptions of the body formed by observations of the behaviours of other women, oral transmissions of shared experience, women's intimate long term knowledge of each other, and folk idioms. In contrasting what she found in her initial research in the 1970s to her follow-up research in the 1980s, Davis (1988, 1997) also demonstrates that a widespread medical knowledge about menopause had a significant influence on women's changing ideas about their bodies and in the ways they communicated these ideas. Instead of continuing to use the folk idioms of "blood and nerves" to describe biological processes, biomedical models had been adopted to explain life processes.

As with other biological processes such as pregnancy and menopause, wider social contexts influence individual women's infant feeding experiences. An examination of examples drawn from particular individuals' experiences demonstrates both the impact of these contexts and the impact of broader social processes on infant feeding decisions. Moreover, an examination of infant feeding practices reveal how these decisions are experienced differently by individuals depending on the myriad of other aspects of their daily lives.

I begin this chapter with the story of Faye to illustrate one woman's infant feeding experience within the pro-breast feeding social environment of St. John's. I contrast some mothers' determination to breast feed with the experiences of mothers who do not accomplish their breast feeding goals. Women are subject to social expectations and evaluations of their behaviour as women and mothers. I argue, then, that within the context of social evaluations of "good" mothering and womanhood, the sexualization of the breast is one inhibitor to the establishment of breast feeding as women as mothers attempt to fulfill often conflicting social expectations. I draw on examples of the use of evaporated milk formulas in Newfoundland to further illustrate the connections between evaluations of "good" mothering and parenting through infant feeding practices. Finally, I argue that within the context of infant feeding in Newfoundland, fathers are exploring how they "fit" into their infants' lives and how they can be "good fathers" in an environment that focuses infant care mainly on the actions of mothers.

Faye

In our conversations over coffee cups during her few moments away from her children, Faye, a married mother with three young children, shared with me the story of her infant feeding experiences. Her story is so remarkable that she has been interviewed and her experiences published numerous times by infant feeding researchers and breast feeding advocates:

She [the lactation consultant] told me that she doesn't know anyone who would do this [breast feed with difficulties] for the length of time I did. I get emotional when I think about it because I would do it again tomorrow.

In our meetings, Faye tells me about her determination to breast feed, reflecting the strong pro-breast feeding messages I recognized from promotion campaigns. She also tells me about the challenges of being a 'good' mother and a 'good' partner. Faye shares her emotional story comfortably, as though I have known her for a long time and as if she has told it many times before. She easily recounts her determination to breast feed, her difficult experiences, and her resolve to promote breast feeding to others.

Faye knew very early that she would breast feed her children. As a young woman, she experienced severe back pain attributed to her large breast size. She consulted medical professionals and when weight loss did not alleviate her symptoms she considered her physician's recommendation of a surgical breast reduction. She tells me:

I remember one of my first concerns about this breast reduction. I didn't care about the scarring, it didn't bother me, my bigger concern was, "Would I be able to breast feed?" ... I was a woman pursuing her career and a family was way down the road for me but all I could think about was, "Would I be able to breast feed?"

Assured by the surgeon that the type of surgery she chose would still allow her to breast feed future children, Faye scheduled the surgery.

A few years later, Faye was a newlywed and pursuing a career when she happily discovered she was pregnant. Even though she was not breast fed herself, Faye was convinced that she would breast feed and "didn't really give much thought to the breast surgery because they told me it wasn't going to be a problem." She gave birth to a healthy baby boy and began breast feeding immediately:

The thought of a baby on my breast made me the happiest. There's nothing like it in the world and it was all I wanted. ... When he

came out, I mean he was two seconds old, and he was put right on the breast and sucked like there was no tomorrow.

Faye waited in the hospital for her milk to 'come in' but after a few days the baby still did not seem satisfied after his feedings. Faye used a breast pump to see how much milk she was producing. After an hour of pumping she only produced less than two ounces of milk. Faye was worried and depressed and was convinced that the breast surgery was the cause of her reduced milk supply. Before she left the hospital, the nurses told her to relax and not to worry -- that she was a committed passionate mother whose milk would come in shortly. Faye's milk supply was still low after a few months. She describes:

Well, we knew he was getting some milk because he had dirty diapers but not as frequently as he should have been. ... He wasn't a fussy baby, he was happy although he wasn't gaining like he should.

I'll never forget going to the GP [General Practitioner] and weighing him and she said to me, "You know he's not thriving" and when she said that to me, oh, I mean I read and I knew what thriving meant, and I broke down in tears in her office. She said to me, "You have to come to the realization that this is not working, you are not able to supply him with enough milk, you have to start bottle feeding him. There are lots of options but it's an option you have to seriously consider."

I remember running to the drug store and spending sixty dollars on six types of formulas and four types of nipples because I didn't know which one would please him. I was so upset. I called my husband at work, he came home, and I said, "I can't." He was there mixing the formula while I was saying, "I can't do it. I don't want to do it. I don't want anything to do with formula."

Four days later I was feeling terribly guilty because my baby wasn't thriving and I'm being selfish -- I'm feeding him from my breast because this is what I like but he's hungry. ... I think if he had been a really fussy baby and crooked I wouldn't have been able to deal with it. I would've been, "Well, Jesus, somebody give him the milk." but he was a happy baby so that's why I kept putting it off.

In the end, a serious accident forced Faye into the hospital and her husband and sister-in-law were forced to feed the baby with commercial formula.

Faye continued to read articles and was pleased and comforted to learn that women who have children after breast reductions will notice that their milk supply will increase with each child. Reassured, she felt at ease with her decision to breast feed her second child. Faye's second son was a much larger baby who would "only stop crying when he was at the breast." She remembers her husband coming home from work and finding her in the bedroom with "the baby attached to me and my eyes so red":

I was in such a depression because at that point in time I had this baby on my breast for over eighteen hours. My husband said, "You cannot go on like this, you have to stop." I was crying when I told him, "You don't understand, I want to breast feed my baby."

In the end, Faye used what she calls a "contraption" which attaches a tube to her breast so that the baby would be drinking breast milk supplemented with formula:

I knew how committed I was because it was a pain trying to get that tube and the nipple into the baby's mouth at the same time. But it was crazy trying to do this six to eight times a day. I still had to prepare formula all the time. But I still wanted him on my breast.

Faye continued using this method until the baby weaned himself off it at nine months. Her third child was also fed in this manner and, as Faye proudly told me, breast fed until ten and a half months.

"I knew I was going to breast feed ...": The Effects of Promotion

In my conversations with mothers, Faye was not alone in her solid "breast is best" belief and determination to breast feed. In many of my conversations with both breast

and formula feeders I heard the breast feeding messages that advocates, both professional and lay, are trying to get across: "Breast milk provides immunological benefits that protect a child from allergies and asthma." "Breast feeding provides an opportunity for you to bond with your baby." "Breast feeding is the best way to feed your infant." Further, many mothers told me that they knew they wanted to breast feed very early into, and sometimes prior to, their pregnancies:

And as soon as I got pregnant, I knew – breast feeding. It didn't matter if it was a boy or a girl, I knew I was going to breast feed. (Faye)

I knew that there was nothing else but breast feeding ... I knew how important it was for the baby for its brain, for asthma, allergies. I just knew. (Ellen)

I went to my boyfriend's house and he had all kinds of books from the library. He didn't know anything about babies and he said, "Breast feeding, that sounds pretty cool you know." I said, "Oh, we *are* going to breast feed" and that was it. There was no, "I'm going to try." (Emily, emphasis hers)

Even with their strong convictions, almost all of the breast feeding mothers I spoke with recounted incidences of such painful breast feeding difficulties as cracked nipples, mastitis, engorgement, and thrush. However, all of these mothers continued to breast feed despite their difficulties. For example, Ann is a single mother who advocates breast feeding. When she had a bad case of thrush, a painful infection in the breast, she would cry every fifteen minutes because she knew she would have to breast feed soon. Another time, Ann decided not to use a prescribed cream for her severe rash because she knew the steroids it contained could be passed through her breast milk. Ann told me that she was determined to never feed her child formula or even feed her child anything, including

juice and milk, from a bottle. Still breast feeding after sixteen months, she told me “eventually I will take my body back” when she, or her daughter, decide to stop breast feeding. Some of mothers downplayed their oftentimes painful experiences and only briefly mentioned them in our interviews. Others seemed to view their breast feeding difficulties as ‘badges of honour,’ as proud demonstrations of what they had to endure to “give their baby the best.”

Even though many mothers are well aware of the advantages of breast feeding and their desire to do so, not all mothers accomplish their breast feeding goals. Moreover, there are feelings of frustration, guilt and shame when this method does not work. For example, Carol, a single mother of two who chose to formula feed her children from birth, told me about her sisters’ different experiences of breast feeding:

One of my sisters breast fed and she really loved it. My other sister had a lot of troubles and I kept saying, “Why? It’s not good.” I said, “You’re crazy, why do you put yourself through this?” She said, “I want my child to be healthy.” It’s crazy. Both of her children ended up having asthma although that probably has nothing to do with the way she fed them. She felt under so much pressure that she breast fed both of her children and both times she was miserable.

Carol was not the only mother, breast feeding or not, to recognize that while breast feeding may be widely promoted as the best thing to do for the baby, it is not necessarily the best thing for the mother. Beyond physical challenges, breast feeding takes time and energy which may conflict with other responsibilities such as paid work outside of the home, housework and taking care of other members of the family (see Chapter 6). While frequently recognized by researchers as inhibitors to the establishment and maintenance

of breast feeding, breast feeding promotions rarely address how to overcome these physical and social challenges to the establishment and continuation of breast feeding.

If being a good mother means to do what is best for one's children, and breast feeding is presented as the best thing to do, what happens when breast feeding is not an option for a mother? Some of the women I interviewed breast fed but found it to be a chore instead of the 'natural', enjoyable "fulfilling" experience breast feeding was purported to be. The women who attempted to breast feed but could not for as long as they had hoped told me of their having experienced feelings of isolation, rejection, and failure. Women, and men, who used formula were frequently reminded of the pro-breast feeding, and sometimes anti-formula feeding, environment in which they made their decision. In effect, and as Carter (1995:25) recognizes, formula feeders are the most aware of the social pressures to breast feed. This was an extremely sensitive topic to those women who switched from breast feeding to formula feeding.

Joan and Peter:

After years of trying to conceive, Joan and her husband had succeeded and she was pregnant. She read many books during her pregnancy and frequently referred to the "What to Expect"⁵⁶ series of books to help her understand what her pregnancy and raising a small infant would involve. Joan knew that she wanted to breast feed for at least the duration of her four month maternity leave even without reading. Her husband, however, agreed with her decision based on what *he* had read in the books.

⁵⁶ The "What to Expect Series" by Arlene Eisenberg, Sandee E. Hathaway, and Heidi E. Murkoff (New York: Workman Publishing Company) includes the popular What to Expect When You're Expecting (1996, revised edition) as well as What to Expect: The First Year (1996) and What to Expect: The Toddler Years (1996).

Joan and Peter became parents of a healthy baby girl. Breast feeding proved to be challenging as Joan struggled to find a comfortable position in which to feed her baby. Because of her larger size, Joan had to feed the baby in a 'football hold' whereby the baby was cradled with her legs away and behind Joan's body instead of the typical 'cradle hold.' Although uncomfortable, sometimes awkward, and almost never discreet, Joan and her baby settled into a fairly normal breast feeding routine.

After eight weeks of breast feeding, Joan noticed that she was not producing as much milk as she had in previous weeks and that her daughter did not seem to be gaining enough weight. She consulted her paediatrician who simply told her to keep monitoring the baby's weight. She talked with her mother who, although she had no experience with breast feeding, supported Joan in whatever she decided to do. Joan felt she had to decide what she should do from the many options suggested by such influential sources as her physician, the lactation consultant, her mother, and her friends, not to mention what she had read in the books.

Joan tried to increase her milk supply by using a breast pump to stimulate an increase flow of milk but hours of pumping only resulted in a few ounces of milk safely stored in the freezer. After much thought and painful hours with the breast pump, Joan felt defeated and angry. She began to switch her infant to commercial formula. She describes her experience:

The biggest was feeling inadequate and not being able to do it. Feeling at a loss because I wasn't getting support. Nobody said, "Do what you feel is right" or, "Do what you feel is best for the baby." In the public health system, I felt terrible because I felt like, "Who are they to tell me how I'm supposed to feed my child?" And

here I was doing it for the baby because she wasn't gaining the weight, because she wasn't thriving, well I didn't think she was.

It was a hard time and I never got the support from the people that were supposed to be helping me. I stopped going to the breast feeding clinic because I wasn't breast feeding anymore. One of the nurses called me and asked me how things were going. I didn't tell her one way or the other. I just said everything was fine. I didn't tell the family doctor either that I had switched because I didn't want to hear it. I didn't want to hear, "Oh you should go back to it, you can still do it." I didn't want to hear it. I made my decision and I was happy with it.

With the widespread enthusiasm for promoting breast feeding, how many parents feel like Joan when their decision to formula feed leaves them outside of a vital network of support?

The act of infant feeding itself provides opportunities for evaluation by others when mothers, and in some cases, fathers breast feed in front of others. The sexualization of the breast is one inhibitor to breast feeding as mothers try to be both 'good' mothers and 'good' women in an environment where these roles frequently conflict with each other.

My "Breast Feeling" Research: Sexualized Breasts and the "Male Gaze"

... He looks at me and then to my chest. So I opened my blazer. My breasts were so engorged, pushed up and probably looked like sexual objects in his eyes. But in my eyes, they didn't belong to him, my husband, or even me. They are my daughter's. My breasts are what sustain, satisfy, and comfort her. It is for her that I pumped, deprived myself of sleep, and drank lots of water

[instead of alcohol] while on vacation. (excerpt from "A Night on the Town")⁵⁷

I use this excerpt from a story anonymously written for a contest on a popular breast feeding website to illustrate often conflicting discourses surrounding women's breasts as sexual objects⁵⁸ and, perhaps the other extreme, women's breasts as infant feeding 'tools'. As sociologist Cindy Stearns recognizes, "given the strong cultural preference for sexualized breasts, women who breast feed are transgressing the boundaries of both the good maternal body and woman-as-(hetero)sexual object" (Stearns 1999:309, see also Young 1998). Further:

The good maternal body is not commonly believed to be simultaneously sexual, despite the obvious facts of human reproduction. The sexual aspects of women and the maternal aspects of women are expected to be independent of each other. (Stearns 1999:309)

Women are not seen as being able to be both breast feeding mothers and sexual beings simultaneously. For example, at the breast feeding public forum in St. John's⁵⁹ during a discussion on the female breast as a sexual or as a functional body part, the father representative on the panel described his wife: "When she's breast feeding, she's a breast feeding mother. In other contexts – she's a sex goddess!" Similarly, some of my male friends and acquaintances jokingly referred to my research on infant feeding practices as

⁵⁷ "A Night on the Town." Entry into the Breastfeeding.com Spring 2001 Story Contest. No author named. Electronic document, http://www.breastfeeding.com/reading_room/bar.html, last accessed June 29, 2001.

⁵⁸ For an overview of the history of the sexualization of women's bodies see, for example, Weitz 1998a.

⁵⁹ "Promoting a Breastfeeding Culture: Building Community Support." Public Forum Presented by the Health Care Corporation of St. John's. October 15, 1999.

my “breast feeling” research. They also offered to “help me” with my research while mockingly showing me their flexing hands at breast level as if ‘groping’ two large breasts. The joking behaviour of these men suggests that they immediately interpreted the female breast as sexual.

These examples illustrate the hegemonic belief that ‘good’ mothers breast feed but ‘good’ mothers don’t show their lactating breasts, or at the very least, do not show their lactating breasts in the presence of men⁶⁰. While not as explicitly as the excerpt from “A Night on the Town”, women and men in my interviews subtly revealed their opinions of what women’s breasts were for, where and how they should and should not be seen, and by whom.

In the hopes of encouraging a discussion about how they view their breasts and breast feeding, during interviews I asked breast feeding mothers what strategies they employed when breast feeding in public. Many women declared that they did not mind breast feeding in front of people but that the baby got a better feed if s/he was fed someplace quiet and out of the way. Other women described the measures they took to ensure their feeding would not be seen so as not to bother others, what Stearns describes as “the invisible breastfeeding mother” (Stearns 1999:313).

Breast feeding militants often told me how they ‘aggressively’ breast feed in the most public places to force others to accept the sight of breast feeding as a normal.

⁶⁰ More specifically, Young emphasizes that it is not so much the exposure of the breast that is problematic, but the exposure of the nipples: “Breasts are a scandal because they shatter the border between motherhood and sexuality. Nipples are taboo because they are quite literally, physically and functionally, *undecidable* in the split between motherhood and sexuality” (Young 1998:133, emphasis author’s).

natural thing to do. Some mothers, such as Emily, were almost annoyed by the question in its implication that breast feeding had to be 'discreet.' She answered my question:

I just whipped it out and fed him. Someone said to me the other day, "But you gotta' be discreet." I said, "Why do people have this impression that we get on the table and we strip off our clothes and do a table dance and then we get down and feed our babies." It doesn't work like that.

In contrast, as a new mother, Ellen was careful not to breast feed her infant in front of those she thought would be uncomfortable by the sight. She tells me of her father's surprising 'non-reaction' as she breast fed her five month old at her parent's house:

My father came right over and looked right at my breast and the baby feeding. I was shocked. I mean he was right there looking at me and he was fine. I think that took a lot for him to come over and look at what was going on. ... I was really proud of him to come over and see that. I think they [her parents] realize how important it was.

Ellen, wanting to be the "invisible breast feeding mother," underestimated the impact that campaigns to promote breast feeding would have on those around her.

Interestingly, not one person I talked to over the course of my fieldwork said that the sight of an infant on the breast was disgusting. Uneasiness with breast feeding was expressed more in terms of the sight of the breast *itself* as "gross" or, at least, something that was improper to look at, even inadvertently.

What defines a suitable location in which to feed one's infant? Who defines this location? How are women evaluated in terms of this appropriate location? In turn, how might this location influence women's infant feeding experiences? In terms of breast

feeding, the appropriateness of feeding outside of the home is differentially and complexly interpreted by different individuals.

Infant feeding researchers such as Kay Matthews et al. (1994) and Sylvia Warren (1998) argue that modesty and the reluctance to expose one's breast in front of others are one set of attitudes contributing to the low breast feeding rates in Newfoundland. In fact, during fieldwork, I did not see a single mother breast feeding in public although three mothers breast fed in front of me in their homes⁶¹.

To breast feed in front of others is to display parenting behaviour that in turn may be evaluated. Earlier in the chapter, I introduced Joan and her struggle to maintain breast feeding and her experiences of switching to formula. Here, I include an excerpt from a conversation with Joan and her husband Peter to show the contrasting and somewhat contradicting assessments of infant feeding in public:

- AE: What do you think or say when you see someone else breast feeding?
- Peter: I think it's great but I don't think it's something that should be done while you're sitting there, just haul out your boobs and, (pause) I don't agree with that but that's my view.
- Joan: When I see somebody breast feeding I get this warm feeling all through me. I think how sweet, how gorgeous, and I really love to sit and watch because I think it's beautiful.
- AE: Regardless of place?
- Joan: Umm, no. I would have to say in public places, for example a restaurant or the mall, I just don't think that that is a conducive place. I mean, I know it's a natural thing to feed your child. You can feed your child there, or anywhere else. I guess just traditionally, I think it should be done not in private but in an atmosphere that's not public.

⁶¹ I did see babies being fed with bottles in public places such as shopping malls and restaurants. Regardless of the contents of these bottles, breast feeding advocates would argue that the frequent sight of babies being bottle fed and not breast fed in public may deter mothers from initiating and maintaining breast feeding.

- AE: What do you think when you see someone formula feeding.
Joan: I really don't have any reaction one way or the other. It isn't an issue at all.
Peter: I think that there may have been a problem but also that it's robbing the baby somehow, like, what the hell's wrong with you.

Joan and Peter both acknowledge that breast feeding is the 'best' but that there exist suitable places in which it must take place. In contrast, while the sight of formula feeding or bottle feeding is more common ("I really don't have any reaction"), the *act* of formula feeding is questioned ("it's robbing the baby somehow").

The act of feeding in front of others, and discussions about this act, also provides the opportunity to express one's opinions on breast feeding. The breast feeding promotional video Breastfeeding: Go With the Flow⁶² (BCNL 1997) involved a scene with a mother breast feeding in a mall in rural Newfoundland. The producers of the film had asked each of the managers of the stores for their permission to appear in the background of the film. For the most part the managers were supportive of the film. One manager, however, made the comment that while she felt that breast feeding was a good thing, that to do so in public "was like using a public washroom with the stall door open."

Emily was nineteen years old when she found out she was pregnant, her partner twenty years old. As a young mother, Emily was always being told how she should feed her infant by well-meaning family members, friends, and professionals. In the end, she

⁶² As I mentioned in Chapter Three, Breastfeeding: Go With the Flow (BCNL 1997) is a video, poster and brochure package produced by the Breastfeeding Coalition of Newfoundland and Labrador, funded by the Canadian Prenatal Nutrition Program, Health Canada.

found feeding in front of her partner's male friends the easiest because they did not evaluate or question her decision. Surprisingly, as Emily describes:

I was the first person he ever saw breast feeding. He was fine with it and he just figured that that's what it's all about. His friends at first were a little embarrassed but after a couple of weeks they all came around to it. They thought it was perfectly normal. I felt more comfortable sitting down and breast feeding in front of his brother and friends than I did in front of my own friends and my own family because they never used to say anything. You know, they would go, "Oh, he's hungry again," while my friends would be like I can't see how you can do that so many times. The guys didn't know any better. They figured that that was just it. That's just the way you fed them (laughs). I was more comfortable around guys.

Emily's example illustrates that she was always aware of possible evaluations of her feeding methods. As well, Emily acknowledges that there are men who accept that breasts are not just sexual objects and, perhaps, that men may evaluate the behaviour of mothers less frequently than other women.

The boundaries that define an appropriate place and method of breast feeding are socially constructed and as the above examples show, are differentially interpreted and challenged. Breast feeding in front of others demonstrates to others one aspect of 'good' mothering. At the same time, exposing one's breasts, therefore running the risk of falling under the "male gaze" (thus changing the meaning of one's breasts from maternal to sexual), may define these mothers as "bad." If a mother decides to use formula and bottles to feed her infant, she may be considered a "bad" mother for not breast feeding. In the end, to feed an infant in the presence of others allows for opportunities for evaluation regardless of infant feeding method.

"Carnation Babies": Evaporated Milk Formulas and "Bad" Mothers

The use of evaporated milk (EM)⁶³ formulas to feed infants was perhaps one of the most contentious issues for many of the people with whom I spoke. Tinned milk became a popular infant feeding product in many Newfoundland homes beginning in the late 19th century because it was less expensive than commercial infant formulas and could be used in other food preparations. As Matthews et al. (1994: 79-80; see also Crellin: 1994) explain, evaporated milk was commonly used in Newfoundland households for tea, puddings, and baking. Historically, fresh milk, and commercial formulas to some degree, were scarce and expensive in Newfoundland. Tinned, evaporated milks provided a readily available and relatively inexpensive way to feed infants, small children, and other family members. A large number of people, representing many generations, reported being fed with evaporated milk. As many Newfoundlanders have said to me, "Sure, we're all Carnation⁶⁴ babies."

Evaporated milk formulas are the least recommended form of infant feeding after commercial milk and soy based formulas and is not recommended for feeding until an infant is at least twelve months old (Matthews et al. 1994). They are less digestible and is higher in fat content than commercial formula (ibid.). In preparing the formula, sucrose and iron supplements must be added in order to provide adequate carbohydrate

⁶³ "Evaporated milk is cow's milk, (whole, 2% or skimmed) evaporated to approximately half the original volume" (Friel et al. 1999:240).

⁶⁴ Carnation Milk is often used to signify a popular Nestlé brand as well as tinned evaporated milk in general.

content⁶⁵. The preparation of EM formulas is, therefore, more complicated than the 1:1 ratio of ready-made commercial formulas (Matthews et al. 1994: 79-80). When mothers in their study were asked how they mixed the formula, Matthews et al. report "that several mothers were not measuring the water, milk, and sugar proportions properly for evaporated milk feeding, or could not tell the interviewer how they were mixing the formula" (Matthews et al. 1994:80).

Despite the acknowledged health risks, in the early 1990s 20% of infants in Newfoundland were fed with EM formulas within their first month (Matthews et al. 1994). By six months of age, 31% of infants were fed in this manner. None of the parents whom I spoke to used EM formulas themselves but all recognized its use as a problem in Newfoundland and a few knew some mothers who continue to use EM formula for feeding small infants.

Many mothers who choose to use EM formulas do so for economic reasons because these formulas are less expensive than commercial infant formulas. Currently, prepared commercial formula can cost up to \$5 per 750 millilitres while it costs approximately 65 cents for the same amount of evaporated milk formula prepared in the home (Muzychka 1996). This may also explain the high proportion of low income families using this method (Myres and Yeung 1979).

⁶⁵ The formula for a six-ounce bottle of evaporated milk infant formula consists of two ounces whole evaporated milk diluted with four ounces of water and two teaspoons of sucrose added. It is also recommended that an iron supplement be added to the first bottle of the day (Friel et al. 1999:240).

Infants who are fed with evaporated milk do gain more weight than breast fed and commercial formula fed infants⁶⁶, but some researchers suggest that they do so because of the higher fat and sugar content of these formulas⁶⁷ (Matthews et al. 1994; among others). Myres and Yeung (1979), among others, report that mothers, especially in low-income families, equate large babies with good health:

Chubbiness was taken by mothers as being an indication that the infant was well fed and generally well cared for. The maternal attitude that a fat baby is a healthy baby and a thin one is 'sickly' appeared to be widespread among low-income families. (Myres and Yeung 1979:116)

In breast feeding advocacy discourse generally, and in some of the interviews I conducted for my study, the use of evaporated milk was specifically linked with the development of childhood and adult obesity, poor food choice and eating habits, asthma, and allergies although many of these 'conditions' are also attributed to the use of infant formulas in general⁶⁸.

In contrast to the days when evaporated milk based infant formulas were the norm, to feed with tinned milk in Newfoundland today is frequently met with scorn even

⁶⁶ There are a number of studies that examine the relationship between infant feeding methods and weight at different life stages: weight during infancy (see for example Bindon and Cabrera 1988; Friel et al. 1999; 1997); childhood weight (see for example Patterson et al. 1986); and connections between infant feeding and adult weight (see for example Gillman et al. 2001).

⁶⁷ Myres and Yeung (1979) suggest that because of its quantified nature, formula feeding frequently leads to overfeeding as caregivers want the infant to finish the bottle and, also, the tendency for early introduction of solid foods into a formula fed infant's diet.

⁶⁸ In a project funded through Health Canada, Friel et al. (1997, 1999) concluded that babies were not suffering from being fed evaporated milk formulas. This report was met with negative reaction from pro-breast feeding and infant health advocates who claimed that Friel's study was flawed in its design (Spencer 1996). As well, breast feeding advocates in particular felt that the study could undermine breast feeding in the province by stating that evaporated milk, or any type of formula, is a suitable infant food.

more intense than that directed at commercial formula. Emily, a breast feeding advocate who was fed with "Carnation Milk" describes to me her idea of the effects of feeding babies with evaporated milk formulas and her reaction to those who continue to use this formula:

We've all got asthma, we all got allergies, we're all overweight and it all leads back to the Carnation. So it just seemed like there's no way I'm putting that stuff in my baby's stomach.

My friends would be giving their babies Carnation and they used to have to wash their clothes out twice [because of the smells and stains left from spit-up] and I used to say to them, "You put that stuff in our kids' stomach? Ughh." ... I say to them, "I suppose if you can't afford the formula," and one of them would say, "(We) can afford the formula but Carnation is the best stuff for them." I tell them, "Get out of my house if you're going to tell me Carnation is the best."

Like other mothers, whether breast or commercial formula feeding, Ann also had very strong things to say about the use of evaporated milk in Newfoundland. When Ann was recovering in the maternity ward after the birth of her first child she observed that the mother rooming with her was feeding her child with evaporated milk. When Ann confronted the mother, the mother insisted that the formula was 'just fine' for her baby because she was adding vitamins and minerals to the milk, insisting that EM was just as good as expensive commercial formula and breast milk. A physician was with a third mother behind a separating screen. Overhearing what was being said, Ann told me that the physician "whipped the screen separating the beds open and told her, in no uncertain terms, that evaporated milk was *not* just as good and that it would not be allowed in the hospital" (emphasis hers). This contrasts with Martha's experiences in the 1950s and 1960s when her physician recommended evaporated milk formula to feed her infants.

The physiological effects of commercial and evaporated milk formulas on infant health have been examined and reported on in medical journals. What may be important to investigate, however, are the *socio-cultural* impacts on entire generations of children being fed with an infant food which is now widely presented by international and national health researchers as an inferior food and socially stigmatized by many living in the province today.

Infant Feeding, Bonding and "Good" Fathers

Campaigns promoting breast feeding are primarily targeted to women in order to increase the number of mothers who breast feed and the duration of breast feeding. How do fathers' roles factor into a "pro-breast feeding environment" if the decision whether or not to breast feed essentially lies with the mother? Fathers are encouraged to support and to subtly encourage mothers to breast feed. Fathers are also pressured to contribute more to housework and childcare⁶⁹ and to be active figures in their children's lives. In the pressure to be "equal" partners and parents, how do fathers participate in infant feeding, especially when the mother breast feeds?

Women are encouraged to breast feed their babies because, among other benefits, it encourages a stronger bond between mothers and their children in its body-to-body contact (see for example Kennell and Klaus 1998; Myers 1987). Mother-infant bonding is purported to "reduce the probability of child abuse and neglect, failure-to-thrive, juvenile delinquency, and depression in the child" (Adams 1995:415). Further, as Law

⁶⁹ I discuss these ideas in more detail in the following chapter.

points out, this emphasis on skin-to-skin contact and it's argued importance in developing a strong bond with an infant:

... led to a presumptive identification of breastfeeding with bonding and formula feeding with 'separation' – and thus to an equation of parent with *mother*. (Law 2000:424, emphasis author's)

Faye acknowledges the idea that only mothers can 'bond' with their infants when she described to me how she reacted to her husband's suggestion that she switch to formula:

He had no idea, he has no understanding. The connection will never be made there and I'm not saying that fathers with children don't bond but not like mother and a child. I have friends who chose not to breast feed and they have a lovely relationship with their children but I believe that in those early stages there is no bonding like that. That flesh on flesh, there is no bonding like that.

In contrast, Beth told me that even though breast feeding is promoted as a way to 'bond' with the baby through close, skin-to-skin contact, she felt she bonded more with her infant children because she used a bottle to feed them:

I really liked bottle feeding. They say you can only bond if you breast feed but I found I bonded more simply because I could see the child's face. When the baby is at the breast, the child is under your breast, you can't see the child's face. In bottle feeding, you can look into your child's eyes while both hands are on the baby. With breast feeding you have one hand free to do other things which takes away your attention from the baby⁷⁰.

Even though breast feeding is promoted as almost seemingly the only way to "bond" with the infant, Beth's description demonstrates that there are other ways to "bond" with your

⁷⁰ In contrast, some breast feeding activists present bottle and formula feeding as freeing the mother's hands to do other things besides holding (and therefore 'bonding' with) their children.

children. Fathers may not be getting the “skin-to-skin” (mouth-to-nipple) contact that Faye describes but can bond with their infants in other ways.

Peter’s relationship with his infant daughter changed after Joan switched to formula simply because he had more opportunities to hold his daughter:

Peter: I felt kind of left out because obviously I can’t breast feed.

When Joan switched to formula I had more interaction with the baby but I still had to learn. I was very awkward when I held her. But over time I became more intimate with her. I don’t know I just became more attuned with the baby. I could see a lot more of what was going on than when she’s just napping. So there was room for me to feel an extra bond with the baby.

Joan: The baby became attached to her dad very quickly after she was switched to formula. I could go away in the afternoon which was a great relief. Pete took over and the baby really knew her dad.

If breast feeding is promoted as essential to mother-infant bonding and therefore to overall psychological well-being, how can fathers ‘bond’ with their infants if they are not breast feeding? Indeed, what roles do fathers play when the decision to breast feed is not theirs? In sum, how are men ‘good’ fathers when ‘good’ mothers breast feed?

Chapter Summary

Through an examination of parents’ experiences feeding their infants in a pro-breast feeding, anti-formula feeding environment, I have shown that, within social expectations of men and women as parents, the practice of infant feeding is experienced in different ways in the daily lives of individuals. However, as Murphy points out:

However mothers decided to feed their babies, infant feeding remains a highly accountable matter. Whether they intend to breast feed or formula feed, women face considerable interactional challenges as they seek to establish that they are not only good

mothers but also good partners and women. (Murphy 1999: abstract)

As one aspect of parenting, infant feeding practices are primarily focused on the actions of women. Among many other social and cultural considerations, the sexualization of breasts creates a potential conflict between being a 'good' mother and a 'good' woman. Even though 'good' mothers breast feed, 'good' mothers do not show their breasts in the presence of others. If being a 'good' mother means breast feeding, mothers (and fathers to some degree) who formula feed often face negative evaluations of their behaviour. Moreover, if breast feeding is the "best", and infant formula is inferior to breast milk, the use of evaporated milk formulas in Newfoundland is met with a heightened level of judgement and scrutiny. Within these contexts, fathers must find their place in their infants' lives in a culture that focuses infant care on the actions of the mother. Regardless of the infant feeding methods chosen, infant feeding practices are also opportunities for others to evaluate how well a mother or father parents according to wider social and cultural expectations.

Chapter Five
“You Just Get Up In the Morning and Do It”:
Infant Feeding and the Work of Everyday Life

As I demonstrated, promotion campaigns and everyday pro-breast feeding encounters have an impact on the way people think about infant feeding. Among the parents I spoke with, breast milk was widely recognized as being the ‘best’ infant food. How, then, do we explain why not all mothers breast feed? While most of the women I interviewed did breast feed for some amount of time, I heard such responses as, “Breast feeding is best but: I want my freedom,” “It just didn’t work for me,” “I didn’t have enough milk,” and most frequently, “I had to return to work.”⁷¹ These responses illustrate that while promotional campaigns espouse the advantages of breast feeding, how a mother can do it along with her other responsibilities, desires, and/or priorities is frequently ignored.

How do women negotiate the expectations of themselves and of others with the realities of everyday life? How do other responsibilities influence women’s experiences with infant feeding? What roles and responsibilities do women assume in their daily lives? How is gender difference experienced within these roles and responsibilities?

Anthropologist Vanessa Maher (1992a: 29) asserts, “the degree of freedom with which women are able to manage [infant] feeding appears to depend on the configuration of roles which they are called upon to play in any given society.” Similarly, in her

⁷¹ These reasons for ceasing breast feeding are frequently cited by other infant feeding researchers (for example, Maclean 1990; Matthews et al. 1994; Sage Research Corporation 1995; and Warren 1998 among many others).

examination of the contradictions in parenting expectations, sociologist Meg Luxton recognizes that “the emphasis on the private responsibility of child-rearing and the widespread refusal to recognize the social aspects of it, presents serious difficulties for parents in the day-to-day activities of raising their kids” (Luxton 1997: 163).

Pam Carter states in her book Feminism, Breasts and Breastfeeding that “it is useful to conceptualize the situations in which feeding occurs as working conditions in order to avoid the tendency to see tasks undertaken by women as simply arising from their natural biological capacities” (Carter 1995: 78). In contrast, anthropologist Matthew Gutmann (1997, 1998) explores how changing socio-economic conditions are affecting male identity in a neighbourhood in Mexico City. Although housework and childcare are still spoken of in terms of women’s work, more men are taking on the responsibility and possibly even pleasure from these duties as mothers of young children increasingly are employed outside of the home. Men assume this responsibility not only because there is no one else who can, but also because women are increasingly demanding it of them (although many men may not admit to this). In turn, ideas of masculinity are gradually becoming defined by a man’s participation in parenting.

Rather than view infant feeding responsibilities as innately feminine, I present them in terms of often constituting women’s, and sometimes men’s, unpaid labour. In short, infant feeding and decisions concerning infant feeding are work. Whether

mothers⁷² decide to formula feed or to breast feed, to feed an infant requires the time, planning, coordination, mental and physical energy of parents (after di Leonardo 1987 on 'kinwork')⁷³. As well, this work must be accomplished in addition to other, sometimes conflicting, responsibilities.

When parents describe their infant feeding experiences, they are also describing other aspects of their everyday lives in terms of their responsibilities as parents and adult members of their society. When the parents I interviewed discussed how they feed their young children interesting things were said about how work, both paid and unpaid, outside and inside of the home is negotiated vis-à-vis childcare responsibilities, how unpaid labour is divided among members of the household, and about how parents continually make choices among these frequently competing aspects of their everyday lives.

Parenthood frequently involves reconciling work inside and outside of the home and childcare strategies (including infant feeding) with the meanings and lived experiences of gendered divisions of labour. I begin this chapter with the example of "Beth" drawn from my field notes as an example of the how infant feeding practices "fit" with other responsibilities and priorities. I follow with descriptions of how some mothers in St. John's manage infant feeding and childcare with employment outside of the home. Then, I describe the mothers and fathers who make the decision to be a "full time parent."

⁷² I purposefully say "mothers" here rather than parents because the decision to use 'breasts-for-feeding' are ultimately the made by mothers. Also, infant feeding *decisions* are frequently mothers' responsibility even if they decide to give infant feeding *tasks* to others.

⁷³ Of course infant feeding can also be paid labour when parents pay caregivers to feed and otherwise care for their infants.

leaving their paid positions to care for their children full time. I conclude with a discussion on gendered divisions of labour.

Beth

Snow had just fallen, making the city at once beautiful and difficult to navigate. I trudged down the street, up the recently shovelled walkway, and rang the doorbell to the large, stately house. Beth answered the door with a smile on her face and welcomed me into her warm home. I handed her the plate of muffins I had brought to share and she waited patiently as I unzipped my coat and removed my boots. She invited me into the living room and offered me either coffee or tea. I sat alone on the chesterfield looking at the books on her shelves, the photographs of family on the walls, the toys neatly piled in the corner, while she prepared the refreshments in the kitchen. As we talked through the wall about the weather outside, I unpacked my interview paraphernalia, negotiating my thoughts between offering to help her in the kitchen and the fear of infringing on her space. That tension was relieved when she entered the room with a tray of tea, cups and saucers, the unwrapped plate of muffins, and pretty napkins. As the tea cooled, I described my research and what to expect in the interview.

Beth is a married mother of two boys and a girl and is in her early forties. It was early into my field work and Beth was only the second mother I met who had chosen to formula feed her children. I was wary of the questions I asked and the words I used, aware that she too was aware of the anti-formula feeding environment in which she made her decisions. I wanted to hear her story, her experiences, her account of the way her

world works. I asked the questions I had asked all of the people I interviewed but with a little more caution. As the interview progressed we developed a certain rhythm. I asked a question, she told me everything she could think of to answer it. In the end, I found that she had the same things to say about parenting as the other women I had interviewed. She wanted to do what was best for her children and she learned what constituted “the best” through years of trial, error, and commitment to what she felt was right⁷⁴. As she talked about her first pregnancy she recounted:

When I found out I was pregnant, I went out and got everything. I was going to be a really good mother. (...) There was no question in my mind that I was going to breast feed because every book I read said you should.

For Beth, “you have to be a particular type of person to breast feed successfully.” Her desire to do what was “best” for her child conflicted with what she called her “type A” personality. Although she chose to leave her paid job when she had her first child, her dedication to her household responsibilities conflicted with her desire to breast feed. She described her typical day as a new mother divided between feeding a constantly hungry child who never seemed to sleep with keeping the house in order. To make things worse, they only had one car that her husband would take to work and since her son was born in a large snowfall winter, she found herself in the house all of the time feeling incredibly isolated and alone.

After three months of breast feeding her first child, she was exhausted and felt as though she never got anything done, so she switched to commercial formula and did not

⁷⁴ The similar descriptions of motherhood from women I spoke with are akin to those that Faye Ginsburg (1991, 1993) finds in her study of “pro-choice” and “pro-life” activists.

attempt to breast feed the other children when they were born. For Beth, the image of breast feeding as a natural, relaxing, and enjoyable experience was not realized:

Only positive things were said about it. So much of this is the idealism of having a baby that is stuck in the books, versus the reality of what works and what doesn't work. They should inform people of the downsides to breast feeding to curb all this ensuing guilt by mothers who give up breast feeding. No mother should feel guilty about how they feed their baby.

I never had any problems breast feeding. Maybe I should have because I may have dropped the idea earlier. Physically breast feeding was not a problem but I found it emotionally draining. I got to the point where I thought to myself, why did I even have this child? My original life was disturbed, I never got any sleep, the anticipation of having this baby was replaced by drudgery and exhaustion and I blame it all on the breast feeding. ...

By the time I had my third child everything was fine. I mean it wasn't perfect but I knew it wouldn't be perfect I was just able to deal with things and discover what worked.

What worked for Beth was to develop strategies by which she could organize her day so that she could get the tasks she needed to complete done. Formula feeding fit into this strategy because not only did it seem to satisfy the babies' hunger but it also allowed her to follow a sort of routine in her day.

Beth was happy that our conversation moved away from questions about infants towards older children. She complained that she feels as though there is so much emphasis placed on the early years when there is so much more parenting that needs to be done as they get older. For Beth, to be a good mother means giving her children nutritious meals throughout their lives, not only when they are infants. As she pointed out, "All of these mothers are so concerned about breast feeding but how many of them give their older children good meals and how many of them give them junk food?"

When I asked Beth about how household chores are divided, she described how things have changed in the household over the years. When I asked what tasks her husband performed when her first child was born, Beth replied:

He wasn't comfortable taking care of the small ones and I thought, "Why am I forcing this?" Not everyone's good at it and I don't see the point in pushing men to do it if they're not comfortable with it. I took care of the infant care. I don't see the use of making someone do what they do not want to do. I give everybody space to do what they're good at.

The division of labour in Beth's household has developed over the years. Because she is home considerably more than her husband, she does all of the housework including basic finances, cooking, and childcare. Her husband, a professional who frequently works long hours away from home, is the main financial provider for the household. He is also responsible for financial investments and will occasionally do the grocery shopping.

As each of her children grew, Beth re-structured her life around their ever-changing needs. When the youngest of her children reached kindergarten, she chose to volunteer at the children's school and write freelance articles at home. She chose this type of 'extra' work because she could "mould that kind of work better into the family instead of posing outside limits on them which may not exactly fit."

Beth's experiences with infant feeding bring to light the various aspects of women's daily lives: the characteristics of being a "good mother" that involve work responsibilities both within and outside of the home and the division of labour within the household.

Women Working Outside of the Home

Partly as a result of the women's movement, but increasingly out of economic necessity, by the last few decades of the 20th century, the majority of North American mothers of young children had paid jobs outside of the home (Hochschild 1989:2). Based on research conducted in rural Newfoundland communities during the 1970s and 1980s, Benoit (1982, 1990), Davis (1988) and Porter (1993) each suggest that women's primary work was family work centred in the household and physically and symbolically separated from the work of men. Porter (1993: 127) argues that, unlike the male world in which work and home were clearly separated, there was no such separation for women. The domestic sphere was the site of women's work and other aspects of their everyday lives (a point also highlighted by Davis 1988: 73). Furthermore, these researchers suggest that even when women pursued wage labour outside of the home, they did so with the priorities of their families in mind (see especially Porter 1993).⁷⁵

According to the Women's Policy Office (Government of Newfoundland and Labrador 1997⁷⁶), 56% of women in Newfoundland recognized unemployment to be one

⁷⁵ There are a number of publications that focus specifically on women's roles in both paid and unpaid labour in Newfoundland. For more detailed descriptions from a historical perspective see especially Murray (1979) for a description of outport women's domestic contributions and Forestell's (1995) description of wage labour in St. John's between the two World Wars. More theoretical approaches include those by Antler (1977) who describes women's labour as determined by their secondary role to men in the fishing industry, and Porter (1993) whose sociological study of women's socio-economic roles explores the many economic contributions of women. Benoit (1990, 1995) and George (1995, 2000) also provide useful descriptions and analyses of both paid and unpaid labour in Stephenville, NF.

⁷⁶ This report is based on the information gathered in telephone questionnaires with 757 women, randomly chosen from areas across the province, in February 1996.

of the top three concerns of women living in the province⁷⁷. Further, 86% of Newfoundland women surveyed in 1998 felt it is valid for women to have a family and a career and many reported that they felt their lives were good or very good because they had jobs (*ibid.*). However, over half of all employed mothers were very concerned with balancing work and family (Government of Newfoundland and Labrador 1997; Lamphere et al. 1993). In other words, while many women in Newfoundland consider themselves fortunate to be employed, they also struggle to balance this work with the work of their family.

A woman's decision to pursue labour beyond her 'motherwork' is not always an easy one but one that is frequently based on negotiating personal desires, gendered expectations, and financial realities. Similar to di Leonardo's (1987) discussion, in my conversations women frequently described housework, childcare responsibilities, and market labour to be competing responsibilities (Lamphere et al. 1993:274; see also Hochschild 1989). Mothers expressed feelings of guilt and frustration if they focused their efforts too much into one sphere. As one mother in my research sample from St. John's said to me, "If I devote the time I want towards my career, I feel as though I am neglecting my family. When I focus on my family, I feel as though I'm not dedicating myself fully to my career. It's an ongoing struggle."

⁷⁷ According to 2000 statistics, the unemployment rate in Newfoundland was 16.7 % compared to the Canadian unemployment rate of 6.8% (Statistics Canada 2000, electronic document).

Childcare in Newfoundland:

The responsibility of finding suitable childcare, a task most often completed by women, is challenging in Newfoundland and Labrador as the province does not license formal, subsidized daycare for children under the age of two years⁷⁸. Mothers and fathers in my research sample employed a variety of strategies in order to provide care for their children while they were at work. Linda, a married mother of a nine-month-old girl, created a company in which she is self-employed and works from her home. Linda hires a nanny who cares for her baby and performs basic household chores around the house. She describes this situation as ideal because not only can she focus on her career, but she also gets to spend time with her daughter throughout the day. Dona has both a husband who will care for their children and an employer who allows her time and a room in which to breast feed when her husband brings the baby to her office. As well, she has a flexible workplace that allows her husband to bring the baby to be breast fed during breaks. Other mothers called upon their family and sometimes friends to fill childcare 'shifts'. In sum, and similar to the findings of Lamphere et al. (1993), childcare in St. John's usually depends on a family's access to financial and familial resources.

Work and Infant Feeding:

In the context of infant feeding, there is a great deal of talk about mothers who work outside of the home and the potential impact of this paid work on breast feeding patterns and, in effect, on a woman's ability to mother. However, as Van Esterik and

⁷⁸ Since daycare centres, which are regulated by the provincial government, are not permitted to care for children under the age of two, many parents privately hire nannies and childcare givers to care for younger children.

Greiner (1981: 186) recognize, "... employment may not be as important a factor as the conditions in the work environment." Research on infant feeding and women's work tends to focus on women's paid work '*outside*' of the home and the potential impacts these responsibilities may have on successful breast feeding and childrearing. Rarely do these studies focus on responsibilities '*inside*' the home, the largely unpaid, unrecognized, and undervalued labour.

In my research data, mothers who worked outside of the home employed different infant feeding strategies, especially those who breast fed. Some mothers delayed returning to work so that they could breast feed for as long as possible. A few mothers pumped and stored their breast milk to feed their babies while they were at work. Some mothers slowly replaced breast milk with formula so that they would no longer have to be there for feedings or worry about finding the time to pump milk. Others had left their paid work to stay home with their children and therefore lengthen breast feeding duration.

Women's work outside of the home does not generally impact on the *practice* of breast feeding (as opposed to the *decision* to breast feed) for the first few months of the infant's life since most mothers take maternity leave from their work⁷⁹. For mothers who breast feed, this means that they are available to feed their infants⁸⁰. However, as we see

⁷⁹ Schmied and Lupton (2001) argue that it is not the employment that impacts infant feeding practices but that socio-economic status influences what options are available to mothers. More breast feeding supportive options, such as extended maternity leaves and flexible work schedules, are generally available mostly to women of higher socio-economic status.

⁸⁰ In their cross-cultural examination of infant feeding practices, Winikoff and Castle (1988) recognize that maternal employment is not a consistent independent predictor of breast feeding rates.

in Beth's case, 'work environment' *in* the home may have an effect on infant feeding practices.

Full Time Parents

Many families in St. John's have both parents working outside the home. Some families, however, decided to have one parent home to care for the children. In my research, four of the fifteen mothers I interviewed decided to leave their paid employment so that they could devote themselves to being the primary caregivers of their children at least until they reached school age. The other mothers returned to their paid positions outside of the home once maternity leaves were over although some returned on a part time or reduced work schedule. However, three fathers left their paid employment or altered employment schedules so that they could be the primary caregivers for their children.

Four sets of parents in my research sample made the conscious decision that the mother of the pair would leave her paid position to become a 'full-time' caregiver for their children. For example, Faye and her husband decided that she would stay at home as his income alone could support the family. As she points out:

I have my education. We could be out having two incomes. I could have a babysitter for my children. ... It's a lifestyle choice and my husband and I have made so many sacrifices [to do it]. ... It's not like this is my place. If I was the one out earning the big job he would choose to be at home and he doesn't have a big problem with that.

For Faye and her husband, one parent staying home to care for children made them both better parents who were more attuned to their children's needs.

Barbara is married and has four children, the youngest of which continues to breast feed after two years. When her first child was born, Barbara took full maternity leave from her full time occupation. She told me that, after a few months, she could not stand being at work when she knew her baby was at home with a babysitter. Although Barbara recognizes that her family had to make some serious financial adjustments, she left her permanent, full time position to be at home with each of her children. Once in a while, she accepts contract work that can be accomplished from her home. Barbara became very excited in our conversation about women who return to work before their maternity leave has expired. She commented: "They say it's because they are bored. I've been depressed, tired, run ragged, but never bored. There's something wrong if you're bored."

In three instances, fathers left their employment and became the primary caregivers to their children, it was mostly because their partners had a higher income than themselves. Steve and Peter, both fathers of toddlers, are "stay at home dads." Both fathers agree that one parent should stay home to care for small children. Since both of these fathers have an infant under the age of two, and formal subsidized daycare is not available, their partners agreed that if one income has to be sacrificed so that their child is "well taken care of," it should be the lesser one. Steve also recognized that if he did return to work, all of his income would go towards employing a private childcare worker for his children resulting in no extra income.

How do mothers, 'traditionally' viewed as the caregivers, view these arrangements? When Joan spoke of her feelings about having to leave her family every day to go to work, she said:

They (husband and daughter) have a great relationship and I'm very jealous of it sometimes. I would like to just take the day off sometimes so I can stay home with them.

If I had had more opportunities to talk with fathers involved in full time wage work, perhaps I would have heard more examples of working *parents* wanting to spend more time with their children.

Gendered Divisions of Labour

According to the results of the 1996 Canadian Population Census (Statistics Canada 1998: electronic document), among those fifteen years old and older in St. John's, 76.5% of males⁸¹ (and 49.8% of females) reported spending less than fourteen hours on housework per week, 18.4% of whom did no housework at all. In contrast, 50.2% of females (and 22.5% of males) reported spending more than fifteen hours per week on housework, with 26.9% of females (and 8.7% of males) spending more than thirty hours a week doing this unpaid labour (ibid.). In sum, although almost half of the male population reports some time spent on housework, women report spending more time. It is unclear in these statistics, however, which housework tasks are being accomplished by the members of which gender.

⁸¹ In their report, Statistics Canada (1998) uses 'males' and 'females' instead of 'women' and 'men' (as I do throughout the thesis). I presume this is done to include the population of teenage respondents in their sample.

During the interviews I conducted with parents in St. John's, the mothers described how household tasks were divided between what they could get done in the day and what their husbands, or in some cases older children, would do to help out. Generally, mothers assume the responsibility of completing household chores unless fathers are home more. In all the families, women were almost exclusively responsible for the care of infants while men assumed more childcare responsibilities as children grew older.

In her article, Bonnie Fox (1997) explores how labour is divided when partners become parents in terms of "privatized parenthood" whereby couples specialize their roles and divide their work. According to Fox (1997), the division of housework is based on both existing gender ideologies and on who is home the most (see also Frank et al. 2000). Based on qualitative data collected in the U. S., Fox (1997) describes the first few months of new parenthood as particularly important to the negotiation of division of labour¹². She explains that, shortly after the birth of a baby, women in the research sample were more driven towards finding their newly acquired "mother" identity while their partners tended to take on a heightened "breadwinner" role. As Fox states, "socially unrewarded by their motherwork, this drive in part explained why some of the women did so much housework and met such high standards of housekeeping" (Fox 1997: 153). In other words, motherhood draws women into housewifery (*ibid.*).

¹² The transition to parenthood is explored in more detail by such researchers as Fox (1997), Luxton (1997), Walzer (1996), among others.

Even when mothers pursue wage work outside of the home they are frequently responsible for many chores *inside* the home, what Hochschild (1989) terms “the second shift.” Joan described her “double duty” of her job and the household chores even while she was pregnant. Now that her husband, Peter, is home with the baby while she works, he has assumed many of the household chores⁸³ so that she can spend more time with the baby when she gets home from work⁸⁴. But as Joan points out, this division is not entirely altruistic: “He’s a bit of a neat freak, he can’t let it (a messy house) go, so I’d say if you want it done you do it.” As she laughingly describes some of Peter’s attempts at laundry, Joan recognizes that some chores are best left with her but is relieved to come home from work to a clean house.

In a recent study of the impact of gender in influencing parenting behaviour, Frank et al. (2000) found that parents do not “switch” parenting roles when the father is the primary caregiver. Instead, a new system of parenting is created whereby various elements of what are thought to be “traditional” mother and father roles are combined and divided between the parents. The authors found that primary caregivers are more active in housework than the employed parent regardless of gender (ibid.). Beyond taking on some of the household chores, Peter also had to learn how to care for their small child.

⁸³ In general, men as fathers were seen to have more control over their time and tended to be responsible for “tasks” that they could accomplish at their convenience. Women as mothers tended to assume the routine, less flexible daily chores (Hochschild 1989:8).

⁸⁴ Frank et al. (2000) describe caregivers as “stepping back” in the evening to allow the employed parent to intimately interact with their children. Similarly, Fox (1997: 149) found that primary caregivers allowed the time their employed partners were at home to be spent with children. Fox describes this as not only allowing time for the working parent to bond with the children, but also gave the primary caregiver a ‘break’ from the children.

Peter told me, "I think it's harder for me because I was never 'taught' or 'shown' how to mother." Joan also recognized that: "We're both from traditional families where traditionally the man doesn't take care of the children."

While 'traditionally' fathers did not care for their children, I did hear examples of fathers actively assuming, and enjoying, childcare responsibilities. When I asked her what role her partner took with their infant son, Emily replied:

I didn't change the baby's diaper for the first two months because his father did it. He had his first tub bath with his father. His dad changed him, he burped him, he dressed him, he bathed him, he did everything, and he carried him in the snugly and then he'd rock him to sleep.

In my research among parents in St. John's, there were variable cultural expectations of fathers and their role in childcare and housework. I heard descriptions of men's participation in housework in families in St. John's, suggesting that many fathers of young children are increasingly taking part in both childcare and household work (see Gutmann 1997, 1998).

Among the households represented in this research, parents described to me how they "worked out"⁴⁵ who would do which tasks based on what they were 'good' at and according to their work schedules. Almost all parents, after apologizing for dirty dishes in the sink or toys scattered over the floor, told me: "Sometimes, things just do not get done. They are just not as important anymore."

⁴⁵ Hochschild (1989) Lamphere et al. (1993:217) found that household arrangements were rarely discussed or planned but "just seemed to happen."

So far, I have focused this section on gendered divisions of labour in the contexts of conceptions of work. How do we describe the work of single parents who don't have anyone to divide labour with? Ann is a single mother whose daughter was 18 months old and still breast feeding when we first met. Ann had already completed two years of university when she found out she was pregnant and decided to return to her studies after her daughter's first birthday. Ann feels that she can offer more to her daughter if she's 'complete,' meaning if she has a well-paying career. She strives to get high grades in her courses because she feels she needs to prove that she can succeed at her studies and secure meaningful employment as a single mom. Ann relies on social assistance and student loans to support her and her daughter while she is in university. Her decisions, from what subjects to major in to which second-hand sofa to purchase, are made in terms of the child she alone is raising.

Ann told me that she is fortunate to have family and friends who enjoy caring for her daughter while she is in classes and when she needs a break or some time to herself.

When I asked Ann whom she relies on for support she answered:

There's no one there when you get home. Who you can turn to and say, "I need to study, can you take care of her?" People are supportive and help out but I get up in the morning and do what I have to do.

In our conversation, Ann further explained to me she must balance her priorities and be very organized so that she can get through her day. For instance the week before our first interview she had papers to write, her daughter was sick, the laundry needed to be done and her home cleaned.

In using Ann as an example of life as a single parent, I do not mean to imply that women who have partners necessarily have less of a burden. Indeed, one may argue that, in some cases, having a partner means one more person to look after and yet another person to negotiate with. Ann's story illustrates what all of the mothers in this thesis do: that mothers, and fathers, have enormous responsibilities in their day-to-day living. After attempting to describe to me how she organizes and accomplishes these responsibilities, one exasperated mother simply ended: "You just get up in the morning, put your two feet on the floor, and go. You just do it."

Chapter Summary

Infant feeding and decisions concerning infant feeding are work which constitutes women's, and sometimes men's, unpaid labour. Feeding infants, children, and other members of the household takes time, planning, coordination, and the mental and physical energy of parents. Further, this work must be accomplished along with other, sometimes conflicting, responsibilities.

Parenthood frequently involves reconciling work inside and outside of the home and childcare strategies (including infant feeding) with the meanings and lived experiences of gendered divisions of labour. Decisions to pursue paid labour beyond the work of parenthood, or to become "full-time" parents, are not made lightly but are considered in terms of personal desires, gendered expectations, and financial realities. Moreover, in considering this point, it is important to recognize the diversity in work arrangements as families "just do" their day-to-day living.

When parents talk about their infant feeding experiences, they are also describing other aspects of their daily lives and the ways in which they prioritize, juggle, and cope with what they do on a day-to-day basis. I use these discussions to demonstrate other aspects of parents' everyday lives in terms of their responsibilities as parents and as adult members of their society. In doing so, I argue that infant feeding *options* are often promoted, and infant feeding *practices* often evaluated, outside of the larger social, cultural, and indeed, the diverse individual contexts in which they exist.

Chapter Six:
By Way of Conclusion

Feminists and anthropologists assert that even though lactation is a biological process, breast feeding can be viewed as a site where what is 'natural' is not a 'natural' phenomenon. Rather, infant feeding practices, including breast feeding, are influenced by specific historical and socio-economic factors and are defined and interpreted by such discourses as those relating to science, medicine, and motherhood. An examination of infant feeding practices demonstrates the ways in which wider social contexts influence infant feeding decisions. Moreover, an examination of examples drawn from particular individuals' experiences reveals how infant feeding decisions are experienced differently depending on the myriad of other aspects of their daily lives.

Ideas about infant feeding practices have developed over time and are influenced by larger social concerns about the health of infants and, moreover, about the health of the 'state.' In my discussion of the Child Welfare Association in St. John's I have shown that the concern over, monitoring of, and intervention in infant and child health through campaigns targeted at mothers have existed in Newfoundland since early in the 20th century. While breast feeding has always been promoted as the optimum infant food, infant formula grew increasing available and acceptable within the changing social, economic, and political contexts of St. John's. It is this acceptance of infant formula, and its prevailing use, that remains an issue for breast feeding advocates in St. John's as we move from the 20th to the 21st century.

The monitoring and supervision of infant health and breast feeding promotions initiated by the state has resulted in a creation of a widespread consciousness of infant health. Within this 'consciousness,' the perceived health of infants is evaluated not only by the state but by individuals in the community as well. Breast feeding, then, is both *formally* promoted in state funded and operated campaign such as those by Health Canada and the Breastfeeding Committee of Canada, and *informally* in people's everyday encounters as individuals identify and participate in the pro-breast feeding movement. The pervasiveness of breast feeding promotion creates a pro-breast feeding, anti-formula social environment in which infant feeding decisions are made.

While current health initiatives encourage women to breast feed as well as encourage the acceptance of breast feeding in the larger society, the socio-economic conditions and viewpoints of the women themselves are often ignored. I have argued that infant feeding in current contexts exists in a pro-breast feeding, anti-formula feeding environment in which decisions, at once private in the sense that they are made by individuals, remain a public concern. The promotion of breast feeding in both formal and informal encounters has an impact on ideas about breast feeding and on infant feeding practices. However, as pervasive as pro-breast feeding messages are, parents do not always think about being evaluated as they cope with everyday realities and juggle different paid and unpaid responsibilities.

Through an examination of parents' experiences feeding their infants in a pro-breast feeding, anti-formula feeding environment, I have shown that infant feeding practices are social indicators of 'good' parenting. Within social expectations of men and

women as parents, the practice of infant feeding is experienced in different ways in the daily lives of individuals. As one aspect of parenting, infant feeding practices are primarily focused on the actions of women. Among many other social and cultural considerations, the sexualization of breasts creates a potential conflict between being a 'good' mother and a 'good' woman. Even though 'good' mothers breast feed, 'good' mothers do not show their breasts in the presence of others. If being a 'good' mother means breast feeding, mothers (and fathers to some degree) who formula feed often face negative evaluations of their behaviour. Moreover, if breast feeding is the "best", and infant formula is inferior to breast milk, the use of evaporated milk formulas in Newfoundland is met with a heightened level of judgement and scrutiny. Within these contexts, fathers must find their place in their infants' lives in a culture that focuses infant care on the actions of the mother. Regardless of the infant feeding methods chosen, infant feeding practices are also opportunities for others to evaluate how well a mother or father parents according to wider social and cultural expectations.

In my interviews with parents in St. John's, talk about infant feeding easily led to conversations about other responsibilities of being a parent. I present infant feeding responsibilities as often constituting women's, and sometimes men's, unpaid labour. In short, infant feeding and decisions concerning infant feeding are work. As well, this work must be accomplished in addition to other, sometimes conflicting, responsibilities. When parents talk about their infant feeding experiences, they are also describing other aspects of their daily lives and the ways in which they prioritize, juggle, and cope with what they do on a day-to-day basis. I use these discussions to demonstrate other aspects

of parents' everyday lives in terms of their responsibilities as parents and as adult members of their society. In doing so, I argue that infant feeding *options* are often promoted, and infant feeding *practices* are often evaluated without the consideration of the diverse individual contexts in which they exist. Further, when parents describe their infant feeding experiences, they are also describing other aspects of their everyday lives in terms of their responsibilities as parents and adult members of their society.

Parenthood frequently involves reconciling work inside and outside of the home and childcare strategies (including infant feeding) with the meanings and lived experiences of gendered divisions of labour. Decisions to pursue paid labour beyond the work of parenthood, or to become "full-time" parents, are not made lightly but are considered in terms of personal desires, gendered expectations, and financial realities. Moreover, in considering this point, it is important to recognize the diversity in work arrangements as families "just do" their day-to-day living.

An examination of infant feeding practices contributes to existing anthropological understandings of body politics, politics of reproduction, gender divisions of labour, and the family. Moreover, by illustrating the historical, social, and cultural contexts in infant feeding takes place, I have shown that infant feeding practices reveal the diverse aspects of being a 'good' parent in St. John's.

Appendix A:
Interview Parameters

Questions to record socio-economic conditions:

- How old are you? Are you married? For how long? How many children do you have?
- Where are you from? Where is your partner from? (other questions surrounding family composition, i.e. siblings, parents)
- Do you work outside of the home? Does your partner work outside of the home?

What are your occupations?

- What (high) school did you attend? What is the highest level of education you have completed?

Questions surrounding pregnancy, birth, and the early postpartum period:

- What types of materials did you read during pregnancy? How did you hear about these sources? What kinds of things did they say? What struck you as interesting or memorable? How did these sources influence your decisions?
- Did you attend pre-natal classes? What types of things were you taught in these classes? Did they discuss infant feeding options in class? What did they say? What was your overall impression of these classes?

Exposure to infant feeding methods:

- How were you fed as an infant? What does your mother say about how she fed you? What do other members of your family or your friends say about infant feeding?
- How do most of your friends/family feed their children?
- How did you think you would feed your children before you got pregnant? during pregnancy? after birth?

Experiences of infant feeding:

- Who did you talk to about how you would feed your baby? What types of concerns did you have? What kinds of advice did you get from your partner? from family? from friends? from members of the medical professions?
- How do/did you feed your infant when you are not at home?
 - Breast feeding – Did you do anything different when breast feeding in front of others? (explore issues surrounding exposing one's breasts and reactions from others).
- How is/has this infant feeding method worked for you?

- When do you expect to or when did you (if applicable):
 - Switch to formula? Switch types of formulas? Introduce solid foods?
 - (if applicable) How much does formula cost you? Has it changed how you live? How do you make formulas? Are they complicated to use? How did you choose?
- In general, who do you turn to when you need encouragement or guidance for your decisions? When do you find you need this kind of support the most? How do people around you encourage you if at all?
- How do you see your infant feeding decision now? Is/was it what you expected it would be? Would you do things differently, how?

Experiences with health care professionals and advocacy groups:

- How often do/did you take your baby to the physician? What types of things does/did the physician check?
- How often does the public health nurse visit? What types of things does this nurse check?
- Have you had any contact with La Leche League or any other breast feeding advocacy groups? Did they contact you? What did they say? How did they address your concerns? What kind of experience did you have?

Household dynamics (during infancy):

- What is your typical day like? What household tasks do you do in a day?
- How has your household work changed since you have had the baby/children? What has changed, if anything, with the birth of each child?
- Who manages the household, for example the finances, the housework, and the childcare?
- Does anyone help you around the house and how? (division of labour)

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