

CHOICE OR CIRCUMSTANCE? AN EXPLORATION OF BREASTFEEDING
PRACTICE AMONG NOVA SCOTIAN MOTHERS CLASSIFIED AS OVERWEIGHT
OR OBESE AND INCOME-RELATED FOOD INSECURE

by

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DEDICATION

There is nothing worse than a sharp image of a fuzzy concept.

Ansel Adams

When I was younger, I frequently visited my cousins' house. Displayed on the walls throughout their home were a number of pieces of art, including work by photographer Ansel Adams. I was drawn to his photography – for its beauty, starkness, and apparent ability to reveal something valid and true about our world. These images are forever etched in my memory. It's funny how perspective can change ...

I wish to recognize Alice, Beth, Dawn, Jennifer, Lee, Lynn, Michelle, and Tracy.

This work is only possible because of your stories. In sharing your perspective, you have forever changed mine. Thank you for your inspiration.

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ABSTRACT

Breastfeeding is a complex, relational practice spanning bio-physiological, social and structural considerations. Consistently, mothers across Nova Scotia report lower rates of breastfeeding initiation and duration of exclusive breastfeeding compared with mothers from other Canadian provinces. While breastfeeding is represented as a contributor to obesity prevention and supportive of food security (both timely public health issues for Nova Scotia), evidence suggests that excess maternal body weight and income-related food insecurity may negatively impact breastfeeding practice and outcomes.

This qualitative study explored breastfeeding expectations and experiences among Nova Scotians also identifying as income-related food insecure and overweight or obese. Informed through feminist, post-structural methodology, this inquiry aimed to identify dominant discourses that shaped understandings of breastfeeding, excess body weight and food (in) security among participants who identified as living within these contexts, specifically how these discourses informed participants' breastfeeding experiences and practices.

Eight participants who were pregnant for the first-time with intention to breastfeed were invited to participate in three, separate, face-to-face, audiotaped interviews (prenatal, first month postpartum and 3 months postpartum) and six participants completed the study. Discourse analyses were conducted with prenatal (n=8) and postpartum (n=12) interviews.

Findings suggest that the participants' prenatal understandings of breastfeeding, obesity and food (in)security aligned with dominant discursive representations of these

health issues, and informed through a socially constructed normative understanding of what it means to mother in a good and proper way. That is, participants identified that *choosing* to breastfeed, *preventing* obesity, and *avoiding* food insecurity are responsibilities of “good mothering”. These discourses were reinforced through exposures with institutions throughout the perinatal and postpartum period. Once participants became mothers, their experiences with breastfeeding during this time were largely shaped with a continued attendance to these dominant discourses. However, some participants resisted and reframed their conceptualization of good mothering to identify with maternal subjectivities that were both situation and context-specific.

Ethical, supportive practice requires practitioners to critically reflect on how discourses shape normative maternal identities and their effects for health-related parenting practices that include breastfeeding.

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CHAPTER 1 INTRODUCTION

Breastfeeding is a complex practice that spans biological, psychological, social, political and cultural factors. Over the past several decades, breastfeeding has occupied a privileged and unique position as a health practice that remains largely unchallenged for its benefits to mother, infant and broader population health goals. Empirical evidence suggests breastfeeding, particularly prolonged exclusive feeding, may be associated with a host of positive health outcomes for mother and infant/child. Compared to alternative infant feeding methods, breastfeeding has been suggested to play a role in myriad short- and long-term health benefits including reduced morbidity and mortality due to gastrointestinal and respiratory infections in early childhood (Horta, Victora, & World Health Organization, 2013). Breastfeeding has also been associated with mitigating the risk of developing obesity, a condition represented as having a pronounced impact on both individuals and societies across the globe (Horta, Bahl, Martines, Victora, & World Health Organization, 2007). More recently, however, both scholars and the public alike have explosively challenged that this privileged, normative position of breastfeeding represents a simplistic view of a complex practice (Colen & Ramey, 2014; Himmelstein, 2014; Jung, 2016; Rosin, 2009).

Today, breastfeeding is regarded as the normative and “gold standard” of infant feeding. This “breast is best” message is being heard and acted on by the 90.3% of Canadian mothers who currently initiate breastfeeding (Chalmers et al., 2009). However, the course of infant feeding can change quickly in the postpartum period due to a variety of circumstances. The most recently available data suggests that only 14.4% of nursing mothers in Canada will reach the public health benchmark of exclusive breastfeeding for

6 months duration (Chalmers et al., 2009). Changes to breastfeeding practice among Nova Scotian mothers have been observed over the past decade (Public Health Agency of Canada, 2008); where 80.2% of Nova Scotian mothers reported initiating breastfeeding in 2011 compared with 88.6% of mothers in 2014 (Statistics Canada, 2016). There has also been a steady increase in rates of exclusive breastfeeding at hospital discharge in this province from 48.5% of live births in 2006 to 60.1% of live births in 2014 (Perinatal Epidemiology Research Unit, Dalhousie University, 2015). However, both initiation and duration rates of breastfeeding (Millar & Maclean, 2005; Public Health Agency of Canada, 2008; Reproductive Care Program of Nova Scotia, 2005; Statistics Canada, 2016) continue to remain lower in Nova Scotia relative to other populations across Canada. These observations may be viewed both positively and disconcertingly for those actively working to promote breastfeeding and increase breastfeeding rates in the province.

Particularly challenging for those promoting breastfeeding are the breastfeeding practices among those categorized as “vulnerable” and “at risk” (Millar & Maclean, 2005), including those mothers who are categorized as income-related food insecure. In the public health field, income-related food insecurity is understood as a situation whereby an individual’s or household’s lack of economic resources precludes the ability to eat well, putting s/he/them at risk of nutritional-related ill-health, including obesity (Walls, & Richmond, 2011; Olson, 1999; Townsend, Peerson, Love, Achterberg, & Murphy, 2001). Research also suggests that women who are food insecure are also at risk of pre-pregnancy obesity (Laraia, Siega-Riz, & Gundersen, 2010). Excess maternal body weight experienced among women living with income-related food insecurity may

partially explain poor breastfeeding practices among these women. Notwithstanding that women with excess body weight are more likely to experience birth interventions (e.g., caesarean delivery) (Siega-Riz & Laraia, 2006) that are reported to negatively impact breastfeeding (Keely, Lawton, Swanson, & Denison, 2015), Rasmussen and colleagues were the first researchers to report that pre-existing excess maternal body weight or excess gestational weight gain may negatively impact breastfeeding initiation and duration through bio-physiological mechanisms (Rasmussen, Hilson, & Kjolhede, 2001; Rasmussen & Kjolhede, 2004; Rasmussen, Hilson, & Kjolhede, 2002). More recently, Garner and colleagues suggested that while many of the reported breastfeeding challenges experienced by women of excess body weight are similar to those experienced by women of normal body weight (e.g., latch and positioning), these issues are prolonged among women of larger size (Garner, McKenzie, Devine, Thornburg, & Rasmussen, 2016). Ironically, and in spite of the documented breastfeeding challenges among women with excess body weight, there is also interest by health stakeholders to improve breastfeeding practice (both initiation and duration) as a strategy towards addressing the “obesity epidemic” (Lau et al., 2007).

Despite an increased body of research that aims for a greater exploration of the experience of breastfeeding, empiricism dominated by the positivist paradigm continues to permeate public health breastfeeding discourse, which in turn influences how health professionals, policymakers and researchers understand, promote and reify breastfeeding as a normative standard and good health practice. This has the potential to limit the understanding of breastfeeding to only its health associations (benefits), rather than understanding why breastfeeding practices occur the way they do. For example, a current

gap in understanding is why breastfeeding practice alters so drastically in the post-partum period (Public Health Agency of Canada, 2009), whereby the majority of mothers stop breastfeeding earlier than recommended by health practitioners. This discourse potentially limits the actions we take as public health stakeholders to understand and support breastfeeding practices from intention of breastfeeding to breastfeeding practice. Moreover, this limiting view may continue to further impact research directions through the inquiries we make concerning breastfeeding, and what is or is not valued as best evidence to advancing our understanding about breastfeeding practices.

In addition to its position as a “natural” and “healthy” way to feed an infant/child, breastfeeding needs to be understood for the dynamic and highly contextual practice it is. Breastfeeding is a socially relational practice, meaning that it includes an ongoing negotiation between a nursing woman and her infant/child, that is further contextualized within the prevalent discourses surrounding gender, class, socioeconomics, social perceptions of body weight and body image, and health. If health stakeholders are to better support mothers in their infant feeding practices, then it is these “other” aspects of breastfeeding practice that require greater attention and acknowledgement.

This study is an inquiry into the experience of breastfeeding from the perspective of individuals signified, through mainstream health discourse, as experiencing obesity and income-related food insecurity. Chapter 2 reviews the literature pertaining to breastfeeding, obesity and income-related food insecurity – how they are positioned and understood and how they relate. Conventional biomedical evidence suggests that breastfeeding, obesity and income-related food insecurity are related in a manner that has not been fully explored and that each of these issues has the potential to affect the health

of the population. Independently, low-income status and excess weight or obesity have been associated with less likelihood of initiating breastfeeding, and a reduced likelihood of breastfeeding for a prolonged period of time (Baker, Michaelsen, Sørensen, & Rasmussen, 2007; Millar & Maclean, 2005; Milligan, Pugh, Bronner, Spatz, & Brown, 2000). Therefore, women who are living with material constraint or classified as overweight have the potential to be categorized as at risk for not breastfeeding and become a target of health professional interest and intervention. This issue is even more complex given that excess pre-pregnancy weight is represented to be on the rise among populations classified as low-income, suggesting the two variables are associated (Hinkle et al., 2011). Despite these empirical associations, and their resultant effects on the practices of health practitioners, experiences of breastfeeding practice have not been adequately examined from the perspectives of women who are identified through dominant discourses as having these multiple issues.

If health policymakers and practitioners are focused on reducing health inequities – particularly among vulnerable groups – we should be questioning why the insights and voices of “target” populations (e.g. those classified as low-income and with excess weight, groups of interest to health practitioners for intervention) are relatively underrepresented in the breastfeeding literature and how this affects health-related knowledges, understandings and care practices. It is for these reasons that the purpose of this study is to reveal experiences of breastfeeding among those we classify as most vulnerable, so we might bring forth into dialogue marginalized aspects and understandings of breastfeeding practices. Bringing forth these accounts may help us to reframe how we (as health practitioners) understand breastfeeding and transform the actions and discourse

concerning infant feeding practices. When our understanding of breastfeeding moves beyond the dominance of biological and health outcome-related aspects of the practice, we (as health practitioners) might begin to better support mothers in their infant feeding practices based on the context of their lives and experiences.

In today's world, health and the epistemological views that inform our understandings of it, play an increasing role in shaping our "reality" – how we understand or identify ourselves, others, and our social relations (Nettleton, 2006). Seemingly neutral, the knowledges associated with bodies, health, population health or public health are discursive and have effects on everyday social reality. The modern view of health is dominated by biomedical and empiricist discourse, which constitutes individuals (subjects) as autonomous and free with an emphasis on individualism such that their health is under self-regulation and within their control. Ironically, when health practices and related outcomes are simultaneously constituted through "uncontrollable" or natural factors such as "sex" or "race" (World Health Organization, 2017c), this creates the potential for individuals to position themselves both *in control* and *out of control* of their health.

Through this modern discourse of self-regulation, individuals are positioned in constant pursuit of adopting a state of health and of negotiating the hazards that accompany that pursuit. By negotiating hazards, I mean individuals are encouraged to minimize risk (factors that get in the way of the health "project"). If observed to be working to minimize risk, this signifies both individual and collective rationality and being morally good; on the other hand, deviance is reflective of the individual (or collective) who fails to regulate or aspire towards the ideal self (Coveney, 1998). Finally,

what are good, rational and normal health behaviours are dictated predominantly by the “expert systems” of health (including medicine, science and health promotion) (Petersen, 1997). Therefore, health as a moral obligation informs the subjectivity of individuals; subjectivity suggested to be understood as the dynamic and contextual process of how people understand who they are and their relations within the social field, and consequently experience their lives (Lupton, 1996). To this end, the discursive constructions of good, bad, normal or abnormal health practices create subjectivities based on the health practices in which one engages and thus individuals experience themselves as good or other.

Chapter 2 outlines the dominant discourses that shape health and lay understandings of breastfeeding, body weight, and food security. This chapter presents the argument that, for women today, *choosing* to breastfeed, *preventing* obesity, and *avoiding* income-related food insecurity are all considered goals and responsibilities of being a good, moral, normal, contributing member of society. These practices or concepts are also greater than personal capabilities and capacities, but are part of being concerned with parenting (mothering) the *right, good* and *normal* way. Groleau and Sibeko (2012) further describe that the rules and routines that constructed mothering were historically (re)produced through family and community structures across varying generations. More contemporarily, this has given way to institutional (public health) involvement where moral mothering is produced through the norms and discursive actions within these institutions (Groleau & Sibeko, 2012). Public health institutions represent a *lack* of breastfeeding, the perception of *increased* obesity and the *prevalence of* income-related food insecurity as concerning issues necessitating public health action in Canada and

across the globe. Collectively, an individual experiencing all of the same circumstances is suggested to be in a vulnerable position because they are perceived less likely to achieve ideal health status, and are in need of intervention (e.g. support and guidance) from the health professional community.

It is for these reasons that I have framed this inquiry through the lens of feminist, poststructural (FPS) philosophy, informed predominantly through an orientation to the theories of Michel Foucault. This methodology and its key concepts form the basis of Chapter 3 and conclude in Chapter 4, through outlining the approach used in this study in accordance with FPS philosophy.

Feminist poststructuralism is an important lens through which health-related practices can be theorized. It has the potential to reveal how power operates through discourse to constitute subjects, creates knowledge and works (through discursive practices) to establish understandings and particular ways of knowing about our social world. It encourages us to theorize a social world that is about multiple perspectives – both fragmented and contradictory. For feminism, a poststructural lens also conceptualizes a power that is both repressive and positive; that is, people have the ability to resist and contest those discourses to which they are exposed, reshaping other and alternative subjectivities. Therefore, through this lens, our understanding of breastfeeding, obesity and income-related food insecurity should be grander than any one, dominant perspective that informs knowledge; knowledge which in turn informs health policy, education and health professional practice trajectories. This philosophical orientation allows for a more complex exploration of the social, historical, and political

influences on health practices, and the continued effects of these factors – discourses – on how these experiences are understood.

Foucault’s writings on the body, biopolitics, governmentality, disciplinary power and moralizing practices, provides important insight into how health is positioned in contemporary society and the tactics or strategies that are involved to sustain power throughout the social field as it applies to health. Power, in this sense, shapes our knowledge concerning bodies, health and acts in the creation of dominant ideologies within the social field. Discourse has its own effects in dismissing or silencing alternative knowledges and other ways of understanding health such that our view of health has a possibility of becoming “partial and misinformed” (Travers, 1995, p. 214). In relation to how the partial view of health is understood and acted upon by health professionals, Gingras (2009) observes: “those with power [health experts] prevent different ideas from being heard because those readings subvert the dominant ideology, and detractors are kept silent because the powerful won’t take risks, which reinforces the dominant views by default” (Gingras, 2009, p. 88). Using feminist poststructuralism for this inquiry will enable a critical reflection on how professional practices inform dominant understandings about breastfeeding, obesity and income-related food insecurity.

Feminist poststructural philosophy is also critical as its orientation allows for the social constitution of “woman” or gender to be an important part of the research (Lather, 1991, p. 71) and a point of critical reflection. Breastfeeding, obesity and income-related food insecurity cannot be separated from their relationship with gender. More specifically, these topics cannot be removed from their discursive associations with

motherhood, and the normative standards applied to mothering. As summarized by Lupton (1996):

Any discussion into the role of food and eating in the context of the family must incorporate an analysis of the meanings and norms around motherhood and femininity, for in households in western societies, the purchase and preparation of food for the family is the responsibility of women (Lupton, 1996, p. 39).

This research is more than an in-depth exploration into the breastfeeding practices of those constituted as experiencing obesity and income-related food insecurity. It is also an inquiry which challenges us to question what counts as legitimate knowledge (Lather, 1991) across three related health concepts, and cautions us to consider the outcomes when we use knowledge from one lens without attending to the other experiences that inform our health-related practices. This research is about exploring the other experiences towards a greater understanding of the circumstances that surround breastfeeding practice within the context of discursive constructions of obesity and income-related food insecurity. In Chapters 5 and 6, I present findings as they pertain to the exploration of breastfeeding practice among those constituted through discourses of excess maternal body weight, new parenthood, poverty and income-related food insecurity. It is through those chapters that the complexities and tensions of breastfeeding, among other related health practices, are revealed. Finally, Chapter 7 concludes this exploration with a discussion about how these findings can contribute to enhancing our perspective of infant feeding practices – within the sociological and public health fields, ultimately toward improving the care and support provided to parents across all diverse circumstances.

Within the health field, the dominant breastfeeding discourse suggests that exclusive breastfeeding is a practice that warrants promotion and protection among *all* women, including those women who are classified by health practitioners as most vulnerable. However, it is not acceptable to consider that all women are on equal footing with respect to the practice. This exploration is an important step to broaden our understanding of breastfeeding through exploration that unravels the complexity of the practice, the knowledges and understandings that inform it, and brings into dialogue the marginalized aspects of breastfeeding. Including other experiences of breastfeeding, and the breastfeeding experiences of others will challenge us as health professionals and researchers to reflect on our own practices, what we know about breastfeeding, such that we might reshape our understanding of breastfeeding for the betterment of practice and policy.

CHAPTER 2 LITERATURE REVIEW

This chapter is focused on a review of the literature pertaining to the health concepts of interest for this study: breastfeeding, obesity, and income-related food insecurity. The body of research surrounding breastfeeding, obesity and income-related food insecurity is both vast and unwieldy. This chapter does not form an exhaustive review of these concepts, nor is its intention to persuade the reader toward a unitary understanding of them. Rather, its focus is to discuss the dominant discourses that shape conventional understandings of breastfeeding, obesity and income-related food insecurity, with an emphasis on the dominant discourses that circulate within the health field.

2.1 Breastfeeding

Breastfeeding. The act of a mother feeding her infant or young child with milk from her breast, the milk that is made just for her baby. By all accounts, it is nature's perfect food and nature's perfect feeding vehicle. Or is it? Breastfeeding is much more than its biophysiological definition: "to feed (a baby) from a mother's breast" (Merriam-Webster, 2012) and represents a host of complex practices that span biological, psychological, social and cultural factors. I would argue that there are few health-related topics that are so contested, resisted and generally polarizing, as breastfeeding. Its discursive formation sets the tone for the type of mother you are and how you intend to mother.

Breastfeeding can be argued as one of the initial opportunities for a woman to perform her role as mother. Performance, in this sense, is the discursive practice of doing what is expected of mothers or what is suggestive of that subject position (which is in itself, constituted through discourse). The act of breastfeeding reifies the discursive

positioning of a mother's role as primary caregiver and with overall responsibility for feeding the family (DeVault, 1994; Lupton, 1996).

Labbok (2000) wrote that the meaning of the word breastfeeding has historically depended on who was speaking (Labbok, 2000). However, it is the bio-physiological definition of breastfeeding and the signification of breastfeeding as the performance of good motherhood, which dominates and represents this concept in modern society. Moreover, biomedical science legitimizes and rationalizes how breastfeeding, and its signification as a good mothering practice, is positioned in lay and health discourse, using authority and expertise to constitute breastfeeding mothers as good and moral mothers (Marshall, Godfrey, & Renfrew, 2007). This is not to say that breastfeeding discourse should *not* include a biological and physiological dimension. Rather, it is an observation that breastfeeding discourse within the health field is heavily weighted towards the medical aspects of breastfeeding practice and the moralization of mothering, compared to understanding alternative experiences around which breastfeeding practice does or does not occur, or alternative and potentially resistant discourses of breastfeeding. These dominant discourses then impact how breastfeeding practice is promoted throughout the social field.

Over the following sections, I will outline the dominant perspective regarding breastfeeding from historical and biomedical (bio-physiological) perspectives in an attempt to illustrate the dominant discourse pertaining to breastfeeding. I will outline how this discursive positioning affects how we currently understand and know breastfeeding, the claims we make about the health benefits of breastfeeding, and its influence over breastfeeding-related practices (education, policy, others) within the health

domain. I will challenge the health discourse that positions breastfeeding practice as an individual “choice”; rather, suggesting that breastfeeding practice is a concept that has been constituted through historical and social contexts. By illustrating these contexts, I will also provide an argument for the discursive positioning of breastfeeding as a practice, and moral imperative, of good mothering.

This section is critical toward addressing *why* and *to whom* breastfeeding is promoted, and *how* breastfeeding (or lack thereof) contributes to maternal subjectivity. Finally, it will provide necessary context for the further exploration of breastfeeding practice among mothers signified as experiencing obesity and income-related food insecurity.

2.1.1 A brief history of breastfeeding – the rise of breast is best

In the 21st century, breastfeeding holds a privileged position as the “optimal” practice of infant feeding. An historical examination of infant feeding practices reveals that this discourse is not new; even with drastic changes in civilization over time, and differences across cultures, languages and economies, the dominant discourse on breastfeeding practice, or the value of human milk, has remained relatively consistent – that breast is best and deemed necessary for the survival of the human race (Thulier, 2009).

Documentation of breastfeeding practice dates as far back as 4000-3000 BC from sources that include imagery in art; religious and medical texts; personal diaries; and the discovery of infant feeding artifacts (Fildes, 1986; Thulier, 2009). Historically, human milk has held a privileged and sometimes magical position. In Greek mythology, breast-milk had the ability to render one immortal. It was lauded for its ability to protect

“mortal” children from demons and predators. Moreover, human milk was used in potions and remedies and was valued for its curative properties (Fildes, 1986).

For much of civilization, this magical milk did not require the act of maternal nursing, but could also come from a wet-nurse. Wet-nurses were lactating women from (predominantly) minority status groups who were often employed by a family for the purposes of breastfeeding an infant or young child. During the colonial era (1500s to 1900s), wet-nursing was practiced mostly among the upper classes and predominantly among European nationalities; however, there is also evidence of wet-nursing being common among the urban, working class and lower class Europeans as well (Nathoo & Ostry, 2009). There is limited evidence to the extent of wet-nursing practices in colonial Canada; however, the evidence that does exist suggests that wet-nursing played a less significant role compared with its role in Europe (Nathoo & Ostry, 2009). In colonial Canada, wet-nursing was used during emergencies and only among the most upper class in Canada’s New France, paralleling its growth in popularity in European France across all class categories (Nathoo & Ostry, 2009; Sussman, 1975).

The employment of a wet-nurse has been contextualized as serving predominantly male interests – improving sexual relations between the infant’s father and mother (e.g., sexual relations during lactation was considered taboo) and avoiding adverse effects on the health, figure, and beauty of the nursing mother (Fildes, 1986). Economic interests of the household were also important in pre-industrial times as is commonplace today; wet-nurses freed mothers from child-rearing duties so they could provide for the household, either by bearing more children (enhanced fertility) or by working themselves (Fildes, 1986; Sussman, 1975).

The ideal wet-nurse had desirable qualities to ensure good quality milk and a copious supply. These characteristics included personal and interpersonal practices; health status; appearance (including complexion); and size of breasts and nipples, which were all believed to affect the valued properties of breast-milk. Their numbers of children and educational level or intellect were also important characteristics of interest (Fildes, 1986). The wet-nurse provided the nursed child with all her characteristics and qualities: “what affected the nurse, affected the child” (Fildes, 1986, p. 189); too often, this close relationship left wet-nurses as scapegoats for infant mortality (Thulier, 2009).

We continue to see evidence of idealism regarding the nutritional composition of breast-milk in biomedical discourse on breastfeeding. For example, there are rules that govern what should or should not be consumed by lactating women for its impact on the composition of breast-milk, and ultimately the nursing child. Some examples include both conventional and alternative nutrition recommendations, pharmacological, and social practice considerations such as consumption of alcohol during pregnancy and lactation (Health Canada, 2011, 2013, 2014; Public Health Agency of Canada, 2014, 2015b).

The critique of wet-nursing practice and the movement towards focusing on maternal breastfeeding to signify good vs. bad mothering has only been documented in more recent times (around the middle of the 17th century into the 20th century) where maternal breastfeeding and artificial feeding of breast-milk substitutes emerged as the dominant (and dichotomized) modes for infant feeding. During this era, there was a “widely shared faith that science, efficiency and cooperation would solve all of society’s problems” (Thulier, 2009, p. 88). With increased societal interest in the role of women’s

activity for the betterment of society came greater attention paid to breastfeeding practice as important to realize these social goals.

Breastfeeding was valued in post-colonial North America for its ability to support health and viability of a growing population – mostly through a recognized reduction in infant mortality among breastfed babies; therefore, the state, medical community and religious leaders had a vested interest in promoting the practice (Blum, 2000; Thulier, 2009). As the era of scientific motherhood emerged, children’s rights and infant mortality were at the forefront of societal concerns and mothers increasingly sought medical (scientific) advice for infant feeding practices (Thulier, 2009). The growth of public health as an institution ran parallel to this social discourse; “proper” and good mothering practices (including breastfeeding) supported building a powerful nation during times of war and state policies and programs (including those provided by public health) began to dictate how mothering should or should not occur (Blum, 2000).

Ironically, the women’s rights movement and the technological and scientific revolutions of the early 20th century also marked a shift towards bottle (or “artificial”) feeding practice which is juxtaposed with the increased reliance on medical discourse, science and manuals for the “how to’s” of child rearing (Thulier, 2009). The medical community increasingly scrutinized wet-nursing practice because of its potential associations with infant mortality. On the other hand, bottle-feeding of artificial breast-milk substitutes represented faith in science and a safer alternative. Subsequently, bottle-feeding became the norm during the first-half of the 20th century and breastfeeding rates fell to an all-time low by the 1970s (Thulier, 2009). Several factors are suggested to contribute to the upward trend in breastfeeding rates over the past number of decades;

including, more scientific research related to understanding links between breast-milk and health outcomes; evidence-based practice as a pillar of health promotion; and global health policies focused on the promotion and protection of breastfeeding (e.g. International Code of the Marketing of Breast-milk Substitutes, Innocenti Declaration) and the identification of companies and jurisdictions which violate these policies (Participants of the WHO/UNICEF Policymakers' Meeting, 1990; World Health Organization, 1981).

These historical contexts and the shift from social to medicalized perspectives continue to shape modern views of motherhood and breastfeeding. A brief history of breastfeeding in Canada reveals the rise and fall in breastfeeding practice due to a multitude of the aforementioned cultural, economic and political factors. After a decline in breastfeeding was observed in the post-World War II era, breastfeeding initiation has been mostly on an upward trend among all Canadian mothers since the 1960s (Nathoo & Ostry, 2009). The most recent statistics today indicate that 90.3% of Canadian mothers initiate breastfeeding; however, attrition rates are high and most mothers will not reach the public health benchmark of exclusive breastfeeding for 6 months (Chalmers et al., 2009). Moreover, artificial feeding of breast-milk substitutes is highly contested within medical and public health discourse for both risk and danger to infant health and welfare, and is only recommended if breastfeeding is contraindicated for mother and infant. Wet-nursing is no longer *en vogue* (Thorley, 2008), and the availability of pasteurized human milk in Canada is scarce (Kim & Unger, 2010) and may only be accessible to some of the most critically ill pre-term babes or through rising underground market sharing or cross-nursing practices (Rotstein, 2012; Vogel, 2011). Therefore, the dominant infant feeding

practices in Canada include a mother breastfeeding; manually or mechanically expressing and providing her own breast-milk through supplementation devices; formula-feeding her child; or some variation on or combination of those practices.

2.1.2 Biomedical and other representations of breastfeeding

The biomedical perspective on breastfeeding begins with its anatomical and biophysiological considerations. To breastfeed signifies the provision of nourishment (human milk) to another human by the (female) breast, in addition, this milk is (“ideally”) received directly from the lactating breast into the recipient’s oral cavity.

Biophysiological, breastfeeding practice includes both the act of providing nourishment through human milk and also the mechanism of mammary gland lactation (Labbok & Krasovec, 1990). Further, breastfeeding falls on a continuum of practices that include full, partial or token. “Full” breastfeeding is defined as exclusive or “almost exclusive” breastfeeding (i.e. no other liquid or solid other than breast-milk is provided through the infants’ oral cavity), “partial” breastfeeding is defined as mixed feeding (i.e. some breastfeeding mixed with other liquids and/or solids) and “token” breastfeeding is breastfeeding only occasionally (Labbok & Krasovec, 1990; Labbok, 2000). The specificity in the above explanation of breastfeeding is not without purpose, for it relates to the suggested and ideal health outcomes of receiving human milk, *in this manner* and forms the practices of health professionals within public health education and policy activities.

In contemporary society, breastfeeding practice is discursively positioned as the gold standard for infant feeding. It is widely acknowledged (and accepted without hesitation) within the health community that breastfeeding benefits infants, mothers,

communities and societies (León-Cava, Lutter, Ross, & Martin, 2002). Expert institutions such as the Canadian Pediatric Society (Boland, 2005), American Academy of Pediatrics (Eidelman et al., 2012; Gartner et al., 2005), and the World Health Organization (World Health Organization, 2017a) universally maintain that human or breast-milk is the “optimal food for infants” (Boland, 2005), a “normative standard” of infant feeding (Eidelman et al., 2012), and that breastfeeding mothers should practice exclusive breastfeeding for 6 months, and continue to breastfeed for up to 2 years and beyond (Boland, 2005; Eidelman et al., 2012; Gartner et al., 2005; World Health Organization, 2017a). Moreover, these organizations use language that includes “correct” (Gartner et al., 2005), “only” (Gartner et al., 2005), and “normal” (World Health Organization, 2017a), to describe appropriate breastfeeding practice and its considerations. As summarized by the World Health Organization (WHO):

Breastfeeding is the normal way of providing young infants with the nutrients they need for healthy growth and development. Virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large (World Health Organization, 2017a).

Contemporary representations of breastfeeding are based primarily upon a volume of empirical, scientific evidence, with the aim being to associate breastfeeding with health benefits or to understand factors that support or deter women from (normal, correct, normative) breastfeeding. The magnitude of this evidence has grown in recent decades, alongside increased interest in efforts to promote breastfeeding. In the 1970s – when population-level breastfeeding rates in North America were at their lowest (Nathoo & Ostry, 2009; Wright & Schanler, 2001) – only about 2300 articles about “breastfeeding”

were published in journals indexed in PubMed's biomedicine-based database. A similar search from 2000 to present yields nearly 15,000 articles, suggesting the dominance of this form of evidence in shaping the discourse.

The empirical, scientific evidence to date associates breast-milk with health outcomes for infants that include reductions in:

- Infant mortality and morbidity due to diarrheal and other gastrointestinal infections;
- Respiratory infections;
- Risk of developing asthma;
- Ear infections (otitis media); and
- Risk of Sudden Infant Death Syndrome (Infant Feeding Joint Working Group, 2015; León-Cava et al., 2002).

In addition, infant outcomes that are suggested include improved child development through enhanced parental attachment and bonding; improved intelligence; and reduction in the risk of developing chronic disease (Ip et al., 2007; León-Cava et al., 2002).

Breastfeeding is also suggested to protect infants from developing obesity (Yan, Liu, Zhu, Huang, & Wang, 2014), which is of particular relevance to this study (see section 2.2).

Maternal benefits have been suggested to include enhanced attachment or mother-child bond (Britton, Britton, & Gronwaldt, 2006); augmented postpartum weight loss (see section 2.2); child-spacing (Sundhagen, 2009); and reduction in risk of hormonally-mediated cancers (in particular, breast and ovarian) (Chowdhury et al., 2015; World Cancer Research Fund & American Institute for Cancer Research, 2007). For the broader community, breastfeeding is suggested to improve the overall health and viability of

populations and also reduces health care costs which is of particular importance for publicly-funded health care systems (Ball & Bennett, 2001; Bartick & Reinhold, 2010). As such, breastfeeding is presented as a foundation of primary health care. Breastfeeding “costs” nothing (financially, directly), is understood as an environmentally sound practice, and alternative feeding methods are positioned as unaffordable or unsafe (e.g. requiring sterilization of bottles and accessibility/availability of a safe water supply) (Butz, Habicht, & DaVanzo, 1984; Esrey & Habicht, 1986).

Some studies have suggested a dose-dependent relationship with health outcomes, whereby more exclusive breastfeeding and increased total duration of breastfeeding are more beneficial (Chowdhury et al., 2015; Harder, Bergmann, Kallischnigg, & Plagemann, 2005; Harmon-Jones, 2006; Kramer & Kakuma, 2012; World Cancer Research Fund & American Institute for Cancer Research, 2007). For example, the association between breastfeeding and obesity prevention has been based on these findings (Harder et al., 2005). Therefore, the focus of public health messaging is “early, often, and exclusive” to ascertain full breastfeeding benefit to mom, babe and society (World Health Organization, 2017d).

While the scientific and medical evidence in support of breastfeeding is mounting, there are parallel arguments that problematize the weight of this evidence (and its resultant discourse) in informing health-related initiatives. While short-term outcomes of breastfeeding can be observed during the actual practice, methodologically, there are challenges in studying longer-term outcomes due to the types of research studies employed to abstract this information, namely observational (non-experimental) studies

which are complicated by confounders (Adair, 2009; Kramer, 2009). States Wolf (2007a):

In breastfeeding studies, potential confounding makes it difficult to isolate the protective effects of breast milk itself or to rule out the possibility that something associated with breast-feeding is responsible for the benefits attributed to breast milk. As the number of years between breastfeeding and measured health outcome grows, so too does the list of possibly influencing factors (Wolf, 2007a).

In other words, those who breastfeed may have other parenting practices or life circumstances that also differ from those who do not breastfeed, and these other factors may also influence long-term health goals and outcomes.

While desirable methodologically, from an ethical perspective, randomization of infants and children into breastfed and formula fed study groups, or stratified into comparison groups for length of infant feeding duration is inappropriate or unfeasible. The range of definitions and practices reflecting breastfeeding further complicates interpreting research leading health stakeholders to bring consensus and consistency to the language (Labbok, 2000). Thus, the facts on the benefits of breastfeeding (and the risks of not) have the potential to be misinterpreted, misunderstood and uncertain (Wolf, 2011; Wolf, 2007a). Even the Canadian Pediatric Society acknowledges the limitations in drawing causal conclusions from the current evidence base pertaining to breastfeeding research:

While the [infant feeding] recommendations are based on available scientific evidence, it is important to note that many infant nutrition studies are not randomized trials. Such research is neither possible nor ethical in many

circumstances ... It is important to emphasize that additional research is needed in many areas of infant nutrition. These guidelines are based on current evidence, however, secondary to incomplete data, significant controversy exists in many areas. As further data become available from well-designed and well-conducted studies in both developed and developing countries, it is expected that these recommendations can be further validated and/or refined (Critch & Canadian Paediatric Society, Nutrition and Gastroenterology Committee, 2016).

An editorial published over a decade ago also acknowledged the significant challenges that persist with breastfeeding studies. However, the statement concluded differently: “[we] recognize that more research in infant feeding is needed. However, there is no evidence of *harm* [sic] in the recommendation [to promote exclusive breastfeeding for six months]” (Boland, 2005).

But is there no “harm” in this recommendation? A number of medical sociologists and feminists (Dykes, 2005; Faircloth, 2009a, 2009b, 2010a, 2010b; Knaak, 2005; Knaak, 2010; Kukla, 2006; Kukla, 2009; Murphy, 1999; Murphy, 2000; Wall, 2001; Wolf, 2003; Wolf, 2005) have challenged the dominant ideologies surrounding breastfeeding through their research. Wolf has been particularly critical of the use of biomedical literature to inform the position of breastfeeding as the optimal form of infant nutrition (Wolf, 2011; Wolf, 2007a; Wolf, 2007b). She contends that apart from the associations between breastfeeding (or rather breastmilk) and the incidence of gastrointestinal infections (necrotizing enterocolitis, enteritis), that the research linking the benefits of breastmilk with health outcomes are fraught with methodological inconsistencies and further questions (Wolf, 2011).

The emphasis on empiricist literature (which is admittedly methodologically-challenged) in breastfeeding promotion reifies the discourse in relation to breastfeeding and creates dilemmas for a feminist exploration of the practice. Currently, breastfeeding is predominantly understood as a healthy, good, normal behaviour and great weight is given to the scientific associations between breastfeeding and health outcomes. This is not a complete story. What is missing is greater attention to the cultural, social, political and historical circumstances that shape women's experience in relation to the practice. It is these other experiences that are considered less frequently and are traditionally missing from health professional education and practice considerations (Law, 2000; McCarter-Spaulding, 2008).

These alternative and potentially resistant discourses may be linked with structural and social inequities, play a defining role in the breastfeeding experience and may provide valuable insight to why breastfeeding practices occur the way they do (Law, 2000). Such experiences include breastfeeding as a laborious (Dykes, 2005) and isolating practice (Maclean, 1988). Where deemed possibly beneficial for the mother-nursed child bond, it can be detrimental to other familial relations (e.g. partner to partner, mother to her other children, or sibling to nursed child) (Lavender, McFadden, & Baker, 2006; Wolf, 2007a; Wolf, 2007b). Additionally, breastfeeding may conflict with a breastfeeding mother's career (Gatrell, 2007) and her emotional and physical health (Maclean, 1988; Schmied & Lupton, 2001).

Costs also operate on a much deeper and structural level. For example, successful breastfeeding practice may be complicated among survivors of sexual abuse (Kendall-Tackett, 2007; Wood & Van Esterik, 2010) or for those with body dysmorphia (Barnes,

Stein, Smith, & Pollock, 1997). For black women, the historical context of servitude through wet-nursing may inform their attitudes towards the practice (Blum, 2000; Kukla, 2006). Breastfeeding also runs parallel to a counter-discourse whereby the breast is hypersexualized, creating the potential for discomfort for a nursing mother and others within her social network (Groleau, Sigouin, & D'souza, 2013; Groleau, Pizarro, Molino, Gray-Donald, & Semenic, 2016; Johnston-Robledo, Wares, Fricker, & Pasek, 2007; Nathoo & Ostry, 2009). While there is a discursive focus on heralding the practice of breastfeeding, the practice is still embedded in a discourse of domestication – an “embarrassing” and “threatening” practice where the act continues to be delegated to private spaces (Johnston-Robledo & Fred, 2008; Mahon-Daly & Andrews, 2002; Nathoo & Ostry, 2009; Stearns, 1999) because female breasts are thoroughly and obsessively discursively constructed in western societies as sexual objects.

Breastfeeding, through discourse, is represented as a moral imperative – a good mothering practice, within the health community. This is exemplified through the use of (primarily) biomedical evidence and surveillance practices that focuses on physical health outcomes of infants/children and mothers, within a framework of children’s vulnerability. In an era of “scientific motherhood”, mothers are participating in a discourse that constitutes experts (health and otherwise) as those who hold knowledge and understanding about the world, including parenting capabilities and capacities (Apple, 1995; Faircloth, 2010b). The implication of scientific motherhood is that breastfeeding is constructed as a medicalized concept: “infant feeding becomes ‘facts’ that women need to be informed about and convinced of” (Wall, 2001, p. 593). It is also the manner in which we measure the capabilities of mothers (Knaak, 2005; Kukla, 2009). The practice is open

to surveillance or monitoring and the self-management of risk, where not breastfeeding (re: formula feeding) is constituted as risky behaviour. It is the mother's responsibility to properly feed her infant. As summarized by Groleau and Rodríguez (2009):

In the wake of WHO's various calls to promote breastfeeding, research on breastfeeding has been dominated by an epidemiological-biomedical approach, reducing the ontological status of breastfeeding to its purely biological or performative aspects. Breastfeeding has been mainly studied, and therefore defined, by both its health performance, i.e. how it affects the physical health of the baby and mother, and by the socio-demographic and maternal psychological factors associated with it. But positivistic knowledge of this kind prevents us not only from understanding why these mothers choose not to breastfeed but also from planning and implementing policies and programmes promoting breastfeeding that more effectively meet the needs of disadvantaged mothers (Groleau & Rodríguez, 2009, p. 81).

The purpose of this section is not to form an extensive argument against the science upon which breastfeeding policy and practice-based decisions are made. Even health professionals and breastfeeding researchers acknowledge the need for further studies, citing the limitations and sometimes insurmountable complications of research in the area of breastfeeding, hindering the ability to determine causal links between breastfeeding and (the majority of) health outcomes. Rather, it is an attempt to highlight the complexity of the discourse and suggest that the positioning of successful breastfeeding as fundamental to human health may be problematic insofar as limiting our ability to consider alternative understandings of the practices surrounding breastfeeding.

When dominant discourses are strongly supported by numerous social institutions, alternative or resistant discourses face an uphill challenge. Within the dominant discourse of breast is best or breastfeeding is normal, the dominant discourse suggests that breastfeeding is achievable and accessible to *all* mothers, given they have the necessary tools to facilitate engagement in the practice. This discourse persists despite the evidence that not *all* mothers can or will breastfeed; a mother defined as “white, well educated, married, older than 25, of a higher socioeconomic status, and not employed outside the home” (McCarter-Spaulling, 2008, p. 209) is most likely to succeed at breastfeeding or be in a situation where breastfeeding is contextually possible for them. But what are the particular implications for understanding breastfeeding practice through this lens? What are the particular implications for those members of society prioritized by health professionals because they don’t fall into these “success” categories and to whom promotion for and support of breastfeeding is subsequently directed?

2.2 Obesity

Excessive body weight (or body fat, or body fat mass) has evolved into a major public health concern and a medicalized issue over the past several decades, which we commonly understand as obesity. Obesity is a medical-clinical definition of a person’s body mass index or BMI (body mass divided by their height in meters squared (kg/m^2)).

Similar to the preceding section on breastfeeding, the following section is concerned with presenting the dominant discourse of obesity and how we have come to understand obesity as a health issue. It begins with a review of the current status of obesity, followed by a section on the medicalization of obesity, concluding with how

obesity and breastfeeding are associated. The topic of obesity spans an enormous body of knowledge that crosses biomedical, social science and lay boundaries. This is not an exhaustive review of the issue but instead seeks to contextualize obesity in contemporary public health understandings and its relevance to breastfeeding, which are central to this study.

2.2.1 Current status of overweight and obesity and its implications

The most current surveillance data on measured height and weight estimates that 62.1% of Canadian adults (ages 18 years or older) are classified as overweight or obese (1 in 4 with obesity) and 8.6% of Canadian children and youth (ages 6-17) are classified as obese (Public Health Agency of Canada & Canadian Institute for Health Information, 2011). It is suggested that prevalence of obesity among Canadian children and youth has stabilized; however, with the caveat that self-reported rates are often lower than objectively measured rates of obesity (Public Health Agency of Canada & Canadian Institute for Health Information, 2011). Within the Canadian population, there are certain subgroups that have been identified as experiencing disproportionately higher rates of obesity, including:

- Canadians of aboriginal descent (particularly those living off-reserve);
- Residents of the Atlantic Canadian provinces (West-East gradient in obesity prevalence is observed, where population-level obesity rates increase from the Western to Eastern Canadian provinces); and
- Children and youth (Public Health Agency of Canada, 2012), particularly those living in the Atlantic Canadian provinces (Shields, 2005).

Socioeconomic status may have a relationship with body weight; however, the relationship between income (as one of many dimensions of “socioeconomic”) and weight is less understood. Empirical evidence suggests a relationship between obesity and socioeconomic status such that persons (in particular, women) who are categorized as low-income may be at increased risk of obesity (Drewnowski, 2009), although other evidence points to this relationship being less clearly defined (Kuhle & Veugelers, 2008). The mediating factor for excessive weight among low-income populations may be attributed to food insecurity and its relationship with diet quality (see section 3).

Obesity among women and children in Nova Scotia is the issue of interest for this study. Recent surveillance data for Nova Scotia indicates that 30% of adult women are classified as obese and a further 32% of children and youth are defined as overweight or with obesity; these rates are among the highest in Canada (Shields, 2005; Tjepkema, 2006). Furthermore, maternal obesity is observed to be on the rise in Nova Scotia. Dummer and colleagues (2012) observed that self-reported pre-pregnancy weight among Nova Scotian women increased, on average, by 0.5kg for each reporting year (1988-2006), and that 31% of women in the pre-pregnancy time period were classified with overweight or obesity in 2006 compared with 14% in 1988 (Dummer, Kirk, Penney, Dodds, & Parker, 2012). Similarly, Fell and colleagues (2005) found that both pre-pregnancy weight gain and gestational weight gain trended upward significantly among Nova Scotian women between 1988 and 2001 (Fell et al., 2005).

It is generally understood and acknowledged within health and lay discourse that the number of persons with excess weight is increasing, which has brought attention by governing bodies and others across the social field to questioning why (World Health

Organization, 2017b). As noted by Gard and Wright (2005), obesity is a “subject that has generated an almost visceral reaction...no one completely escapes responsibility for the waistlines of Western populations; body weight appears to be one of those topics which can be seized upon by people of virtually any ideological persuasion” (Gard & Wright, 2005, p. 16). Due to the rise of the number of persons around the globe carrying excess body weight and the health risks suggested with increased body fatness, obesity has been identified as a priority issue for the 21st century, stimulating alarm and action not only in the health sectors, but across institutions that include government, schools and the family on how best to address the “global epidemic” (Kopelman, 2000) known as obesity or “globesity” (World Health Organization, 2017b). Persons categorized with obesity are represented across lay and health discourse as the equivalent to a “ticking time bomb” and are represented for being at increased risk of a host of co-morbid and/or deadly conditions such as type II diabetes, heart disease, and certain cancers (Kopelman, 2000). Excessive body weight is also represented as creating an undue economic burden for societies. In Canada alone, overweight and obesity has been estimated to directly cost the health-care system over \$6.0 billion annually (Anis et al., 2010).

A cursory review of scientific literature into the obesity epidemic will indicate that several, inter-related themes dominate. The dominant representation is that obesity is believed to occur when there is an imbalance between “energy in” (re: diet) and “energy out” (re: physical activity) (Weinsier, Hunter, Heini, Goran, & Sell, 1998). Preventing obesity and remedying obesity requires attendance to the energy in/energy out equation primarily through encouragement of a nutritious diet and daily physical activity or by limiting habitual consumption of caloric-dense, low-nutrient foods and sedentary

activities. Genetic factors are also suggested to play a role in the regulation of energy balance, and subsequently risk of obesity, although these relationships are eclipsed by the discursive focus on energy balance (Wardle, Carnell, Haworth, & Plomin, 2008).

Secondly, there is a discursive emphasis on the discovery of universal understandings of obesity in relation to the human body. That is, all humans are presumed to be on equal footing (more or less) with respect to obesity etiology and methods of preventing and treating obesity are understood as having the potential to be universally applied. While there are certain subgroups commonly associated with higher risk of obesity, there are relatively fewer studies devoted to *understanding* excess weight within the social, cultural, environmental, political contexts of these at risk groups, beyond understanding those variables that affect the energy in/energy out equation. Despite suggesting that obesity may be experienced diversely, the discourse that currently supports the dominant understandings of obesity is based on homogeneous knowledge and weighted heavily towards knowledge arising from quantitative and biomedical studies.

Finally, the discourse is dominated by the ideology that individual behaviour or choice is the reason why people become fat and stay that way. That is, the suggestion that the human body operates in fairly predictable ways that can be both known, and controlled, and it is human behaviour that is required to be modified in order to meet normative standards associated with body weights. While research does allude to the role of external contexts (environmental, social, political) as factors in the development of obesity, the prioritized obesity prevention and treatment interventions continue to focus on altering the *behaviours* of individuals (Brauer et al., 2015; World Health Organization,

2000; Lau et al., 2007; Oude Luttikhuis et al., 2009; Shaw, Gennat, O'Rourke, & Del Mar, 2006; Waters et al., 2011) which has implications for the political changes that are required to alter social and environmental conditions to positively influence body weight (Puhl & Heuer, 2010).

Within the enormity of the research field investigating the epidemic of obesity, and the dominant discourses that are prevalent, there are still many questions that remain unanswered. Specifically, obesity remains an unpredictable and unknown issue to which anyone is potentially at risk. This discourse appears despite not definitively *knowing* why obesity develops, the inability to predict *when* it will develop nor identify *who* will develop obesity, and that there are not effective, long-term ways of controlling obesity or correcting (reversing) obesity if it does arise. For example, research indicates that even when using the discursive energy-in/energy-out concept of obesity, only a small portion of people who intentionally lose weight will be able to maintain this in the long-term. (Barte et al., 2010; Weiss, Galuska, Khan, Gillespie, & Serdula, 2007; Wu, Gao, Chen, & Van Dam, 2009)

Vogels and Westerterp-Plantenga (2012) studied the factors that impacted on maintenance of weight loss in 103 participants, 2 years following a 6-week restrictive diet program in which all participants lost a significant amount of body weight (Vogels & Westerterp-Plantenga, 2012). Anthropometric measurements (including height, weight, and waist circumference) were completed at study baseline (before diet program) and repeated just after completion of the diet program, 3 months, 1 year, 1.5 years and 2 years post-completion. Successful weight maintenance was defined as participants not regaining more than 10% of their body weight – only 12.6% of participants could be

defined as successful by this criterion. The remaining majority regained more than 10% of their body weight in the 2 years following the diet program (Vogels & Westerterp - Plantenga, 2012).

If and when persons with a higher BMI do restore their value into a normal category, we have no long-term evidence to suggest that they will be healthier or live longer. Specifically, this is due to the lack of long-term evidence that demonstrates successful weight maintenance (see previous paragraph) and its relation to health outcomes, or studies that demonstrate participants successfully moving into a normal BMI category – rather than weight loss (kg) or regressing toward the “normal” BMI from baseline BMI. In their meta-analysis, Wu and colleagues (2009) found that average BMI loss (pooled data) was 0.87 kg/m^2 in studies where a diet & exercise intervention was conducted (Wu et al., 2009), suggesting that restoring to a normal BMI may be a lofty outcome for any lifestyle intervention. Alternatively, weight regain (which is common) may negate any short-term health benefits associated with moderate or substantial weight loss, such as is suggested by McLaughlin and colleagues (2008) in relation to enhanced insulin sensitivity (McLaughlin et al., 2008). Similar to breastfeeding research, obesity research is fraught with methodological challenges and study limitations. While systematic reviews have outlined the proposed etiology of child and adult obesity (Wofford, 2008), there are still many questions to address.

At the same time that dominant discourse signifies obesity as a simplistic issue (e.g. balancing the energy in/energy out equation), there is a parallel discourse that describes obesity as a “complex” condition with complex solutions. This discourse rests primarily in the public health fields where practitioners are actively engaged in work

toward *preventing* obesity – work that primarily focuses on shaping activity and dietary behaviours. The most recent iteration of the clinical practice guidelines on the management and treatment of obesity suggest that due to the complexity in managing obesity and related co-morbidities once an individual develops obesity, that prevention of obesity is critical (Brauer et al., 2015; Lau et al., 2007).

Moreover, the urgency of the obesity crisis has broadened its focus to prevention of obesity among the youth demographic. Prevention of childhood obesity has become a critical issue in this regard, relating not only to an increase in child-centred discourse (Wall, 2001) but the empirical understanding that children with excessive weight are more likely to retain this weight (and potential effects of this weight) into adulthood (Lau et al., 2007).

With public health stakeholders focused primarily on the prevention of obesity, rather than treatment, mothers are strongly positioned as the conduits to either perpetuate or end the cycle of obesity within their families. States Klohe-Lehman and colleagues (2007): “Mothers *should* [sic] be the focus of interventions for childhood obesity, as they are the primary providers of food” (Klohe-Lehman et al., 2007, p. 197). This statement highlights the pervasiveness of the discourse whereby mothers are implicated in the health and wellbeing of their children in a taken-for-granted manner.

This discourse is also reinforced by biomedical research suggesting maternal obesity to be the strongest predictor of obesity in children (Hediger, Overpeck, Kuczmarski, & Ruan, 2001; Whitaker, Wright, Pepe, Seidel, & Dietz, 1997) and may predict excess maternal weight post-partum (Nohr et al., 2008). Preventing obesity among women of childbearing age, prior to conception, is regarded as the most effective

means to avoid maternal obesity and resulting effects on mother and child (Lau et al., 2007).

Thus, obesity among women of childbearing age has become greatly concerning from a population health and health system utilization perspective. Both obesity at conception and excessive gestational weight gain, irrespective of pre-pregnancy BMI category (Crane, White, Murphy, Burrage, & Hutchens, 2009), is associated with increased risk of serious complications during the gestational period (e.g. gestational diabetes and hypertension, pre-eclampsia) and during birth (e.g. caesarean delivery, augmentation of labour, post-partum hemorrhage) (Bhattacharya, Campbell, Liston, & Bhattacharya, 2007; Crane et al., 2009; Kabiru & Denise Raynor, 2004), and is also linked with poor neonatal outcomes such as large birth size for gestational age, congenital or metabolic abnormalities (Crane et al., 2009; Davies et al., 2010).

Through these contemporary discourses surrounding obesity, women-as-mothers become “targets of concern” and their health-related practices are scrutinized (Keenan & Stapleton, 2010); these practices include breastfeeding and food choice within the context of socioeconomic constraints. It is not just children who are engaged in practices putting them at risk for developing obesity, but it is the practices of their mothers, which are open for examination and refinement (McNaughton, 2011). This moralization plays a critical factor in how mothers identify and understand themselves and their roles.

2.2.2 Obesity as a medicalized discourse and technologies of power

As members of Western society, we presume we know the histories of all fat bodies, particularly those of fat women; we believe we know their desires (which must be out of control) and their will (which must be weak). This constant ‘silent

presumption' in knowing certain bodies reifies the culture of knowingness. We read a fat body on the street, and believe we 'know' its 'truth': just some of the characteristics we have come to assume define fatness are laziness, gluttony, poor personal hygiene, and a lack of fortitude (Murray, 2005, p. 154).

The above quote highlights the challenge in obesity discourse (albeit, all discourse) – that discourse shapes what is real and true for us. This section provides a critique of obesity – how excessive body weight has been discursively shaped into a medicalized issue through the language of obesity, and the resultant effects of this discourse on how fat, female bodies are represented and understood.

Sobal (1995) suggests that the medicalization of obesity has occurred in several broad ways: 1) through changing our view of excessive weight or fatness in naming it as obesity; 2) in categorizing obesity as a disease and an epidemic; 3) in the increased involvement of the medical establishment in understanding and communicating about obesity; and 4) through the use of medical, psychosocial and behavioural technologies to treat the obese or those at risk of becoming obese (Sobal, 1995). A poststructuralist perspective would extend these concepts to suggest that the term obesity constitutes subjectivity and collectivity (how we know, understand and identify ourselves and others in the social field) and that techniques associated with excessive weight are deployed in a form of biopolitics or the governing of bodies throughout the nutritional and related health fields (Beausoleil & Ward, 2010). That is, health professionals employ discursive tactics and strategies that both naturalize and pathologize obesity (e.g., linking factors that are understood to be natural such as gender to risk of developing obesity, using surveillance techniques to understand obesity and to define certain subgroups at risk), but

also that the discourse positions obesity as something that must be avoided, and that self-regulation of behaviour (e.g., watching what you eat, how much physical activity you engage in) should occur.

Body mass index (BMI) constitutes the major discursive technique used for constitution of subjects and collectives and forms a complex relation of power. The BMI becomes a numerical value assigned to an individual based on these measured physical characteristics in order to constitute them into classes of weight such as “underweight”, “normal”, “overweight”, “obese” and “morbid” obesity (Kopelman, 2000), and then this classification signifies a meaning associated with a degree of health risk, and a normative standard. For example, an individual who has a BMI of between 20-25 kg/m² is considered normal and therefore is the least likely to develop co-morbidities or poor health (Kopelman, 2000), whereas an individual with a BMI of 35 would be categorized as obese with greater risk for developing ill health (Kopelman, 2007; Kopelman, 2000).

While the definition of obesity through BMI was historically a clinical definition, the language of obesity has extended beyond the clinical walls into other areas of social life. The categories and labels themselves associated with obesity and BMI have become a critical part of relations of power across the social field, whereby individuals have the potential to identify and understand themselves (or are identified) as normal or (deviant) other with corresponding effects. Further Cohen and colleagues (2005) about the dominant representations of obesity:

In addressing [obesity], we need to acknowledge that while the word had a specific clinical definition; it does not have the same meaning within clinical practice – any more than in broader society. Instead, even in the clinical setting,

‘obesity’ is often imbued with value judgments and biases that associate overweight not only with poorer health but also poorer character and lack of education (Cohen, Perales, & Steadman, 2005, p. 154).

Puhl and her colleagues have spent years researching how persons categorized as with obesity are represented within the social field. In their most recent review of the literature, Puhl and Heuer (2009) found that negative representations of obesity are present across institutions such as workplaces, schools, healthcare and in the media (Puhl & Heuer, 2009). Health professionals share biased attitudes towards those classified as obese – defining them as lacking self-control or will-power, lazy, and with poor compliance (Puhl & Heuer, 2009); similar sentiments have been found to exist among health professional trainees, that include physicians, nurses, dietitians (Puhl, Wharton, & Heuer, 2009; Swift, Hanlon, El-Redy, Puhl, & Glazebrook, 2013). Dorfman and Wallack (2007) further observe that the individualist cultural philosophy contributes to the framing of obesity as individual responsibility, which in turn affects the dominance of downstream approaches to obesity management in the public health field. Again, this is a reflection of biopolitics and the importance of self-regulation and self-discipline in relation to obesity-related behaviours. They argue that the social and political considerations regarding obesity get “lost” within an audience that is familiar with the values of autonomy and willpower as central to public health issues (Dorfman & Wallack, 2007).

Other critiques of the obesity epidemic point to the methodological challenges of BMI. One of these critiques is that BMI represents a (very) crude, *population level* estimate of body weight (Gard & Wright, 2005). BMI doesn’t account for where body

weight is concentrated (e.g. visceral adipose vs. subcutaneous adipose, the former represented as being more risky to health) or the type of tissue (e.g. fat vs. fat-free) (Department of Health and Human Services, Centers for Disease Control and Prevention, 2012). Because of this, it has the potential to be unreliable for athletes or those with greater lean/fat-free body mass. Additionally, BMI may be less specific for identifying “true” metabolic risk among diverse ethnicities (Carroll et al., 2008).

Subsequently, there is the potential that not all persons who are categorized with a BMI of 25 and above will experience the physical outcomes they are represented for being at risk for – outcomes that include metabolic syndrome, diabetes, cardiovascular and cerebrovascular diseases, certain cancers, and increased mortality. To further illustrate this point, one needs to only look at the vigorous scientific and lay debate generated by a study conducted by Flegal and colleagues (2005) that did not find an increased relative risk of mortality among those classified through BMI as overweight compared with normal weight (Flegal, Graubard, Williamson, & Gail, 2005). The findings further suggested that not only was being overweight not attributed to a relative risk of mortality, but was slightly *protective* against the relative risk of mortality (Flegal et al., 2005). McHugh (2006) reviewed the outcome of this finding through interpretations by the media and scientists and the potential impact of the study results on lay public understandings of the “issue” (McHugh, 2006). Aside from reviewing the methodological challenges in studying obesity and the need for further research, he also cautioned the need to “responsibly” communicate health research to the public (McHugh, 2006); this comment speaks to the power of discourse to dissuade alternative ways of

thinking about the health risks of excess weight, even when “evidence” suggests otherwise.

The findings from Flegal and colleagues have since been replicated in the Canadian context, whereby BMI classified as overweight (between 25-30 kg/m²) was associated with the lowest risk of mortality (Orpana et al., 2009). Similar to McHugh (2006), the Canadian researchers cautioned the interpretation of this study as not equating to a lower risk of morbidity, and the importance of appropriately framing the public health message in relation to the findings of this study (Orpana et al., 2009; Andres, 2012; Flegal, Kit, Orpana, & Graubard, 2013; Stevens et al., 2012)

Despite these methodological challenges and considerations, BMI is used for the regulation of individual and collective bodies. In the regulation of the self, BMI is a target or an ideal to be realized by offering a particular truth and resultant knowledge about the body (Evans & Colls, 2009). It offers a place for the examination and comparison of oneself relative to normative others within the population. In the monitoring and surveillance of populations, BMI is used to legitimize the health of the population, to compare and contrast geographical areas or categories of populations, and to label them as unhealthy or healthy, normal, deviant or compliant. Within this relation of power, not only do individuals police their own body weights, but also health promotion interventions are targeted and promoted among those who are not in compliance with normative body weight standards.

BMI is used extensively throughout empirical research (including epidemiological and surveillance data) and in knowledge translation, and lay communications. Evidence used to legitimize the urgency of obesity is addressed through the BMI (despite its noted

methodological challenges), and gives space for institutions to become involved in remedying the obesity crisis or controlling body weights within the population through strategies and interventions that target populations at risk. Positioned within a biomedical (humanist) discourse that values autonomy and individualism, BMI (as an individual statistic) provides the foundation to ground an individualist rationale for interventions that target energy-dense diets and sedentary lifestyles, which are understood within dominant discourse as the *fundamental causes* of overweight and obesity (World Health Organization, 2016). This occludes examining excessive body weight within its broader social and political contexts. As stated by Puhl and Heuer (2010): “Society regularly regards obese persons not as innocent victims, but as architects of their own ill health...” (Puhl & Heuer, p. 1020) thereby increasing not only weight stigma within the population, but widening health disparities and social inequalities related to persons living with excess body weight (Puhl & Kyle, 2014). The following section will provide an important example of the need for such context by examining the relationships among breastfeeding and excessive weight.

2.2.3 Obesity and breastfeeding

Contemporary primary healthcare focuses on the gestational and early infancy periods as a critical time period for building a foundation of health and where life-long health practices are established (Health Canada, 2012a). Breastfeeding is suggested to play a key role in primary health care and improving breastfeeding practice (duration and exclusivity) is a priority for action (Public Health Agency of Canada, 2009). Biomedical evidence associates breastfeeding with the prevention of obesity in children, and also points to the potential for breastfeeding to augment postpartum weight loss in mothers

(Lau et al., 2007). However, evidence also suggests that existing maternal obesity can hinder breastfeeding success. The focus of this section is on an exploration of the relationship between obesity and breastfeeding and the discourses that shape this relationship.

There are several dominant hypotheses for the association between breastfeeding and obesity prevention across the life course – one that emphasizes the biological components of breastmilk, while the remaining hypotheses point to the importance of caregiver behaviours in the practice of breastfeeding. The first hypothesis is related to the composition of breastmilk. Obesity-related hormones present in human milk have been theorized as having a role in the development of infant body composition primarily through glucose homeostasis pathways. The presence of substances including leptin, adiponectin, ghrelin, glucose, insulin, insulin-like growth factor, interleukin-6, resistin, obestatin, and tumor necrosis factor in human milk may have implications for the resultant fat or fat-free masses among breastmilk-fed babes, and the promotion of slower weight gain (Fields & Demerath, 2012; Savino, Fissore, Liguori, & Oggero, 2009; Savino, Liguori, Fissore, & Oggero, 2009; Savino, Liguori, Sorrenti, Fissore, & Oggero, 2011). The macronutrient composition of breastmilk (low protein, high fat) may also be favorable for protection against obesity (Rolland-Cachera, Deheeger, Akrouf, & Bellisle, 1995).

The second mechanism for the association between breastfeeding and weight relates to appetite regulation and feeding control. Breastfeeding has been suggested to encourage an infant's self-regulation of appetite and hunger/feeding cycles more favourably, including caregiver-led regulation or control (Blissett & Farrow, 2007; Fisher,

Birch, Smiciklas-Wright, & Picciano, 2000; Graziano, Calkins, & Keane, 2010; Taveras et al., 2004), which is thus hypothesized to promote favorable body weights across the life course. The rationale suggested is that the practice of breastfeeding shapes “responsive feeding” patterns in infants such that infants who breastfeed are more responsive to their own hunger and satiety, and similarly, the mothers who nurse them are more sensitive and “appropriately” responsive to their baby’s hunger/satiety cues (DiSantis, Collins, Fisher, & Davey, 2011).

It is important to note that the relationship is further suggested to be dependent on the *mode* of infant feeding – at the breast vs. bottle, rather than properties that distinguish human milk from other substances. Li and colleagues (2010, 2012) studied exclusive bottlefeeding, irrespective of type of milk, is strongly associated with “emptying the bottle”, inferring that mode of feeding in infancy plays a role in regulation of intake and subsequent risk of weight gain (Li, Fein, & Grummer-Strawn, 2010; Li, Magadia, Fein, & Grummer-Strawn, 2012). In another study, DiSantis and colleagues (2011) conducted a retrospective investigation of children fed by bottle or by breast at infancy and found that children fed human milk by bottle were 67% less likely to demonstrate satiety responsiveness at age 3-6 years, than those with a history of being fed human milk directly from the breast (DiSantis et al., 2011). There was no difference found in appetite regulation between the direct breast and formula groups; attributed by the authors to the small group size of formula-fed children leading to an inability to detect any association. Moreover, no associations between mode of infant feeding and weight outcomes during childhood were established. Brown and Lee (2012) contribute to the debate by suggesting that the apparent relationship between breastfeeding and appetite regulation

(satiety responsiveness) only emerges with breastfeeding that lasts longer than 6 weeks in duration (Brown & Lee, 2012).

A systematic review by DiSantis and colleagues (2011) points to the “dearth” of studies in this area presenting difficulties in determining associations between this hypothesis and its relation to childhood weight development (DiSantis, Hodges, Johnson, & Fisher, 2011). Despite the contradictions among these findings (and the lack of good evidence), there is still evidence of this hypothesis embedded within the discourse of breastfeeding across the health domain whereby exclusive nursing *at the breast* (direct breastfeeding) is the ideal mode of infant feeding.

Finally, interactions between breastfeeding practices and the introduction of complementary foods have been theorized to play a role in subsequent body weight; although, similar to the regulation of appetite hypothesis, contradictory and/or unclear evidence exists in relation to this theory. Evidence that supports this theory suggests that breastfeeding duration is associated with a mother’s greater adherence to recommendations of timing of introduction of complementary foods and beverages (Burdette, Whitaker, Hall, & Daniels, 2006). Greater weight gain has also been observed in infants where early introduction of complementary foods occurs (< 4 months of age) (Huh, Rifas-Shiman, Taveras, Oken, & Gillman, 2011). Schack-Nielsen and colleagues (2010) showed similar results whereby later introduction of solid foods in infancy was associated with a decreased risk of adult obesity (Schack-Nielsen, Sørensen, Mortensen, & Michaelsen, 2010). However, the same study also showed no association of duration of breastfeeding on adult weight (though there was an inverse association with BMI at 1 year of age), despite there being positive associations between duration of breastfeeding

and later introduction of complementary foods (Schack-Nielsen et al., 2010). Among women with high pre-pregnancy BMI (≥ 30.0), Baker and colleagues (2004) demonstrated an interaction between breastfeeding and timing of the introduction of solid foods on infant weight gain, whereby longer breastfeeding among their study participants attenuated the weight gain response of early (< 16 weeks or 4 mos) introduction of complementary foods (Baker, Michaelsen, Rasmussen, & Sørensen, 2004).

Despite these studies, a systematic review determined that there was no relationship between early introduction of solid foods and adult obesity (Moorcroft, Marshall, & McCormick, 2011). Research continues to work towards understanding the interactions; however, given the evidence to-date, Kramer (2010) is pessimistic on the relationship, if any, to obesity (Kramer, 2010).

From the obesity prevention perspective, exclusive breastfeeding for six months continues to be supported by health stakeholders as a recommended strategy to help break the cycle of obesity for both mothers and their children (Lau et al., 2007), suggesting that the risk of obesity can be reduced in breastfed infants and that breastfeeding may support postpartum weight management in nursing mothers (Kramer & Kakuma, 2004; Krause, Lovelady, Peterson, Chowdhury, & Østbye, 2010). Even with the various hypotheses (and their limitations) presented above, the recommendation of exclusive breastfeeding for 6 months duration exists despite inconsistencies in, or paucity of, research determining the overall effect and etiology of breastfeeding with respect to obesity prevention (Bartok & Ventura, 2009; Gillman, 2011; Hediger, Overpeck, Kuczumski, & Ruan, 2001b; Owen et al., 2005; Owen, Martin, Whincup, Smith, & Cook, 2005). This links back to the pervasiveness of the discourse that represents breastfeeding

as the gold standard of infant feeding practice, and a practice to which good women ascribe, even though the present biomedical evidence upon which these recommendations are heavily weighted suggests exclusive breastfeeding may only have a modest to small effect on body weights across the lifespan.

A sampling of studies investigating breastfeeding and its effects on weight outcomes again points to the inconsistencies between these studies and difficulties in interpretation. Salsberry and Regan (2005) did not find an association between breastfeeding and early childhood obesity; however, their definition of breastfeeding was not specific enough to warrant understanding of the association (ever breastfed vs. never breastfed) (Salsberry & Reagan, 2005). The GENESIS study (2008) found that exclusive breastfeeding had a protective effect on infant's weight at 6 and 12 months of age. The researchers used mother-reported infant feeding data (exclusive breastfeeding, exclusive formula feeding, mixed feeding – both breast and formula) based on the WHO criteria; however, it was unclear from the study how duration of breastfeeding was captured (Moschonis, Grammatikaki, & Manios, 2008).

Twells and Newhook (2010) found that exclusive breastfeeding up to and including 3 months duration was associated with a decreased risk of obesity among Newfoundland preschoolers (Twells & Newhook, 2010). This association remained after controlling for a variety of confounding variables. Interestingly, maternal pre-pregnancy weight was not factored into this model, despite the documented associations between maternal and child weight, the recognition that parental anthropometrics are an important variable in the interpretation (Horta et al., 2007), and the study being done in a province with high prevalence of child (Shields, 2005) and adult (Tjepkema, 2006) obesity.

The PROBIT study was a large, randomized-controlled trial in the Republic of Belarus that assigned mothers-to-be/baby dyads to a Baby-Friendly Initiative (BFI) hospital (experimental) vs. hospital with standard infant feeding policies (control – i.e., usual care and policies) (Kramer et al., 2007; Kramer et al., 2009). The BFI (also known as the BFHI or Baby Friendly Hospital Initiative in other jurisdictions) is a program of the World Health Organization and the United Nations Children’s Fund (UNICEF) whereby hospitals and/or community health services are designated “baby friendly” upon the implementation of specific actions or steps that are suggested to promote breastfeeding and optimize breastfeeding initiation and duration (World Health Organization & UNICEF, 2009). While duration of exclusive breastfeeding was significantly associated with the intervention, the researchers could not associate breastfeeding with resultant weight outcomes among the children at 6.5 years. It should be noted that exclusive breastfeeding at 6 months was low across both intervention and control groups, (Kramer et al., 2007) and duration (Burke et al., 2005; Harder et al., 2005) and level of exclusivity (Harmon-Jones, 2006) may have a role to play in obesity prevention.

Systematic reviews investigating the associations between breastfeeding and obesity have also concluded with mixed results. Owen and colleagues (2005) reviewed both published and unpublished (n=36) quantitative studies and concluded that any reported effect of breastfeeding on obesity was related to confounding variables and publication bias (Owen et al., 2005). A weak inverse relationship was observed between duration of exclusive breastfeeding and mean BMI (Owen et al., 2005). Their findings came after their review of published studies found an association between breastfeeding

and obesity at increased duration (Owen, Martin, Whincup, Smith et al., 2005). Conversely, Arenz and colleagues (2004) conducted a systematic review of published evidence investigating the relationship between breastfeeding and childhood obesity (Arenz, Ruckerl, Koletzko, & Von Kries, 2004). They determined that increased duration of breastfeeding had a “small but consistent protective effect” against obesity in childhood. They further indicated that the protective effect on obesity was greatest when controlling for less than seven potential confounding variables, suggesting that residual confounding was a limitation for the studies included (Arenz et al., 2004). These findings were echoed in a systematic review conducted by Horta and colleagues (2007) where the researchers investigated several claims about the long-term implications of breastfeeding, including development of overweight and/or obesity (Horta et al., 2007). Based on a review of 33 observational studies, the authors concluded that there was a small, protective effect of breastfeeding on later development of overweight and obesity, with slightly greater effect on development of obesity rather than overweight. Again, they cautioned that residual confounding and publication bias could affect interpretation and impact on the “true” association between weight and breastfeeding (Horta et al., 2007).

Yan and colleagues (2014) recently published a meta-analysis of 25 studies investigating the association between breastfeeding and risk of childhood obesity. They concluded that increased duration (≥ 7 months) of any breastfeeding was associated with a protective effect on childhood obesity (Yan et al., 2014). The authors also cautioned that the magnitude of this association may have been impacted through confounders, type of breastfeeding (exclusive vs. partial) and the cut-off measures used within the studies

for childhood obesity; moreover, publication bias was noted within the meta-analysis (Yan et al., 2014).

There are also suggested to be associations between existing maternal obesity and breastfeeding; although, there is much less evidence in this area compared with breastfeeding and obesity prevention across the lifecourse. Women who present with obesity at conception or who gain excessive weight during pregnancy are less likely to initiate breastfeeding than women of normal BMI (Kugyelka, Rasmussen, & Frongillo, 2004; Li, Jewell, & Grummer-Strawn, 2003) and more likely to terminate breastfeeding prematurely (Hilson, Rasmussen, & Kjolhede, 2004; Hilson, Rasmussen, & Kjolhede, 2006), independent of social support or other psychosocial variables (Baker et al., 2007; Hilson et al., 2004). For women with excessive weight who breastfeed, breastfeeding has been suggested to have a protective effect on early adolescent obesity among persons born to an overweight mother (Salsberry & Reagan, 2007). On the other hand, maternal obesity and a lack of breastfeeding may have an additive effect on childhood obesity risk (Li et al., 2005).

Considering this brief, narrative review of the literature, it is apparent that there are gaps in understanding how breastfeeding and body weight are related, and the strength of the relationship has shifted over time – where earlier studies have theorized a stronger link between breastfeeding and prevention of obesity, more recent studies have contradicted these findings or minimized any ‘true’ association. With the present evidence, breastfeeding might have a small role to play in weight development during the lifecourse, but this appears to contradict the existing discourse within public health where breastfeeding is suggested to be a population health consideration for obesity prevention

(Armstrong & Reilly, 2002; Deckelbaum & Williams, 2012; Perrine et al., 2011; Province of Nova Scotia, 2012).

What might be a more important lens for health practitioners is to expose the challenges that may exist in attempting to breastfeed from the perspectives of women of differing shapes and sizes – rather than assume that all women are on equal footing when it comes to the practice. It is only within the last decade that researchers have been studying the relationship between existing maternal weight and breastfeeding success. Literature is now indicating that breastfeeding may be compromised in mothers with pre-pregnancy obesity and in those who gain excessive gestational weight.

Maternal obesity at conception as well as excessive gestational weight gain is hypothesized to compromise the lactogenesis II pathway through the delay of the onset of copious milk production and secretion (Rasmussen et al., 2001), as well as delay the prolactin response to suckling which is also associated with poor initiation of breastfeeding and early cessation (Rasmussen & Kjolhede, 2004). Other considerations such as latch and positioning difficulties, greater complications during birth due to excessive weight, or body image concerns (Hauff & Demerath, 2012) might augment the likelihood that mothers will not breastfeed, independent of motivation and support (Hilson et al., 2004), and socioeconomic and other demographic variables (Oddy et al., 2006). Mok and colleagues (2008) found that women classified as obese were more likely to give up exclusive (full) breastfeeding within the first 3 months postpartum compared with women classified with normal body weight; moreover, insufficient milk supply was cited as a rationale for cessation of full breastfeeding (Mok et al., 2008);

similar findings were detailed in Turcksin and colleagues (2014) recent systematic review (Turcksin, Bel, Galjaard, & Devlieger, 2014).

Healthcare providers who routinely support women during the post-partum period may be largely unaware of, or have varied understandings for, the potential for multiple difficulties affecting breastfeeding success in mothers with excessive weight (Garner, Ratcliff, Devine, Thornburg, & Rasmussen, 2014; Rasmussen, Lee, Ledkovsky, & Kjolhede, 2006). Moreover, in public health practice, these challenges are not discussed or integrated within breastfeeding marketing and promotion. This is ironic, considering the pervasiveness of the obesity discourse. Along with the stigmas associated with obesity, this suggests that healthcare providers from the primary care, acute care and public health sectors may not be providing optimal support for these women.

Despite these associations from the biomedical literature, as well as obesity and breastfeeding being situated within a variety of social, environmental and political contexts, there is limited evidence exploring the experience of breastfeeding from the perspective of mothers who are classified as being obese. As presented earlier, about one-third of adult women in Nova Scotia are categorized with obesity, while the number of women with excessive pre-pregnancy weight is increasing. Furthermore, Nova Scotians are among the most at risk for income-related food insecurity in Canada (Health Canada, 2007, 2012b, 2012c), which disproportionately affects women, notably single mothers (Health Canada, 2007, 2012b; McIntyre et al., 2002) and has a relationship to body weight. The final section will outline the relevant literature in this area, specifically relationships among food insecurity, obesity and breastfeeding, in order to set the

rationale for an exploration of breastfeeding practice among women classified as both obese and income-related food insecure.

2.3 Food insecurity, obesity and breastfeeding

Food security has been summarized as a “fundamental human right...when all people at all times have access to sufficient, safe, nutritious food to maintain a healthy and active life” (Food and Agriculture Organization of the United Nations, 1996). This broad and complex definition includes dimensions of food availability, food access, and the appropriate use of food (Food and Agriculture Organization of the United Nations, 1996). Food insecurity, defined as the “inadequate or insecure access to sufficient, nutritious, personally acceptable food” (Davis & Tarasuk, 1994, p. 51) is an issue that is examined globally; the most recent population-health surveillance data suggests that 8.3% of households across Canada experience food insecurity (Roshanafshar & Hawkins, 2015). Nova Scotia is consistently recognized as one of the provinces with the highest income-related food insecurity in the country (Health Canada, 2007, 2012b; McIntyre et al., 2002; Roshanafshar & Hawkins, 2015), which has led to the focus on understanding and addressing issues of food security in this province.

There are various discourses that shape our understanding of community, household and individual levels of food (in)/security and their relationships with health. Similar to the discourse surrounding breastfeeding and obesity, the presence or absence of household food security is another example of the normative practices of motherhood. The discourse is univocal insofar as a good mother provides the necessities of life for her children, including an important responsibility for feeding her family healthfully

(DeVault, 1994; Lupton, 1996; Maxwell, 1996). The next section outlines some of the prevailing discourses surrounding food insecurity at the household or individual level, which are most relevant to this research.

2.3.1 Poverty, individualism and food security

What does it mean to be in poverty? How is this issue constructed and understood in society? Understanding how poverty is represented gives insight into how issues *linked* with poverty (such as food insecurity) are shaped and subsequently addressed.

Recognizing that there exist diverse understandings of poverty, nonetheless, in societies where neo-liberalism, capitalism and individualism are the dominant discourses, poverty discourse is dominated by the representation that the lack of material resources is caused by a lack of free will on part of those experiencing material deprivation. That is, individuals have not done enough to alleviate or prevent their situation, as if their actions caused their poverty. In this “victim-blaming” discourse, poverty literature then relates “individual characteristics (e.g. income-level, education, personal coping mechanisms) to individual outcomes (e.g., health status, disease incidence, social adjustment, etc.)” (Raphael, 2007, p. 146). Poverty discourse represents poverty as an individual problem, caused by the type of individual characteristics one possesses, leading those in poverty to a higher risk of health inequities, through issues that are tied to it such as food insecurity. Normal is the person who is not defined or classified by these boundaries, whereas abnormal (to be in poverty) signifies someone bounded by these classifications.

Food security (or food insecurity) discourse cannot be separated from poverty discourse, that is, empirical evidence suggests that families risk going hungry because they lack the material resources necessary to secure food for themselves and others in

their household. Rose (1999) states that income is “an important determinant for food insecurity and hunger” in the population, despite income being a crude measurement of poverty (Rose, 1999, p. 517S). Subgroups of the population that risk being identified as *income-related* food insecure include households managed by single mothers, children, immigrants and off-reserve peoples of Aboriginal descent (Health Canada, 2007).

While there is increased acknowledgement within public health discourse that household food insecurity is an issue of social injustice, this is not the dominant knowledge nor is it the dominant action. The dominant discourse positions the individual and the household as a central focus for actions to remedy food insecurity, rather than a critical examination of the historical, social and political contexts through which individual and household-level food insecurity, through material inequities, has been shaped. Evidence for this discourse can be found through examining traditional responses to household food insecurity – the historical ways in which health professionals and researchers understand and address this issue. For example, the availability and use of charitable food banks, school feeding programs, or providing capacity-building opportunities (including improvements in food skills and budgeting) (Power, 2005), that eclipse a discourse that orients itself toward addressing necessary social conditions and practices that shape food security in households.

This is not to deny there are groups of other nutrition professionals and stakeholders working towards addressing food insecurity from the perspective of structural inequities (Williams et al., 2006); however, the prevailing discourse still suggests that issues of food security are caused by individual, self-inflicted circumstances. Travers (1995) explored the pervasiveness of the individualist discourse on food

insecurity in her research with women categorized as food insecure (Travers, 1995). Her research participants described feeling blamed by nutrition professionals and/or policymakers for their circumstances and inability to adequately cope in their situation. Pedagogical practices offered by the professionals to their food insecure clients such as budgeting and improving nutritional knowledge were part of this larger discourse and orientation toward individualism (Travers, 1995).

Thus, the prevailing discourse of food insecurity has been critiqued for simultaneously situating food insecurity as an issue attributed to structural inequities (social, historical and political factors) (Power, 2005; Struble & Aomari, 2003) while also exhibiting an individualist focus (Maxwell, 1996) or that food security is within a persons' control and something that can be pursued. The dominant discourse has the potential to constitute subjectivity such that individuals feel humiliated, punished and shamed by *their* situation (Hamelin, Habicht, & Beaudry, 1999; McIntyre, Officer, & Robinson, 2003; Tarasuk, 2001). Others attempt to hide their constitution within this subject position by adopting what are considered abnormal or deviant behaviours such as pawning household items in exchange for food, hiding food from children or stealing (Hamelin, Beaudry, & Habicht, 2002).

2.3.2 Income-related food insecurity and obesity

The individualist discourse informing the dominant understandings of food insecurity also informs the understanding of health consequences of food insecurity. Dominant discourse posits that *proper* nutrition is difficult to *achieve* in a state of food insecurity, augmented by the association between food insecurity and risk of compromised nutritional health (Olson, 1999). In industrialized countries, food

insecurity has historically resulted in *overnutrition* (and its associative outcome – obesity) (Badun, Evers, & Hooper, 1995; Drewnowski, 2009; Olson, 1999; Tarasuk & Beaton, 1999), whereas food insecurity in developing countries has been historically associated with undernutrition (Struble & Aomari, 2003), though in the past decade, overnutrition in developing countries has also been described (Popkin & Gordon-Larsen, 2004; Tanumihardjo et al., 2007). Overnutrition has been summarized as a diet that represents “severe overconsumption of nutrients” whereas undernutrition has been described as a diet with “severe underconsumption of essential nutrients”; both over- and undernutrition are linked to poor nutritional status (Castillo et al., 2012, p. 246). In a state of overnutrition, a person may consume foods that are energy-dense (adequate calories, or more calories than necessary) but not nutrient-dense (relative imbalance of essential micronutrients, for example). The link between food insecurity and overnutrition is based on this concept, whereby foods such as refined grains and those higher in sugar and fat (foods that may still contain essential nutrients but are typically labeled as unhealthy) are lower cost compared with lean protein-based foods and vegetables and fruit – foods that are typically understood as healthy (Drewnowski & Specter, 2004); in addition, eating foods of greater energy-density is suggested to cost less but is of lower nutrient quality (Drewnowski & Darmon, 2005).

Although there are still unclear associations (Kuhle & Veugelers, 2008), obesity has been suggested as a possible outcome among women who are classified as food insecure (Gooding et al., 2012; Olson, 1999; Townsend et al., 2001). The hunger and obesity paradox has been primarily attributed to the potential for increased poor diet quality, or overnutrition, among food insecure households – overnutrition again being

understood as the consumption of cheaper, energy-dense, but low nutrient-dense foods (Drewnowski & Specter, 2004). A discourse that suggests that people who are poor choose not to eat well or counsels those who are poor and at risk of food insecurity to choose healthier foods is problematic insofar as it individualizes an issue which requires addressing structural questions, for example, how foods that are healthy became expensive in the first place or how it is that people do not have adequate material resources to purchase foods.

Therefore, women classified as income-related food insecure (or at risk of food insecurity due to material deprivation) may also have the potential to enter motherhood with excess body weight or gain excessive gestational weight. Household food insecurity has been linked with excessive pre-gravid weight status, excessive gestational weight gain and increased risk of pregnancy complications (Laraia et al., 2010). Olson and Strawderman also found that a combination of early pregnancy obesity and food insecurity were strong predictors of major weight gain (> 4.5 kg above referent, pre-pregnancy, weight) by 2 years post-partum (Olson & Strawderman, 2008).

While the above studies imply a relationship between food insecurity and obesity, they do little to describe how the relationship might occur, and in what context. A study by Olson and Strawderman (2008) explored overweight and obesity within rural, food insecure women of childbearing age using a prospective, cohort design (Olson & Strawderman, 2008). In their study, they found that food insecurity did not predict post-partum obesity; however, early pregnancy obesity predicted food insecurity 2 years post-partum. They hypothesized this finding to be related to lay discourses attached to obesity insofar as influencing the potential of these women to secure stable employment and

financial security (Olson & Strawderman, 2008; Puhl & Heuer, 2009). The implication of this finding is a subversion of the discourse that currently dominates health and lay understandings of the issue. Rather than describe that food insecurity and obesity are linked through the types of foods that are ‘chosen’ by these families, it implies that the pervasive, discursive constitution of fat women as lazy, stupid and less-than (Murray, 2005), hinders the ability for these women to be economically secure so that they can purchase the types of foods they wish to feed themselves and their children.

The discourse not only implicates women described as food insecure with their own risk of excess weight, but they are also implicated in their children’s risk for developing excessive weight, among other health considerations. Nowhere is there a better example of mothering as “responsibility without power” (Daykin, Naidoo, Bunton, Nettleton, & Burrows, 1995, p. 63) as in the case of food insecurity discourse. As Bell and colleagues (2009) argue: “... single-mothers, and women living in poverty have been most notably singled out as posing ‘risks’ and ‘dangers’ to their offspring” (Bell, McNaughton, & Salmon, 2009, p. 164). Added also by Cassiman (2008):

Structural problems, most commonly associated with poverty, are reinvented as personal failings embodied by the ‘welfare queen’, discursively sending mothers receiving welfare to the margins of moral motherhood and personhood (Cassiman, 2008, p. 1692).

Bronte-Tinkew and colleagues (2007) provide an example of the dominance of this discourse in their study of toddler’s health outcomes in food insecure households (Bronte-Tinkew, Zaslow, Capps, Horowitz, & McNamara, 2007). They found that food insecurity was associated with parental depression and parenting practices that negatively

affected infant feeding (including breastfeeding duration). Both of these factors were then associated with an increased risk of overweight in children. While the study was focused on parenting, it is worth noting that the measures of parental depression and parenting practices were characterized through *mothers*, even when the majority of participants reported a double-parent family structure (Bronte-Tinkew et al., 2007). This again links back to the discourse that vilifies mothers in poverty as being unfit or unable to “properly” raise their children (Cassiman, 2008; Fineman, 1991), and their position being targeted and under scrutiny for health intervention or research.

Within a discourse that emphasizes individualism, women-as-mothers are thus positioned in conflicting and shifting discourses related to financial and health self-governance. In these discourses, they find themselves vulnerable to food insecurity and its effects, while at the same time placing their children in vulnerable circumstances because of their failure and inability to adequately nourish them (McIntyre et al., 2002). These realities conceal alternative ways of understanding the subjectivity of those constituted as food insecure and how food insecurity can be addressed.

2.3.3 Income-related food insecurity and breastfeeding

Breastfeeding is represented to be an important means for supporting food security among vulnerable, pregnant Canadian women and their families (Public Health Agency of Canada, 2015a). It is also suggested to be an independent mediator of childhood obesity across diverse socio-economic and racial groups (Procter & Holcomb, 2008; Woo, Dolan, Morrow, Geraghty, & Goodman, 2008). Despite the proposed ‘good’ associated with breastfeeding among socio-economically disadvantaged persons, low-income women are less likely to breastfeed or are at risk of premature weaning (Millar &

Maclean, 2005) and are thus targets for health promotion initiatives.

Mothers experiencing disadvantage are represented as less likely to breastfeed and are a population of interest for health professional intervention; consequently, there are a variety of empirical studies dedicated to understanding breastfeeding within the context of households experiencing material deprivation. A common theme amongst all the studies is the historical, social, political and institutional circumstances that surround breastfeeding practice in this demographic. As suggested by Heinig and colleagues (2009), a mother's context will dictate the infant feeding practices to which she ascribes, even if the practice runs counter to (health) professional advice (Heinig et al., 2009). Health professionals need to be aware that the discourse that dominates modern-day understandings of breastfeeding practice has the potential to further marginalize those who are unable or unwilling to meet the normative standards of this practice, including being exposed to countering discourses.

Raisler (2000) conducted focus groups with low-income women to investigate their experiences with breastfeeding through their exposures within the healthcare system and beyond (Raisler, 2000). In relation to the healthcare system, they suggested that the relationship between the mother and her healthcare providers shaped the breastfeeding experience. Mothers described positive experiences related to health professionals ranging from the manner in which they addressed their intention to breastfeed (e.g., acknowledging the mothers were doing the right thing by breastfeeding or that their breasts were ideal for the practice) to respecting their autonomy in the hospital and valuing their decisions (e.g., pacifier use, use of formula, maternal medications) (Raisler, 2000). On the contrary, health professionals who were perceived to be judging or

unsupportive negatively influenced their experience, but this did not necessarily change whether they continued to breastfeed or not (Raisler, 2000).

Moving beyond their exposures within the healthcare system, the concept of “getting on with my life” summarized the experiences of these mothers (Raisler, 2000, p. 258). Mothers spoke about balancing breastfeeding in the return to work/school (see also, Kimbro, 2006; Racine et al., 2009) and a lack of supportive environment for breastfeeding (Raisler, 2000). Similarly, mothers described breastfeeding in public as problematic due to cultural norms associated with personal modesty and some also described that this extended into private spaces – nursing in front of siblings and partners was a hindrance on breastfeeding practice. Finally, the “bonding” commonly associated with breastfeeding was positioned as both an “asset or a liability” (Raisler, 2000, p. 258). While the practice constituted them as “mommy” or “motherly” (Raisler, 2000, p. 258), it also required them to be attached to their baby constantly, and the feeling of being tied down (Raisler, 2000).

Mitra and colleagues (2004) took a different approach to studying breastfeeding among low-income mothers by investigating the relationship between known factors influencing breastfeeding intention and self-reported breastfeeding initiation (Mitra, Khoury, Hinton, & Carothers, 2004). They conducted a survey of over 600 participants from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in the state of Mississippi. WIC programs receive federal funding from the United States Department of Agriculture Food and Nutrition Service to provide nutritional support and health education for at risk (e.g. low-income, pregnant) women and their young families; breastfeeding promotion is a key focus of the programs (United States

Department of Agriculture, Food and Nutrition Service, 2012). They found that breastfeeding intention was associated with self-efficacy of the mother, the perception of facing fewer barriers to breastfeeding, and knowledge about breastfeeding benefits. In their conclusion, the authors summarized that targeted education and support programs would help to “alleviate” any barriers to breastfeeding in this population (Mitra et al., 2004, p. 69).

Reviews of primary research have also been done in an attempt to summarize the factors that are suggested to impact on breastfeeding practice among low-income or disadvantaged women. The findings from these reviews align with some of the primary research findings described in the preceding paragraphs. MacGregor and Hughes (2010) conducted a review of qualitative literature on the experiences of breastfeeding among women considered disadvantaged (i.e., teenage and low-income mothers) (MacGregor & Hughes, 2010). Based on their review of nine studies, they found that barriers to breastfeeding among women ranged from physiological to social considerations. Perceptions (real or socially constructed) of pain associated with latching; “myths” about breastfeeding – low-milk supply or the “ease” of bottle-feeding; cultural norms of breastfeeding including the feeling of being embarrassed to breastfeed in public places (see also, Groleau et al., 2013) and the need to move back into a normal routine were some of the identified concerns associated with continuing to breastfeed (MacGregor & Hughes, 2010). Social supports were suggested to have both positive and negative influences on breastfeeding practice whereby immediate family support (including partner), previous exposure to breastfeeding through social networks, and health

professionals may influence the infant feeding practices of these mothers (MacGregor & Hughes, 2010).

Milligan and colleagues (2000) also conducted a review of the literature related to factors affecting breastfeeding duration among low-income women (Milligan et al., 2000). Some of their findings echoed MacGregor and Hughes (MacGregor & Hughes, 2010), such as breast discomfort with nursing (see, Heinig et al., 2006; Heinig et al., 2009) or the role of social support networks (see, Heinig et al., 2006) but they expanded on the concepts of postpartum fatigue and mental health (e.g. anxiety, depression) among low-income women and its negative impact on physiological production of milk and developing a milk supply (Milligan et al., 2000). Similarly, in their exploration of the meaning of insufficient milk supply among women from Brazil living in poverty, Groleau and Cabral (2009) also described that insufficient milk supply cannot be solely explained as a psychosomatic phenomenon, but rather as a socio-somatic experience related to the complexity of the environment in which women experiencing poverty are situated (Groleau & Cabral, 2009).

An important consideration is that these factors may not be unique to mothers classified as low-income and may be experienced by a diverse number of mothers, across class categories and other classifications. This begs the question as to whether breastfeeding research focuses on the breastfeeding issues of low-income mothers, to further target these women for health-professional support and surveillance (as a form of governmentality), and to constitute them as in need of support? Focusing on the breastfeeding issues of low-income women suggests a reproduction of dominant discourses where low-income women are understood as incapable of providing adequate

care to their children and thus, requiring the expertise of health professionals to guide them. Research that aims toward a more nuanced understanding of breastfeeding practice, through an understanding of the various discourses that shape knowledge concerning breastfeeding and nutritional-related parenting practices in general, will provide a much needed perspective on this issue.

2.4 Representations of breastfeeding, obesity, food insecurity and parenting within public health resources

This final section summarizes an examination of the discourses that exist within Nova Scotia public health educational resources pertaining to childrearing, specifically the *Breastfeeding Basics* and the *Loving Care* series. These books have been developed and published by the Nova Scotia Department of Health and Wellness and are provided by Public Health Services free-of-charge to Nova Scotian families and are also available online for free, internet download. Prior to hospital discharge post-birth, a public health nurse visits each family to complete an assessment and provides a package that includes these resources, suggesting that there is exposure to the discourses within these texts. This section includes an examination of both language and visual imagery in relation to breastfeeding and the representations of parental roles, and how together, these constructed the topics under consideration for this study but also how they have the potential to create discursive actions and/or subject positions.

Poststructuralist philosophy retains that experience is dynamic and shifting, situational, and constituted through discourse. An examination of the discourses that exist within documents provided to research participants is useful to contextualize their

constitutive possibilities, as these are but some of the “social structures in which individuals collect the subject matter from which they construct their accounts” (Hardin, 2003, p. 538). Further Hall (2001), discourse is a “system of representation...and will appear across a range of texts, and as forms of conduct, at a number of institutional sites within society” (Hall, 2001, pp. 72-73).

Discourses within these documents, as represented through both written language and visual imagery, are what Foucault refers to as *the episteme* (e.g., state of knowledge at a given period of time) (Foucault, 1970). These discourses have had the potential to shape the experiences and subjectivity of the participants in relation to excess maternal body weight, income-related food insecurity, breastfeeding, and motherhood. Therefore, the intention for including this review is to examine how the topics of breastfeeding, motherhood, income-related food insecurity and maternal body weight are represented (or not) within these books.

This review also includes an examination the use of visual imagery from the public health documents – in particular, visual imagery in relation to breastfeeding and parenting, and how together, these constructed the topics under consideration but also how they create subject positions. Visual imagery is included as part of this system of representation (Hall, 2001) as images, and the meanings and representations they imply or convey, also play a critical role in constructing our social world and thus are implicated within relations of power (Rose, 2007). As stated by Rose: “we know what we like but we also know that other people will be looking at the images we choose to display” (Rose, 2007, p. 26). What we display visually is also literal in its goal of communicating a message to a particular audience and is productive in its intended

effects. In this exploration, I also followed the sites of interpretation (how meanings of an image are created) offered by Rose (2007), and concur with Goldstein's (2007) principle that photographs do not lie, but the photographer(s) might through their purposeful construction of images (Goldstein, 2007; Rose, 2007). To this end, the famous photographer Ansel Adam's statement: "There is nothing worse than a sharp image of a fuzzy concept" applies whereby the photographer is not merely *taking* a photo but *making* a photo, all along asking critical questions about the composition and message intent.

What is presented should not be viewed as discounting the breastfeeding or other parenting practices that are described within these resources. Nor it is suggestive that breastfeeding shouldn't form a central part of health promotion activities. It is, however, useful to be mindful of the *way* in which particular aspects of parenting are positioned or represented within these publications. Both texts and images within these parenting resources combine as signifying mediums in relation to parenting, breastfeeding, and other parental practice topics.

The central argument is that representations of breastfeeding (also maternal body weight, food (in)security, motherhood) that are provided to women and their families by organizations positioned as being authoritative (e.g., experts – public health or other health stakeholders) are intended to represent a particular perspective of reality and may not represent the infinite range of possible experiences that are experienced by diverse families. This is critical insofar as evidence suggests that women will reject infant feeding advice and related supports if their experiences are not congruent with normative messages (Heinig, 2009).

The overarching discursive action within these texts is to rationalize recommendations on breastfeeding and other parenting practices through an attendance to biomedical, empiricist discourse. The message across the public health field is that breastfeeding is superior to any other form of infant feeding; consequently, breastmilk and breastfeeding are described throughout the resources in such a manner in which all ills are cured - “lots of benefits”, “perfect food” (Parent Health Education Resource Working Group, 2015a, p. 34), but also using science and scientific language in order to justify its position. For example, by describing how breastfeeding lowers risk of illness and disease, focusing on the benefits, describing normative standards for weight gain and growth, and even showing a visual of the baby’s growth of the baby’s stomach. As summarized in the introduction page to *Breastfeeding Basics*:

Congratulations on deciding to breastfeed your baby! You are giving your child the *best* start in life— nutritionally, socially, emotionally, physically, and intellectually ... you have the satisfaction of knowing you are giving your baby the very best (Nova Scotia Department of Health and Wellness, 2015, p. x).

Across all the publications reviewed, this discourse permeates. Within this discourse, breastfeeding also continues to be represented as a choice or decision made by (predominantly) women. As the quote suggests, when women make this choice, the outcome will be that they are satisfied with knowing they are making good on their mothering potential.

The focus on doing best for your baby occurs despite a plethora of evidence suggesting that breastfeeding practice is influenced through the multiple and varied contexts in which women and their families live their lives (see 2.1). These contexts (for

example, and of interest for this study – income, food or housing security, and body weight) may ultimately limit autonomy in decision-making rendering *choice* a perplexing verb to use. The remaining subsections will outline several of the other representations within these texts, in an effort to highlight how institutions reify dominant discourses concerning parenting and parenting practices concerning health.

2.4.1 Reproducing mother as responsible for childrearing

It is evident that the intended audience for these publications (and their content or messaging) is the subject position of mother – that is, the female who has recently given birth or is intending to give birth and who is looking to mother normally: “All parents wonder if they’ll be a good parent, if they’ll know what to do” (Parent Health Education Resource Working Group, 2015a). By positioning the mother as the intended audience, this reifies the cultural positioning of the birthing female as the central figure in (all) childrearing-related practices. This is a very subtle positioning made possible through examining how language is used but also the images selected and presented within the publications.

The texts use second or third-person language throughout to illustrate or describe how childrearing should ultimately occur. The speaker is positioned as the “public health expert” or resource author and the “you” within the documents is most habitually used to signify the mother subject position. The third person (e.g., dad, parents, grandparents, health care providers) is used to signify others potentially involved in the childrearing process in a supportive role. This is significantly apparent within the *Breastfeeding Basics* resource – where the use of the word you is entirely focused on the position of mother (Nova Scotia Department of Health and Wellness, 2015). This is certainly a

taken-for-granted action given the type of information that is conveyed within this resource (e.g., the how-to's of breastfeeding). But the use of you as mother is also evident within the *Loving Care* series. Consider the following examples. In the first quote, the mother is the primary person to whom the quote is directed in relation to the act of skin-to-skin contact, followed by an additional statement about the potential or alternate role of the father (or non-parental partners) within this practice:

To cuddle skin-to-skin, lay your naked baby belly down on *your* [sic] chest and cover her with a blanket. *Dads and partners* [sic] can snuggle skin-to-skin with their baby, *too* [sic] (Parent Health Education Resource Working Group, 2015a, p. 10).

Or the next statement, found in the same publication, continues to position the father as naturally distant from the parent/child attachment: “There are many ways that fathers can connect with *their* [sic] baby...” (Parent Health Education Resource Working Group, 2015a, p. 36).

The use of you to represent the position of mother, however, shifts under the chapter titled “Dads and Partners” in the *Loving Care: Parents and Families* resource, when the second person language focuses on the other people potentially involved in caregiving (Parent Health Education Resource Working Group, 2015b). Still, within this section, it is apparent that the subject position of mother continues to be represented as the primary care provider for her children and fathers or partners bring a supportive or supplementary role:

Whatever shape your family takes, living with a new baby can be just as tiring and confusing for a new dad or partner as it is for a new mom ... you

[representing the father or partner] may sometimes feel a bit left out. Everyone asks about the baby or the mother. *No one seems to see that parenthood is affecting you, too* [sic] (Parent Health Education Resource Working Group, 2015b, p. 17).

In yet another example of the normative, mother discourse, with particular interest in the language of “mothers have to” implying requirement for responsibility, followed by partners “can too” – suggesting that their role is optional:

You’re not *just a babysitter ... Share baby care.* [sic] No one ‘just knows’ how to take care of a baby. Mothers *have to learn how to change a diaper and give a bath.* [sic] Partners *can learn too.* [sic] Your baby depends on you for loving care (Parent Health Education Resource Working Group, 2015b, p. 17).

Another deliberate manner by which mother is represented as central to childrearing and positioned as the intended audience for the messaging within these resources is through the use of visual images. Rose highlights the importance of visual images to constructing our social world and refers to *scopic regime* as “ways in which both what is seen and how it is seen are culturally constructed” (Rose, 2007, p. 2). Jenks (1995) describes the importance of the visual in our everyday such that “vision is a skilled cultural practice” (Jenks, 1995, p. 7). This is important to consider in the case of health promotion and population health where the end goal is to maximize the potential for the population to adopt recommended lifestyle practices. The use of visual imagery is a key approach for how population health initiatives support their goals.

The majority of images selected for the resource *Loving Care: Birth to 6 months* publication show babies and/or babies and their (presumed) mothers. Only a minority of

images (my count was 9 out of a total of 109 images in this publication) represented what might be described as a conventional adult male position, and by extension, male father, partner or support person (Parent Health Education Resource Working Group, 2015a). This suggests that not only is the action deliberate but it also reinforces dominant discourses that shape parental subject positions with whose role is what in relation to caregiving.

In the breastfeeding section alone (pages 32 to 45), there are no conventional male figures represented, only those figures represented as (presumed) mothers and their babies. In several of the visual images where one might presume that a male figure is represented, the male figure is partially hidden, further signifying their reduced role in providing childcare and childrearing (images that are described are not included due to copyright restrictions).

In the image represented on page 24 of the resource, the male figure that is represented is holding a baby in the air in a playful manner (Parent Health Education Resource Working Group, 2015a). However, this figure is turned away visually from the camera so that the recipient of this image only get a limited view of his facial features. This image is intentional in highlighting the importance of the baby (again, child-centred discourse) while minimizing the role of the parent (father), or at least limiting the male figures role to one of a “playful” caregiver.

Similarly, in the image found on page 67, a sleeping baby is being laid into bed (or perhaps being picked up) by a (presumed) male figure with arms extended (Parent Health Education Resource Working Group, 2015a). This figure has no facial features in the frame, cut off deliberately at the upper torso, in order to draw attention to the action –

care for the sleeping baby. The extended arms both represent the action of placing the baby to sleep, but might also signify distancing between the adult male and the baby in caregiving. These images reaffirm both a child-centred discourse with a minimization of the role of the male figure in care.

2.4.2 The sensuous nurturer

There is evidence to suggest that breastfeeding is represented in a sexual manner within these publications. This discourse of objectification and sexualization of breastfeeding does not begin with the feeding baby, but how the women providing the nourishment from their breasts are portrayed within these documents. This discourse is very present within North American culture where one cannot separate the breast from sexual ideologies of “the breast” and, as a consequence, the act of breastfeeding is viewed as embarrassing or threatening, which has historically necessitated the practice to be confined to a private, domestic space (Johnston-Robledo et al., 2007; Johnston-Robledo & Fred, 2008; Kukla, 2006; Mahon-Daly & Andrews, 2002). There is no better representation of this concept than the cover page selected for *Breastfeeding Basics* (Nova Scotia Department of Health and Wellness, 2015) and a similarly constructed (although not entirely mirror) image used for the beginning of the section on breastfeeding within the *Loving Care: Birth to 6 months* book (Parent Health Education Resource Working Group, 2015a, p. 33).

It is interesting that these images were the ones selected to headline the publication and breastfeeding section, respectively. Not to suggest that the images aren't representative of *an* experience of breastfeeding, but it is critical to reflect on what these images represent and how they have the potential to be interpreted by differing audiences.

Because these are still images, there is no other context in which to support this examination other than what can be observed within this resource. By contrast, if this was a video or real live scenario of a (presumed) mother nursing her (presumed) child, there might be very different mechanisms of interpretation by watching the interactions between them. Similar to the images presented on the previous page depicting male figures with babies, these photos limit the viewer's ability to gather more information that would help in interpretation but also result in asking further questions about what is being shown and why. I'm aware that these images are being used to support and improve breastfeeding practice within the population. However, they also portray breastfeeding as an easy, calm act; in both images, both mother and baby look healthy and content, which is but one of a multitude of potential experiences of what it is like to nurse a child.

One of the more pronounced aspects within these images is how breastfeeding is constructed as a sexual or sensuous act. In both images, the nursing mother's breasts are very full, hard – almost engorged (Nova Scotia Department of Health and Wellness, 2015; Parent Health Education Resource Working Group, 2015a). Notwithstanding that engorgement can occur, it is described within *Breastfeeding Basics* as a “challenge” that is more likely to happen in the early days post-partum and affects the ability for the baby to properly latch (Nova Scotia Department of Health and Wellness, 2015, pp. 45-46). Not only do the babies look older within these images, they also look content with their feeding and properly latched. With this added information, it does not support that the images are meant to represent the issue of engorgement so much as representing a youthful, attractive woman with larger breasts nursing her child. With the addition of the lacy, exposed bra, low-cut shirt, low lighting and the posed nature of the photos, the

images invoke similarities with contemporary and commonplace advertisements featuring lingerie or swimsuit models. This raises the question as for whom these images are being constructed. For other women? For men? Why? Recalling that both these images were selected for the cover pages of the resource/section on breastfeeding, why would public health stakeholders select these highly suggestive images to represent the practice of breastfeeding? Would this not further add to the discourse of female sexualization, one that is proposed to impede breastfeeding practice? It seems at odds with public health goals of protection, promotion and support for breastfeeding that include critiquing the hyper-sexualization of breasts in North American/Western culture and its impact on breastfeeding goals.

2.4.3 Knowing parenting: constructing experts and doers in childcare

Discussing the authors of these publications is important for understanding the meaning behind the content and what messages the authors are attempting to convey. These publications are produced by the Nova Scotia provincial government, which implies that the government has an interest in the manner in which you choose to parent your child (including feeding practices). While the state does have an interest, however, it is ultimately the families (i.e., parents – specifically mothers, see 2.4.1) who are positioned as responsible for actions that permit the protection, promotion and improvements to the health and wellbeing of their families. Moreover, the authors of these books, while representing the government, are also identified as public health experts from various health professional backgrounds (e.g., nursing, dietetics, dental hygiene). Through this, they represent a particular worldview from a privileged socio-demographic position (upper-middle class).

The parenting practices that are discussed within these publications are ones in which the state (by way of their identified experts) is recommending parents (i.e., mothers) to dutifully follow in order to provide “loving care” to their babies. If a person aligns with these practices, this suggests that they are providing this standard of care and the experience will result in loving outcomes – be that good mothering or parenting. Conversely, if parents are unable to provide care in the manner disclosed within the books there is the potential to invoke guilt. How might a parent react if, due to challenging life contexts, they are unable to provide the standard of parenting outlined within these books? The critical question is whether this suggests they are providing less than *Loving Care*?

The publications repeatedly draw attention to parents (mothers) anxieties and unknowns regarding parenting practices and childrearing and use the content within the resources as a response to addressing them. For example, in this quote signifying a new mother: “I was happy when I brought my baby home, but I was scared, too. How would I ever figure out what she needed? How would I know what to do?” (Parent Health Education Resource Working Group, 2015, p. 2). In doing so, the authors continue to construct subject positions of experts being knowledgeable about parenting, and learners (parents and families) as unknowledgeable and needing support.

2.4.4 Narrowing the view: what about the others?

What is visible within these resources carries just as much significance as that which is invisible within them. These invisible contexts include those related to the issues under consideration – particularly excess body weight and food insecurity, but also other forms of infant feeding (e.g., formula) that are still practiced by a significant

number of families today (see section 2.1).

Pertaining to breastfeeding, a noticeable shift occurs within the public health resources where breastfeeding is provided less attention than other childrearing topics as the books progress from content focused on the newborn and early infancy periods to content focused on older infancy and toddler ages. This occurs most specifically within the *Loving Care* series. Extended nursing is a topic embedded within sections pertaining to returning to work or school, dental care or the section on weaning within the *Breastfeeding Basics* publication but again, the overall focus of these documents is on breastfeeding in the early infancy stage. For example, the topic of breastfeeding receives a whole section within the *Birth to 6 months* publication, in addition to many visual images depicting babies nursing from their mothers. By contrast, within the *Loving Care* publications targeted at older infancy and early toddlerhood (*6 to 12 months*, *1 to 3 years*), as well as *Parents and Families*, there is less discussion about breastfeeding. In fact, there is not even a unique section dedicated to the considerations of breastfeeding beyond 6 months and extended breastfeeding beyond a year or more. This is an interesting observation insofar as the breastfeeding targets for public health is for mothers to breastfeed exclusively for 6 months and to continued breastfeeding beyond 6 months.

Secondly, the topic of formula feeding receives very little to no attention. Parents are instructed to refer to an additional document if they are interested in learning further about formula feeding. This sends an initial, subtle message that alternative forms of infant feeding do not belong in the *Loving Care* series, nor are they representative of providing *Loving Care*. Moreover, upon review of this resource, there is a marked difference between the formula feeding resource and that of the others that were reviewed.

First, there are no photos or graphics pertaining to babies and families – the resource is strictly published in blue and white. Even the same image of the growth of the baby’s stomach that is found in the *Loving Care* book is black and white – rather than in colour. The stark visuals signify that formula feeding is a *dark* practice. Secondly, the language used within this book is more direct, objective, less loving or soft than what is represented within the other resources and focused even more so on the potential harms that can befall from feeding an infant formula. For example, “risk”, “safety”, “caution” and “don’t” are all language used throughout the resource to describe both formula and its impacts. What *is* consistent with the other resources however, is the representation of mothers as the primary caregivers to their children as well as the validation of their positions through science and biomedicine. Based on how formula feeding is represented within this resource, the stakes are particularly higher to implications for maternal subjectivity if mothers have made an informed decision to not breastfeed.

Pertaining to the other contexts of interest for this study (e.g., income and food security, and excess maternal body weight), these and their implications for breastfeeding outcomes are largely invisible from the publications. Again, reaffirming the very narrow view of breastfeeding that is presented and the absence of presenting diverse contexts in which infant (breast) feeding may occur. For example, in the following quote, there is a noted lack of sensitivity to food insecurity for potential mothers:

You may find that you need to eat more than usual while you are breastfeeding. Listen to your body. Don’t ignore feelings of hunger or thirst (Nova Scotia Department of Health and Wellness, 2015, p. 90).

As well, the nursing mother who is primarily represented through these publications is

one who is in a partnered relationship and is privileged to be returning to employment (implying she was in a type of employment whereby she was granted a maternity and parental leave) or school. There is no mention of additional challenges when breastfeeding. For example, the aforementioned quote relays a message that only might be acted upon by a woman who is not under duress related to a lack of affordability and access to healthy food.

Similarly, the following quote also demonstrates a form of bias in the message it relays, depicting a situation whereby the nursing woman is: 1) employed, and 2) in a vocation or employment arrangement whereby working from home is an option. This again signifies that messaging is tailored toward a particular audience, and not inclusive of all Nova Scotians, nor all contexts: “Working from home for a part of the day may be another way to ease back into work, while making breastfeeding part of your workday” (Nova Scotia Department of Health and Wellness, 2015, p. 64).

It is clear that the mothers represented within these resources are implied to be representative of a particular socio-demographic position, with limited situational challenges addressed. While there is a small reference to parenting within the context of low income, housing insecurity or food insecurity, such as the statement: “New parents may feel stressed for many reasons...you may have concerns about money, jobs or housing...” (Parent Health Education Resource Working Group, 2015b, p.38), there are minimal suggestions as to how these may be overcome other than emphasizing practices within the parents’ own self-control – for example: “take care of yourself – eat well and get the rest you need”, or “solve the problems you can – concentrate on the things that are important to you. Try to let other things go” (Parent Health Education Resource Working

Group, 2015b, p. 38). Single-parenting is addressed, but only minimally within a half-page section and the quote “taking care of yourself physically and mentally is especially important as a single parent” (Parent Health Education Resource Working Group, 2015b, p. 52), seems at odds with the other recommendations within these resources whereby the discourses of child-focus, good mothering and legitimacy through science dominate. Finally, excess body weight among mothers and its implications for breastfeeding are not addressed, despite a multitude of studies that suggest otherwise.

2.5 Research problem, question and objectives

There is a current gap in knowledge that informs our understanding of breastfeeding practice, particularly as it relates to under-represented populations (Renfrew et al., 2007). Thus far, this chapter has highlighted that breastfeeding is a complex practice crossing biological, psychological, social, political and structural considerations. Women categorized as having obesity and income-related food insecurity may be faced with a variety of challenges in their experience of breastfeeding, yet their experience has thus far been absent in the literature. This is also reflected within the public health resources circulated to Nova Scotian women and their families. While empirical evidence has produced associations that identify women classified as income-related food insecure and obese as at risk for not breastfeeding, and/or not continuing to breastfeed, these associations are “insufficient for understanding the complexity of contextual barriers that such mothers face” (Groleau & Rodríguez, 2009, p.82).

At first blush, promoting breastfeeding is not the issue. What is problematic is the promotion of breastfeeding through dominant representations to the exclusion of nuanced

understandings of the practice. Currently, breastfeeding is represented as a normative standard and moral imperative of good mothering. Additionally, maintaining an appropriate weight and being food secure are understood to be good practices. The facts and truths ascribed to these topics have direct implications for how we may perceive the realities of poor women such that discourse positions them universally as a population at risk for obesity, and risking the health of their families. Such knowledge and understanding is grounded in the deployment of BMI and discursive practices such as examination and surveillance (Coveney, 1998), combined with the use of tactics which are productive in engaging people to self-regulate through health-promoting personal practices such as eating well and staying in shape, as well as setting an example through doing/providing the same for your children. These tactics shape how health and health services are provisioned during pregnancy and post-partum periods, and continue to support a discourse whereby science and health experts shape how we understand our reality.

Health practices, and parenting practices, are grounded not only in personal beliefs and capacities, but also in the social learned messages about what is right, good and normal. The dominant, post-positivist viewpoint (using biomedical empirical evidence and surveillance medicine) juxtaposed with modernization and neoliberalism has resulted in a society which positions the individual as autonomous, rational, and otherwise informed about choices related to their health and wellbeing. Through dominant discourses, breastfeeding is understood as a rational choice of being a mother and marginalizes diversity in experience; simultaneously, breastfeeding as rational also represents good and healthy whereas not breastfeeding represents bad or unhealthy.

Exposure to the dominant breastfeeding discourses have the potential to constitute mothers according to the normative standards of infant feeding depending on which practices they follow.

Collectively, these viewpoints imply that breastfeeding is both accessible and desired by all mothers, and that breastfeeding may be experienced in the same way. Feminist poststructuralist philosophy suggests that this is not the case and that the experience of breastfeeding is varied, multi-plural and constituted through the discourses to which a person is exposed. Because other experiences are absent from it, the dominant discourse that surrounds breastfeeding is problematic, and through its prominence and authoritative positioning, informs how we continue to support women to breastfeed and promote breastfeeding activity in the population.

What is needed is a more complex and critical exploration of how women experience the challenges and supports of breastfeeding within the context of plurality and subjectivity. That is, to consider the historical, situational, and political realities that contextualize the act of breastfeeding within the concept of what it means to *be* a breastfeeding (and obese and poor and food insecure) mother. With this lens, we can begin to shift away from the biomedical and scientific discourse that dominates (Mitchell, 1996) toward accepting and recognizing that breastfeeding is a: “biologically and socially *constructed* [sic] entity” (Spencer, 2008, p. 1826).

Specifically, research is needed to explore the subjective experiences of breastfeeding women signified through the discourses of obesity and income-related food insecurity. This perspective is currently not present in the health literature and will provide valuable information that will begin to uncover under-represented experiences of

breastfeeding with the intent of (re)shaping knowledge and understanding of breastfeeding as a dynamic practice situated in discourse and discursively mediated social relations.

To this end, this dissertation outlines a **qualitative exploration of the breastfeeding experiences of women who are constituted through discourses of obesity, low-income and food insecurity**. Specifically, the research question that this exploration seeks to address is **how do women signified as obese, low-income and food insecure experience breastfeeding?** By researching income-related women who self-identify with the discourses of (imminent) motherhood, obesity and food insecurity, my research objectives for this study were to:

1. to explore and articulate the discourses of breastfeeding, obesity, income-related food insecurity and motherhood that existed among participants;
2. to examine how participants experienced breastfeeding within the context of excessive body weight and financial challenges that affected their ability to eat the foods they wanted or needed;
3. to examine institutional discourses relating to breastfeeding, obesity, income-related food insecurity to which the participants had been exposed; and
4. to discuss how experiences of breastfeeding and motherhood (as articulated by participants) resisted the dominant, institutionalized discourses of breastfeeding, obesity and income-related food insecurity.

Through these objectives, my intention for this research was to understand how discourses have constituted the subjectivity of research participants and their experiences and to reveal the ways in which discourses of breastfeeding, motherhood and other

health-related practices (weight and food management) are (re) produced and reified and the implications of this to health practice and policy activity. Findings from this study will be useful to inform contemporary policies that impact health-related practices at individual, institutional and social levels.

CHAPTER 3 METHODOLOGY

This chapter presents an overview of feminist poststructuralism (FPS) as a theoretical framework for the process of inquiry into breastfeeding practice within the context of obesity and income-related food insecurity. Its purpose is to orient the reader to the philosophical underpinnings of this framework, which is a necessary lens through which the literature concerning breastfeeding, obesity, and income-related food insecurity is presented and concurrently critiqued, and subsequently shapes the course of the research process. Sections will introduce FPS through its poststructuralist and feminist roots, and its major theoretical concepts while attending to its relevance as a framework for inquiry into the breastfeeding practices of women signified as obese and income-related food insecure. Specifically, my overview will focus on a Foucauldian orientation to FPS, and its concepts.

Feminist poststructuralism as a methodology is informed through the philosophical and theoretical underpinnings regarding both *feminism* and *poststructuralism*. However, FPS, its possibilities and value for health research should be considered greater than the sum of its namesake parts. Independently, both feminism and poststructuralism operate as important and valuable lenses through which health is understood. Collectively, the philosophical and theoretical concepts that inform FPS provide, arguably, a more favorable, fluid backdrop to understanding the complexity of health and human nature and the meanings we ascribe to the experience of being human. Today, complex health issues require attending to complex understandings of these issues – a one size fits all approach does not work, nor does it effectively represent or respect the complexity and range of experiences related to health. This is one of the many

reasons that FPS is increasingly becoming known and used as a lens through which inquiries concerning complex health practices – such as breastfeeding, obesity and income-related food insecurity are made.

Understanding FPS begins with a brief overview of epistemology and ontology. Both of these concepts are closely intertwined and are critical to positioning the qualitative research process; however, their understandings need not be esoteric. Epistemology has been described as the “...organizing principles which allow us to know what we know, and who we are, and to validate those beliefs within particular moral frameworks” (Coveney, 2011, p.14). Ontology is concerned with knowing and understanding reality and what we consider our truth (Creswell, 2007). Together, epistemological and ontological assumptions inform how we approach health-research related inquiry.

Humanism is the epistemology that circulates predominantly throughout contemporary society. St. Pierre (2000) describes the dominance of the humanist epistemology for framing our reality, including ourselves and our social relations, and how we continue to understand it. Humanism becomes our moral compass and how our truth is informed. It is:

The air we breathe, the language we speak, the shape of the homes we live in, the relations we are able to have with others, the politics we practice, the map that locates us on the earth, the futures we can imagine, the limits of our pleasures (St. Pierre, 2000, p.478).

By extension, humanism also dominates and is embedded within understandings and knowledge that exist throughout institutions such as the health and human sciences, workplaces, government and schools.

Corliss Lamont's book *The Philosophy of Humanism* (1997) provides an overview of the principles of humanist philosophy. Lamont outlines humanism as a philosophy of human life that is naturally-founded and scientifically-determined: "advocating the methods of reason, science and democracy" (Lamont, 1997, p.13). As such, humanism affirms an essential or biological rationale for human identity and behaviour (International Humanism and Ethical Union, 2008). In other words, humanism is the tenet by which we, for example, understand gender or sex as a determining factor influencing health, or how governmental officials rationalize income policy decisions based on an individual's inherent capacity to be self-sufficient or reliant. Humanism also suggests that individuals are positioned as free, autonomous and rational, and possess the desire to continue to be so (Lamont, 1997). Humanism values truth or the pursuit of it, prioritizing grand theories and universal narratives to describe and/or rationalize human or societal actions (Lamont, 1997). Humanism also suggests a unified human experience, of which the essence of that experience can be determined, rather than multi-plural, varying and perhaps contradictory understandings of what is real. Finally, humanism supports human progress, suggesting that humans and societies are inherently made to evolve in pursuit of fulfilling greatest potential (International Humanism and Ethical Union, 2008; Lamont, 1997).

Humanism is problematized for FPS and thus, FPS as a framework may be used to challenge our assumptions and claims to truth of what we know and understanding

within the health and human sciences. Moreover, FPS enables an exploration of the structures that regulate us as health practitioners and affect our actions in health-related decision-making, research endeavours, policies and care practices – actions that contribute to dominant discourses across the health-related fields. For these reasons, FPS is an important framework for exploring complex health practices.

3.1 Poststructuralism

Poststructuralist philosophy has been largely informed through the contributions of French philosophers and theorists that include Michel Foucault, Jean-François Lyotard and Jacques Derrida and employs key concepts such as *language, discourse, power* and *subjectivity*. Poststructuralism is closely associated with postmodern philosophy. Agger (1991) suggests “significant overlap” between the two, but allows for this distinction between them: “...poststructuralism...is a theory of knowledge and language, whereas postmodernism is a theory of society, culture, and history” (Agger, 1991, p.112).

While there is no one way to define poststructuralism (and poststructuralists would reject the totality associated with a true definition), poststructuralism is a theory of contemporary society that contextualizes meanings (truths, what we perceive as our reality) based on a socially, historically, and politically-centered understanding of language and knowledge production, and exploring the effects of these (Lupton, 1996). In other words, language is viewed as a dynamic, shifting and contextual concept that assigns meaning to objects and our experience as humans, and what allows us to claim knowing or truth (Weedon, 1997). Language in this case is thought about in the broadest

sense and includes verbal, non-verbal, written, visual, among other forms of human communication and interactions. Joan Scott (1988) argues:

[language is] a meaning-constituting system. That is, any system – strictly verbal or other through which meaning is constructed and cultural practices organized and by which, accordingly, people represent and understand their world, including who they are and how they relate to others (Scott, 1988, p.34).

From a humanist perspective, language is “neutral”, exists inherently and is used by humans to reflect meaning, but from a poststructural perspective, language is both “constructed and constructive” (Alvesson & Sköldböck, 2009, p. 232); poststructuralism is concerned with exploring how language, or more specifically, patterns of language have constitutive effects. Repeated patterns and practices of language are understood in a poststructural framework as the concepts of *discourse* or *discursive practices*.

3.1.1 Discourse

Discourse is a critical concept for poststructural philosophy and a FPS framework for it helps theorize power and the effects of power. Language provides a tool for discourse and discursive practices to operate. Described as the use of language in relation to an object – “practices that systematically form the objects of which they speak” (Foucault, 1972, p. 49) – discourses “institutionalize and regulate ways of talking, thinking and acting” (Jäger & Maier, 2009, p. 35), and, like the poststructural perspective concerning language, are socially, historically and politically-occasioned (St. Pierre, 2000). In other words, discourses allow for the possibility of what is (and can be) said

and sayable at a given point of time and place and with whom (context), and language is “a system always existing in historically specific discourses” (Weedon, 1997, p.23).

If we were to apply this concept of discourse to the health sciences, for example, there are particular ways in which we describe, classify and subsequently know people – by numerical measurements such as weight, height, waist circumference, body mass index, or even income status. From there, we are further able to assign meaning to these measurements – meanings that are contextualized through health. For example, if a person measures within a normal range for weight/height, they are suggested to be healthy and not obese, or high household income denotes greater possibility for positive health status, including reduced obesity risk. These actions are commonplace throughout the health field; they are taken-for-granted, institutionalized and regulated, accepted without question, and considered appropriate in a contemporary, health science context, whereas classifying people in this manner under another context may not be. Furthermore, these practices have effects.

Poststructural philosophy suggests that discourses signify; that is, the discourses to which we are exposed shape not only our identities, and how we come to understand ourselves and our being, but the actions and beliefs that we present outwardly in our interactions with our social world. In contemporary society, health is theorized to play an increased role in understanding ourselves and our social relations (Nettleton, 2006). This has implications for the effects of dominant discourses that circulate and are reproduced within the health field insofar as their ability to affect and shape knowledge and understandings beyond the health field, and into other aspects of life. In this sense, dominant discourses within the health field can become dominant discourses in

contemporary society generally, and have the potential for a governing and regulating effect over our view of ourselves, of our actions, and our relations.

3.1.2 Power

Power and discourse are concepts that cannot be separated. However power, in the poststructuralist sense, is not centralized to a sole source or sources (such as an institution), and individuals do not “consciously” wield power over others. A concept of power as something that can be given away or built, or confined to a single, powerful entity reifies the humanist perspective of the individual or collective of individuals as free, autonomous and will-full. For example, it is commonplace in the health promotion field to speak about the role of the health promoter in “empowering” or “enabling” individuals to become healthier. Notwithstanding that poststructuralists might contend that becoming healthier is a moral action produced through discourse, the concept of empowering and enabling embraces a humanist view as it suggests that individuals do not have a voice or are limited in their power, and require the help or support from experts to act. Similarly, poststructuralists would reject as too simplistic the notion of a health care provider as wielding power over a patient or client.

By contrast, a poststructuralist view is that power emanates from the effects of discourse, through the use of language, to legitimize certain meanings and understandings while silencing others. In this manner, power is strategic, productive and has effects. Power produces knowledge, and in return, knowledge produces power (Arslanian-Engoren, 2002). This perspective regarding power is of relevance for the health sciences as it helps theorize how dominant understandings and concepts such as healthy eating, and the meanings and knowledge reflective of those concepts, can play

such a key role in regulating actions and activities of populations – without any one or any entity directly wielding force to govern anybody. The regulation of health practices of those constituted as mothers is relevant for the purposes of this research.

Power has the potential to exist everywhere and anywhere in this “entanglement” or web of discourse (Jäger & Maier, 2009). As Foucault describes power, “it’s a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised....it’s a machinery that no one owns” (Foucault & Gordon, 1980, p. 156). Foucault theorizes that power exists through discourse and the actions and activities that are constituted within that discourse. In this manner, everyone has the opportunity to be exposed to discourse and perpetuate or resist it. No one “owns” power; therefore, power in this form becomes a strategic and efficient means of regulating actions and eliciting population control within the social field, through holding individuals responsible for regulating themselves.

This theory of power operating through discourse also suggests that what is said and sayable (or beyond speech – what is present or included) within discourse competes for legitimacy and truth (since contemporary society is framed within a humanist perspective which values the truth) or reflects the real, while contesting discourses are excluded as alternatives, others or rejected altogether. For example, we assign labels such as normal, appropriate, healthy to infant feeding practices that are discursively valued in the social field – such as breastfeeding. Furthermore, within the same discourse, other infant feeding practices – for example, mixing infant cereal with Carnation milk – are considered inappropriate, wrong, risky or even dangerous. In the health field, these are dominant discourses that have formed and shaped what is real within these relations;

the result is that the former are practices that we speak about and engage with and the latter are practices that are silenced. This is the power of discourse: its ability to prohibit based on its authoritative, hegemonic structure; it is what is prohibited or excluded which becomes problematic. As theorized by Foucault (1980) in relation to the power of discourse and its effects:

In a society such as our own, we all know the rules of exclusion. The most obvious and familiar of these concerns what is prohibited. We know perfectly well that we are not free to say just anything, that we cannot simply speak of anything, when we like or where we like, not just anyone, finally may speak of just anything (Foucault & Gordon, 1980, p. 216).

Apart from its powerful effects on normalizing actions and activities in the social field, another prominent effect of the power of discourse is its effects on subjectivity and a biopolitics of the body.

3.1.3 Subjectivity

According to poststructural philosophy, subjectivity is a rejection of the “unique, fixed, coherent” individual (Weedon, 1997, p.32) that forms the basis of humanist epistemology. Subjectivity refers to the “self” or “selves”, and is further described as ones’:

Conscious and unconscious thoughts and emotions...her sense of herself and her ways of understanding her relation to the world...precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak (Weedon, 1997, p.32).

For poststructuralists, the concept of subjectivity suggests that the self or selves are constituted in and through the discourses to which one is exposed – discourses that are shaped through historical, social and political circumstances. We are born into existing relations of power and the discourses that shape them (St. Pierre, 2000) whereby subjectivity is “produced and not a given” (Rossiter, 1988, p.212). To further illustrate this point, we can look at the concept of being “born” and labeled at birth as a girl or a boy. While physical characteristics may differ between the two, poststructuralist philosophy argues our “maleness” or “femaleness” (subject positioning) is constituted through the dominant discourses and meanings assigned to being female or male. It is not a given that because you are born with a particular sex organ, that you will identify with the dominant discourses which shape that subject position. This identification is shaped only through exposure to the discourses that form our dominant understandings of being male or female.

Because different subject positions are formed dependent on discursive exposures, the self/selves are not stable, but rather considered destabilized or decentered, and constantly in negotiation. As Butler (1990) argues: “the culturally enmired subject negotiates its constructions, even when its constructions are the very predicates of its own identity” (Butler, 1990, p.195). In other words, self/selves (which only exist through discursively constituted subject positioning) are negotiating constituting subject positions through this ongoing exposure to (and employment of) varying discourses. This destabilization and decentering of subjectivity is the space that allows for resistance, agency and the possibility for social transformation. As summarized by Sawicki (1991) in relation to contesting and resisting dominant discourses:

The ability for freedom lies in the capacity to discover the historical links between certain modes of self-understanding and modes of domination, and to resist the ways in which we have been classified and identified by dominant discourses. This means discovering new ways of understanding ourselves and each other, refusing to accept the dominant cultures' characterizations of our practices and desires, and redefining them from within resistant cultures (Sawicki, 1991, pp. 43-44).

In other words, when we understand how our selves have been constituted through dominant discourses, we gain the freedom to resist and transform those power relations. The plurality of subject positions, and the ability for constituted subjects to contest and resist their positions, also pluralizes the experience of being. Compared to a humanist epistemology – where total, universal or unifying experiences define the truth or essence of experience, for poststructuralists, there is an understanding of multi-plural experiences.

Discourse then constitutes subjects and/or collectives (bodies of subjects) and the actions (behaviours, rules, rituals, regulations, etc) undertaken by subjects and collectives that further reify these discourses. In this manner, they form complex relations of power. It is the *repetition* of discourse or discourses that gain strength, dominate and are powerful. Through this process, dominant discourses become what is real and truthful about a concept. They are not only taken-for-granted in their ability to fix understandings and knowledges about a concept or topic, but they also fix the constitution of subject or collective positions (subjectivity).

Subjectivity and biopolitics

Foucault furthers his concepts of discourse, power and knowledge by exploring how discursive practices operate and insert themselves in the physical body through discipline, allowing for the production of “subjected and practiced bodies, ‘docile’ bodies” (Foucault, 1977, p.138). He notes that “a body is docile that may be subjected, used, transformed, and improved” (Foucault, 1977, p.136). The concept of docile bodies is particularly relevant to the health fields where biomedical and empiricist discourse (led by humanist epistemology) dominates and bodies (both individuals and populations) become not only the site for the insertion of this dominant discourse, but also the sites for the reproduction of this discourse. Foucault terms this concept *biopolitics* whereby bodies become objects that can be controlled or managed (observed, scrutinized, and surveyed) through techniques of disciplinary power and technologies of the self (Foucault, 1978).

Biopolitics is a form of ethics whereby subjects govern themselves in particular ways that are expected of them, such as healthy practices (e.g. eating, sleeping, physical activity, hygiene), both for a personal ethics but also for the good of the collective: “The imperative of health: at once the duty of each, and the objective of all” (Foucault & Gordon, 1980, p.170). Experts within the health field (e.g. health professionals, practitioners and researchers) reify the dominance of a biomedical discourse by perpetuating, through their exposure to and engagement with, discursive practices and techniques. These techniques range but could be collectively summarized as *the gaze* (Foucault, 1977), including practices such as monitoring and surveillance; the use of evidence-based practice (evidence largely based on a positivist or constructivist

paradigm); technologies and instrumentation; compliance or adherence to guidelines; normative standards, categories and characterizations; and pathologization of individuals (Coveney, 1998; Foucault, 1973; Petersen, 1997).

Additionally, when experts apply individually centred theories of behaviour change to their practices, including a determinants of health lens, or use language such as empowering or enabling, these are also discourses that institutionalize and regulate our professional subjectivity and the manner in which we view and engage with our clients, patients, and populations. When experts perpetuate these positions, they in turn contribute to the discourse, which shapes knowledge and subjectivity and develops hegemonic ideologies (Gingras, 2009; Henderson, 1994).

Others within the social field may also participate in the discursive construction of these concepts through their actions, and continue to re-inscribe the dominant discourses. The following section will provide an example of this through an examination of the subject position of mothers.

Subjectivity and motherhood

Subjectivity is also a useful concept to illustrate the complexity of motherhood, which is a central point of relevance to a study of breastfeeding practice, among other health and eating practices related to the family and childrearing. Under poststructuralist philosophy, to be a mother is not a natural or neutral position, but rather, is a subject constituted through the discourse of motherhood and the meanings and understandings embedded within that discourse. In response to Denise Riley's theories on motherhood, Linda Alcoff (1988) cautions:

...that we should talk about the needs of women with children and of course refer

to these women as mothers, but that we should eschew all reference to the idealized institution of motherhood as women's privileged vocation or the embodiment of an authentic or natural female practice (Alcoff, 1988, p. 428).

The constitution of the subject position of mother thus begins with its link with the gender of woman (Rossiter, 1988). Since women are solely capable of bearing children through the physical experience of pregnancy and childbirth, the women role extends into mother and accompanying responsibility for the health and welfare of their offspring (Kukla, 2009; Rossiter, 1988); this occurs in the social field despite an understanding that birthing, rearing and familial practices vary across the animal species (Emlen, 1995). Moreover, lactation is not physiologically confined to the female sex (Bartlett, 2000) but becomes the gendered practice of breastfeeding that in turn, helps to constitute maternal subjectivity (Shaw, 2004). As Lupton (1996) observes in relation to the hegemonic discourse of mother: "once the child is born, the mother is then expected to maintain a highly committed approach to her infant's feeding...the infant's body becomes a symbol of a mother's ability to feed and care for it as well" (Lupton, 1996, p. 42).

Foucault theorizes that the formation of the family and mother are strategic and the result of relations of power which constitute sexuality and our understanding of it (Foucault, 1978). The family as an institution becomes the site of the "deployment of sexuality" which is productive in "...controlling populations in an increasingly comprehensive way" (Foucault, 1978, p.107). Continues Foucault: "...family-child complex...the first and most important instance for the medicalization of the individual. The family is assigned a linking role between general objectives regarding the good health of the social body and individuals' desire or need for care" (Foucault & Gordon,

1980, p.174).

Rather than focus on the creation of the “mother as hysterical or nervous woman”, (Foucault, 1978), Foucault’s thesis could have expanded on the powerful discourse of family *as* mother and the discursive role of a woman situated within this context – the gendered or feminized role of the mother (Hekman, 1996, p.2). The implication of this discourse is that the family (and the central figure of mother) becomes the site for regulatory, normative, discursive practices concerning health (and other strategic relations). Furthermore, the dominant subject position of mother (assumed as the primary caregiver of infants/children) is constituted through the normative standards of mothering practice inscribed through discourse – including those related to health. One of these is a subject that adheres to appropriate caregiving practices that include household food and health management.

Simons (1996) builds on Foucault’s theories of sexuality and motherhood, theorizing that the subject position of mother is located within a ”maternal matrix” which is a series of coherent discourses related to:

- 1) female anatomy;
- 2) desire to bear children;
- 3) preference for reproduction in secure heterosexual setting;
- 4) propensity and ability to rear children;
- 5) caring orientation to others;
- 6) predilection for domestic issues;
- 7) prioritization of children (Simons, 1996, p. 199).

The totality and congruence of these factors operates in the social field in a discursive manner to naturalize and normalize the position of mother, including of responsibility for domestic life and all that this entails (DeVault, 1994). Furthermore, the discourse of mother provides a standard by which actions and practices relating to this discourse are

examined, and in doing so, provides the means for women-as-mothers to constitute themselves as good, bad, or other.

DeVault (1994) and Simons (1996) both point to how the discourse of mothering constitutes the subject position of mothers, simultaneously creating mothers, but then mothers are also creating other mothers through their engagement with and perpetuation of the dominant mothering discourses (DeVault, 1994; Simons, 1996). As summarized by DeVault (1994) in relation to the discourse of “mother” to bear responsibility for feeding the family: “the broad pattern of women taking responsibility for care at home has been pervasive and powerful...as women grew up, they learned, both from their own mothers and from more general ideas about what mothers should be” (DeVault, 1994, p. 96). Rather than assume that all women wish to be mothers (or wish for their actions and practices to be reflective of the dominant, hegemonic discourses within the subject position of mother), mothering should be viewed as a socially constituted and constructed subject position with an ideology that women-as-mothers may either embrace or resist, as well as potentially taking up whatever subject positions occur in-between.

Maternal subjectivity plays a central role in current health discourse, whereby experts within this discourse across all settings position women in their role as mothers as the primary caregivers and central figures for supporting health within the family institution, and more broadly, for the welfare of the state. Moreover, the discourse of risk, vulnerability and innocence of children is juxtaposed with the prevailing discourse that positions mothers as the primary caregivers (Kukla, 2009). Mothers are thus positioned as morally responsible and obligated to uphold the health of their children (Bell et al., 2009) throughout their actions within the social field.

These discourses are powerful, persuasive and dominant. In the health field, the dominance of discourses pertaining to the role of mothers is reflected in the number of public health and other initiatives (including education, marketing, and programming) directed towards mothers as the conduit and person of influence for health practices and health improvement in the household and broader societal institutions (Apple, 1995; Bell et al., 2009; Delany, 2010; Keenan & Stapleton, 2010; Knaak, 2010; Kukla, 2009; Lupton, 1996, 2012a; Maher, Fraser, & Wright, 2010; McNaughton, 2011; Ristovski-Slijepcevic, Chapman, & Beagan, 2010). The activities and choices of persons constituted as mothers are open to observation, surveillance, monitoring and scrutiny (by themselves, each other, other lay persons and multiple experts) for their adherence to good, appropriate and normal health practices.

Ironically, modern society also positions mothers as unable to effectively govern the health of their children – even when morally responsible for doing so. Scientific mothering is an aspect of biopolitics whereby faith is placed in the hands of health (experts) for the how-to's of child rearing (Lee, 2007), such that experts exert greater control over the (health) decision-making of mothers (Apple, 1995). Scientific mothering has been shaped by a variety of historical, social and political factors, including gendered practices within medicine and health, and enables an explanation for the increased dependence on “experts – scientific and medical, to tell [mothers] how best to raise their children” (Apple, 1995, p.174).

Maternal subjectivity and mothering discourse was a central focus of Rossiter's (1988) exploration of early mothering (Rossiter, 1988). Using a poststructural theoretical orientation, she explored the experiences of early mothering (pregnancy, childbirth and

the early postpartum period) for several women. Through the narratives of her research participants, she discovered that their experience and subjectivity as the sole caretakers of their children were shaped through historical, social and discursive factors, including exposures throughout the prenatal to postnatal environment. The subjectivities were either embraced or created tension and were expressed as a failure of expectation of what it would be like to mother. For one mother who refused this subject position, this resulted in her act of self-isolation for fear of judgment and further guilt about her parenting practices (Rossiter, 1988).

Dominant mother discourses powerfully operate to shape the identity of “women-as-mothers” such that subjectivity is created within the discourse of how normal, women-as-mothers act or are to be. It is this powerful discursive construction of the *essential* woman-as-mother to both bear and rear (nurture) children that is open to challenge and will form a central argument for the exploration of breastfeeding practice(s). While some women-as-mothers may embrace this subject position, others may not or may experience a struggle in their negotiation of this subjectivity. The motherhood discourse is but one of a multitude of discourses in which women-as-mothers may be exposed, constituted and negotiating. For example, women are also diversely constituted as workers/non-workers, sisters/daughters/friends, Asian/Black/Caucasian/other races/cultures, upper/middle/lower class among (many) other subject positions. Discourses that constitute these subject positions may form spaces for alternative or opposing subject positions to emerge, or offer a point of resistance to the dominant mothering discourse – in which the mother is understood as the primary and loving caregiver for her children.

The hegemonic power of the mother discourse has the potential to contribute to

the marginalization of women-as-mothers who adopt this subject position and who fail to meet, contest or resist, the normative standards associated with it. Within a discourse where women-as-mothers are positioned as accountable for the health outcomes of their children, there is the potential for guilt, shame and stigma for unhealthy, irrational, bad, or risky health choices and practices. Such practices include infant feeding with breastfeeding represented as the gold standard and formula feeding as the risky *choice* (Shaw, 2004), *prevention* of obesity (McNaughton, 2011), and striving to maintain good and normal household food management practices in the absence of material resources (Devine et al., 2006).

3.2 Feminism and poststructuralism

Feminism is a movement with an aim toward understanding power as it relates to patriarchy and exploring the ways in which the female (as gender and/or sex) has been constructed and positioned in society. Feminism moves beyond gender to incorporate an understanding of power and the relations of power as it relates to other disenfranchised or underrepresented social groups constituted by class, race or other. Thus feminism “is a politics” (Weedon, 1997, p.1).

In early theorizing, the concept of feminism was often grounded in an understanding of an essential female, biological body as what differentiates women from men. Essentialism as a basis of difference, results in an exploration that reveals positive (celebratory) experiences and negative (oppressive) consequences of valuing a biological rationale for the essence of what makes us women or men. Observes Alcoff (1988): “in attempting to speak for women, feminism often seems to presuppose that it knows what

women truly are” (Alcoff, 1988, p. 405); essentialism was historically used as a starting point for feminists to explore how women are positioned in society and question how and why patriarchy exists. The humanist epistemology values essentialism, which is again troubled under a poststructuralist lens. What a poststructuralist view posits is that gender and sex are constituted through discourse, rather than biologically determined; FPS then aims to explore how discourse and discursive practices operate to constitute gendered or other (e.g. raced, classed, sexed) subjectivity/ies.

This poststructural concept becomes a valuable lens for feminists who work in health-related fields, as it challenges the privileged and potentially “dangerous” (Sawicki, 1991, p. 55), dominant position that humanism has in the human and health sciences. Humanist theories that dominate the health and human sciences are privileged and normalize engendered (or raced, classed, sexed) experiences based on innateness or the naturalness of gender differences. The review of literature in chapter 2 highlights how the discourse of mothering shapes how health professionals and others understand a mother’s role in relation to health (breastfeeding, obesity and food security) – the constitution of a mother still rests on an essentialist understanding of gender. As previously presented, expert systems, including health professionals and researchers, are positioned in a relational role participating in and sustaining discursive practices that standardize or normalize particular ways of thinking or acting, enabling control and regulation over discourses that shape our understanding and knowledge concerning health issues (Arslanian-Engoren, 2002) such that “poststructuralist theory acts as a reminder to attend to the margins as a means for reversing the usual adherence to dominant values” (Gingras, 2009, p. 179).

As stated earlier, the physical body is not denied for poststructuralists, rather is it theorized as an object for the insertion of various discourses and the practices and knowledge that embody that discourse. Essentialism or a biological rationale for the differences between man/en and woman/en (or other subjectivities) is therefore seen as another “powerful” discourse (Weedon, 1997, p. 49), which operates to constitute and shape identity rather than the *reason* for identity itself. FPS (and the writings of Foucault) have stimulated debate and critique from feminists surrounding the constitution of gender through discourse and discursive and what this means for a feminist politics (see, Buker, 1990; Hekman, 1996; Sawicki, 1991). FPS is concerned with exploring how woman comes to be through discourse and the historical, social and political contexts surrounding this, and how this forms a strategy for furthering social and power relations. As Weedon (1997) suggests: “[FPS is]...not a devaluing of women’s experience but an understanding of its constitution and its strategic position within the broader field of patriarchal power relations” (Weedon, 1997, p.71).

By reframing the constitution of subjectivity, then, FPS also enables an examination of experience: “why it is contradictory or incoherent and why and how it can change” (Weedon, 1997, p. 40). Experience is not natural, nor is it absolute (Scott, 1988). Rather, experience is constituted within discourse (patterns of language) and because of this, there is no one, absolute truth that can be understood pertaining to the lives and experiences of others. Understanding experience in this manner is another important consideration for health professionals, in our relations with our clients, patients, stakeholders and populations because it provides an alternative view for understanding health practices within the social field – particularly why health practices occur or do not

occur. An FPS orientation to practice and research allows us to attend to factors that conceptualize experience, the social, historical and politically-constitutive manifestations of experience and to ask critical questions about experience in our interactions with others (and how our professional subjectivity informs these encounters). In this regard, feminist poststructuralism provides us an opportunity to conduct a reflexive practice, that is, to understand our own professional subjectivities that are operating within discursive fields, and those constituted subjectivities among our patients, clients, stakeholders, research participants and the population at large.

SUMMARY

Poststructuralism is a philosophy that is skeptical of modern societal focus on absolute, universal truths formed through humanist (positivist) epistemologies. It maintains that patterns of language, known as discourse, assign meaning to our reality and through this process, constitute subjectivity and form relations of power, which result in self-discipline over actions within the social field. This philosophy thus challenges any presuppositions or taken-for-granted assumptions regarding human practices – including those that are assumed to be natural or innate. Poststructuralism has much to offer feminism and an FPS view is also a critical lens by which health practices can be explored, particularly those practices related to gender and under-represented groups such as those signified as obese and income-related food insecure. Thus, FPS can be a particularly useful lens for research that aims to explore one of the most engendered practices, which is infant feeding.

Through theorizing the constitution of subjectivity and experience through exposure to various discourses, we can then challenge the hegemonic ideologies, which have shaped dominant understandings of health practices within the social field, and how we contribute to these ideologies in our professional endeavours – such as policy development and professional practice. We can then ask important questions such as what maintains dominant, discursive positions? What discourses are prevalent among those we categorize as marginalized (e.g. obese and low-income)? What discourses exist in relation to breastfeeding practice among those signified as marginalized? How might these discursive positions differ from the hegemonic ideologies that exist within the health field? How are health professionals implicated in maintaining these discourses through ongoing relations with these communities? What are their effects and implications? And finally, how might we apply a broadened understanding of experience to health practice in supporting all women in their infant feeding practices?

Therefore, FPS provides an important means to view and research our modern healthcare system (including healthcare practices and health promotion efforts to which we are exposed) by challenging or interrogating the taken-for-granted assumptions that guide and shape normal, given or rational health practices and helping to reveal (for example, through the analysis of discourse) how/what has constructed these practices and continues to reproduce them.

For Cheek and Gough (2005), this type of perspective enables “scrutiny of aspects of healthcare that previously may have seemed innocuous or neutral” (Cheek & Gough, 2005, p. 307). It is a philosophy which does not argue what or how we *should* understand the issues of breastfeeding, obesity prevention, and food insecurity but rather *how* we

have come to know and understand it in certain ways, to the exclusion of others, *and the effects of such practices*. A feminist poststructural orientation offers us a critical lens by which we can consider alternative viewpoints and realities of these and many other healthcare issues in a more reflexive and inclusive manner.

CHAPTER 4 RESEARCH DESIGN

This chapter details the design and approach that I used to explore breastfeeding practice among Nova Scotian women signified as overweight or obese and low-income, food insecure. As presented in Chapter 3, this qualitative study was conducted using the theoretical perspectives of FPS, with a particular emphasis on Foucauldian concepts. This chapter summarizes the research design employed, including the approaches used to facilitate participant recruitment and the approach to data analysis. The chapter begins with a statement of researcher disclosure, highlighting the specific challenges that I encountered in attending to an FPS framework while conducting this study. The chapter concludes with a section on researcher reflexivity, which is a critical exercise for research that is conducted in a social critical framework.

4.1 Researcher disclosure

As discussed in chapter 3, FPS maintains that subjects are constituted through discourse. However, in order to address the experience of breastfeeding by those signified as obese and income-related food insecure (including exploring those discourses and discursive practices which classify or constitute them as such), the approach to research must have a point of reference by which these experiences can be explored and the discourses examined. Therefore, a philosophical dilemma occurs whereby the research is embedded in a process of preexisting signification and discursive production. Throughout participant recruitment, data collection and analyses, I acknowledge that I was signifying research participants through normative, discursive classifications of obesity and income-related food insecurity.

Research participants for this study were identified according to normative, post-positivist categories and assumptions (Appendix A). Through this process, I was reconstituting them as mothers, overweight and/or obese and income-related food insecure and – as they volunteered and consented to be part of this study according to those categories (their study engagement) – they too self-identified within these classifications. By constituting research participants in this manner and recruiting research participants who self-identified with these classifications enabled me to meet the following research objectives for this study:

1. To understand how discourses constitute or signify women as overweight and/or obese, low-income and food insecure; and
2. How these women experience breastfeeding having been signified as overweight and/or obese and low-income food insecure.

Dominant discourses have already signified the research participants in these subject positions. My goal was not to re-signify, rather it was to reveal the experience of breastfeeding within these contexts and to explore any resistance, or alternative discourses, which shaped their experience. Finally, in constituting the research participants according to normative categories, I also fulfilled necessary obligations for ethical approval of this study and the qualitative tenant of trustworthiness.

4.2 Research approach

The study employed qualitative inquiry using the theoretical framework of FPS. In the proceeding sections of this chapter, I will summarize the study setting, study participants (recruitment and sample size), and the sources of data.

4.2.1 Setting

The setting for this study was the Halifax Regional Municipality in Nova Scotia, Canada. All study participants were expected to delivery their babies at the IWK Health Centre, which serves as the largest birthing centre in Nova Scotia (over 4700 babies were born at the IWK between 2014-15) and is the birthing centre for women who live in the Halifax Regional Municipality. Additionally, the Centre provides primary, secondary, and tertiary care to women, children, youth and families across the Maritime provinces (IWK Health Centre, 2016a).

4.2.2 Participants

Participants for this study were purposively recruited for their ability to provide narrative to their experience of breastfeeding practice, within the discourses of pregnancy, new motherhood, excess maternal body weight and income-related food insecurity. In an FPS framework, experience is produced through discourse; therefore experience is used to illuminate the knowledges, understandings (through discourse) that are produced and reproduced (Scott, 1992).

Inclusion criteria

Participants who identified as “intending to breastfeed” and also met the following inclusion criteria (based on post-positivist assumptions), were invited to participate in this study:

- Resident of Nova Scotia;
- Intention to birth baby at the IWK Health Centre in Halifax, Nova Scotia;
- Female over the age of 18 years;

- Ability to understand and speak English (consent and interview);
- First pregnancy (primigravida);
- Singleton pregnancy (known to be having only one baby);
- Self-reported pre-pregnancy body mass index ≥ 27 (classified as at overweight according to biomedical discourse; (Lau et al., 2007) calculated based on self-reported, pre-pregnancy height and weight);
- Self-reported risk of food insecurity; use of two-item survey tool which has been validated against the United State's Department of Agriculture's Household Food Security Scale for use in families with young children (Hager et al., 2010)
- Low-income as assessed by Statistics Canada's Low-income cut-offs (LICO) requiring the potential participant:
 - Self-reported total household income after tax;
 - Postal code (first three digits only) to determine community size according to the census;
 - Household size (number of persons living in dwelling) (Statistics Canada, 2012).

Once participants expressed interest in participating in the study, I used the pre-screen questionnaire (Appendix B) either by phone or by email in order to establish inclusion or exclusion from the study.

My intention was not to purposefully recruit participants based on diverse geographical (e.g. urban, suburban, rural), cultural (e.g. race, ethnicity) or situational (e.g. exposure and/or access to antenatal and other care supports) contexts. However, in recognition that discourses reflect varying social, cultural and political contexts, any

contexts and exposures self-identified by participants during data collection were considered throughout the analysis process.

In order to be considered for participation in this study, potential participants disclosed their intention (willingness) to breastfeed their child; however, I also recognized that shifting circumstances impacted on their ability to follow through with this intention (e.g. circumstances during and after birth that shaped the context for infant feeding). Once participants consented to participate and subsequently enrolled in the study, I retained them irrespective of their infant feeding practices post-delivery. The exploration of the circumstances that impacted on their infant feeding practices became an integral component of the analysis and findings of this study (see section 4.3).

4.2.3 Participant recruitment

Participant recruitment occurred through an iterative process, adjusted based on feedback from my supervisor and committee members, personal reflection as well as information I received from participants themselves. I received initial ethics approval for this study from the IWK Health Centre (protocol #04506) in fall 2013 and subsequently began the process of participant recruitment.

My primary recruitment tool for this study was the recruitment poster and postcards (Appendix A), which I designed using a professional printing computer program (Apple Pages) with a purchased stock image of a mother with her baby. These were also professionally printed so as to maximize the potential for interest among research participants, who were likely to be exposed to a variety of research recruitment posters in the settings in which they interacted. For the posters and postcards, I paid particular attention to the language and the manner in which they were written. Rather

than use language such as obesity and income-related food insecurity which may invoke emotion or a lack of understanding by potential participants because of the discourse that shapes these concepts (see Chapter 2), or this language being understood and used dominantly within the health-related fields, I adopted language to promote the study as attempting to understand breastfeeding among women who identified with “concerns over weighing too much” or “having been considered by others as heavy or overweight” in lieu of obesity (Volger et al., 2011), and “struggle with not having enough money to eat in ways they want or need to” in lieu of income-related food insecurity. This approach was also adopted so as not to further constitute potential participants as obese or income-related food insecure and minimize the discursive effects of that constitution.

Recognizing the importance of engaging with health care providers who may be directly engaged with the population I was interested in studying (Burroughs et al., 2003; McMillan et al., 2009), I initially began my process for participant recruitment with the IWK Health Centre. As I was interested in recruiting participants to the study while they were pregnant, I focused my engagement on the Perinatal Centre (PNC), which provides a range of primary and tertiary care services to women from the Halifax Regional Municipality, including women categorized as having high risk pregnancies (IWK Health Centre, 2016b). Through communication with the PNC manager (Appendix C), I was able to meet with several members of the Perinatal Centre (PNC) care team to describe the study and request that recruitment posters be placed around the Centre. This proved to be an important area for participant recruitment since I gained the majority of interest, and subsequent enrolment, in my research study through this method.

In addition, I engaged with a family physician and past board member of the North End Community Health Centre to seek their support for this study and guidance for areas of recruitment. As a result of this engagement, I was able to place recruitment posters at the North End Community Health Centre, and also established a connection through Dalhousie Family Medicine (Chebucto) to place recruitment posters there. During our meeting, my contact further validated my recruitment approach as she expressed many of the same ideas and approaches that I had initially proposed for recruitment.

I also conducted a presentation at the former Capital Health District Health Authority's Public Health office for public health nurses and I met face-to-face with the coordinator of the Volunteer Doula program through the Chebucto Family Centre, where I described the study and distributed recruitment posters, requesting their support and promotion for participant recruitment. Finally, I connected via email with the executive directors of the Bayer's Road Family Centre and Dartmouth Family Centre and the coordinator of the Mi'kmaw Child Development Centre – Family Resource to provide them with posters for study promotion.

Previous research has highlighted that the participation of women categorized as low-income and marginalized in health research is fraught with challenges, due to a range of factors that include presumptions made by the researchers (stereotyping), social positioning and participants' skepticism of the health research enterprise (Joseph, Kaplan, & Pasick, 2007). The sensitivity of the topic(s) under exploration along with reduced visibility of breastfeeding practice (breastfeeding continues to be relegated to private spaces and is a marginalized practice in certain contexts) may have further affected

recruitment for this study (Faugier & Sargeant, 1997). The discourses that underpin obesity and income-related food insecurity continue to be open to stigmatization (Puhl & Heuer, 2009) and this has the potential to also impact research recruitment. For example, in their qualitative study of the experience of overweight and obesity among male youth, Morrison and colleagues describe recruitment challenges related to their study finding that the sensitivity of the topic of obesity as well as the further requirement of establishing a rapport with an outsider (researcher) posed significant challenges for recruitment (Morrison, Gregory, Thibodeau, & Copeland, 2012).

Because of these issues, as well as others that I may never fully identify or understand, I also experienced challenges and complexity in recruiting participants for this study. In consultation with my primary supervisor, I submitted two amendments to my ethics protocol in order to maximize study participation within the range in which I had originally proposed (between 8-15 participants). First, to broaden the range of potential participants, I changed the protocol to include women with a BMI at or above 27 (from my originally proposed inclusion of BMI over 30). This would help continue to meet the criteria of this study (exploring breastfeeding within the context of excess body weight), which proved effective at enrolling participants. Secondly, I requested an amendment to recruit through Kijiji, a local website for buying, selling and advertising products and services, which helped promote the study more broadly.

4.2.4 Sample size

There are no set guidelines to determine sample size for qualitative inquiry. Further, to determine an appropriate sample size for a research study guided by a poststructuralist approach runs counter to the philosophies of this perspective since

accounts of experience are understood to be only a partial account of reality. Qualitative inquiry is also not concerned with generalizability, rather the richness of information provided within the participant sample that enables the revealing of practices, experiences and discourses.

The focus for this study was on depth of investigation (e.g. detail and intensity) supported through the interviewing and analytical skills of the researcher, which also included a certain level of judgment and intuition in determining an appropriate sample size (Sandelowski, 1995). I originally proposed to recruit between 8-15 women to participate in this study. A variety of reasons were explored for proposing this range. First, was the presumed difficulty reaching potential participants because of the sensitivity of the topic under exploration (see section 4.2.3), second, was the commitment to the study. The repeat, face-to-face interview structure required an investment made on behalf of both the participants and the researcher during a major transition and life event (pregnancy, childbirth, early parenting). A third rationale was the time taken to generate these data. Because I collected data over the course of 6-9 months for each participant (prenatal, 0-3 months postpartum, and 3-6 months postpartum), there was a pragmatic rationale for keeping the participant sample size within this range. Finally, this study was anticipated to generate a large volume of data or *text corpus* for analyses (Gaskell, 2000) due to the repeat interview structure. The latter two factors specifically focused on narrowing the sample size due to the limits of myself as the primary researcher in both data collection and analyses (Gaskell, 2000).

All of these earlier considerations came to fruition throughout the data collection process. I faced difficulty in recruiting participants, specifically those who met the

inclusion criteria for this study or those who continued with the study. Once potential participants were exposed to the recruitment advertisements, they identified themselves as wishing to participate by leaving a voicemail or emailing me directly about the study, at which point I followed-up with these individuals to provide them with further details about the study and to seek further their interest in participating. I was contacted by 16 individuals during the data collection timeframe; 5 individuals did not respond after I provided them with further information or they did not meet criteria in the first place which was disclosed during communication (e.g., second pregnancy). Once potential participant interest was established, I asked them to complete a demographic questionnaire in order to establish their inclusion into the study (see section 4.4 for further details). The rationale for completing the demographic questionnaire was fully explained to potential participants – through email correspondence or verbally. Two potential participants were excluded due to self-disclosed income level and food insecurity.

In total, 9 individuals met the inclusion criteria and were considered eligible to participate; 8 participants eventually enrolled in the study. These eight participants were considered enrolled in the study after they provided written informed consent to participate in the interviews (Appendix D). Informed consent was completed face-to-face, at the time of our initial interview. Of the enrolled participants, 6 women completed the study in its entirety (n=18 interviews). The remaining two women only completed the prenatal (initial) interview (n=2 interviews). One participant shared that her pregnancy ended in a stillbirth, while the other participant ceased communication after she initially contacted me to set up the newborn interview. I presumed she became busy (I received

her email prior to the December holiday season) and then assumed she had relocated internationally to be with her baby's father based on information that she provided to me during her prenatal interview. Upon discussion with my primary supervisor and members of my committee, it was decided that data recruitment could cease and my efforts would be focused on seeing the remaining participants through to the end of their data collection period as well as data analyses and interpretation of findings.

A complete list of study participants and a brief description of their particular context is provided in Appendix E. Any description of the participants provides contexts that they identified during the time of their prenatal interview. Any details pertaining to their story that have relevance to the context of postpartum interviews are woven within the Chapter 6: Findings After Birth. I assigned pseudonyms to the participants for this study in order to protect their identities.

4.2.5 Data sources

The primary source of data that was collected for this study was one-on-one repeat interviews with research participants before birth (n=8), and after birth (n=12). A second data set – the demographic questionnaire (Appendix B) was used solely in the pre-screening for this study, in order to establish inclusion and potential for enrolment. The demographic questionnaire also supports trustworthiness of the study, by providing documentation that the participants selected for this study could identify as experiencing excess body weight and income-related food insecurity. The following sections outline these sources and their applicability to the research objectives.

Primary data source: in-depth participant interviews

A feminist research practice transforms knowing from a positivist-centred, objectively driven inquiry to one in which knowledge is understood as context-specific and relational (Hesse-Biber, 2013; Lather, 1991). To this end, *experience* is the focus of inquiry in order to delineate understandings of social reality (Scott, 1992); feminist research is not solely concerned with understanding experience through the voices of women, but through diverse marginalities within society such as race, class or sexuality (Hesse-Biber, 2007).

For this inquiry, the primary data source for this study was women's accounts of their experience of breastfeeding practice, within the context of pregnancy, new motherhood, excess maternal body weight, poverty, and income-related food insecurity. These accounts of experience were obtained through one-on-one (researcher – participant) semi-structured (or open), face-to-face interviews, where subjectivity, meaning and context were all considered important aspects of the account. I emphasize this is *an* experience rather than *the* experience as an FPS perspective retains the plurality of experience rather than an essence or unified experience. The experiences shared through the interview process were recognized to be partial, and potentially shifting, experiences of breastfeeding (and/or infant feeding) practices within the contexts of excess body weight, poverty, food insecurity and mothering.

I utilized the seminal approaches of Oakley (1981) and Rossiter (1998) in their respective explorations of early motherhood as models for this study (Oakley, 1981; Rossiter, 1988). In her experience of interviewing women over the course of their transition to motherhood, Oakley asserted the masculine orientation to interviewing as

problematic for feminist research, because it emphasizes an approach to interviewing that reduces researcher bias and maintains researcher objectivity through detachment, an attendance to rigour and structure (Oakley, 1981). This type of interviewing is still strongly represented within health science research. In contrast with this masculine approach, Rossiter (1988) described her engagement with the interview process and co-constructing the experience alongside her participants. Her participants asked questions and sought advice regarding motherhood and her experiences of mothering. Because she was conducting repeated interviews, there was a collaborative approach to the interview as the relationship developed (Rossiter, 1988).

I employed an active interview approach for this research, focusing on conversational dialogue and interaction between participants and myself as part of a co-constructive, sense-making activity. While I used an interview guide (Appendix F), the topics covered were not systematically posed and rigid (e.g., question/answer with no probing) and allowed for flexibility throughout the course of the interviews.

The active approach to interviewing is suggested to be more conducive to eliciting dimensions of experience and helps situate the participant and researcher as subjects producing knowledge about that experience (Gubrium & Holstein, 2003, p.74). The active interview is also a site of discursive formation and reformation, which formed part of the analysis and interpretation, rather than analyzing solely the narratives provided by the participant (Gubrium & Holstein, 2003). This style of interview helped to examine both *what* and *how* the participant experienced the subject matter under investigation, allowing for a more in-depth narrative of the experience to be revealed within analyses and interpretation. The active interview approach also enabled me to

examine my own subjectivity and how this subject position was shaping the interview process. This is an important part of forming my own reflexivity on the process.

The relationship between the researcher and the researched during in-depth feminist interviewing is discussed extensively by Hesse-Biber (2013) including an outline of strategies to maximize value from the interview process and minimize differences attributed by class, age, socioeconomic, ability, gender, culture or other that may effect the interview (Hesse-Biber, 2013). Similar to Rossiter (1988), I found myself using my own experiences – specifically as a mother – to reduce any potential power differentials that existed between the participants and myself (Rossiter, 1988). These experiences were peppered throughout the interview so as to keep the conversation flowing about *their* experience but nonetheless helped to develop rapport with participants, which was essential to the success of the study. I was particularly mindful of active listening – allowing the participants to speak freely and without agenda, and attending to the manner in which I was dressed for the interview, how I spoke to the research participants, and any other body language throughout the interview so that participants felt comfortable and trusted that it was their story and experience under exploration. I used “markers” throughout the interviews as a form of active listening (Hesse-Biber, 2013) – taking notes and probing participants on particular details that they shared in their stories as they related to the experiences of the participants. For example, I frequently used questions such as “you just mentioned...can you tell me more about...?” or, “how does...make you feel?” throughout the interview to elicit further information about their experience. I collected field notes pertaining to the feel of the interview and the emotions that were conveyed by the participants. I referred to these while transcribing and conducting

analyses in order to recall the nuances that existed throughout the interviews and to aid with analyses.

A repeat interview structure was used with the purpose of reflecting the shifting context of pregnancy to parenthood, and the temporal aspects associated with these transitory experiences, including those which impact on breastfeeding (Heinig et al., 2006). My approach is consistent with an FPS perspective where context is an important dimension of experience and shapes subjectivity (in this case, the maternal subject position) at any given point in time. Three in-depth interviews were conducted for this study:

1. Interview 1 (prenatal, initial) took place when the participants were in their 3rd trimester or 28-40 weeks gestation;
2. Interview 2 (newborn) took place after birth. All of these interviews took place when the participants' babies were approximately 3-4 weeks of age;
3. Interview 3 (infant) took place about 3 months after birth.

The timeframe selected for the interviews was not arbitrary. The third trimester (initial interview) reflects a time during pregnancy when one is least likely to experience a pregnancy loss; therefore, participants might have been more open to participate in the study and continue without attrition. Secondly, the third trimester reflects a time when participants were more likely to have repeated exposure to various points of contact within the health care system, including primary care provider(s), public health (e.g. through prenatal classes), allied health professionals (e.g. possibly dietitians in relation to weight status and/or nutritional health risks due to income-related food insecurity), and

other health services (e.g. ultrasound and lab services) so had greater ability to speak to these experiences.

The second interview (newborn) was conducted during a period of time when infant feeding is most intense, and when breastfeeding attrition begins to occur (the most recent surveillance data indicates that compared with 83.2% of Nova Scotian women who initiate breastfeeding, 40.1% will be exclusively breastfeeding at 3 months post-partum and 55.6% offer some range of partial breastfeeding) (Chalmers et al., 2009). In addition, conducting an interview during this time allowed the participant the ability to reflect on how the birth process situated their breastfeeding and/or other infant feeding practices.

Finally, the third (infant) interview was conducted at a point in time where research indicates most women will cease breastfeeding (Chalmers et al., 2009). This interview further reflected the changing context of parenthood (mothering) and its relation to infant feeding, and other health-related practices. The interview guide was developed to reflect the particular context of each of these timeframes.

Participant interviews were conducted over a period of 17 months between January 2014 and May 2015. Each interview was audio-recorded, with participant consent. All interviews averaged just over an hour in length. Prenatal interviews (n=8) ranged from 33 – 106 minutes; newborn interviews (n=6) ranged from 58 – 95 minutes; and infant interview (n=6) ranged from 40 – 104 minutes.

I transcribed each interview verbatim after they took place. This approach was taken in order so that I maintained a level of familiarity with the interview – revisiting the emotions and verbal nuances that were used to support the participant narratives. Because of the importance of the use of language within my methodological framing,

these were included as part of the transcripts. For example, I highlighted areas where the participants stressed (or minimized) a particular word or phrase. I also used field notes to corroborate the emotions of the interview. I paid particular attention not only to *what* was being said but *how* this statement was being conveyed. This approach was critical in order to inform the analyses and interpretation of findings.

The strength of using the repeat interview structure resulted in generating a volume of text (narrative) useful for interpretation and analyses and allowed me the ability to probe and clarify meanings from previous interviews during subsequent participant interviews. As participants revisited their stories with me, they validated their experiences that they had described within previous interviews and in many cases added additional details, which helped to triangulate the findings.

From a philosophical position, the use of the repeated interview structure acknowledges the transitory and dynamic nature of pregnancy and new motherhood and how these experiences provide additional contexts for breastfeeding and other health-related practices. Finally, from the research perspective, a key strength for the repeated interview structure was that it facilitated building a rapport between the participants and myself. From this emerged a relationship that helped to minimize any power differentials that existed between the participants and myself, lending itself to a more conversational tone and familiar dialogue throughout the interview process and the potential to explore the experience of the participants more intimately rather than the participant experience being part of a 'formal' interview.

While the repeat interview structure added significant strength to the research process, one of its major limitations was the higher degree of participant burden. In

reference to the approach used by Rossiter (1988) I indicated that I would contact research participants by email around the time of their expected delivery date to remind them of our next interview and to confirm a time and place (Rossiter, 1988). Each participant was receptive to the use of email or phone for this form of communication and for finalizing details of the interview.

Finally, each participant was provided a cash honorarium of \$25 per interview, an approach that is recognized to give “the participant absolute choice over how to spend the money” (Community University Research Alliance, *Activating Change Together for Community Food Security*, 2013, p. 2). The stipend was provided to express gratitude for their participation in the study and as a courtesy to recognize the general intrusion into their lives. The value of the honorarium was decided through personal communication with a local researcher with expertise in research pertaining to income-related food insecure populations and was considered appropriate as to not affect any income or social assistance benefits received by participants, but also to minimize any perception of participant coercion (P. Williams, personal communication, February 13, 2013). The honoraria (and justifications) employed for this project are consistent with studies within Dr. Williams’ current program of research (Community University Research Alliance, *Activating Change Together for Community Food Security*, 2013).

In accordance with Dalhousie University and IWK Health Centre policy, each participant also signed a form at the time of interview indicating that they had received the honorarium for participating in this study (see Appendix H).

Secondary data source: demographic questionnaire

The demographic questionnaire was used for descriptive purposes only (Appendix B). This information was primarily used to assess whether eligible participants met inclusion criteria, and was used to describe the participants broadly (or provide contextual information for the exemplars in their narratives). The questionnaire was administered prior to the initial interview, after interested participants provided verbal or written consent that they wish to participate in the study. The demographic data was not used for any further sub-analyses (for example, narratives by age, BMI, or income).

4.3 Data analysis

Discourse analysis formed the basis of data analysis and is a method consistent with a feminist poststructural research approach. Discourse analysis is a means of revealing how language is used and occasioned in “historical, social and political conditions...our words are politicized, even if we are not aware of it, because our words carry the power that reflects the interests of those who speak” (McGregor, 2003). The purpose of discourse analysis is to explore and describe the links between discourse and the hegemonic (power) structures that exist in our social world, acknowledging that they will be also occasioned based on our understanding of the world and the discursive practices that have influenced our knowledge of it. Revealing discourses may not provide answers but may support a process of social transformation, or the ability for action and change at the societal level. This is particularly useful for feminist politics, which is interested in how change or transition can occur within this complex web of power relations (Mills, 2004). It helps move the researcher further away from positivist

orientations to experience to how experience is historically and socially situated (Crowe, 2005).

There is no one best way to approach discourse analysis, nor is there one way of understanding the concept of it. Analysis, however, is facilitated if it is positioned within an understanding of the concept of discourse. For this research, I was drawn to the concept of discourse as described by Rose (2007):

Groups of statements which structure the way a thing is thought, and the way we act on the basis of that thinking. In other words, discourse is a particular knowledge which shapes how the world is understood and how things are done in it...discourses are articulated through all sorts of visual and verbal images and texts, specialized or not, and also through the practices that those languages permit (Rose, 2007, p. 142).

What Rose emphasizes about discourse is not just the structure of the statements that form discourse, but their “meaning, force and effect within a social context” (Mills, 2004, p.11). The *effects* of discourse are a key focus of Foucault’s writings, for their purpose in revealing relations of power and the constitution of subjectivity through discourse.

The participant interviews provided representations of discursive frameworks that reproduce knowledge/power relations. Therefore, text (or the language embedded as part of that text) formed “an example of the data itself” (Lupton, 1992, p.148). Studying these texts (with an attendance to both the spoken and written) helped to reveal discursive constructions and relations of power as they pertained to concepts such as excess maternal body weight, income, food insecurity, parenting and infant feeding practices as experienced among the participants (Francis, 2000; Lupton, 1992).

My approach to analyses drew upon Foucauldian and feminist discourse analysis methods outlined and discussed within the literature (Jäger & Maier, 2009; Mills, 2004; Rose, 2007; Tonkiss, 2004; Willig, 2013). Analyses of the interviews occurred in an iterative fashion encompassing a variety of steps.

With respect to the interview, discourse analysis began with the transcription of audiotaped interviews into transcribed texts. Recognizing that this conversion results in an immediate reinterpretation of the data (Poland, 1995), I was careful to transcribe verbatim and be particularly mindful of the manner in which topics were described and experienced by the participants; I referred to notes taken during the interviews concerning emotions or the strength or minimization of particular topics under discussion. This also formed the first step of analyses because of the level of immersion in the audio data and the ability to draw initial interpretations across the experiences of research participants.

Following transcription, I then re-read each interview, line-by-line and in detail for key words, themes, repeated structures and statements (Gavey, 1989) to begin the process of identifying discursive constructions – how participants constructed the issues under exploration as part of this study (particularly, breastfeeding, excess maternal body weight, food insecurity, poverty, and parenting) (Rose, 2007; Willig, 2013). The repetition of themes within the data pointed to the type of information that the participant(s) were trying to convey about the topic under discussion (Tonkiss, 2004). This step also involved identifying particular discourse fragments, collective symbols, and discourse position (Jäger & Maier, 2009) of the research participants in relation to the topics of interest. Jäger and Maier (2009) describe discourse fragments as language (text) that refers to a concept (Jäger & Maier, 2009). Various discourse fragments make

up a discourse strand – the “spectrum of what is said and sayable at a particular point in time” (Jäger & Maier, 2009, p. 46) concerning a topic. Collective symbols are those that are understood by members of a group and help that group make sense of, and link, discourse strands (Jäger & Maier, 2009). Finally, discourse positions are those subject positions constituted through exposures to discourses (Jäger & Maier, 2009); these vary and may reflect the dominant discourses but also subvert the dominant discourse. It was at this point in the analysis that I met with my supervisor (who was able to review two transcripts stripped of identifiers) where we reviewed the emerging discursive constructions and discussed how our interpretations were similar or different and the process for moving forward with the remaining analyses.

The next step in my analytical process was to begin the interrogation of the use of language – emerging patterns, words, and themes. Willig (2013) labels this step as identifying the action orientation of the discourse – identifying how participants’ constructions of the varying discourses are deployed to produce an action and the resultant outcome of this. The critical question that Willig poses for this stage in the analytical approach is to address “what is gained from constructing the object in this particular way, at that particular point in time in the text” (Willig, 2013, p. 132). This stage is also concerned with positionings and practices – ways in which subjectivity may be constructed through the exposure to varying discourses and the subject positions that present themselves within discourse but also how discourses relate to legitimizing actions and practices. For this particular study, discourses provided the rationale for participants’ practices as they pertained to infant feeding, eating within the context of limited financial

resources and living with excess body weight. Other types of questions that I referred to during this step included:

- What is the form and strategy of argumentation?
- What is the logic?
- What is the collective symbolism regarding the topics? How are concepts linked?
- Who/what actors are mentioned? How are they positioned as subjects?
- What references are made? (sources of knowledge)
- How is meaning produced? and
- How is truth produced? (claims, legitimacy, persuasion) How are contradictions, uncertainty and alternatives handled? How are actions and inactions justified, through what justificatory strategies? (Crowe, 2005; Fowler & Lee, 2004; Gavey, 1989; Jäger & Maier, 2009; Mills, 2004; Rose, 2007; Tonkiss, 2004).

The third step in the analysis looked contrast or variation within the text and attendance to the invisible, unseen or unsaid (Gavey, 1989; Rose, 2007; Tonkiss, 2004) and focusing on differences and tensions that existed between constructions of discursive objects (Willig, 2013). For example, while one participant constructed breastfeeding within the discourse of healthier (relating to a broader biological or medical perspective) another constructed breastfeeding as an inexpensive feeding approach (relating to a capitalist or neoliberalist perspective). Alternatively, participants used both discourses simultaneously to construct the object of breastfeeding. This again reflects the diverse nature of experience, rather than unified understandings and knowledges and helped to

identify varying subject positions in relation to the concepts of breastfeeding, obesity, and income-related food insecurity. For this step, I used the techniques suggested by Strauss and Corbin (1990) (i.e. analysis of a word, phrase or sentence; systematic comparison of two phenomena; waving the red flag) (Strauss & Corbin, 1990).

Examining subjectivity was the next step in the analytical process. Subjectivity was explored through examining the varying discourses, related actions, available subject positions, and practices as described by the research participants. That is, how participants' experienced themselves within the topics of interest for this study. Subjectivity is the stage by which I also began to draw on feminist concepts of agency and resistance describing how participants' experienced themselves aligned or in contrast with particular subject positions and the actions that they took (Willig, 2013).

The final step for the analysis was to contextualize the information gathered throughout the analysis process to identify the dominant discourse strand(s) within the interviews and other documentation. The completeness of the discourse strand is apparent if no new arguments become present. It is also recognized that the discourse strand (built upon the various discourses supporting it) is subject to evolve because it is occasioned. Thus, for this research the discourse strand that will be identified is specific to the time and place, and through the accounts of experience of this group of women, and may be inapplicable at a different time and place and among other persons.

I used Microsoft Word to manage and organize the data; broad classifications for the analyses were "Before Birth" encompassing findings from the prenatal interviews (n=8) and "After Birth" for the interviews taking place during the newborn and infant stage (n=12). Each document was first labeled as per the object under consideration –

breastfeeding, income-related food insecurity, or excess maternal body weight to align with original research questions. Additional documents were added – mothering and relations with health care providers as the analyses evolved. This represented the importance of these discursive areas of investigation within the participant narratives, particularly in relation to participant subjectivity and other subject positioning. Within each document were the exemplars that pertained to the discourse fragments or symbols. They were used to describe the discursive constructions as they emerged and I also used memoing to build upon the analytical questions suggested by previous scholars (Crowe, 2005; Fowler & Lee, 2004; Gavey, 1989; Jäger & Maier, 2009; Mills, 2004; Rose, 2007; Tonkiss, 2004; Willig, 2013).

4.4 Ethical considerations

The current health discourse signifies women experiencing low income, food insecurity and obesity in particular ways that amount to a feeling of stigmatization. Exclusive breastfeeding is signified as the gold standard of infant feeding while formula-feeding practice is positioned as risky and dangerous within public health discourse, or is absent from discussion all together. Pregnancy and new motherhood is positioned as a vulnerable time where women are constituted as mothers through strategies that include monitoring and surveillance by the health care system and other self-governing practices.

In light of these discourses and the sensitivities surrounding them, the study was approached in a respectful and non-judgmental manner. All documentation for participants (including informed consent) was created at a reading level of grade 8 or lower so as to maximize accessibility. Particular attention was paid to describing what

participation in the study meant and what the study would or would not provide. For example, all participants were told that findings from this study may benefit other women in similar circumstances, but it may or may not benefit the participants themselves (Oakley, 1981). Participants were all assured that participation (and the experiences that they shared) would not negatively impact on the care they would receive throughout their pregnancy, birth or in the post-partum period.

The interview had the potential to be a sensitive and distressing experience for participants, and for a couple of participants, this was the case. The interview structure that I used (active, open, collaborative, respectful) helped to minimize potential or real distresses as they arose. Participants were not coerced into answering questions or discussing experiences that they were not comfortable with. I offered to hold interviews in an environment that was most comfortable to them. I conducted 10 interviews in the personal homes of the participants, while the remaining interviews were conducted in a private location at Dalhousie University where their anonymity was assured. I closely monitored reactions to the line of inquiry. While the majority of interviews proceeded without incident, there were a couple of interviews in which the participants became upset at different points as they recalled their experience. At no point did any of the participants request to stop the interview or decline the line of questioning even when this option was offered to them. I interpreted this as a sign of comfort with the interview environment and with the rapport that we had co-created. I also interpreted that the participants' felt supported and validated as they recalled their experiences and expressed their beliefs about the issues under exploration.

As is a challenge with all studies that are qualitative in nature, anonymity is not guaranteed. I was personally aware of the participants, their context and experiences, and additional personal and sensitive information about them (e.g., home, community, places of work, family members, considerations pertaining to their health or social status, etc.) merely from conducting the interviews. Participants were all advised that their study participation as well as their personal information and other self-identifiers (e.g., hometown, family members, community groups, place of work, etc.) would be kept confidential and that pseudonyms would be assigned to each participant and only this information would be used in data analyses. Additionally, I was the only person to listen to the audio-recordings and transcribe the data. In order to ensure anonymity of research participants, all identifying information was removed and not used in any data reporting and kept separate from the original data or other identifying materials (i.e., demographic questionnaire, emails between participants and myself, consent forms, receipt of participant stipend).

In order to protect and maintain confidentiality, all computer files pertaining to this research are password protected. All original data files including transcripts and audio-recordings are retained (locked and filed away) according to institutional policies of Dalhousie University and the IWK Health Centre, Halifax, Nova Scotia. Issues pertaining to anonymity and confidentiality were described as part of the informed consent process (Appendix D, see 4.5).

4.5 Informed Consent

The process of attaining informed consent for this study was in accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Interagency Advisory Panel on Research Ethics, 2014). Ethical approval for this study was sought from the IWK Health Centre, Halifax Nova Scotia with original approval given in fall 2013 (protocol #04506) and final study amendments approved in February 2014.

Individuals who expressed interest in the study through email or phone message were subsequently contacted and provided additional information on the study purpose, methods, participant expectations, voluntary nature of the study, benefits, risks and assurances of anonymity and confidentiality. I also described the process of determining participant eligibility. Participants were given the opportunity to have their questions answered or to seek clarification about any aspect of the study. Participants were also assured that they could decline participation or withdraw from the study at any point in time, without any impact to themselves, or the care that they or their family members (e.g., babies) would receive throughout the remainder of their pregnancy, through childbirth and thereafter. Participants were additionally assured that none of their health care providers would have any knowledge of their participation in this study.

After they verbally expressed interest to continue with the study and proceed with assessing inclusion eligibility, I then administered the demographic questionnaire (Appendix B) – either verbally or through email correspondence. If participants were deemed eligible to participate, we agreed upon a convenient time and place to complete the written consent form (Appendix D) and to conduct the first interview. If participants

were deemed ineligible to participate, I explained this to them (along with the rationale) and thanked them for their interest in participating. At the time of the first interview, I reviewed the written consent form with each participant (Appendix D) and obtained written consent to continue with the study. Each participant was provided with a copy of the consent form.

4.5 Rigour

Rigour for this study was established using a variety of approaches. Trustworthiness was established through my use of both field and process notes throughout the data collection and analytical processes. These notes allowed for the space to record observations, reactions and attitudes as they pertained to the exploration and provided assurance and validation for methodological coherence (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Collecting and analyzing data concurrently allowed for me to maintain my immersion within the data. The multiple interview process also allowed me the ability to clarify meaning and experience for the participants based on previous interviews. While not a form of member checking, it nonetheless provided another opportunity for participants to validate their experiences and in many instances, add additional details to their story. Credibility was enhanced through data triangulation – using multiple data points with the same participant (Shenton, 2004). Regular discussion with my supervisor, committee members, and as member of an academic-peer discussion group through the data collection and analysis processes also supported credibility.

Interpretive rigour was ensured through the use of comprehensive descriptions,

in-depth interviews, and quotations. Interpretive rigour of the analysis was established by ensuring that findings were adequately described for plausibility and coherence of one aspect of reality (with exemplars used from the text and linked to philosophical underpinnings); and that the linkages were also made to contradict or reinforce taken-for-granted assumptions as described by the participants (Crowe, 2005; Rose, 2007). Finally, rigour was supported through detailed record keeping for decisions and rationales related to the research.

4.6 Reflexivity

Reflexivity is an important tool in qualitative research, despite having a variety of definitions. It is not merely researcher reflection, but accounts for self-awareness and maintaining a self-critical stance throughout the research process. As described by Pillow (2003), reflexivity is about:

[being] critically conscious through personal accounting of how the researcher's self-location (across for example, gender, race, class, sexuality, ethnicity, nationality), position, and interests influence all stages of the research process (Pillow, 2003, p. 178).

It is also an understanding that the positioning of the researcher is reflected within the research itself and s/he continues to create knowledge and understandings about the subject matter through her or his actions and thoughts. Being reflexive can be a messy and uncomfortable position for researchers using postmodern philosophies (St. Pierre, 1997; Pillow, 2003) for how does a researcher conduct a reflexive project when subjects

and their experiences are constantly in negotiation, shifting through exposures to discourses and discursive practices, including those provided by the researcher?

In recognition of this dilemma, I adopted research practices in an attempt to reflect an ethic of reflexive research. I used methods and techniques that placed emphasis on the participants' accounts of their experience (in their own language), multiple interviews across space and time, and the removal of any attempt that this research will address any one truth regarding the experience of breastfeeding, obesity and food insecurity. I've located discourses that pertain to the concepts of interest by using a variety of sources – specifically, participant interviews but also texts distributed to research participants.

The disclosure of my own positioning is also an important component of the reflexive journey. This practice of self-positioning and reflection throughout data collection and analysis occurred through researcher journaling and observation, understanding that my own subjectivity ultimately played an important role in how I interpreted and understood the accounts of my participants.

CHAPTER 5 FINDINGS – BEFORE BIRTH

This chapter summarizes the findings and interpretations based on analyses conducted with prenatal interviews of study participants (n=8). Titled *Before Birth*, these findings represent the participants' particular context and experience of living in a pregnant physical state, or not yet mothers since at the time of interview, they had not yet given birth to their babies.

Pertaining to pregnancy and anticipating motherhood, throughout the interviews, I listened to participants describing many unknowns and at times, demonstrating difficulty situating themselves (their experience) within the perspective (or subject position) of being mothers and/or breastfeeding mothers, relying on past exposures with friends, family and broader social networks to construct their perspectives. As a result, I also observed and interpreted that they were experiencing a sense of bordering a space and time that encompassed both the physical state of being pregnant and the future of being a (breastfeeding) mother.

Through my analysis of the data, I interpreted overall tensions that resulted from exposure to varying overarching discourses. On one hand, I interpreted that some participants experienced a sense of preserving their own identities and autonomy – where different positions emerged that resisted or challenged dominant discourses. On the other, I also interpreted that they recognized (and also acted within) a pervasive societal discourse commonly referred to as good motherhood (see Chapter 3) a discourse whereby the needs of children are prioritized and traditional roles of mothering are identified and reinforced. This is also a space where parental (maternal) actions are negotiated and agency is exercised. Foucault's theoretical concepts of the gaze as medical and social

surveillance, biopower and governmentality were critical to the experiences of the participants insofar that they reinforced beliefs and knowledges pertaining to pregnancy, impending parenthood and other topics, but also produced subjects and subject positions from their exposures. This will continue to be elaborated on in Chapter 7 (Discussion), in particular how the tensions that I interpreted pertained to identity (mother or other) were constructed through discourse and implicated in the beliefs, values and practices of the participants and their relationships with family, friends and care providers.

5.1 “It doesn’t become about me, it becomes about [baby]”:

Representations of mothering

5.1.1 The physical body as a site for (re)producing mother

Throughout their interviews, all participants referred to a type of physical body that they believed was ideal to both bear and nurture children and in doing so, reproduced the essentialist female perspective. Primarily, participants described the linkages between this ideal physical maternal body and the practice of breastfeeding, constructing an ideal maternal body as one that *can* and *will* breastfeed. Secondary to this was how the ideal maternal body was linked with other parental practices. This was unsurprising as the interview guide was developed to specifically explore the concepts of breastfeeding, body weight and food insecurity. However, within the conversational approach and positioning of the interview, participants were given some latitude to elaborate on any topic or concept that they deemed relevant to the practice of mothering. From these narratives materialized a representation of the ideal maternal body as signified by the participants. Upon closer examination of these representations, it became evident to me that participants were drawing on the ubiquitous dominant biomedical and

scientifically oriented discourses that exist throughout society that have the effect of classifying the physical body as ideal or other and impacting on health-related bodily practices that are enacted. These biomedical discourses consequently reinforced beliefs among the participants whereby they constructed an ideal maternal body as one that, through natural means or actions:

1. Wasn't of larger body size/weight, or was meeting bio-medically-established weight-gain recommendations for a healthy pregnancy;
2. Wasn't of larger breast size or breasts were without physical deviations from the "norm" (e.g, nipples with physical damage, inverted shape);
3. Was well nourished (e.g., participants ate well), even when physical duress related to pregnancy occurred (e.g., morning sickness);
4. Was clean of drugs – prescription or illegal;
5. Existed without pre-existing medical or psycho-biological conditions (e.g., mental disorders, diabetes, eating disorders, others); and
6. Was youthful (e.g., biological age).

It is an important distinction that not every participant constructed the ideal maternal body using each of these conditions. However, all participants spoke about their bodies and bodily-related actions (or how bodies of others are represented within society) and made remarks about how particular characteristics or classifications impacted the maternal body standard and subsequently, linked with parental actions and practices.

What emerged is that participants described an ongoing questioning or speculating, and a sense of mistrust if they perceived that their evolving, pregnant bodies were fallible, their bodies weren't presently functioning as they *should* or that their

bodies wouldn't function as they should when the time arose to perform traditional mothering roles. They further contextualized these experiences through the pervasive, dominant discourse of good mothering (including the discourse strand that pertains to child privilege) such that the state of their maternal physical body (e.g., ideal or other) was directly implicated in their perceived ability to correctly "be pregnant" or to mother, impacting on health-related practices and outcomes.

For example, Lee described her "worry" about not nourishing her pregnant body well enough through extreme morning sickness, but went further to describe feeling a sense of relief once she realized that her baby was protected from any adverse outcome. She stated:

I had been really worried because I was having financial problems and I was not...I was not buying food *I should have been*, I'm certainly not eating all the *food I should have been* cause I couldn't keep most of what I ate down...but I was worried a great number of times about not gaining weight...losing weight during the first 5 months of my pregnancy, *constantly terrified that my inability to keep food down was preventing the baby from getting what it needed*. As it turns out the baby always gets everything the baby needs and that's why I felt like shit for 4 months. But yeah, the baby gets everything [it] needs but because of how little I was taking in and keeping down it was definitely screwing me up.

Throughout her narrative, Lee described herself as experiencing ongoing emotional turmoil because she perceived that her pregnant body (and the context in which she had limited financial resources to access food) was failing to do the things it "should" as an ideal, pregnant woman. I interpreted her repeated use of the word "should" as a strategy

used to emphasize the focus on surveillance of practices of the self, which Foucault would argue is a discursive strategy related to political action of discourse on the body (biopolitics). Lee clearly situated her experience within the discourse of child privilege whereby her subject position as an ideal or moral pregnant woman was shifting under emotional duress because she perceived herself as not providing adequate nutrition for her growing baby. Only when she was assured that the baby was fine (by those she identified as having expert knowledge – i.e., health care providers) did Lee move beyond the needs of her child to identify with the possibility of herself being subject to food insecurity. I noticed also how Lee described her baby as independent from her, while at the same time linking her health-related actions to him.

In another example of constructing the ideal body, Tracy described that the change in her body weight following bariatric surgery (and resultant outcomes such as freedom from prescription medications) had a positive influence on her ability to become pregnant. She stated: “well, being a larger woman...I was told I could never have children.” whereas after surgery, and upon becoming pregnant, her body was “extremely healthy at that time.” By suggesting that a reduction in body weight was implicated in her ability to become pregnant, Tracy was reinforcing biomedical discourses as a rationalization for physical health. Lynn also described the “complications” that arose from experiencing pregnancy with excess maternal weight, which signified immoral maternal behaviour, stating: “It doesn’t feel right morally, it doesn’t feel right in any way, shape or form. Like it feels like I’m actually kind of hurting my kid by being this overweight. It’s scary...”

Because of the focus on breastfeeding for this study, I was particularly drawn to how participants constructed the ideal maternal physical body in relation to breastfeeding, most specifically drawing upon an essentialist perspective of the female body to rationalize their beliefs. This perspective was nicely summarized by Lee when she described breastfeeding as a natural, but also taken-for-granted, female body process: “I assume it’s just gonna work...I just assume that it’ll be innate and instinctual and natural and that I will just work.”

While breastfeeding was positioned as a natural action of mothering, participants also described potential issues arising with breastfeeding based on their perceptions of whether their breasts (and bodies) met the ideal maternal physical standard. Both Tracy and Alice, who identified as having larger breasts, questioned the relationship of breast size to breastfeeding practices throughout their interviews (again linking with discourses of biomedicine, scientific perspective of the body, good motherhood and child privilege). Both women were concerned about the potential that their breasts would *smother* their child when breastfeeding. In addition to experiencing life-long excess body weight, coupled with large breast size, Tracy stated: “[the idea of breastfeeding] was ... kind of felt uncomfortable to me.” She went on to describe the apprehension she felt about breastfeeding her baby with large breasts.

Alice explored this concept throughout her interview, indicating that she both accepted and resisted the discourse shaping her understanding about ideal breasts and breastfeeding outcomes. Despite identifying her breasts as “ideal” to feed (with large breast size signifying adequate nourishment), like Tracy, Alice was uncomfortable in risking the safety of her child in order to breastfeed. She was adamant and resolved that

her “un-ideal” breast size would not be implicated in causing harm to her child, privileging child discourse in her statements. Her comments demonstrated the tension she experienced as she drew on competing discourses (one being ideal, natural maternal body and the other as good mother who protects her child) to validate her actions, stating:

Like is it harder if you have big boobs to breastfeed? Is it that I heard people say ‘oh you can’t breastfeed those big boobs’. I’m like – OK but there’s so much milk in there like why can’t I? They’re like ‘it’s too hard for people with big boobs to breastfeed’ [I: why do you think they say [that]?] They think I’ll smother the baby. [I: Smother the baby?] They’re not going to let the boobs smother the baby! *Like I’m not going to let the boob smother the baby obviously!* If I have to hold the boob up, *I don’t know but I ain’t going to let it smother the baby!*

Alice presented an alternate representation of her large breasts not as a hindrance, but as a benefit to breastfeeding. By doing so, she constructed that child privilege and good mothering practice may be represented through not only ideal breast size and breastfeeding safely (so as to not hurt the child), but also through the amount of milk (nourishment) that her baby could receive: “...my boobs are huge so I know I have a lot of milk in there!” and later in the interview “my, my breasts are huge and this child is gonna drink [from them].” This is again suggestive that Alice was caught within competing discourses. She viewed her physical body and large breast size as ideal to provide adequate nourishment to her baby – a good mothering practice; yet, simultaneously, indicating the size of her breasts also posed a risk for harm to her child. In both situations, Alice was using good mothering discourse and child privilege to justify both considerations for breastfeeding or not.

During Michelle's interview, she described judging her breasts compared with others (specifically her sister who was also pregnant at the time) in relation to the practice of breastfeeding. Discourses pertaining to child privilege, natural and essentialist maternal bodies and self-blame were evident within her experience. Michelle described feeling "nervous" over hearing stories about babies not latching onto the breast and the potential that she might experience the same. She stated:

I get nervous ... what if like ... if we have to go to formula like ... there's like sometimes you ... *the boobs just don't do what they're supposed to do* and it's not that the baby won't latch on, *it's something like ... within you*. [later in the interview] it's just that ... it's ... you have to feed your child so it's a necessity. And that's the way I mean, before formula's happened and before all of ... the new technology and stuff? That was the only way. *You breastfed your child that's why your body works, that's the way ... mother nature works*. So. Better to go that route than ... another route.

Later in the interview, Michelle went on to suggest her breasts may not be equipped to breastfeed because of the type of nipples she had and the amount of early lactation her breasts were experiencing. She conveyed a sense of relief when realizing that her breasts did have some prenatal leakage, as if to say her body wasn't failing her, stating:

I freaked when my sister was like 'oh I've ... I've had leaking since 20 weeks and' I'm like ahhh, I haven't had any leaking – oh no! so I went home, I was like trying to milk them...and then there was some like liquid coming out. *I was like ok, they're there ... my boobs already getting so much bigger already so I know the milk is in there so ... that freaked me out ... I was like I know every body is*

different but ... so ... yeah that would be, I looked into that because I was like, *my nipples ... are not very like, breastfeeding nipples* so that would be my concern yeah.

In other instances, some participants were not concerned about the size or shape of the breasts and nipples, but the potential for human milk as an instrument to cause harm to the baby. Tracy identified as having a history of being diabetic and described fear of “transferring” her challenges to her baby through her breastmilk, or that in some way, her challenges as a diabetic woman would negatively impact on the outcome of her baby:

What if I don't have enough milk produced for him to eat? Um, being a diabetic I worry about that. Is he going to get the insulin? Cause he's not going to be ... he's getting what I'm getting but at the same time, after he's born, am I still going to be a diabetic? And is that going to transfer through to my milk? What I have to eat – am I going to be able to get enough nutrition to be sufficient for him?

Similar to Tracy, Jennifer also discussed the possibility for her breastmilk to be affected by her experience of living with food insecurity:

What I think and believe is the case is that my proper nutrition is going to go into my breastmilk to my baby ... so if I'm not feeding myself properly, then my baby's not getting as good of nutrition as possible. [I: does that concern you?] Very much so.

I interpreted from Jennifer's statement that she perceived that certain foods that were affordable and accessible to her had the potential to affect the composition of her breastmilk and ultimately the nutrition for her baby. This again reflected a discourse emphasizing idealism as it pertained to the relationship between the maternal body and

breastmilk. Similarly for Dawn, the ideal maternal body was well nourished and it was important “to make sure I get the right kind of [food]...it’s definitely become a lot more important.” Her use of the food bank was implicated in this construction of the ideal maternal body and her choices within that context had shifted for the health of her baby, again linking to child privilege.

Not only were the participants themselves implicated in this discourse of idealism pertaining to the female, maternal body, but their friends and family members were also implicated. Alice described how her sister would call daily to determine whether she was eating well during her pregnancy. As I reflected on Alice telling her story, I interpreted her response as annoyance – as if she was incapable of following recommendations for ideal pregnancy outcomes without the surveillance of her sister. Alice’s annoyance may also have signified her position of proving herself to meet this ideal image of a good, pregnant woman (social and personal surveillance) and positioning herself as expert in this role.

It was critical to attend to how participants’ narratives constructed the type of physical body capable of both childbearing and childrearing. As they described their beliefs concerning this physical body, it became clear to me that this construction (and the dominant discourse represented within it, that of the essentialist female body) would have the potential for a profound effect on their experience of breastfeeding and other health-related practices – such as maternal weight management and food security. Their descriptions of how they met or did not meet this image would become an important worldview by which their experiences and subjectivity were realized once they gave birth to their babies.

5.1.2 Am I fit to mother?

This discourse strand relates to broader societal discourses of good mothering and child privilege, at the same time privileging biomedicine and post-positivist paradigms. While the previous discourse strand signifies and reinforces the participants' particular perspective on an ideal physical maternal body that is equipped to both bear and nurture children, this strand is more specific to the infinite social, environmental and political positions that discursively construct an image of the ideal mother and ideal mothering practices. Throughout the interviews, participants constructed mothering within its particular (traditional Western) roles and responsibilities of mothering or parenting in general.

Participants who identified that their babies would be raised by only themselves (no other parent present) also constructed their role to encompass other facets that aren't usually discussed in the literature pertaining to traditional mothering roles and responsibilities (but *are* implicated in traditional *paternal* roles) – for example, securing employment, having adequate income, etc. In addition, participants who weren't in partnered relationships also described their position as a single mother-to-be as contrary to the ideal image of a heterosexual married mother.

As with other discourses, the *fit to mother* discourse created subject positions that reinforced the discourse of ideal mothering, but also resisted this discourse. Take for example the stories of Tracy, Lee and Lynn, all three of whom indicated that their babies would have no paternal involvement. The anticipation of single parenting resulted in a lot of unknowns for these participants (which Tracy termed “terrifying”), but participants also demonstrated their agency and resistance to the situations and contexts that work to

shape their subjectivity as single mothers living in low income circumstances. Tracy summarized this by saying, “I don’t want his [baby’s father] negative money...I’m doing it [parenting] on my own and like the money’s ah...*whatever struggle it’s going to be it’ll be mine* – not his [baby’s father]. I don’t want that at all.” Similarly, Lee and Lynn shared a tone of defiance and described acrimonious relationships when speaking about their babies’ fathers. For example, when Lynn first told her baby’s father that she was pregnant, he suggested that his parents would take custody of their baby because Lynn “...was never going to be a fit mother.” Lynn described how this enraged her but rather than defend her own self as “fit” and capable of parenting, she instead pulled from a discursive position of child privilege to state:

This is basically what he wants to happen...probably because I’ve been pissing him off with telling him point blank – you need to shape up, you need to stop, the way that you’re living if you want to be in the baby’s life. And...you know – *BE* stable, um and be a positive role model for this kid. Because...there’s enough crap in the world. She [baby]...she’s, she needs positive people in her life and if you’re not going to be one of them, then you’re not going to be in it.

In her statement, Lynn was demonstrating how she would go about protecting her child from poor social influences, drawing upon child privilege for this justification.

When asked about their experiences finding out they were pregnant, a few participants demonstrated a reification of the ideal mother image and how they positioned themselves as different from that. For example, Tracy constituted herself as “the scandal”. This subject position was negotiated through the context of experiencing a medical mix-up early in her pregnancy, resulting in her understanding that she had lost

the baby. Tracy recalled feeling conflicted about the perceived inevitable outcome (i.e., pregnancy loss), but ultimately came to the conclusion that perhaps a pregnancy loss was a more favourable situation compared with bringing a baby into the current context in which she was living her life. As such, she constructed herself as the unfit mother, using the term “scandal” to signify this subject position: “... I had debated like you know, *you don't have a job, you don't have anybody to help you support this child so maybe this is the best thing*. Like, I had come to terms with that ...”. Further along in the interview, Tracy further justified her use of the term scandal, suggesting that her actions were not representative of societal norms for pregnancy. She stated, “And I always, I always say – *no I'm a scandal*. Cause like, you know I'm [maternal age over 35 years] ... I'm kinda, I've left my husband, pregnant with another man's baby ... [laughing] I'm a big scandal!” Similar to Tracy, when finding out she was pregnant, Lee recalled: “I thought the world was ending and I wanted to kill myself” and continued by stating:

The last thing I wanted to do in my entire life was message some ... perfect stranger on Facebook and tell him I was pregnant with their child ... [pregnancy] was definitely unplanned ... I found out I was pregnant and I was like – crap! This is not part of my plan ... but I've definitely accepted it ...

I interpreted from these statements that Lee's experience of finding out that she was expecting a baby did not align with normative representations of what pregnancy was about. While Lee recognized the existence and pervasiveness of the subject position of ideal mothering, she also resisted the stereotypes associated with this discourse. In addition to attending prenatal classes offered through public health or community or family centres, some participants described using technologies to support their

preparation for the arrival of their babies. In Lee's instance, she described using a phone app to provide her with information on her pregnancy. She discussed that for some situations, the app was useful, such as when the app provided information on the developmental milestones of her pregnancy (specifically her baby's gestational developmental milestones). With sarcasm, Lee also described that some information from this app wasn't useful to her at all, nor did it reflect her context:

[the app's] like 'now's a good time to start cooking meals in advance and putting them in your freezer' and I was like – *yeah, cause I know where I'm gonna live in two weeks*. I don't know how I'm supposed to ... cook meals in advance and put them in my freezer and it's advising me to stock up on dry goods and all this stuff and I was like, I'll just take it as it comes.

Her statement suggests how Lee recognized the discursive construction of a traditional mother-to-be role; however, she resisted that subject position by stating "I'll just take it as it comes". This also demonstrates that she didn't feel it was necessary to prove her capabilities within discursive female domestic roles, positioning herself as 'fit to mother' on other grounds.

Being fit to mother also involved considering partners and social networks and their related actions as influential on their babies. Dawn stated:

I don't know, ever since I've been pregnant I look at everything completely differently. And I don't know, I don't hang out with anybody anymore? ... Just a lot of people that I know and it's just stupid stuff that they do and I'm like – I don't want that around my child, you know what I mean?

Similarly for Alice, Lynn, and Lee, being fit to mother or performing mothering involved protecting their babies from negative influences in their lives and consideration for the circumstances in which they socialized. This also involved considering their partners or the baby's father's social networks and the types of activities they engaged in.

5.1.3 Mothering mysteries – constructing the unknowing subject

Every participant discussed having minimal expectations about what mothering was going to be like, often describing it as “unknown” or sharing unknowns about how they would experience mothering and actions related to that position. Frequently, these unknowns resulted in the participants describing their experiences and anticipations of parenting in terms of fear – “nervousness”, or feeling “terrified”, “freaked out” or “scared”. They described drawing upon relationships between themselves and others in their social and care environments (e.g., family, friends, care providers) or reliance on books and other media in order to bridge the gaps in their own knowledge or their feeling of inadequacies about their expectations and abilities to perform as a parent. As a result, they adopted a “learner” or “unknowing” subject position on the topics of mothering or mothering-related practices.

On the other hand, participants constituted as experts those with the scientific knowledge and expertise (drawing again on dominant biomedical discourses) to speak to the pregnancy experience and upcoming mothering roles and responsibilities. Most often, these experts were described as primary care providers or other health care professionals – identified throughout our conversations as family physicians (or doctors), obstetricians, public health nurses and doulas. Participants described a reliance on these experts to provide the information necessary for them to be comfortable within their pregnancy

experience and also to provide them with reassurance about impending parenting and the responsibilities that ensued. Moreover, participants looked at these professional relationships as a means of gathering information to support them in self-monitoring or self-surveillance, often describing the relationship in terms of measuring, quantifying and objectifying their experience of being in a pregnant state or as a new parent. Participants spoke of a variety of discursive tools – surveillance, measurement (weights, lengths, lab tests, lab values) and scientific knowledge that was employed by experts in order to monitor their pregnancies and also described how these discursive strategies may also be used in the early post-partum period. Again, Foucault’s exploration of the medical gaze and governmentality is very useful in order to interpret their collective experience.

For example, Dawn described her expectations for the health care system once she became a mother. She described the role of the public health nurse as a person coming into her home and helping to monitor her baby’s growth. Again, Dawn signified the public health nurse as an expert while positioning herself as unknowing or a learner. I perceived that she rationalized this relationship through her belief that she did not have experiential knowledge of the practices constituting good parenting:

So I might get a health nurse to come to the house once a week and just make sure everything’s going ok? And like the baby’s gaining weight good and everything like that? I think that I might do that just where it’s my first kid?

I interpreted Dawn’s description of her expectations with her care provider as one where she has constituted herself as unknowing in the situation of pregnancy and impending parenthood. Furthermore, she described seeking expert advice for questions pertaining to her pregnancy and parenting. Although Dawn positioned herself as unknowing and in the

position of needing to learn from experts (or relying on that guidance, expertise, surveillance and monitoring), she also described the tensions that occurred within this subject position. For example, her reliance on the care and guidance of experts occurred in the absence of rapport or positive communication, this resulted in a negative experience and Dawn subsequently resisted the efforts of the care provider altogether.

She stated:

Doctors are kinda rushed...these days. They – I don't know, they don't spend so much time in there, talking to you and asking you if you have questions or stuff like that. And they're like 'ok everything's good. You've gained this much weight and you've, you're taping this high now' and then they pretty much leave. And you've sat there for like an hour before you see them. It sucks ... So I want to make sure when I do go to the doctor and just like ... I don't know ... Just cause things are getting harder now? And I'm finding there's more things that I do want to ask my doctor about, where I'm getting higher up in my pregnancy.

Dawn described the feelings resulting from her inability to ask questions of her care provider:

It kinda stresses me out a little bit where it's my first kid and stuff and I don't know what I'm supposed to expect? You know what I mean? Like I have no idea what to expect so it'd be nice if there was a little more chatting involved? For sure, it would definitely be nice.

As a result, Dawn was actively seeking out alternative health care providers to support her during her pregnancy and beyond, demonstrating her agency regarding her health care during her pregnancy.

Similarly, Alice positioned herself as an unknowing subject when I asked her to describe her expectations for parenting. As evidenced in her statement, she alluded to another person (e.g., expert or professional) having the knowledge necessary to guide her throughout her early postpartum. She stated:

Like I want to know what to expect. *Like if you're a first-time mom, you don't know what to expect.* I want to know what to expect in the first three days. Like am I going to be like super tired? Am I going to be like super not-hungry? Am I going to be like eating a lot? Like what do I expect? ... [later on in the interview] I better [sic] have the knowledge. I need ... somebody's gotta give me the knowledge that I need – trust me. Or this ain't gonna work.

Other times, participants relied on family, social networks in addition to care providers to support them in enhancing their knowledge about pregnancy, parenting and parenting-related practices. Several participants were anticipating single parenting their child, as there was no identifiable partner available to support them. They oscillated between single parenting as an “unknown” and “terrifying” and single parenting as a form of resistance and agency – against the situations and contexts in which they were situated and the broader societal discourses that were working to shape their identities as single, pregnant women living in low income circumstances (see section 5.4).

SECTION 5.1 SUMMARY

The manner in which participants talked about their pregnant bodies, and represented impending parenting reified the dominant discourse of good mothering. Participants described that this discourse included both social and physical components and used this perspective in supporting their beliefs. Moreover, by positioning

themselves as unknowing and reliant on the use of experts to support their understandings of their evolving bodies and expectations as new mothers, they continued to draw upon and reify the dominant biomedical discourses that circulate throughout the health system pertaining to parenting and pregnancy. Discursive actions such as surveillance and monitoring played a critical role in participants' perceptions of breastfeeding, within the additional contexts of excess maternal body weight and income-related food insecurity. The remaining sections of this chapter will focus on how participants' perceptions of, and expectations for, breastfeeding were positioned, within the additional contexts of excess maternal body weight, and income-related food insecurity and how these situations were represented as a whole.

5.2 “Everyone knows it’s better for your baby if you can”:

Representations of breastfeeding

Participants drew on a multitude of discourses when describing their perspectives on and expectations for infant feeding (breastfeeding). As mothers, participants constituted themselves as primarily responsible for providing nourishment for their babies and identified without question with this position. Through this constitution, they drew on discourses that pertain to essentialist mothering, ideal mothering and related practices and scientific and biomedical knowledge. Moreover, they reified the taken-for-granted social norm within North America that: “mothers [breastfeed] ‘because [they] want to’ and out of love; a maternal behavior that involves women’s time, energy, body and emotions; a 24/7 activity with an ambiguous time frame...” (Groleau & Sibeko, 2012, p. 29).

In doing so, they all constructed breastfeeding as a privileged practice, emphasizing the importance of breastfeeding to (predominantly) child health while also rationalizing this construction through the role that breastfeeding plays in constituting good mothers through its representation as an ideal mothering practice. However, the immediate social network and broader public environment surrounding the participants also played a role in constructing their beliefs, values and anticipated practices about infant feeding.

5.2.1 Weighing the costs

Breastmilk was compared and contrasted with both breastfeeding and formula as the three major considerations for infant feeding by the participants, with breastmilk constructed as most acceptable (granted that there were no negative influences on breastmilk – see section 5.1.1), followed by breastfeeding and then formula feeding. Participants used breastfeeding and breastmilk somewhat interchangeably in their narratives, and no questions were specifically asked to differentiate the two. However, it was clear from their descriptions of their infant feeding practices that they were signifying breastfeeding as direct feeding of breastmilk from breast to infant's mouth, while providing breastmilk referred to providing expressed human milk with the use of a bottle. Aspects of the practice of direct breastfeeding were found to be the most influential on their expectations for infant feeding, rather than providing expressed human milk itself (albeit, the breastmilk required being *pure* – see section 5.1.1).

Initial comments made by participants highlighted that they were constructing breastfeeding and breastmilk through two broad, dominant representations: 1) child privilege (again drawing on scientific and biomedical discourses and essentialist

perspectives of the female body) and 2) economic benefit (a neoliberal or capitalist discourse). A third consideration was the potential for a bonding experience or enhanced attachment with their babies while an opposing representation was that breastmilk had its own identity independent from the study participants. Lee best summarized the views of the participants by describing breastfeeding (more specifically breastmilk) as:

the best possible option for the baby ... as far as I'm concerned like, health-wise and biologically and so on and so forth. I don't know why I would ... ever go about feeding my child artificial food when I have all that...the child needs inside me ... yeah ... in my mind there's no, like I, I understand that like sometimes for medical reasons or what-have-you that people *can't* breastfeed? And I'm so glad there are other options available but ... I don't understand why people don't breastfeed ... I don't know why you would elect not to breastfeed and spend money on artificial, mass-produced, stuff that you're feeding to your child that comes out of a can from a grocery store. I don't eat out of a can from a grocery store, I'm not gonna feed my baby stuff out of a can from a grocery store.

Others echoed her sentiments like Jennifer who said: “everyone I've ever talked to...ah, of course breast is best. Is what you hear” and Tracy: “... I know it's the best thing.” For Alice, her belief in breastfeeding being “really really good for the baby” was a precursor to “try my hardest [to breastfeed] cause I know it's healthy *for the baby*.”

Dawn's story was unique in that her partner (baby's father) was present during (all) the interviews – this was the only situation where this occurred and it was as a result of interviewing the participants in their own living environments. When asked about her feelings about breastfeeding, she stated “certainly the healthier ... alternative.” It was at

this point her partner spoke up to state that he disagreed. Even though I was not there to interview her partner or to ask him any questions specifically, I allowed the dialogue to continue without my interruption. Her partner challenged her position of breastfeeding being healthier through his belief in the value of medical technology. He stated:

“Because they put stuff in...like the...baby formula? Like they put stuff in there...too that is healthy, and stuff that you wouldn't have from the milk that [comes from you].”

While it was only a short exchange, their dialogue pointed to the discourses that Dawn was drawing from in constructing her position and viewpoint – that of breastfeeding as natural and subsequently, healthier. However, her remarks were also suggestive of the mystery that surrounds breastmilk through her repeated use of “I don't know” and then placing blame on her mother for encouraging this point of view. She stated:

I don't know, that's all like artificial stuff though? Or ... I don't know. That's the way I feel about it ... *it seems so like artificial*. I don't...It's mom, it's mom that puts it all in my head. That's what it is it's mom. I know it's my mother!

Both breastfeeding and providing expressed breastmilk were valued among participants as a cheaper (or as indicated by Beth, “inexpensive”) alternative to formula feeding. Formula feeding was perceived to be less accessible by participants because they all identified as living in situations of income or resource constraint.

For some participants, the cost of infant formula greatly impacted their perceived abilities to retain autonomy or choice in their infant feeding decisions. Michelle described that her decision to breastfeed was “obvious” and primarily based on income, but also in consideration of the health benefits (specifically to the child) and other

benefits such as bonding or attachment. She also attached an ultimatum to her infant feeding decision by stating that:

I was like my baby's not gonna have a choice! He must latch on! I'll sit there for 12 hours and [baby] must because ... for us to add that ... cost on top of diapers and food ... stuff like that...it's not...[affordable to formula feed]

For Lynn, her decision to breastfeed was based on assessing the cost of the alternative, thus breastfeeding was the default. When asked to verify that her decision process was made within the realities of income constraint, Lynn reiterated: “that was exactly how I came to the decision. I can't afford cans of Similac, I can't afford cans of...like it just there's no money for it.” Lynn also feared that her baby might not be able to tolerate her breastmilk (see section 5.1.1). She became emotional when discussing that, for her, there was no other alternative to breastfeeding her child:

I'm really concerned [if baby can't tolerate my breastmilk], which I'm praying that it's not. I may actually have to give up my child because...I can't afford [holding back tears] I can't afford....that's been something that's been going through my mind since I found out I was pregnant.

Participants constructed the concept of attachment in different ways. Some looked forward to the experience of breastfeeding through bonding and developing a relationship with their babies. Stated Lynn: “I'm hoping it's going to be one of those nurturing things that you know, it's, it's gonna happen, it's gonna be fine.” For others, attachment meant “clinginess” or an issue of “appropriate boundaries” and these representations became part of their consideration for breastfeeding. Perhaps being exposed to negative

viewpoints and perspectives on their bodies were implicated in this concept of clinginess (see section 5.3). Stated Jennifer:

... Do I really want something clinging to me all the time – every time I need a feeding, it's ... a little daunting ... [further along in the interview] I'm having difficulty getting past something clinging to my breast. I am not one that likes to ... allow my husband to touch them. I've never been one that likes any sort of fondling or anything so having a baby attached to them, it still seems a little unnatural to me, even though I know it's supposed to be the most natural thing ... possible ... it's gonna be very awkward to start.

Similarly, Dawn's experience watching her sister breastfeed influenced her expectations and beliefs about breastfeeding. She indicated that breastfeeding was "definitely demanding. Definitely demanding for her ... the baby constantly ... on you type thing and like constantly in your arms and stuff so ... um probably [expecting] pretty much the same." Later in the conversation she indicated she would use a breast pump as a means of resolving the issue of clinginess that she associated with breastfeeding (see section 5.2.4 for further discussion on meaning of the breast pump). Dawn said:

I'm going to try to pump off more than have the baby ... constantly ... stuck to me, cause I don't know, I don't really ... I don't know clinginess I don't like – I mean I know it's different when it's your baby and stuff. But I just, I don't know, I don't like clinginess ...

Lynn's history of living in group homes and "people not being so good [to her]" had greatly affected her perceptions of breastfeeding. She described that she wanted to explore the concept of "appropriate boundaries" with breastfeeding – which included *how*

long to breastfeed (until what age), *how* (latch versus express and provide breastmilk), and *where* (private versus public breastfeeding). Feeling personally exposed was an important consideration for Lynn, although she also recognized that exploring these boundaries and what they meant for her breastfeeding practice resulted in a tension for her related to maternal attachment. Still, she aligned with a good mother subject position through protecting her child and indicating that she would provide nourishment the right and correct way, despite resisting the idea of breastfeeding her child in public. Lynn stated,

When you've been shoved into situations where you're being forced to expose yourself. It ... it's really damaging and so, it's like, where, where do you draw the line? You know what I mean? You don't want ... my issue is that I don't want to put my baby through the same thing that I went through. I don't want her to feel detached from me because ... I choose not to stop breastfeeding, or what-have-you ... I'm probably not going to breastfeed in public. I'm probably going to like, take bottles and stuff around ... [I: So that's where the pump comes in then?] Yep. That's for my own thing but that's also for her own thing. I think protecting her from prying eyes is, you know, it's a good thing. You know, yes I'm exposed but she's also the one that's being fed so ... you know it just, it, it makes sense to me?

Beth shared a similar sentiment. While she wouldn't elaborate on the meaning behind her statement, she indicated that she wouldn't entertain breastfeeding in public: "because I don't want people interfering with my own personal life – my own personal business."

5.2.2 Expertise and experience

While participants described breastfeeding as a natural practice – drawing on essentialist or biomedical discourses in rationalizing their position, they also constructed breastfeeding as a practice requiring learning from others. This resulted in some uncertainty and apprehension concerning their expectations for breastfeeding, which reinforced the participants’ general belief about feeling unknowledgeable regarding parenting. As such, the relationships that existed within participants’ social networks had implications for their infant feeding decisions, how they came to understand breastfeeding, and influenced their perspectives about the practice. Participants sought out information about breastfeeding formally and discussed using a variety of tools in order to enhance their understanding and expectations about breastfeeding, including attending prenatal classes offered through public health or family centres, watching videos (online or DVD), searching the Internet, using phone apps or reading books related to pregnancy and early parenting. They also described discussing breastfeeding with their primary care providers; however, this was not always the priority during their prenatal appointments where monitoring of their pregnancies was emphasized.

Participants also described receiving information (elicited or not) from family and friends who had experience with breastfeeding. This information was constructed as valid and believable because, as Dawn suggested: “I take [mom’s] word for it cause she had all three of us and breastfed all of us.” Dawn’s reflection suggests that experiential understanding of breastfeeding was valuable to her relations and subject positioning. Those with previous parenting (infant feeding) experience were constituted as knowledgeable or knowing.

Additionally, health professionals were constituted as experts in breastfeeding – but were constituted differently compared with the experiential knowledge of family and peers. When Alice described that she expected to “try hard” to breastfeed, and that the practice of breastfeeding as natural was not perceived by her to be a given, I interpreted her description of breastfeeding as representative of a learned concept. From her perspective, breastfeeding was preferably “taught” by those in an expert role (i.e., health professionals). Stated Alice: “I still need someone to actually like teach me...I don’t know where to go actually...say ‘*hi this is the breastfeeding classroom – where you learn how to breastfeed*’.” When I considered Alice’s statement, I was drawn to how she used the term “classroom” to describe the relational process as to how she envisioned breastfeeding learning should occur, and in doing so, constituting herself as the student or learner and signifying the health professional as the expert; moreover, she used a didactic scenario to construct her beliefs (see also, 5.1.3). On the other hand, Alice appeared to contradict her earlier statement and her beliefs that breastfeeding was a learned activity by suggesting that her breasts must also have a predetermined function: “if I have these...I should use them – they’ve got to be good for something!” Her statement seemingly runs counter to her positioning of breastfeeding as a learned practice. Perhaps the essentialist maternal discourse is too dominant to remain absent from contemporary beliefs about breastfeeding, thus Alice’s back and forth between learning and naturalness of breastfeeding, drawing on two competing discourses. Alternatively, the discourse positioning breastfeeding as natural may have provided some reassurance for her future success with the practice, in the absence of any learning about *how to* breastfeed.

In contrast to her reliance on the expertise of health care professionals, Alice

dismissed any support from her mother for breastfeeding because her mom was “old-school” and has no prior experience with breastfeeding:

I just want to know what I'm doing. Like what I'm doing, how I'm doing it, when I put the breastpads on, when to take the breastpads off, stuff like that – I don't know any of that regarding that. My mom – they don't know cause they didn't even probably...use bras back then...I just talked to her but she don't know – she bottled [sic] us. She knew some stuff but she don't know like up-to-date stuff. I don't know what she's talking about.

Other participants discussed conflicts or confusion that arose between their friends' and family's experiences with infant feeding and the knowledge provided by those positioned as experts and how this was implicated in their own subject positioning. When asked about her expectations of breastfeeding, Jennifer responded:

I really don't know what to expect – I've heard so many conflicting things. Cause if you talk to my mom's generation, they all say 'oh it hurts' and 'expect to have bleeding and cracking and everything' but then if you talk to the public health nurses, they say 'no that means the baby's not latched on right, and they weren't doing it right'. So honestly, I have no idea what to expect.

Similarly, experts could also negatively derail the experience of breastfeeding, even among those who were interested in the practice, like Michelle who recalled that, in her opinion, a lot of people wished to breastfeed, but it was the positioning of the experts that ultimately became the deciding voice. She reflected,

It seems like a lot of people, like wanted to breastfeed...but it wasn't easy...and the nurses told them 'no you must just switch to formula' ... yeah just in

conversation with random people I'm seeing like 'oh no my baby wouldn't latch on so I had to do formula.'

5.2.3 The toils of breastfeeding – integration and negotiation

Breastfeeding is recognized as both a bio-physiological and social practice. However, the bio-physiological perspectives have historically dominated the lay and academic literature and formed the basis of contemporary policies and practices in relation to the support, promotion and protection of breastfeeding (see Chapter 2). While participants described breastfeeding using bio-physiological perspectives, they also described how they envisioned breastfeeding would be integrated within their day-to-day lives and environments – public, work, home and social settings. These points of integration formed the space necessary for anticipating how they would negotiate the practice.

Some participants pointed to the societal pressures associated with choosing to breastfeed or not and even the approach to breastfeeding, again drawing on child privilege as a dominant discourse. This was a noticeable tension for the participants. For example, while Tracy indicated great value and belief in breastfeeding as a privileged and important practice, she also reacted emotionally when recalling the experience that her sister went through when (not breast) feeding her infant:

She'd be like chastised 'you don't breastfeed? Do you know how healthy that is for your child? And she's like 'yeah but my child is still healthy'. Right? You know, observing the forcefulness of everything like engrained that into me...but after I got through the whole initial couple of months of pregnancy, everyone's

been asking ‘you going to breastfeed? You going to breastfeed? You going to breastfeed?’ And I’m like relax – yes!

Tracy went on to describe that she anticipated that health professionals were going to “force” her to breastfeed, again recalling the experiences of her sister and friends when they were making their infant feeding decisions. Tracy specifically singled out nurses for this pressure.

Tracy’s use of the word “forcefulness” points to the strength of the discourse among the health professional body positioning breastfeeding as the ideal form of infant feeding, but also points to how the participants represented health professionals as experts in childcare. Tracy went on to reinforce her prior statements by suggesting that a “cult” of individuals believe that breastfeeding your baby is the “only way” and that you “have” to do it for your child to be healthy. Because Tracy indicated that she was going to breastfeed, I interpreted that on one level she valued and believed in its importance; however, was also positioning herself as autonomous in her infant feeding decisions and resisting dominant constructs about breastfeeding and health system pressure, by stating: “no one’s making me do this.”

Jennifer also shared a similar, negative experience that occurred within her peer group. She indicated that her girlfriends were “pushy about [breastfeeding] ... pushy with their opinions.” Jennifer divulged that before she became pregnant, she hadn’t envisioned breastfeeding. When discussing this with her (pregnant) friends, she recalled: “they kinda tried to pick me apart about that – why would you not do that, it’s the best thing for your baby, *how dare you* not even consider giving breastmilk to your baby.” However, once Jennifer became pregnant, she changed her mind about her infant feeding

choice, even though she was unable to articulate what led to that decision for her: “I have decided I am gonna at least try breastfeeding...I don’t know...as soon as I found out I was pregnant, it was like nope I’m going to try it – that was it.”

For Michelle, the tension I interpreted was not in relation to her social network or health professional relationship but rather a tension that might exist between her subjectivity as a mother and also as an employee:

Because of the work that I do...most of that I can still continue...to do while breastfeeding. *So I won’t be losing out on that?*...I probably won’t be able to do [description of work]. Once he starts...his breastfeeding gaps in between? Are longer? I can go back to doing [work] cause it’s usually about an hour session. So obviously in the beginning I won’t be able to do that. But all the admin and the emails and stuff like that, I can still do that from home so I can still continue while I’m breastfeeding and stuff yep.

Michelle had shared with me that she worked at a non-profit organization and experienced great fulfillment and pride from her role there. She reflected on how her identity might be affected once she began nursing her baby and used the word *losing* to describe her anticipation of how vocational responsibilities might be influenced by breastfeeding. It was important for her that breastfeeding and other aspects of her life co-exist harmoniously, although evidenced by the statements she made during her interview she still questioned whether this plan would be realistic.

5.2.4 My friend, the breastpump

The breastpump was a tool signifying the culmination of participants’ beliefs concerning breastfeeding practice. That is, the breastpump (also known as the “pump”)

represented both the biophysiological value of breastmilk but also represented breastfeeding as a relational and social act. Throughout their interviews, several participants routinely constructed the breastpump as a tool representing freedom and autonomy from the identified constraints – emotional, physical, or societal – of breastfeeding and described how this tool was another means through which breastfeeding practice would be negotiated and integrated into their lives. Participants who spoke about using a breastpump, anticipated that it would give them an identity separate from their babies: “[baby] ain’t going to tie me down – so long as I can pump [breastmilk] off and mom can babysit I’m good!”

At the same time, the breastpump was a means for participants to acknowledge and privilege the role that breastmilk might play in their babies’ lives. Through this representation, the pump came to signify another (more appropriate than formula) infant feeding option for the participants to exercise when and if required. I interpreted the participants’ rationalization of their intended use of the breastpump through the use of scientific or medicalized discourse. Since this discourse privileges *breastmilk* as the preferred form of providing infant nourishment then consequently, just expressing and supplying breastmilk, independent of the relational act of breastfeeding, would be enough to satisfy the requirements of enacting good mothering. Tracy neatly summarized this concept when she anticipated the breastpump would be her “friend”. While Beth envisioned that the breastpump would provide her with an alternative to providing the preferred nourishment of her own, human milk for her baby, if there were concerns that she might not be able to breastfeed. As previously described, for Lynn, the breastpump

offered a form of protection, signifying the device as helping her baby to avoid “prying eyes” in the public domain.

Participants also believed that the breastpump would enable them to visibly value or nurture the relationships of others – be that family members or broader social networks. When partners were identified to be part of the participants’ narrative for childrearing, participants constructed the breastpump as a means by which they could share in the work of feeding. As described by Jennifer, (and also echoed by Beth during her interview) her decision to breastfeed was made in consultation with her partner, but that alternative forms of feeding (including providing formula and expressing or pumping her own breastmilk) were also discussed between them:

For the most part I decided [to breastfeed] myself, with his consultation. I told him this is what I’m thinking and he said ‘yep I support that 100%’. Actually last night we were talking about at what point do we start supplementing formula as well ... it was actually his suggestion. Cause I had told him about my fears of being ... a cow for the first ... however long feeding and he said ‘well this might give you an option that I could help with feedings and I am planning on pumping though, so he’s gonna help with that ... he said it might give you a little more freedom.

While participants acknowledged they were looking for expert guidance (i.e., health professionals) to enhance their understanding about how to pump, Jennifer also perceived that the health professional body would not be the most helpful in this regard. She was reminded of a discussion about breastpumps within her prenatal class, where the public health nurse stated: “*I’m not supposed to tell you guys this*, but I’m going to tell you

anyway, which [pumps] are the good ones, which [pumps] are the bad.” I interpreted that the public health nurse was demonstrating defiance over the discursive rules governing what could or could not be discussed with regards to infant feeding in her role as a health care provider, reinscribing the discourse that breast[feeding] is best. I interpreted that Jennifer recalled this story to me in order to demonstrate the pervasiveness of the breast is best discourse within public health and that there were limits to where potential information could be sought. I further interpreted that for Jennifer, this statement was enough to make her believe that the breastpump (or expressed breastmilk) was a less acceptable means of providing infant feeding in the eyes of the health system.

SECTION 5.2 SUMMARY

Participants described breastfeeding as a physical and social act. They consistently reaffirmed the normative discourse, which situates breastfeeding as a good maternal practice, with a focus on child privilege and wellbeing and an emphasis on the biomedical aspects of infant feeding. However, they also described how this perspective had the chance to cause distress and potential tension if things didn’t go as anticipated, which I interpreted as a direct result of the strength of the discourse of breast is best. The remaining sections pertaining to excess body weight and food insecurity will situate how breastfeeding is represented as related to these other circumstances.

5.3 “A touchy subject”: Discursive constructions of excess maternal body weight

Participants all acknowledged a history of excess body weight before their pregnancy and some recalled experiencing excess body weight long before their

childbearing years. Consistently they all *recognized* carrying extra weight compared with a given normative standard and identified themselves as such. For example, Dawn described herself as being “heavier-set my whole life”, while Tracy defined herself as “heavy all my life” and a “larger woman”, and Lynn acknowledged, “I was 95 pounds when I was 5 years old – I was a big little girl.” Alice, who stated, “I know I’m a big girl” had gained most of her excess body weight in the last couple of years due to a medical issue; she described her reaction to her weight gain as, “a BIG, BIG like what the hell...happened here.”

In telling their stories about their experiences living with excess body weight participants framed their perspectives on their bodies largely through their relations with those within their social setting – be that friends, family, primary care providers, which are shaped by broader social discourses regarding body weight. Participants constructed themselves and their practices at the centre of their own body weight through attending to individual-focused, health behaviours – particularly physical activity, followed by healthy eating. Foucault’s concept of governmentality was apparent throughout the stories of the participants as they negotiated their body weight; as summarized by Michelle, her weight needed to be “checked and maintained.”

In light of participants’ challenges in accessing affordable food, the discussion concerning self-management of weight overwhelmingly favoured opportunities to be physically-active; I also interpreted this as an institutional bias within the obesity discourse to favour physical activity over healthy eating practices in the self-governing of body weight. As summarized by Lynn,

Social assistance doesn't give you any extra money if you're trying to lose weight. So let's say that you need more fruit and vegetables in your diet – they don't pay for that. So it makes it really, really hard to do. Which is why I was walking over the bridge!

Also perhaps not surprisingly, was that the discussion pertaining to excess body weight was given considerably much less attention, compared with other topics during the interview. During the interviews, I interpreted that the participants were either less interested (or comfortable) in discussing their body weights compared with the other topics under exploration – particularly impending parenthood and their expectations around breastfeeding. This was reaffirmed while I listened to the audiotaped interviews, where subtle cues – the manner in which they discussed their bodies and their tone was more hesitant or dismissive, or even defiant when compared with discussing other interview topics. This observation also reflects the sensitive nature of body weight and the way in which participants expressed feeling stigmatized within a system that is unsupportive and fraught with blame, which relates to the neo-liberal discourse that individualizes body weight and emphasizes healthism, signifying individuals as responsible for governing body weight. I also acknowledge that all of these subtle signals that came up throughout the interviews perhaps influenced the direction of the conversation about weight and body-weight related issues and what I was willing to probe upon further with the participants, to keep any potential emotional triggers to a minimum. For example, Beth became sarcastic when discussing her body weight with me. Her body language during the interview and what I interpreted as closed-off responses to my questions also suggested that she was uncomfortable during the

discussion pertaining to body weight, indicating that it was something she was sensitive about discussing.

5.3.1 The ups and downs – relations with health care providers

When asked about their experience discussing their body weight with primary care providers and other health professionals, participants told stories that were both negative and positive and highlighted the pervasive, normative positioning of excess body weight as an individual problem. Positive experiences were described as those where the care provider was constituted as “supportive”, “understanding” or acknowledging the context in which the participants were living their lives. For example, Tracy initially described interactions she deemed judgmental with some health professionals because these health care professionals routinely placed blame on her for her body weight. I noticed how Tracy repeated the word “you” throughout her story to place great emphasis on the dominant discourse of obesity which emphasizes individualism: “at the clinic, they’re like ‘oh *you* have to start losing some weight, *you* can’t eat this, *you*’ve got to eat better, *you*’ve got to...’.” However, upon discussing this with another, more supportive doctor, she found this particular physician to be sympathetic to her situation, which alleviated her apprehension (which she termed “frenzy”) about her body weight.

Similarly, Jennifer indicated that prior to becoming pregnant, she had a previous care provider who was “very critical” of her body weight, describing how she would change her physical activity regime (“I’d push myself that much harder [at the gym]”) if she had an upcoming doctor’s appointment in order to meet the acceptance of her care provider. She further described that the continuous pressure from her physician to lose

weight left her feeling like she was “abused” within the relationship. However, during her pregnancy (at least up until the time of our first interview), Jennifer described having a positive relationship with her (new) care provider, despite being warned by friends that some providers would “shun you” if you were overweight and pregnant. While her relationship with her care provider was represented as positive, her physician nonetheless “liked to see” Jennifer maintain her weight gain below the average. As per her physician’s recommendation, further along during our interview, Jennifer described an increasing amount of self-surveillance once she started to gain weight, again pointing to the normative discourse of individual practices as cause of, and cure for, weight-related issues. In her statement, I also noticed how Jennifer compartmentalized her view of maternal, pregnant body weight into three viewpoints: her weight, the weight of her growing baby, and their combined weight. By looking solely at perceptions of her own weight gain – this was deemed as unacceptable in comparison with weight gain attributed solely to her growing baby (a normative, child-centred discourse). However, the embodiment of the pregnant state created a lot of confusion for Jennifer and caused her the inability to separate self from baby:

Before when I was losing [weight], I wasn’t really focusing on [body weight]...and it was actually good for me. Baby was still getting everything he needed, so it was good for me that I was losing *my* weight. *So this being the first month I’ve gained weight, the past week I’ve been thinking a lot more about it...I’m going through everyday – what am I eating? What am I eating correctly? What am I not eating correctly?* Trying to balance out...what’s good for [baby]...I guess *I’m afraid that it’s me that’s gaining the weight – and not him*

and I know it's helpful for him at this point to be gaining weight...and I have no concept whatsoever of what is him and what is me at this point.

Lynn also described having candid conversations with her physicians about her body weight: “basically they told me *I wasn't allowed* to put on any more weight when I got pregnant because *I was already big enough*.” Echoing Jennifer's perspective, Lynn continued to say that if any weight that was gained was baby weight – it was justified as the child's health was most important and her baby's proper weight gain was supportive of that: “It's one thing if the baby weighs, you know, a good weight. I want her to be healthy, I want her to be as healthy as she possibly can be.”

Alice described having a relationship with her care provider where she perceived herself as unheard and disconnected in relation to her body weight – a feeling that began before her pregnancy and persisted throughout. Alice indicated that she “longed” for a supportive relationship with any physician. Her frustration was apparent throughout the interview and she indicated she was actively seeking new support:

I wish I had a *real doctor* that kinda could sit down and talk to me. I'm not really keen on my doctors. I'm just looking for a new one that could take me from now until the end of my pregnancy...*someone who understands actually*.

Alice identified as having a pre-existing respiratory condition that required her to be on oral steroid medication, with weight gain being one of the more probable side effects. As Alice was giving this context and detailing her accounts of discussing her body weight with her physician, she described the dialogue that had occurred with her physician whereby she was encouraged to lose weight through exercise – again, reflecting

normative discourse emphasizing individual behaviour change that is devoid of context.

From Alice's perspective, this was not a realistic solution. She recalled:

I talked to [doctor] about losing weight but she still just was like '*exercise and blah, blah, blah*'...that's ok but when you're 300 pounds and you're 5'6" exercise is just not...you know what I mean? [later in interview] so a lot of the weight gain came from steroids and...stuff like that from my asthma so...[I: so it's not as easy as...?] No. As she thinks it is. And then once I start exercising and everything my asthma will start acting up so there I'm back on [steroids] so then...and they make you bigger. And then it's like well I did everything for nothing. *You just did everything for nothing*...And you go back to your doctor and she's like 'oh ok well exercise'. I just did that! *Look where...look where I'm at now*.

Taken as a whole, the participants' challenges with health care providers played an important role in reinforcing dominant discourses that represent body weight as a consequence of poor, individual practices. I interpreted that this also contributed to their identity as a heavy subject, which is described in greater detail within the proceeding section.

5.3.2 The heavier you are, the heavier you feel

Excess body weight was constructed as socially and physically abnormal among the participants, with however, the caveat that weight gain during pregnancy was healthy if it was only "baby weight". As Lynn observed,

It's one thing if the baby weighs, you know, a good weight. I want her to be healthy, I want her to be as healthy as she possibly can be. Um, if this is her weight or if this is just basically water weight, then I'm OK with that because

water weight comes off [snaps fingers] or will come off when I'm in the delivery room or whathaveyou else. Um...that being said, if this is just extra weight that's being put on for the sake of being put on – that's not ok with me.

Participants routinely described how this related to the practices that they participated in (e.g., individually focused, lifestyle practices) and how they attempted to achieve goals related to weight loss or normative standards of body size (e.g., surveillance and biopolitics). Participants also described how living with excess body weight influenced their subjectivity, how they identified themselves and their relationships with others – not just as pregnant women, but also as social beings. Summarized Tracy: “being overweight and being that way all your life ‘cause you are judged. People who aren’t...who don’t have that issue of being overweight or anything like that wouldn’t know.”

For Lynn, identifying as overweight felt like it was “weighing her down” both physically and emotionally. Moreover, Lynn blamed herself for her body size, reflecting the dominant discourse constructing obesity as a fault of individual capacities and in doing so, adopting an immoral subject position:

My weight most affects me is by actually being weight...it literally weighs me down, which literally weighs down my mental health. It affects my self-image...it affects self-esteem...[later on in interview] The way that my weight is, it ties into my morals. And so when I feel like crap one day, and I splurge on chocolate or whatever else to try and give myself that extra bit of high that I need to get through my day, it feels like I've let myself down, I've let my morals down. And that's not ok, in anyway shape or form...*I shouldn't be using food the way that I do, I shouldn't be thinking about food the way that I do.*

Participants experienced the dominant obesity discourse linking excess body weight as a moral and personal failure in different ways. For Jennifer, the “personal insecurity” that developed as a result of her living with excess body weight was enough to influence her level of emotional intimacy with her husband. Speaking about her own body weight with her husband was considered a taboo topic:

As long as my husband’s not in the room – I’m ok. That’s something that um...he’s an overweight man but he weighs less than I do so that’s a...personal um, emotional struggle I guess...Yeah it’s not really something I’ve had an issue talking with others about – as long as it’s not him.

Beth and Dawn also described experiences of feeling judged by others in their social field because of their body weight; however, both participants adopted a defiant tone about this and described resisting normative subjectivities associated with fatness. In doing so, they were laying claim to their bodies as their own and not for others to observe and judge. Stated Beth: “A family member by marriage and people when I was in school, people were making fun of me, they were calling me fat and everything...[people should] mind their own business.” Dawn described feeling “discouraged” from a situation where two strangers visibly taunted her because of her body weight. At the time she was pregnant but it was earlier in the pregnancy, before she would be visibly showing her pregnancy. As she recalled her story, I observed her anger about being singled out publically for her body weight. Moreover, and similar to Jennifer and Lynn, Dawn suggested in telling her story that she perceived pregnancy weight was socially acceptable but that fat weight was not:

This black guy was like ‘baby girl, baby girl’ and grabs my shoulder and I was like what! ... And [stranger’s] like ‘my friend wants you though’ and points to his fat friend. I was like *oh so he thinks I’m fat!* [laughs sarcastically] I was like – *I’m not pregnant, I’m fat right? Like I was so mad. I was like ‘I’m fucking pregnant you idiot!’* ... I was so mad though, I was like, *am I not showing, like do I not look like I’m pregnant? Do I just look like I’m fat?...* Like just cause he pointed to his fat friend you know what I mean? So I know what he was insinuating that I was fat so here’s his fat friend you know what I mean. And it was like I wouldn’t look at any of you anyways. I wouldn’t look at any of you if you had gold teeth. Like...[laughter] it wouldn’t matter to me. It was just like – wow! It was so insulting. I was like wow...thanks.

Dawn’s story is further demonstration of the strength of obesity discourse and discourses pertaining to sexuality whereby strangers are entitled to objectify women’s bodies and publically mock those women considered overweight or obese.

Tracy’s story represents another exemplar case of the strength of the obesity discourse and normative assumptions about persons living with excess body weight. In her story, she described experiencing a significant amount of weight gain due to a planned medical intervention just prior to becoming pregnant. At her non-pregnant heaviest, Tracy weighed 300 pounds and she described her sense of self in disarray – a “mess” prior to her weight loss. With a history of living with excess body weight, Tracy experienced persistent judgment and biases from her colleagues and peers. She also suggested that ensuing health conditions also associated with her weight were major influences on her subjectivity (e.g., Tracy experienced high blood pressure and diabetes)

as these health conditions resulted in Tracy continuing to self-blame for her physical state of health. She repeated the word “judged” throughout her interview to describe how societal norms constitute persons living with excess body weight as those without the personal desire or capacity for responsibility or self-management – again, reflecting an immoral subject position. Like the other participants in this study, the obesity discourse had great implications for Tracy’s sense of self. As she reflected on her experience, I noticed that she was attempting to separate herself from her body weight insofar as suggesting that she was doing other “normal” aesthetic things like maintaining cleanliness to overcome her fatness:

You’re judged very differently or so I feel that. When I was 300 pounds...I was judged very differently because [colleagues] said *I smelled all the time* or...that my...*I didn’t look well kept, I looked sloppy*. And no matter the amount of makeup I wore or the hair that I did, cause I did that *everyday*, I showered everyday, I you know, did everything that *any normal human being could do*, I curled my hair, I did everything I could, I sometimes spent 2 hours on just my appearance just to go to work and have [colleagues] say – you look like a bag of dirt...And I was told in no uncertain terms that I lose weight...or find another job. So those were my two choices. So...my self-image was completely, completely in the toilet.

Tracy described the process of losing body weight as transformative. To her, it was as if her whole self-image and relationships within her social network were different by virtue of changes in her physical appearance. The fact that this happened as a result of a medical intervention and in a relatively short period of time is interesting insofar as

presenting the argument that she really wasn't a "different" person, just a person occupying a different body shape. However, as she described this transformation, she insisted that not only was her physical size, but her identity was changed in this process:

When I lost my weight, all the sudden, it's...my whole life changed. It was amazing...jobs were coming...like people looked at me and took me more seriously. They really did...but I think the way I perceived myself changed? And so the way the world perceived me changed. But it was all weight-based. Like I could now go in...instead of being ignored when I walked into a store, I was now the focus of their attention right? So it just, everything's changed after I lost the weight. The health has changed 100 percent. But my whole body had changed and it's like...the way I looked at myself was different, the way I treated my body was different.

5.3.3 Losing it: Breastfeeding as a hopeful strategy

Participants primarily associated maternal body weight with breastfeeding through its perceived impact on maternal weight management during the postpartum period. Participants specifically focused mostly on their belief (through hearsay) that breastfeeding would support postpartum weight management. Additionally, excess breast size (commonly experienced among women with excess body weight) was implicated in perceived success of breastfeeding practice (see 5.1.1).

Breastfeeding contributing to maternal weight loss was not a position expressed across all participants; however, it is deserving of mention as it again reflects Foucault's concepts of self-surveillance and governing of bodies. This construction was based mostly on what participants had heard within their social networks or information

accessed or received pertaining to breastfeeding. Moreover, when breastfeeding was mentioned as a weight loss approach, participants compared breastfeeding with the dominant, individual-focused means of weight loss – exercise and eating healthfully. In this comparison, breastfeeding was viewed as an acceptable and beneficial option for participants. Also, discussed was the perceived (and real) inaccessibility or unaffordability of physical activity and healthy eating; consequently, they were considered as less favourable options for weight management in the early postpartum. Ironically, the inability to exercise was linked with the intention to breastfeed for both Jennifer and Michelle. Jennifer stated:

What I've been told is that breastfeeding will help you lose the body weight...quicker...I would like to think that...I would have free time to be able to exercise after the baby's born but breastfeeding worries me because let's face it, every hour and a half to two hours, if you're doing a feeding, when does that allow a lot of time for exercise?

Similarly, while Michelle suggested that breastfeeding helps you lose pregnancy weight, she was also wary of the truthfulness of this association: "I'm not banking on it, but it's something that I've heard". Echoing Jennifer's concerns, Michelle further described that breastfeeding would prevent her from managing her weight through exercise, suggesting that any attempt to do so would be a "trying" or difficult experience. Similar to Michelle, Alice was cautious about the ability to lose weight through breastfeeding. Yet, she was nonetheless excited that breastfeeding could offer her another potential means of weight management. She stated,

Well this girl that I know she breastfed and she lost like 30 pounds in like 2 weeks. Which was like whoa. I must be counting down the months now like...so if I breastfeed for how many weeks and my baby's this old – you tell me I'll lose what? That was like encouraging...I'm like holy if I could just breastfeed – *not saying I'm going to lose that much but if I could just breastfeed – you know what I mean?* But I heard that it does make you lose weight, I've seen people, you know like they lost weight from breastfeeding. So I'm like maybe if I don't kill myself exercising, I can breastfeed, my asthma won't start acting up and maybe I can actually lose weight...so that's like my intentions I hope...see how the baby goes...we'll see how she goes.

SECTION 5.3 SUMMARY

Despite the relative lack of discussion of body weight within the participant interviews, the manner in which participants' described their experiences as individuals living with pregnancy and excess body weight point to the pervasiveness of the discourse that constructs excess body weight as a result of moral and personal failure. Some participants went as far as to suggest that breastfeeding was a particularly useful tool for weight management, while also suggesting that maintaining their body weight within a given normative standard was challenging while living with income constraint. Through describing their bodies as "heavy" and "overweight" rather than the discursive language of obesity, participants pointed to the social implications of living with excess body weight and how this is further implicated in their relationships with their care providers.

5.4 “You’re doing the best you can to survive”: Discursive constructions of living and eating with income constraint

A large part of participants’ narratives of living with income constraint was the day-to-day “struggle” of living without adequate financial resources. Any financial support that was available to them (e.g., social assistance, unreported wages, regular wages, friends and family) was “already gone” to fixed costs of living such as shelter and utilities; subsequently, access to and affordability of food was very much impacted. This final section outlines how participants constructed the experience of living within income constraint, with a particular focus on how this affected their food security and relations between themselves and the institutions from which they sought support.

5.4.1 The work of feeding – “I’m resourceful I guess”

It is well documented within the literature that, historically, women have largely led household food procurement and preparation (DeVault, 1994; Lupton, 1996). When financial resources are scarce – such as was the case for the participants of this study, a plausible assumption is that the work required for procuring and preparing food is significantly augmented, particularly under the dominant discourses of healthism and self-control. Participants described a range of strategies that they used for accessing food under resource constraint. While some participants indicated that they habitually relied on food banks, there were other means of acquiring food that were described. These included collecting and managing coupons, reading food flyers for sales, buying in bulk, purchasing discount produce, accessing a combination of regular and discount grocers (Giant Tiger, Bulk Barn, Walmart and Gateway Meat Market were mentioned), participating in meal programs provided free-of-charge within the community, or asking

family and friends to support them. Additionally, some participants took advantage of their physical state of pregnancy to access food programs and services available only to pregnant women. For example, Tracy received milk from a program she belonged to, Dawn used the food pantry and trading centre at her family centre, while Alice received a weekly bag of food items through the prenatal program she attended. The participants' subject positioning within this experience was one of resourcefulness.

Personal and household budgeting was a predominant discursive undercurrent among the participants, again reflecting the governing of self. As described by Lee, "I don't have a grocery budget. I have a hope to god I make it to the first budget" or by Lynn: "There has been times in the past where I've gone hungry. It hasn't been in a little while because I've been really trying to make it stretch, like make my money stretch"; both of these participants expressed how they were ever mindful of their budgets in their food practices. Tracy, who was the only participant working within the fast food service industry, described routinely eating fast, cheap food from her place of work because it was a cost-effective way to feed herself within her income constraints: "I usually find myself grabbing two burgers, which is less than two dollars...I usually only eat the small burgers...pile them up with onions, tomatoes and cheese..." Tracy also drew upon a healthism discourse within this habitual food practice, by stating that she ate the "smaller" portioned burger and added vegetables and dairy to this.

Lee, Lynn and Dawn all described the logistical processes of accessing food with limited resources and the effort required for this to occur. Only three participants indicated having access to a personal or family vehicle to be used to procure food, while most relied on public transportation or hiring a cab. All indicated there was no money

available to pay for extra resources that would support food accessibility such as a babysitter, cab fare or even baby carriers or strollers. Again, this suggests the taken-for-granted standard that accessing food is women's work but without additional acknowledgement for the challenges that can arise for the situations and circumstances that women are living in, to better support them to access food.

5.4.2 "The food I like and the food I eat are two different things"

While they did not devalue charity, assistance or short-term food relief, participants' stories highlighted the priority that they placed on food meeting their personal standards of appropriateness or acceptability. In doing so, participants were caught in a tension of prioritizing their own needs and desires even while attending to the challenges of personal and household food insecurity. For the most part, choice and preference became luxuries when experiencing income-related food insecurity. As summarized by Tracy: "I prefer apple juice over orange juice but if you're giving it to me I'm not going to look a gift horse in the mouth."

Even when living with income constraint, participants still constituted themselves as autonomous in food decision-making and attempted to exert their agency in this regard, working a variety of dietary discourses into their decision-making processes. When food was considered with regard to its nutritional composition or dietary quality, the healthism discourse dominated, whereas participants described themselves as identifying with, and subscribing to, moralizing food practices. For example, foods were identified by participants as "healthier" or not ("junk", "treats") and subsequently, were often linked with health-related practices – eating better, eating healthier. Healthier foods were described as "expensive" (e.g., fruits, vegetables, dairy, meat) while unhealthy foods

were described as “cheaper” (e.g., junk food, chocolate, Kraft Dinner, Big Mac and Fries). At the same time, unhealthier foods were acknowledged to serve some utility for feeding (but not nourishing) the body. The labeling of foods as healthy or unhealthy was also linked with discourses pertaining to obesity and body weight management (see 5.3).

Summarized Lynn,

Food is there basically to keep you alive, to keep you healthy and...to help you function properly...food is one of those things where – I never seem to have enough good food. The food that I have is crap. And therefore I feel like crap and *therefore I look like crap* and therefore it’s crap.

While healthy foods were largely represented as more challenging to access among the participants, when accessible to them, participants experienced feeling good about their choices. While in the aforementioned quote, Lynn expressed personal failure by eating foods considered unhealthier. By comparison, when she described accessing healthy foods through charitable means, she adopted a noticeably positive tone about her food decisions:

[Food bank] is amazing. They usually have some sort of meat or they usually have um, processed meat and they usually have fruit and vegetables there and they usually have canned beans and canned tomatoes and um, soups and green beans and healthy things to eat. And they let you go around and pick out anything you need.

In many cases the healthism discourse regarding food was juxtaposed with the physical state of pregnancy in that participants described and discussed the various foods that were tolerated during pregnancy or referred to the manner in which they were *supposed* to be

eating during pregnancy. Shared Lynn, “I’ve been trying to eat more fruits and vegetables...but it’s just so hard. It really is...” or Alice, who recalled how her food management had shifted since pregnancy,

Sometimes I’m like running so much that I’m like...I don’t eat like three times a day or I’ll eat like a big portion later or something like that. But I keep remembering that I’m pregnant. So I’m like no, you have to like, you have to remember like you’re pregnant now, so you can’t do that anymore. Cause before I used to eat like one time a day and be fine or whatever...but I keep reminding myself like it’s not, it’s not you like I don’t worry about myself, it’s...I have to worry about the baby. So...I try to eat more like. I’ll go and I’ll grab like a mini fruit tray or something...sort of to eat so that like, the baby’s not hungry.

In other cases, participants described decisions in foods relating to pre-existing medical conditions (e.g., acid reflux, hypertension, diabetes or other blood sugar issues, food sensitivities, allergies or aversions). However, they were also attendant to the perceived healthfulness of these foods in their decision-making. Stated Tracy in relation to managing her diabetes:

They [health provider] want me to shove this Glucerna down my throat. Glucerna is full of chemicals, its full of...it’s gross! [laughs] Like you know? So they’re telling me, ‘This is the best thing for you’ but it’s full of all this crap, and, and, you know...I’d rather get it from an orange or an apple, cause I do eat or...I eat apple slices everyday that’s my big thing at work they’re like ‘[name] is getting her apple slices again.’ I get two packs of them. I eat apple slices everyday that’s

my big thing at work they're like 'Tracy is getting her apple slices again.' I get two packs of them.

Similar to Tracy, Lee described how her food management practices were affected by her pregnancy and also how she was using child privilege discourse in her food-related decisions. She stated:

I think I eat pretty straight and simply but there's even like, even since getting pregnant there are points in time where I've been like – do I pay rent or do I buy groceries? *Screw this I'm buying groceries, the baby needs food.*

Other participants described not only the types of foods that were personally valued, but also issues of food management, where variety, quality and safety of foods were critical considerations. For example, Alice described routinely receiving spaghetti noodles as part of her weekly, prenatal food basket and while she acknowledged liking this food, it was still not acceptable to her to eat noodles as often as she was receiving them. Variety appealed to Alice because it alleviated boredom with her food practices.

Moldy or expired foods – often found in food banks or with discount grocers, were considered universally unacceptable, particularly from a position of feeding a pregnant body. Stated Dawn,

[The food bank] gives you enough to last about a week for two people. And I mean it's like ... some of it's expired and stuff. Now that I'm pregnant, I won't even like – no way. Like if it's expired one day I'm not even ... I don't care. I'm not trying it, I'm not testing it, I don't care. Like just on account of the baby right? I won't do that. So ... cause the way I see it, the baby's not sitting here making the decision to eat it, so I'm not going to make [baby] eat it.

Dawn's focus on her baby's health is representative of how the discourse of child privilege was ubiquitously present within the participants' stories of their food practices. The safety and security of the participants' babies, and avoidance of potential for babies' being hurt were paramount in participants' beliefs and decisions regarding food; therefore, participants embodied the good mother subject position despite experiencing food insecurity.

SECTION 5.4: SUMMARY

As participants shared their stories of living with limited resources, they all expressed the personal battles that they waged around supporting and advocating for themselves within a broader social system they believed to be discouraging of their circumstances. Participants largely described their institutional interactions as challenging and difficult, and frequently positioned themselves as misfits in comparison to the institutions' power and control. Their frustrations of working within the system typically revolved around accessing additional financial resources to meet their day-to-day needs. However, despite these challenges, the participants all described that they would still go to lengths to provide healthfully for their families, privileging the needs of their unborn children – a further representation of their positioning as a good mother. In doing so, participants' stories demonstrated their power and resilience, through resourcefulness and perseverance, in living on the margins.

CHAPTER SUMMARY

The prenatal interviews offered a variety of constructions of the topics of breastfeeding, poverty, income-related food insecurity, mothering and excess body

weight. The dominant discourse of good mothering was juxtaposed with discourses pertaining to science and biomedical knowledge, healthism child privilege and autonomy within the participants' stories. These perspectives shaped not only their experiences, practices, but also how they identify with themselves and with others. In the next chapter, these prenatal perspectives will be explored further through the contextual lens of birthing and early parenthood.

CHAPTER 6 FINDINGS – AFTER BIRTH

In this chapter, I present the second part of my findings titled *After Birth*, which summarizes the experience of breastfeeding within the context of new parenthood, income-related food insecurity and excess maternal body weight with a particular focus on how these issues are represented within the participant stories. These findings are based on early postpartum interviews (n=12) conducted with 6 participants who completed the study. During the prenatal interviews, the mood of the participants oscillated between a sense of hope and anticipation, and anxieties and fears about what parenting would bring. In the latter two interviews, this perspective underwent a considerable shift and instead was replaced by an acute and abrupt disruption related to the birth of their babies and how the participants integrated their identities within this new experience. My use of the term acute disruption is not to be interpreted in a negative manner, rather to say that having a baby was a profound and life-altering event for the participants in this study. I observed that the shock from this event was more pronounced during the first postnatal interview compared with the final interview, at which point the participants mostly had begun the process of settling into their new, normal lives.

The subject position of mother now had new meaning for the participants and within the environments (people, places, experiences) in which they were situated they were negotiating these relations. Having already envisioned what mothering would be like in the prenatal period, during these final interviews, the participants were speaking to this new identity and enacting the meanings of their experience from that position. It was during the first postnatal interview where the participants particularly drew heavily on

reflections of their birthing experience and the immediate postpartum environment and resultant experiences to construct themselves and their identities as parents, including activities related to breastfeeding, living within income constraint, food insecurity and with excess maternal body weight. These experiences positioned how participants' negotiated their subjectivity and relations with others within a discursive framework of new mother, which will be discussed throughout this chapter.

6.1 Breastfeeding: Representations from the position of mother

Multiple and contradictory contexts played a role in participants' breastfeeding experiences, impacting the participants' experience during the postpartum period and resulting in a disconnect between this new reality and participants' previous, prenatal breastfeeding images and understandings. While previously they had mostly represented breastfeeding as a natural, given, and a process that they hoped would go well, in the postpartum period this transitioned to a representation of breastfeeding clouded by the realities of the practice as it was executed in the everyday. What struck me is that this occurred irrespective of how successful the participants described the early days of breastfeeding. That is, in all of the cases, participants described having had minimal to no issues with the post-delivery latch and initial feedings and it was only in the subsequent days and weeks that participants experienced more difficult circumstances that impacted their abilities to negotiate breastfeeding practices with their babies.

As I listened to their stories, I could not help but reflect on how the situations they described reinforced the importance of the social, environmental and political on breastfeeding practices. While not denying the importance of the biophysiological (latch and lactogenesis pathways) in breastfeeding outcomes, the other stories may be more

influential to outcomes and thus, must be adequately addressed in order to support breastfeeding throughout the population. Not every experience was the same, but there were certain commonalities among the participants in terms of the circumstances that they referred to as relating to their breastfeeding practices. These included:

- Extended hospitalization and/or medical concerns for the baby (all participants)
- Hospital admissions or medical concerns for the participant (Alice, Jennifer, Tracy)
- Negative, consequential interactions with hospital and/or extramural institutions such as child protection services, legal, mental health or social services (Lee, Lynn)
- Finding food or facing food insecurity as an ongoing concern (all participants)
- Living alone and/or with limited social supports (Tracy, Lynn, Lee); and
- Lack of involvement from the baby's father (Alice, Lee, Lynn, Tracy)

The following subsections will describe discourses related to breastfeeding in the postpartum as articulated by participants, and how these discourses shaped their beliefs, values and practices in relation to infant feeding.

6.1.1 Institutions and practices: (re)producing the breastfeeding mother

The participants' experiences and interactions with institutions during the early postpartum became an important influence on how they positioned themselves as breastfeeding mothers. An important site for this production was the hospital including perinatal clinics or inpatient service areas such as labour and delivery, the operating room and recovery, and birth or family newborn areas. All participants who continued with the study experienced delivery by vaginal (n=4) or cesarean birth (n=2) in a traditional

hospital environment. Other institutions that were described by participants were community services, legal services, primary care, public health, and mental health services. Each of these institutions has its' own rules and regulations (discursive practices) governing their practices and actions. The following subthemes will examine how participants experienced various institutional discourses that were meaningful to them personally and how these impacted their experiences as breastfeeding mothers.

Push and pull: Providing for self and as mother

Three participants (Alice, Jennifer and Tracy) described personal health issues in the early postpartum period (early days or weeks post-delivery) that were unanticipated at the time of our prenatal interviews. These health concerns significantly impacted their impressions of early parenting, with particular implications for the beliefs, values and practices that they held regarding breastfeeding. In most situations, the acute medical needs of the participants required that the focus and attention that they would have normally placed on early parenting practices such as breastfeeding, be diverted away from these discursive responsibilities toward the participant getting well. This also included a reprioritization of breastfeeding or a reassigning of the taken-for-granted maternal role of infant feeding to another within their social network. To a lesser extent, some participants also deprioritized regular patterns of eating which I interpreted as directly related to their experience of food security within the early postpartum (see section 6.3). The commonality that existed is when participants prioritized their own self-care, this was perceived by them to be disadvantageous to normative maternal roles.

Alice, who delivered her daughter vaginally, developed a bladder infection that she attributed to the use of catheters (intervention) during her delivery. Moreover, Alice

experienced blood clots and peripheral swelling that required further medical treatment and hospitalization, which she described as 4 separate, short-term stays throughout the 2 weeks following the delivery of her daughter. Alice recalled that feeling very unwell herself, along with medication use, significantly diminished her ability to continue the breastfeeding relationship with her daughter but also impacted on her ability to “enjoy motherhood.” Alice stated the following about the relationship of her physical health to her maternal identity:

I was in so much pain, that like, even to get up and get out of bed like, I was, I was a horrible mess like I was in so much pain that it was just ... like she was there ... [I: it wasn't a priority] no like she was there and it was just like ohhh, I love you baby girl but I couldn't even, I didn't even have the strength to like...get her dressed and my friend was there and she got her dressed and stuff and she was crying in the middle of the night, and I woke up and my friend had her in the bed with her cause she was crying. But I didn't have the physical strength to even like – I didn't have no life ... like I had no life in me man. It was really hard ...

Alice's health issues required that she relied on others (specifically her own mother) to provide the continuity of a maternal role during her absence. Further along in the interview she revisited these events and how they impacted her developing maternal identity. The choice that Alice described within the following passage indicates, again, how she perceived that her power was limited within the situation during the time that she sought medical care with corresponding implications for her maternal subjectivity:

... and I was back in and back out [hospital] and everything else with it. It was horrible cause I kept missing her ... I'm like, *I'm not even enjoying motherhood*

cause I don't even get to see her ... and I didn't want her to get too super attached to my mom, but there was no other choice right?

I sensed that Alice had accepted her decision to formula feed her daughter and had rationalized this decision because she was so physically unwell in the immediate weeks following her daughter's birth. I heard the frustration in her voice as she recalled how difficult it was to breastfeed in the context of these personal health challenges. Despite indicating acceptance of her infant feeding decisions, Alice reflected on how the postpartum events still caused some emotional tension for her regarding the decision to not breastfeed, which I interpreted as Alice signifying breastfeeding as part of maternal identity and proving herself as a good mother. Alice described the feeling of tension as being "depressed" and angry. However, later on in the interview, Alice strongly denied being depressed when she described another experience with an emergency room physician.

From her story, I interpreted that Alice's subjectivity as a patient subverted her identity as a breastfeeding mother. Her position as a patient undermined her ability to fulfill normative maternal roles, including attending to breastfeeding and primary caregiving. Over the following passages, Alice continued to describe how her maternal identity was unraveling in the midst of unforeseen medical challenges, and indicated the range of emotions she felt throughout this situation. I noticed how Alice described the emotional response to her perceived failure in breastfeeding but also how she rationalized her decision to discontinue breastfeeding within this context.

I nursed her for the first ... the first two days. She latched on and everything really good but then, I had end up being on antibiotics so it really didn't. I was

pissed ... Like my milk wasn't coming fast enough or something so I was just getting so discouraged with that. I'm like oh I'm sitting here for like an hour and I'm not getting it – not even a bottle [referring to pumping breastmilk] so I was like I can't do this mom, my patience is running dry ... so mom was like 'ok, if you tried, you know, whatever the case may be, didn't work so it's fine. Like don't discourage yourself' and I was crying cause I'm like a fucking emotional wreck. She's like unable to breastfeed ... it's ok, it's gonna be ok ...

Alice continued later on in the interview:

I was depressed at first cause I really wanted to breastfeed but now since that, I know like, whatever, it can't happen. Like you tried your best ... I'm alright with it now but. I definitely tried.

Drawing parallels with Alice's story, Jennifer also experienced personal health issues (gallbladder surgery followed by acute pancreatitis) in the postpartum period that required hospitalization. Jennifer spent a "whirlwind" total of 2 weeks hospitalized within the first month of her son's life. When asked further about this experience, Jennifer drew on pervasive normative discourses in shaping her maternal subjectivity.

I cried a lot! Cause it was my first time away from him...very emotional roller coaster with having to go through surgery as well as...*I'm his mom, I'm breastfeeding, I'm supposed to be there for him and I couldn't be.* So it was really emotional that way.

Similar to all of the participants in this study, Jennifer positioned high value on the *idea* of exclusive breastfeeding. Jennifer continued to breastfeed even through her hospitalization and, in a story that continued to mirror that of Alice's, shared with me

how this situation caused a tension between her maternal identity and her identity as an unwell patient and prioritizing her own health. Ultimately, Jennifer blamed herself for a situation that was entirely out of her control and through this, constituted herself as a “failed” mother:

It was hell. It really was...it was awful. I wouldn't recommend it for anybody!

The nurses were trying to be supportive but...*if I heard one more person say 'well you gotta look after yourself first' yes – I get that!* But you don't understand that I still have pregnancy hormones going through my body and I'm overly emotional to begin with and I'm not feeling well. *So...pile that on top of feeling like a failure because I couldn't provide for my son.* And also...I'm a very active person to begin with so being told not allowed to lift anything besides him and...*I can't do anything around the house. So everything is on my husband right now.*

In the above quote, Jennifer not only described how her health challenges impacted on her ability to feed her son adequately, but also how they were impacting on other taken-for-granted maternal roles. I interpreted her statement of “I can't do anything around the house” as constituting herself as the person leading household and related caregiving responsibilities. Moreover, Jennifer highlights both biomedical and essentialist female discourses by justifying the existence of this tension because of “pregnancy hormones”.

Similar to Alice and Jennifer's stories, the narrative of mother as patient alongside mother as mother was incongruent for Tracy, who experienced elevated blood pressure in the postpartum requiring medical surveillance and monitoring. She exercised agency and power within her negotiations with her care providers, insisting that she didn't want to be admitted herself as a patient as her son was already an inpatient within the NICU and in

such instance, she would be unable to fulfill her responsibilities of mothering, including responsibilities for breastfeeding.

Then the nurse says ‘let’s go pump’ so as I’m walking ... I’m walking down the hallway with a breastpump in my hand – hadn’t eaten in 7 hours, walking down to get my blood pressure taken and she’s like ‘oh you can pump for 10 minutes while you’re eating’ and I’m like what? Did you ... are you ser[ious]? And then I – she wouldn’t take no for an answer ... and then my OB-GYN comes in and she’s like ‘what are you doing?’ I’m supposed to be pumping! She’s like ‘you’re not pumping breastmilk, your blood pressure is too high’ and I’m like – she tested it and it was 200 over 103 and she’s like ‘we’re admitting you’ and I’m like – I don’t want to be admitted. Cause I thought [baby] would be out. Now I didn’t want him out and me not out ... but I kept fighting it, don’t ask me why I kept fighting it – It would have been free meals but hey ...

Tracy was also caught between competing discourses and described the tension that existed as she occupied varying subject positions – one being that of woman requiring self-care and the other as a breastfeeding mother. Her care providers had opposing perspectives where her nurse was (in that moment) prioritizing normative, maternal responsibilities while her physician was focused on Tracy’s own health.

Breastfeeding invisibility, medical technologies and feminine identities

Discursive medical technologies had an important effect on perceptions of breastfeeding success among the participants. I attributed their reliance on medical technologies to their representation of breastfeeding as an invisible practice, thus necessitating a tangible measure. These technologies were also directly linked with how

participants constituted their maternal self and their feelings of maternal adequacy.

Weight gain benchmarks were the most notable representation of this, secondary to the onset of abundant breastmilk production (with or without the use of a breastpump), but also the nutritional composition of participants' breastmilk was considered by some, reflecting participants' earlier constructions of the ideal maternal body (see Chapter 5).

Participants frequently referred to their babies' weight gain patterns as a means of objectively establishing how well infant feeding was going, which gave them confidence or discouraged them. Lynn, who indicated she was providing formula only when "absolutely" necessary (i.e., requiring sleep or when there was a time conflict), validated her infant feeding practice by stating, "She has been gaining weight which is a good thing. So um, whatever I'm doing, probably a good thing." However, further along in the interview she questioned if her baby was "getting what she needed", referring to the *frequency* of feeding as a means of representing breastfeeding success. Similarly, Dawn suggested that her son's continued weight loss postpartum was attributed to not "getting anything basically" because she was having trouble producing enough breastmilk.

The concept of breastmilk invisibility also played a role in Lee's reflections about infant feeding. When recalling the experience of her son being admitted to the hospital for poor weight gain, she continued to also reflect on breastmilk and the mysteries surrounding its futility,

I know that I breastfeed him before I give him formula but I wonder if there's ... any effect at all to my breastfeeding him like aside from ... aesthetic or whatever. I don't even know if it's giving him any benefit whatsoever. Sometimes I suspect that he's only getting any nutrients from the ... *stupid formula*.

In referring to formula as “stupid”, Lee continued to reinforce her displeasure with having to use formula in the first place. It was evident to me from our discussion throughout the postpartum interviews that Lee continued to place high value on breastmilk; however, she began to show signs of being suspicious of it, which was not evident in the prenatal interview. She continued by describing how medical technologies in relation to breastmilk (accessed through her relationship with her public health nurse) could be used to support her feelings of maternal adequacy,

The public health nurse, she was at my house and I was like well isn't there like, can't someone ... can't I pump this much breastmilk and you guys take a sample of it and tell me if it's ok and if it has everything he needs and she's like 'no there's no way to test your breastmilk to see if' *And I was like well then how am I supposed to know if it's working or if ... I'm running into, you know...how am I supposed to know if... my breastmilk is doing him any good whatsoever if no one can actually answer that question.* There's no way to test, there's no way to know, there's no way to be sure ... I sometimes suspect that the formula's the only way he's getting any nutritional value.

Attending to their baby's weight gain or loss patterns was reinforced through participants' interactions with health professionals. The health system became particularly engaged under circumstances where participants' babies weren't gaining weight or meeting normative weight gain targets. In many instances, it was this initial disclosure that the baby wasn't putting on adequate amounts of body weight that prompted a significant change in breastfeeding practice from exclusive to formula or mixed feeding (“it's the only way I know she's getting what she needs”). Under extreme

circumstances, an intervention such as the baby's hospitalization (Lee) or Child Protection Services (CPS) involvement (Lynn) occurred (see section 6.2).

Participants also defined breastfeeding through the quantification and visual representation of their own human milk, again reflecting a biomedical discourse that emphasizes objectivity. Successful breastfeeding was equated with milk flowing *faster* or with greater intensity, and poor breastfeeding success was perceived through a lack of milk volume – either through observations made from breastfeeding or pumping (manual or mechanical expression). Participants used the breastpump (another medical technology), not only as a means of convenience for feeding, but also as a tool for validating their breastfeeding practices. Alice attempted to restart breastfeeding after finishing her course of antibiotics and stated that she was concerned that her breastmilk production wasn't meeting the needs of her daughter:

Cause she eats a lot – she's a big, big girl and she likes a lot of food so even if I would've [sic] breastfeeding – Holy I think I wouldn't...I'd be oh my god – I'd be doing it every 5 seconds. She's an eater right? And seeing what I pumped off, *well I don't know if like my milk would have come in more fuller but seeing what I pumped off to what she eats? It was like – there's no way I could produce enough to give her what she eats right?*

Alice reiterated her challenges with restarting breastfeeding in our final interview: "... I tried ... but ... *my milk was dry or something?* So there was no milk. Oh I pumped for an hour for like 2 ounces." A similar experience occurred for Dawn, recalling: "I tried pumping off but it just wasn't happening ... hardly any [breastmilk] at all. Like it was

just...wetting like the suction part of the pump and that was it, there was nothing going down...”

One of the other means in which medical technologies collided with the constitution or subversion of normative, maternal identities was in the manifestation of medicalized mothering. In such instances, the medical establishment played a key role in subverting mothering identities in such a manner as to prescribe medication for situations in which the normative, essentialist presumptions about mothering were challenged. A major example of this was in relation to breastfeeding and milk production. Several participants were prescribed (or recommended to take) domperidone to augment milk production as a means of improving breastfeeding outcomes and success. At face value, this practice would appear to be a straightforward solution; however, as participants described their experiences, I began to notice how this had the potential to undermine their feelings of maternal adequacy, and could be problematic for them.

For Dawn, domperidone became the stepping-stone towards cessation of any breastfeeding, secondary to her perception that her son wasn't getting enough milk from her. She described that her milk ducts had been damaged from previous nipple piercings. This was a concern she had previously discussed with her physician during her pregnancy and had very briefly discussed with me during our initial interview. She recalled,

We started getting formula after that [son seen by health professionals] and...I mean I tried the domperidone stuff I'm on that right now to like increase my breastmilk but ... so far, I haven't really seen too much of a difference. I've only been on it for 4 days though so ... [I: Ok – and who put you on that] ah ... *public health told me to go on it* but my doctor put me on it.

The domperidone was prescribed to augment her breastmilk production, which came secondary to the understanding that her son wasn't gaining an adequate amount of body weight. In our final interview, I revisited Dawn's use of domperidone again and how this had impacted infant feeding:

A little bit but not enough to do him [meaning adequately feed son] and then...by the time ... enough came in ... to do him, it was like, I was so used to using formula and I had already had him pretty much completely switched over so ... and formula's much easier cause like the trouble that I had with [breastfeeding]? Just stressed me out so bad that I was like, K no. So ...

Her story again points to how domperidone signified the point of transition from exclusive breastfeeding to formula feeding. She described how domperidone had made, in her opinion, very little difference to her ability to breastfeed and this only resulted in causing further tension for Dawn as she expressed frustration with her perceived lack of success with her breastfeeding experience. Dawn continued to describe how she placed an ultimatum on how long she would continue to use domperidone,

Well public health told me that if...I didn't start producing enough milk in 2 weeks that I wasn't going to anyways, like that was...gonna be like in two weeks' time I was gonna be full of what...like I was gonna get in...so I just left it at that...

I attributed this tension (which Dawn experienced as stress) to a disconnect that existed between Dawn's experience and her expectations about breastfeeding. This change in direction from exclusively breastfeeding to domperidone use planted a seed of doubt in Dawn's perception of her maternal body as naturally functioning the way she originally

presumed it would. Similar to other participants, Dawn had also noted the importance of breastfeeding for health benefits but also a key component of the normative responsibilities of mothering and a taken-for-granted function of the essentialist female body.

Consistent with Dawn's account, Tracy recalled that "they" (referring to the nurses she encountered in the hospital) also recommended that she take domperidone due to poor milk production. However, Tracy also recognized that she was under a tremendous amount of stress with her son being admitted to the NICU and feeling the pressure to conform to normative mothering practices within this context, while attending to her own physical challenges (high blood pressure and recovering from caesarean birth). Tracy was very emotional and crying as she recalled to me how she had felt in this situation:

I kinda feel like I'm defeated or that it's um ... a lot of pressure to do something [breastfeeding] and then if I can't ... you feel like you failed? Right? And that's what I was saying about the whole entire time. Is that I felt like I had failed. I felt like I had failed as a mom, I felt like I had failed with breastfeeding, and ... all this stuff ... but ... I hadn't [crying] it was ... but I wish that people would be trained a little bit more in ... be a little more empathetic towards that? So that's I think what would be different is they would let you know that ... it's important to do it. If [breastfeeding] doesn't happen, it happens ... it'll happen naturally.

What was interesting is that when Tracy approached her doctor about using domperidone as a means of boosting her milk production, her physician recommended that Tracy *not* take this drug, attributing this to the drugs' potential side effects. Tracy's physician

further iterated that “the milk will come”, again linking breastmilk production as a normative, natural female body process as long as Tracy continued to “work” at it. This conflicted with messages that Tracy was receiving from other health professionals, which contributed to her duress and tension at a time when Tracy was already describing a vulnerable sense of self and maternal failure. Tracy did not end up using domperidone, but I did wonder how the messages from health professionals had positioned breastfeeding as unattainable for her. On the one hand, the health professionals who had recommended domperidone as an option had all but suggested that the supposedly normal, biophysiological process of breastfeeding was not working for Tracy, requiring medical intervention to fix this issue. On the other hand, Tracy’s primary care provider disputed this need, but also reiterated the normative processes would ensue – despite there being evidence to the contrary – that Tracy was having challenges with breastfeeding and was significantly stressed in this situation. Being caught between these two messages eventually led Tracy to state: “so I just wish that people would be more....empathetic...and more....sympathetic instead of...pushing things on people and saying *this is the way it has to be or should be?*”

In yet another example, Lee’s son was admitted to the hospital within the few weeks after delivery based on “failure to thrive”. However, Lee was baffled at how this had occurred owing to the fact that Lee had always understood breastfeeding as a normal, biological process. At this point, Lee underwent assessments with health professionals based on her strong desire to continue exclusive breastfeeding. After the professionals could find no obvious reason why her son wasn’t gaining weight, they also recommended that Lee take domperidone based on the lactation consultants’ assessment that “both of us

were doing everything properly – he just wasn't getting what he needed.” What was ironic was that while Lee continued to take domperidone to support her breastmilk production, she also experienced weight gain as a side effect of taking this drug. She was the only participant to identify this connection, indicating that she was “unaware” that weight gain could occur and that it “sucks” (see section 6.3 for findings related to maternal body weight). Nonetheless she still was going to take the drug, which indicated to me that providing her baby with breastmilk was prioritized above her desire to lose weight, reflecting a child-privileged discourse.

6.1.2 “I just figured you breastfeed and it works.” When breastfeeding fails:

Body blame and mother shame

Every participant in the study described experiencing breastfeeding challenges in the early postpartum. While these challenges presented in different ways, there were similarities in how the participants constructed their experiences. First, as they described their stories about breastfeeding, the participants primarily referenced a failure of self – namely their own bodies, as the most probable explanation for this occurrence. Some participants noted that they weren't adequately prepared for the array of issues that could present in relation to infant feeding. Summarized Tracy about her experience,

I thought it was all going to be flowers and sunshine and he's going to get there [breastfeeding] and I'm like...yeah, yeah, yeah...I can carry on with my life but it's not been that way at ALL [with emphasis]...It's been a gong show!

The discourse constructing the essentialist female body implies that breastfeeding is a natural and taken-for-granted function of maternal bodies. When breastfeeding challenges arose among the participants, they were described as a surprise to them,

suggesting to me that their prenatal representation of breastfeeding as a given and straightforward process was disrupted. This finding was consistent with how participants' constructed an ideal image of the breastfeeding mother within the prenatal interviews (see Chapter 5).

Lee was perhaps the most sarcastic and vocal of all the participants when she articulated her perspectives on breastfeeding post birth. It should also be noted that despite the various challenges that she encountered and her new position on breastfeeding, Lee continued to breastfeed even into our final interview (at 3 months), with a goal toward exclusively breastfeeding. When I first asked Lee about her experience of breastfeeding a newborn compared with her initial expectations regarding breastfeeding, Lee suggested that her maternal body had failed her. This came as a complete surprise to Lee, who had expressed strong moral convictions concerning breastfeeding during our initial interview. In order to validate this new revelation about breastfeeding to me, Lee revisited her initial beliefs about breastfeeding, by recalling a discussion she had had with a friend during her pregnancy:

I remember her saying something, she's like 'well what are you gonna do when your tits don't work and you have to buy formula' and I was like well that's not going to happen. But lo and behold – she was right!

Lee's comments suggest a contradiction between her experience of breastfeeding and that of the dominant discourse of the essential, normative female body being one which is positioned as naturally, biologically capable of bearing and rearing children – a role that includes breastfeeding them. As such, when Lee experienced challenges with her baby meeting weight gain benchmarks while exclusively breastfeeding, she blamed her own

body for this failure, and in doing so, reinforced the dominant discourse that breastfeeding is normal and unchallenging for all (good) mothers. She stated,

Boy was I in for a shock! ... I can't believe [child] had to spend a week in the hospital because my boobs don't work. I had no idea, that could even happen ... but I was actually speaking to like one of my best friends from childhood and she was like, 'I don't understand why you're in the hospital' and I was like, because my boobs don't work and she's like 'I didn't even think that was possible' and I was like neither did I! I just thought it worked! Like he'd breastfed less than 30 minutes after he was born – it seemed to be working the whole time. Aside from him not gaining weight, I thought everything was working. I didn't know there could be a problem.

At the same time that Lee identified she was unaware that the female, lactating body could be fallible, she continued to self-blame for the reason that she experienced challenges with breastfeeding. For example, she indicated that her history of disordered eating practices “must” have played a role in her “inability to breastfeed properly”. These practices cannot be separated from Lee’s experience of living as a woman on a fixed income (e.g., social assistance) and the inconsistencies in her access to food.

Consistent with Lee’s perspective, Lynn also expressed concern about a potential relationship between the quality of her breastmilk, her body weight and experience of food insecurity, indicating,

I was worried about um, whether or not she was getting the proper nutrients and things like that. Um ... but I was also wondering, you know, if my weight was

going to affect her weight. Um...like if...if my being so overweight was actually causing the milk to be too fatty and not give her enough, essentially.

Again, Lynn's quote illustrates the concern that participants expressed about their physical self, impacting the nutrition of their baby.

For Tracy, it was the delay of copious milk production that resulted in breastfeeding challenges. Tracy revealed during her final interview that she breastfed her baby (not exclusively) for the first 8 weeks of his life; however, she also indicated feeling "defeated" about her breastmilk taking a long time to come in (almost a full week post birth). She expressed her frustration when challenged with attempting to breastfeed a baby who was accustomed to receiving both breast and formula on account of being hospitalized post birth in the NICU. Tracy's story again points to the importance of context in situating the breastfeeding experience, as she indicated that the situation "really set me back. I think had [NICU] not happened? He'd be a lot better [with breastfeeding]." Tracy described how "upset" she felt as she was negotiating the breastfeeding relationship and the impact of the mother/baby separation on this relationship. She reiterated, "Basically missing those two days [when son was first admitted to NICU] kinda set me back [breastfeeding]. And it didn't help my milk production, it didn't help...if my milk would have come in faster ..." The experiences that Tracy endured within the early days postpartum would continue to have a significant impact on her maternal identity, which she would reveal in our final interview (see section 6.2).

Both Jennifer and Lynn experienced challenges with breastfeeding that they attributed to their weight and/or breast size. While this was not explicitly linked with a

failure of breastfeeding, nor was it indicated to be an insurmountable challenge, both still situated their experience as ‘other’ and different from the norm. As well, both outlined the negotiation that was required to make breastfeeding work. Jennifer stated:

I had one nurse try and tell me *‘oh you should be doing cross-body instead of football hold’*. I tried cross-body – it didn’t work for me, I’m too big chested, I have to do football hold. I can’t even get around him ... because I’m so big in the chest right now. Just ... it doesn’t work. So we do football hold and it works great.

Her story demonstrates the disconnect that occurred between the support of her care provider (who suggested a taken-for-granted understanding of breastfeeding practice) and her experience of breastfeeding with a larger body. Jennifer continued by describing to me the other ways she negotiated breastfeeding – including breastfeeding her son by lying on her bed so as to avoid placing further strain on her body.

Similarly, Lynn described the challenges of breastfeeding with a larger body size, echoing Jennifer’s story by indicating that lying on the bed breastfeeding was a particularly useful position. Like Jennifer, Lynn also directly linked the success of breastfeeding practice to normative body measures:

Because of my weight, I can’t feed her while I’m sitting up. [I: did you expect that would be...?] No, no. *I figured I was just gonna be like everybody else and be able to breastfeed her and whatever* but ... she just couldn’t because of the way my weight sits underneath my breasts I couldn’t sit her there. And so ... well [health professionals] tried different pillows and...there were four of us trying at one point ... it was me and [doula] and two other nurses that were trying to figure

out a way to manoeuver her so that she could actually get to my breast and so ... nothing ... in that case I got really worried that I wasn't going to be able to breastfeed her at all. And I was just like oh wait a second – and then I flopped over on my side [laying down] and was like oh! [I: This works!] Yeah, yeah!

Lynn continued:

The nursing pillow didn't fit ... I had it around me, I had it under me – it just didn't fit ... that, that really kind of freaked me out a bit – it made me very much aware of how much I weigh, which in turn ... if I, if I really had of sat and thought about it at that moment, I probably would have cried but ... um, I think I was more concerned with getting her fed than anything ...

The stories of Lee, Tracy, Lynn and Jennifer point to the complexity of negotiating breastfeeding when the physical body is experienced as other in some way.

6.1.3 “... Just cause it's not their way, doesn't mean it's not ... the right way?”:

Agency and infant feeding

Whereas in the prenatal interviews, participants were prioritizing their infant feeding decisions within a discourse that privileged healthism, medicalization and emphasizing the wellbeing of their children, their perspectives on breastfeeding in the postpartum were very much shaped through their day-to-day challenges and experiences – notably pertaining to living with resource constraint. This was not to say that they did not acknowledge that breastfeeding was still their preferred method of infant feeding, but rather that breastfeeding was recognized as but one option of a variety of options available to them and thus, participants exercised agency within their infant feeding

decisions. Lynn, who was raising her baby as a single mother, suggested that the realities of exclusive breastfeeding misaligned with her present situation:

There's no ... there's no rest period with her so – if she needs any sort of anything ... I'm the one who has to run and get it. But at the same time, um, you know, I'm, I'm doing this all by myself so, she ... [breathing loudly] *instead of, instead of sitting down and, and breastfeeding for four hours, you know, it's one of those things that's...don't get me wrong it would be worth it to do it.* But where it's just me here? I don't think it's ... I don't think it's very ... you know what I mean?

Conducive?

I asked Dawn, who was providing both breastmilk and formula at the time of our second interview, about her feelings regarding breastfeeding within consideration of the various challenges that she had encountered. She stated:

I don't know. I feel like ah ... I don't know, it's not gonna be as healthy for him, to feed him formula and it's gonna be a lot more expensive and stuff but. *I'd rather him get the food that he needs, you know what I mean? And be a happy baby than not right?* So ... when it comes down to it, as long as he's eating good and everything, I'm ok with it I guess, I mean I kinda gotta be right?

I interpreted from her response that she was experiencing a tension regarding her infant feeding practice; she was resigned to her decision to provide formula and tentative to reject the dominant discourse of breastfeeding as best for her son. I noted in her response her use of the healthism discourse to situate her feelings about breastfeeding, but also the child-privilege discourse that is associated with good mothering practice. Dawn justified her infant feeding practices because she was still providing nutrition for her child – again

signifying good mothering. I interpreted within our final interview that Dawn had even more of a confident tone regarding her infant feeding decisions:

I don't know like to me now it's like [sighs] *he's my kid and he's fine* and it's not like, you know what I mean ... he's been so different ever since I started giving him formula. Like he's a happy baby... You know what I mean, and that hasn't changed at all. Like even when he's sick he's happy. And...so, when he was breastfed ... he was still quiet but he was like sleeping a lot, when he was first born because he wasn't getting enough milk and he turned all jaundice-y and stuff so ... like he's happier ... so ... that's the way I feel is best, as long as he's happy and he's getting the nutrients he needs, which he is – cause formula does have it, just not ... the benefits of breastmilk ... kinda like the immune system and stuff like that right?

Dawn continued to describe the infant feeding information she was receiving within her social network, specifically identifying her mother as a source. She also referred to “they” in her narrative yet did not elaborate about whom she was referring to when probed. I noted that she was exerting agency and positioning her choices within a range of what I interpreted of good enough mothering, when she stated:

But yeah so I just basically now I'm just like, shut up. [laughter] like I don't care ... cause I don't anymore. It's just one of those things it's like ... just cause it's not their way, doesn't mean it's not ... the right way? Or it doesn't mean, it's not gonna work for him. Cause all kids are different, right?

Infant feeding practices as a relation of power

As participants negotiated their infant feeding decisions, they also described the important role that health professionals played within these negotiations. Specifically, health professionals were constituted as a key resource and were identified for their expertise in baby care and as gatekeepers to knowledge about newborns. Throughout their stories, the participants universally described that not only was this expertise necessary in negotiating new parenthood and validating their experiences as capable mothers, but also for the decisions that they made regarding infant feeding and other aspects of care. This was particularly important within the early days and weeks postpartum, which is a critical timeframe for establishing a breastfeeding relationship. Within this constitution, the participants continued to self-identify as unknowing or sceptical about their own parenting capabilities (a continuation of this subject position from the prenatal interviews), and in doing so, reinforced the discourse of health expertise and dependence on the knowledge and support from health professionals. This was a reaffirmation of the subject positions they experienced before birth as unknowledgeable in parenting practices (see Chapter 5).

The actions that occurred as a result of negotiating infant feeding practices between participants and health professionals represented a particular relation of power. The power that was exercised by participants within this negotiation manifested as resistance to the discursive practices that dominate breastfeeding discourse, reshaping the practice into something that worked for them. While constituting health professionals as experts, participants would nonetheless resist their expertise if they felt disrespected or that their situational context wasn't being adequately acknowledged and addressed.

For example, Tracy described both positive and negative experiences within the health system. Tracy defined supportive health professionals as those who took the time with her to figure out breastfeeding (e.g., positioning) and those who valued her autonomy. Her family physician was regarded as supportive and provided reassurance and validation to Tracy about her challenging breastfeeding experience by stating, “it’s because of what he’s overcome in the NICU, he’s so little...[breastfeeding’s] new. Just keep going with it and do what you can.” However, Tracy also described that despite feeling supported by her family physician, she continued to experience “pressure” to breastfeed from other health professionals:

They [nurses in hospital] wanted me pumping in between his feedings, and so they wanted me there for every feeding ... and it just got to the point where I wasn’t eating, and I was there all the time and I didn’t even have time to think. And like I said, all that contributed to the high blood pressure and so on ... and ... the force that I felt – like, like I said, *the pressure to keep doing it, and doing it, and doing it*. And I was like – at one point in time, I was like I’m gonna give up on this – frig this. But I didn’t cause he needs...[breastfeeding’s] the best thing for him.

Tracy indicated that despite putting the best interests of her child first (relating to a child-privileged discourse in relation to breastfeeding), she was nonetheless experiencing a sense of failure as a mother: “I kinda feel like I’m defeated...it’s a lot of pressure to do something and then if I can’t ... you feel like you failed? Right?” Tracy again emphasized the point that those health professionals needed to have greater empathy for

the issues encountered by breastfeeding mothers, rather than taking the normative position of “[breastfeeding] is the way [infant feeding] has to be or should be.”

For Tracy, validation from her care providers about her infant feeding decisions was an important factor to facilitate a positive experience in parenting. She stated:

I needed validation that it was ok to not [breastfeed] anymore. Because ... ah ... [with sarcasm] not to be rude but people who breastfeed, some...women who breastfeed, sometimes are fanatical about it. And...there just has been a study released that shows that there's no difference between breastfeeding and not breastfeeding. Right? So saying it's the best thing for your child. It's true...it probably is true, but the studies have come back too right? That said that it doesn't matter either way. And I was watching a TV show in regards to this about how women ... this one lady had twins and another lady just had one. There was [sic] four women all together. One woman didn't have any children and 3 of them did and they all talked about their experiences and one of them formula fed and she was pretty much ripped apart by the other two women because she didn't breastfeed. Right on public, right on television. And they said you know, as a woman ... that's like ... that makes me feel more of a woman, that makes me a mom. And the other woman who formula fed, she said, 'so you're telling me I'm not a mother? Because I'm not ... I don't breastfeed.' Right? And it was just, like to me it was ... this eye-opener too right? And, and, and it's healthier, it's cheaper ... but I couldn't, I couldn't do it.

While the discourse of healthism pertaining to breastfeeding dominated, and despite her acknowledgement of breastfeeding as an inexpensive form of infant feeding (of direct

importance to those living with resource constraint), neither were enough for Tracy to continue the practice. The variety of challenges that Tracy experienced – which began immediately following her son’s birth and subsequent admittance to the NICU, provided the justification for Tracy to resist breastfeeding altogether. Tracy’s support worker (who she met through a community program) provided her further validation that she was successful as a mother.

Lynn also described how her infant feeding decisions were negotiated with her care providers. Lynn was initially breastfeeding but her daughter losing weight prompted Lynn to begin mixed feeding. Lynn recalled an earlier conversation that she had with her public health nurse, who was dismissive about Lynn’s need to use formula:

She didn’t think that I needed the formula ... she basically told me that [daughter] didn’t need it. I didn’t understand because she had told me before that...overall [daughter] was fine. Not she but the doctor at the hospital told me that [daughter] was fine overall and [public health nurse] just basically told me, ‘well yeah, you’re fine, you need to continue to breastfeed, just breastfeed her more. But I couldn’t breastfeed her more because she was never not breastfeeding...it was literally every minute of the day.

Lynn continued,

I told [public health nurse] point blank I don’t think that I should stop giving [daughter] formula [I: and what was their response to that?] No you can, you should. And she made me almost feel bad for ... for giving her formula ... the way that she said things? *It’s almost like, formula is ... this horrible thing to give her. That it should be all breastmilk and all this* and I ... you know – *I’m a first*

time mom of course I'm going to listen to a...a so-called professional right? So I did what she suggested.

From Lynn's perspective, her trust in the expertise of her public health nurse played a role in the removal of her child from her custody (see section 6.2), despite following and trusting the guidance of this professional.

According to the participants, respect was described as a situation when health professionals were perceived to have listened and responded to and/or validated the experiences of the participants and also when they positively acknowledged the participants' agency regarding decisions that they made with regards to the care of their children. This respect was demonstrated through participants' perceived feeling of support or their perception that their health professionals continued on their behalf. Perceiving that the health professionals supported the participants' own sense of personal autonomy was a critical component of this positive relationship. Even within this relationship, the gendered or essentialist perspective on mothers providing primary caregiving ensued.

An ongoing and continuous therapeutic relationship between health professionals and the participants facilitated the development of positive rapport. Health professionals who had multiple, repeated encounters with participants compared with providers with whom they had interacted only one time had greater capacity for developing a rapport with the participants. In some instances, however, continuity in care also heightened the participants' sense of betrayal when negative experiences occurred (refer to the stories of Lynn and Lee in section 6.2). In those circumstances, participants resisted the recommendations of professionals or sought ways to end or change the relationship,

through seeking care and expertise from another professional or discontinuing the relationship. Notwithstanding the implications of this *betrayal* on their maternal subjectivity, the participants also displayed agency in how they negotiated these situations.

Of particular note was how participants' described the services of birth and/or postpartum doulas through the local Volunteer Doula Program. Such services included attending the birth and direct birth support, education, supporting day-to-day activities postpartum (e.g., holding their baby while participant attended to personal hygiene, self-nourishment or other household activities), breastfeeding support, emotional support and encouragement, and general client advocacy. Lynn specifically highlighted that it was her doula who maintained her sense of food and shelter security in the immediate postpartum period; her doula stocked the fridge with food in the weeks after her baby was born, and also ensured that her daughter was adequately clothed and that she had a proper bed for sleeping. Lynn also described the key role that her doula played in advocacy whereby doulas were perceived by the health system and related institutions as a trustworthy partner in care and support.

In what might best be summarized as a validation and balance of both their maternal subjectivity and self-identity, participants universally lauded these providers for the positive support they provided during the birth and postpartum period. None of the participants who used the services of a doula reported anything other than a positive experience, nor did the participants report that their doulas challenged their own autonomy or decisions.

SECTION 6.1: SUMMARY

The events that occurred within the immediate and early postpartum played a profound role in the experience of infant feeding. In most instances, this relationship was not straightforward as the participants' discussed the various challenges that arose as they were entangled within (frequently) competing discourses. There is evidence from the participants' stories that a combination of healthism and biomedical discourse shaped the participants' perspectives and how they signified their birthing and immediate postpartum experience. This discourse played an important role in how participants' decisions regarding care (either their own care or that of their babies) were negotiated with their care providers. It was also a critical lens by which they exercised infant feeding practices and subsequently represented their own capabilities of mothering. Biomedical discourse and its tenets of objectivity, masculinity, technologies and surveillance existed in contrast to the discourse of mother, which is represented through femininity, softness, nurturer, compassion and provider. Being situated within these two discourses resulted in tensions in how the experience of mothering played out for the participants in the early days of parenting.

6.2 Red flags and manifestations of doubt: Representations of mothering on the margins

This section highlights the stories of Lynn, Lee and Tracy as three unique experiences that link directly to the dominant, pervasive discourse of good mothers and the discursive practices that constitute women as such. While not all participants described experiencing this level of surveillance, these stories nonetheless illustrate an

extreme representation of how good mothering discourse is constructed with potentially direct negative implications for women characterized as living on the margins. Lee and Lynn's experiences are linked more directly to their encounters with broader social institutions including health professionals and Child Protection Services (CPS) while in Tracy's case, the institutional setting and the experiences that unfolded there set the course for her rejection of her own maternal identity, or at least the reframing of this identity, which was unique among the study participants.

Both Lynn and Lee's negative experiences with institutions began in the hospital. For Lee, this began when her son was admitted about 10 days post-delivery because of concern with his ability to meet weight benchmarks. In Lynn's case, it was during the immediate postpartum, when she was still in the hospital after delivering her daughter.

Lynn stated:

[CPS] showed up at the hospital *I wasn't you know, trying to hide from [CPS] or anything like that ...* I had actually also contacted a lawyer over them as well [laughing sarcastically] *cause I figured they were just kind of picking on me cause ... I grew up in Children's Aid right ...*

Lynn described how she felt pre-judged about her abilities to 'mother' in a manner deemed acceptable by authorities (e.g., CPS, health professionals) and she based this characterization on her history of living in Children's Aid and/or foster care environments. I noticed how she situated her experience living within foster care as a means of justifying the actions and pre-judgment by CPS. I was particularly drawn to Lynn's use of the word "hide" within her statement, insofar as I interpreted her use of this word to articulate the depth of invisible, yet understood, surveillance that Lynn was

experiencing and how she needed to present herself and her actions as open and transparent so as not to bring any further interest (re: surveillance) into her life.

During this initial visit, and after an extensive amount of questioning, CPS could find no reason to remove Lynn's daughter from her care. However, Lynn did require the advocacy of her birth doula to attest to her capabilities of mothering during this time. This situation further constituted health professionals as experts in parenting and not only reduced Lynn's faith in her own capabilities as a parent, but also the credibility of her narrative. According to Lynn:

Basically they conducted an interview with me and I think it was because I had the other doula there that's probably ... and a witness more or less. That's pretty much the reason why she didn't get taken ... what type of resources did I have, what concerns were brought up to them about doctor's appointments and things like that ... the questions were very, very intrusive. [I: how did that make you feel?] Like a bad parent. *I hadn't been a parent for 4 days or for 3 days yet. And they were telling me 'no, no, no you can't parent'.* So luckily I had [doula] there ... I don't think [daughter] would be with me right now.

As Lynn described her experience being interviewed in the early days post-delivery by CPS, I couldn't help but reflect on how this investigation, which was found to have been inconsequential in the end, took away from Lynn's early parenting experiences and elevated her sense of stress and self-surveillance while diminishing her sense of identity as a parent and as a mother. I also wondered at the time how this experience would manifest in a multitude of implications for breastfeeding and other health-related practices.

Unfortunately, very shortly following our 2nd interview, Lynn's daughter (approximately 4 weeks in age) was removed from her custody. This custodial change was prompted by Lynn's public health nurse (PHN), who from Lynn's perspective, alleged that Lynn's daughter was receiving an inadequate standard of care. Previously, during our initial postpartum interview, Lynn had expressed having a positive, trusting relationship with her public health nurse and valuing the continued support that the PHN provided. However, during our 3rd interview Lynn expressed different, negative feelings with regard to her PHN, namely betrayal and distrust. She further described that the PHN hadn't given her the "benefit of the doubt" in the situation, instead constituting Lynn as ill-prepared to parent. I probed Lynn further about her feelings regarding the situation and whether she foreshadowed this occurring at our newborn interview; she replied,

No. Not like this. And [PHN] basically tried to tell me that she didn't know that CPS was going to take [daughter]. After the fact. *And I basically looked at her and said – no you knew. Don't lie to me – I'm not stupid ...* I basically told her not to [come see me] because she *basically didn't give me the chance to give my daughter what she needed* before calling CPS. She didn't give me a chance to get [daughter's] weight up first off. She didn't give me any sort of benefit of the doubt. That I had been feeding her. She didn't bother checking my fridge for anything...and if she had of, she would have seen ... not much ...

In her response, I observed how Lynn was demonstrating her agency in the confrontation that she had with the PHN, specifically how Lynn terminated the relationship on a go-forward basis. She also positioned the PHN as devaluing not only her identity as a mother, but also as a person. Lynn was extremely emotional during this interview and I

sensed that the emotional stress that Lynn was experiencing was partially because a trusting, privileged relationship between Lynn and her public health nurse was now destroyed. Lynn alluded to feeling failed by a public health system that she had initially respected and trusted to provide support and guidance.

More compelling was that even while she expressed these emotions, Lynn continued to *self-blame* for losing custody of her daughter. She indicated that she was “glad” that her daughter was removed from her care, calling the situation a “wake-up call”, owing to the fact that she didn’t provide adequately for her daughter by nourishing her properly. She described that she would be participating in courses that she believed would deepen her parenting capabilities by augmenting her parenting knowledge and skills. Throughout this narrative, Lynn constituted herself not only as a failed mother, but also not having the expertise or understanding/knowledge required to adequately care for her daughter. In doing so, she constituted health professionals and other institutional representatives as being experts in this regard and ironically, believing in the very discursive characterizations that she was challenging.

During our final interview, we revisited Lynn’s initial experience with CPS in the hospital. Lynn continued to reinforce how CPS and the health professionals within the hospital setting had targeted her from the beginning as a single, low-income parent, recalling:

[CPS] actually showed up at the hospital and tried to take her first. Because the staff there had called and made reports of stupid crap that had nothing to do with me actually raising [daughter’s name]. They had basically said that I didn’t have anything in place, that there was nothing for her when she got back [home].

Which wasn't the case at all. Like you've seen [daughter's name] bedroom – she has clothes up the ying yang. [CPS said that] I didn't have the resources set up in place. I have thoroughly had every resource in the city made available to me by [doula].

Throughout our final interview, Lynn described how she continued to feel characterized as ill prepared to parent and misrepresented by institutions of authority. Lynn validated her feelings by reading to me (verbatim) the legal case notes that were written on the day that her daughter was taken into protective custody. As she read to me these powerful, legal statements, she provided me with additional context to what had occurred and why, which caused me to theorize that the legal case notes were written in such a manner as to constitute Lynn as completely inept as a parent in the eyes of the social justice system. I began to wonder how much the “welfare queen” subject position (see Chapter 2) played into the decision to remove Lynn's daughter from her home and further diminish Lynn's sense of self.

There were many similarities between Lynn and Lee's stories insofar as the description of institutional surveillance on their parenting practices and the authoritative questioning of their capabilities in child rearing. Lee's negative experience began when her son was readmitted to the hospital for monitoring after not returning to his birth weight at 2.5 weeks.

In a story that parallels Lynn's, Lee was also exclusively breastfeeding in the initial weeks after delivery and her son was also experiencing challenges in meeting weight gain benchmarks. In both of these situations, the lack of weight gain for their infants provided the stimulus for institutional involvement. Similar to Lynn, Lee

described not only the surprising revelation that “she was not making enough breastmilk” but also that the readmission of her son started a surveillance process whereby Lee was accused of child neglect. While her son was being cared for within the hospital, Lee went for her regularly scheduled appointment with her mental health provider as a means of unloading the stress of the past several weeks and seeking emotional support. Lee instead recalled being “blindsided” and was further threatened with involvement from CPS. When I asked Lee about why she thought this situation occurred, in her response, Lee referred to the dominant discourse of mothering, particularly what good mothering *isn't*, and how she perceived that she was characterized as not meeting the ‘good mothering’ normative standard. She summarized her thoughts nicely and positioned herself in opposition to the institutions “in charge” (e.g., health system, including child protection services) and her son – alluding again to the entanglement of child-centred discourse within that of the good mother position. Similar to Lynn, Lee described a situation whereby she understood herself to be under a form of constant surveillance:

Well I've got red flags all over me anyways. As far as whoever's in charge is concerned, as far as the welfare of my child is concerned, I'm nothing but a giant pile of red flags. I'm a single mom, I'm on welfare, I live by myself, and I'm already seeking help for mental health and emotional health issues. [Health authority] has a lengthy record of my past involving addictions. So you know, they're just waiting for me to fuck up.

When I probed Lee further about how this situation and perceptions of how she was characterized made her feel, she responded:

Angry ... disgustingly angry. People can change, whether or not those people choose to believe it's possible ... totally betrayed and tricked ... one of the only reasons that I've been seeing you guys [referring to mental health practitioners] every 2 weeks for the past 7 months *is to do everything in my power, to do everything that everyone tells me to ... to make sure that I'm doing everything right and to avoid having CPS come into my life.*

From her response to this characterization, Lee was articulating two key things. First, she was situating her experience within the normative narrative concerning mothering. Lee recognized the dominance of this discourse and described how she was dedicated to following the rules governing good, normal mothering that are also understood and reinforced by “those people” – people that were constituted by participants as experts (see section 6.1.3). For example, Lee was seeking continued support from mental health services as a means of demonstrating adherence to this subject position. Lee made a pointed effort to conduct her own practices in a particular manner insofar as to minimize the multitude of red flags that made up her past history and eliminate any continued perceptions that she was unfit to parent.

Secondly, her story highlights the pervasive, grand narratives that exist in our society relating to mothering on the margins (see Chapter 2). I interpreted her comment about health professionals just waiting for her to “fuck up” to indicate that, according to Lee, her past issues with addictions and mental health had cast a sense of doubt in the eyes of the institution around her capabilities of providing the standard of care necessary for her son's wellbeing. I found it compelling that she argued, “people can change” – acknowledging the fluidity of subjectivity and context (historical) dependence.

Finally, the story of Tracy, who was under significant duress after her son was admitted to the NICU immediately post-birth. While in our initial meeting, we had spoken at length about how this experience affected her perceptions of breastfeeding and early parenting, it was during our final interview when Tracy admitted just how much her mental wellbeing was affected. She was extremely emotional throughout the entire interview and began by identifying as a person suffering with postpartum depression and admitting that she was challenged with the feeling that she did not want to be a mother anymore. In yet another example of using medical technology as a means to enhance a presumed-natural female identity (see section 6.1.1), she stated:

Like I just don't have that mom feeling and it bothers me. And they want ... [care providers] were talking about putting me on oxytocin so I could at least have the bond again. But ... anyway. I feel really ashamed.

The “bother” and “shame” that Tracy described was an interesting way to categorize her experience to the extent that it highlights the incongruences within normative assumptions about mothering. Tracy was uneasy because she wasn't experiencing that “mom feeling”. She continued to reiterate that her care providers were concerned that her feelings weren't consistent with normative mothering, stating her frustration with this:

I don't, I can't have conversations with [care providers] like this because ... they think that I'm schizophrenic or they think that I'm abus--...like I'm going to harm [son] or harm myself. So they automatically go textbook and say, 'ok this is textbook this' or so on right? But it's ... and, and like she said, she said 'now how do you think this is going to turn out?' that's what the social worker said over

there. And I said this is the way I want it to turn out. She's like 'well maybe you should start exploring other options' like she said, 'we can put him in the system ... tomorrow' But there's so much. Like I have a plan in my head and I want it to turn out that way and I'm not gonna stop until everything is exhausted ... The psychiatrist over there thinks it's hormonal. Cause I was on my period for a month and I was taking progestrin and it completely messed my body up. So when I went to see my doctor, she put me on estrogen, she's like those should counteract one another. And she said she wasn't sure if it was hormonal or not.

Throughout our interview, I continued to probe Tracy regarding her feelings about mothering. She stated that while she loved her son, she indicated she was "not the right person for him...not the right person to raise him." Her feelings of shame and guilt as well as the reactions, "tension" and "judgment" experienced from those within her social network again point to the pervasiveness of the discourse situating mothers as the primary nurturers for their children and how any deviation from that is socially problematic (see Chapter 2). For example, Tracy indicated that her family was "mortified that I can give up my child like that" and she described that she believed that her family would "disown" her if she gave up primary caregiving. She continued:

What depresses me is the fact that I'm going to lose friends and family and a chance that I may never see him again. Cause they may keep him from me or just the people talking about things behind my back and how much of a horrible person I am because that's what they think, I'm a troll. That I've decided to do these things and make these choices for other reasons, but nobody really sat down and listened to my choices. I have couple of people have but, and, and some

people don't understand. And I, I think it's, it's all about understanding. Like ... my best friend said to me when you're a mother, you don't think of anything else in this world but your child. So you would starve yourself just so your child would have. And I said, that's ... I am a mother, that's what I do. But I also know that my limitations to that as well.

I interpreted from Tracy's story that while she was acknowledging the existence of a normative maternal identity, she was also resisting it and constituting herself within a different mothering identity – a biological mother, but not a primary caregiver. For Tracy, these subject positions were not mutually exclusive. I could not discern a particular event that prompted Tracy to resist the normative mothering subject position other than to acknowledge that the multitude of challenges that Tracy faced throughout her pregnancy and through her early postpartum manifested in the desire to discontinue as primary caregiver. These challenges included dissatisfaction with her breastfeeding experience, the future of raising a child as a single parent, and living with financial insecurity, along with (possible) postpartum mental health issues.

SECTION 6.2 SUMMARY

The stories of Lee, Lynn and Tracy suggest that the grand narratives concerning parenting, particularly single parenting under resource constraint, culminated in significant tensions between these participants and those with whom they interacted within the health and social system. The discourse privileging child welfare was paramount to this tension. The irony was that while participants were attending to the recommended infant feeding practices, it was these very practices that, when challenging or deemed unsuccessful, constituted participants as bad mothers. When breastfeeding

became challenging, it was at this point that participants resisted the parallel discourse that situated them at the center of blame for the outcome to their child's wellbeing – either by changing their feeding practices, or resisting the support of health professionals. At the same time as demonstrating resistance, participants also pointed blame at themselves, reflecting the dominance of the discourse of normative mothering and the normative maternal body.

6.3 Shifting priorities and new experiences: Excess maternal weight in the postpartum and the experience of income-related food insecurity

This final section details participants' beliefs, values and practices as they pertained to experiencing excess maternal body weight and food insecurity within the early postpartum period. I observed that the discourses revealed during the prenatal interviews in relation to food insecurity and excess maternal body weight were maintained throughout the postpartum experience. These included the dominant focus on excess body weight signifying a lack of personal control over health practices such as healthy eating or physical activity, and that the participants constituted themselves as “resourceful” in order to feed themselves and their families as they experienced food insecurity (see sections 5.3 and 5.4). Universally, participants acknowledged how living with income constraint had direct implications for their ability to manage recommended health practices, including access to physical activity, healthy food and infant feeding.

6.3.1 Weight it out: Body after baby

A main difference between the prenatal and postpartum interviews was how participants described living with excess body weight in the early post-partum. Despite

maintaining their perspectives of healthy eating and physical activity as necessary considerations for weight management, as well as a continued attendance to self-surveillance practices (e.g., use of scales for weighing, describing their clothing sizes and fit) they also acknowledged that their attention in the short-term was diverted from practices of the self and self-surveillance of body weight, to a more present focus on early parenting and self-care, which included good mothering. This was particularly apparent for managing body weight through physical activity, whereby participants expressed the need to wait until *their situation had stabilized* before bringing any change to their physical activity practices. For example, Lynn spoke about starting a weight management program (Fit After Birth) in our first postnatal interview. Despite acknowledging that she would require further information about the financial cost, she also stated:

I'm looking at different ways I can possibly get into shape after ... *after I'm you know, able to do things*. And I've been doing things pretty much all along, I've just ... know that I shouldn't be. Like the doctors told me that I'm not allowed to go up and down stairs, I'm not allowed to ... go for long walks or ... things like that. Or really go for walks period. I pretty much have to keep it ... pretty ... pretty calm. I'm not allowed to do any sort of exercise period right now.

While Lynn was interested in weight management through an exercise program, this wasn't a priority for her due to its perceived unaffordability, but also the need to prioritize her own self-care, including post-surgical (caesarean) recovery. Again, her response reflects the dominance of the discourse of self-regulation within weight management and the discursive emphasis on individualistic approaches for maintaining

body weight. She also maintained the constitution of her health professional as the expert in validating her actions as she sought permission from her doctor to participate in physical activity.

Alice acknowledged that while she was concerned about her body weight in the early postpartum and “getting my body back”, the immediate weight loss in the transition from pregnancy to the postpartum period was enough to satisfy this need, specifically while she was feeling so unwell. She stated,

I want to start dieting but I don't want to like over ... exert myself? Like I want to start to like diet and trying to *get my body back* but I felt like ... I lost weight actually? ... I don't feel like I used to feel. Like my stomach's not as big as it used to be before I got pregnant? So it's kinda like ... ok but I'm trying to like – I want to start dieting and exercising and stuff ... but where I've been so sick it just ... it just hasn't been really that important to me.

During our final interview, Alice identified as feeling better, but was frustrated with her lack of progress in managing her body weight. She pointed out initially she had lost a significant amount of weight, but that her diet had been terrible since starting a new medication. She was resolved in refocusing her practices of the self, though acknowledging that eating well was “expensive.”

Similarly, Jennifer wasn't prioritizing her own body weight in our initial postpartum interview, but indicated that she was “itching to get on the treadmill, but right now I can't ... for six weeks. I'm really hoping my family physician next week will say *ahh we'll start to lift that, you can do this or you can do this* so we'll see what she says.” She again reiterated that while she was “watching” her scale at home, her care providers

were also giving her advice to not push the weight management issue, “*your body’s been through a lot – allow yourself some time to heal* is what they all keep saying.” From this exchange, I interpreted that Jennifer was again positioning her providers as experts in her health-related practices, and that she was primarily linking the individual practice of physical activity as a means of achieving weight management. In addition, Jennifer expressed that she continued to conduct self-surveillance of her weight through the use of her scale, but was nonetheless going to heed the advice of her care providers in terms of when her exercise regime could commence.

During our final interview, Jennifer expressed the perception that her body weight was abnormal by stating, “I hop on the scale and I’m not happy.” Despite her desire to establish a regular exercise routine, this had been put off due to persistent health issues. Jennifer acknowledged that because she was feeling better, she was beginning to explore incorporating physical activity back into her life.

The topic of body weight was also a source of conflict for Lee. She indicated that she didn’t own a scale and didn’t weigh herself, and stated, “I just keep trying to ignore it.” Weight loss was not deemed an immediate priority for her; however, I also perceived throughout our discussion that she seemed bothered by her body weight while also acknowledging that any deliberate weight loss would take time and seemed resigned to put it off for the time being.

For the participants in this study, their practices in relation to managing their body weight were considered secondary to the demands of early parenting. While they continued to identify with a need (at some point) to take steps in managing their weight, particularly in the early weeks postpartum, this was considered a priority on hold.

6.3.2 The dynamics of early parenting and income-related food insecurity

As participants shared their stories, they collectively described the experience of living with income-related food insecurity within the context of new parenting. Continuing their beliefs and experiences throughout their pregnancy, their stories reiterated the resourcefulness and resilience that they applied to their daily lives in living with income constraint. The experience of household food security was greatly influenced by the ability of participants to successfully integrate breastfeeding into their lives. Since most participants experienced early breastfeeding challenges, the partial or fulltime use of formula required considerable financial resources, thus impacting the remaining household members' personal food security.

Short-term relief: Food insecurity in the immediate postpartum

Some participants indicated that they felt more personally food secure during the immediate weeks postpartum than any other period during our interviews, which I interpreted to positively reinforce their subjectivity as a good mother. This was mostly due to the immediate support (financial or food) that some received after the birth of their babies. These resources came from family, care providers and those within their social networks and provided the participants both short-term relief and a sense of certainty about their present lives. The participants welcomed this support as an extension of their identity as resourceful people; stated Lee, "Someone always bails me out at the very last minute...story of my life."

Lee indicated that her mother and aunt provided this bridge of support in the early postpartum. Both moved in with Lee for the initial few weeks post birth, purchasing

groceries and preparing food to keep Lee well nourished over this period. Similarly, Alice was living with her mother in the postpartum and relied on her to access food. Tracy also indicated that she had not experienced any food-related concerns because her mother was providing food for her during this time “there’s always food there.”

Lynn shared in our first postpartum interview that her need to access charitable food assistance through the food bank was reduced. She attributed this to the fact that her doula was preparing meals for her and dropping them off so she was being well cared for in this regard. Lynn also acknowledged that she was relying on frozen food support through her local family centre. Lynn’s doula also provided gift cards to her and facilitated stocking a “fridge filled with food”. At this point in her experience, Lynn was feeling relatively food secure, although she acknowledged that this level of support was likely to “taper off or at least I’m expecting it to.” As anticipated, during my final visit with Lynn, she described how her food resources had dwindled since the early postpartum period, and how the stress of her daughter being removed from her custody had affected her personal food security:

I’ve got vegetables in there now – but I don’t have much. I’ve got I think some cucumber and lettuce and carrots and celery I think. And I think I’m down to my last apple. And I had a bag of grapes ... and I think I still got sugar snap peas in there. That’s pretty much all I have for right now. I think I’ve got a couple of cans of soup and some rice in the cupboard ... I haven’t been to the foodbank yet this month. I’ve just been kinda going down to the Superstore and Giant Tiger and getting whatever I needed. Basically using whatever resource I have been able to ... to have a little bit of food in my fridge right? Now lately I haven’t

been eating either ... as much as I should be, cause I've been too stressed out to eat. Or I'll go to [local support program] and eat something there."

Similar to Lynn, Jennifer indicated that both she and her partner had received extra money as gifts in the early postpartum so they "were able to buy better groceries than we are now." This suggested for me during our final interview how Jennifer's immediate, postpartum feelings of being food secure had reverted back once those unanticipated financial resources were spent.

Notwithstanding the immediate sense of relief that was experienced by some from short-term financial and food security, the addition of a new family member to the household and the integration of their needs within the context of limited household resources had important meaning for the participants in this study.

The ideal and the real: Food practices in the context of limited resources

Participants constructed their personal and household food practices in relation to a normative standard for food management. This extends their original beliefs and values regarding food that they expressed in the prenatal interview (see section 5.4.2). While participants identified that there was an ideal way for household food management to occur, the reality of integrating this into their lives was disrupted through the experience of early parenting, breastfeeding and living with income-related food insecurity. For example, some participants described the challenges of eating with an infant, prioritizing the needs of childcare and infant feeding before personal food access. Stated Lee,

I do eat breakfast – sometimes, I eat lunch – sometimes I just plain forget, I always eat supper – even if it's really late at night. I have to eat on his schedule or

around his schedule? Cause a propensity for him wanting to eat the second my food hits the table is like 99 to 1. So um, at least once a day I have a really great big meal with all the food groups and it's awesome. The other day I was really hungry so I ate 2 chicken breasts and 2 servings of rice and ... like a serving bowl full of salad. I do eat. I don't eat on a regular schedule. *I don't eat ... the way normal people eat.* I said something to the public health nurse about an eating disorder and like this lightbulb went off above her head. And then I was like ah, I didn't even think of factoring that into my ability to breastfeed. But ... cause I thought I was doing so much better. And I think I was doing so much better while I was pregnant and then it all went out the window once the baby was born.

In Lee's remarks, she identified herself as subscribing to non-normative food management practices, but also that she was prioritizing her son's care above her own feeding requirements, reifying a child-privileged discourse and a good mother subject position. I interpreted that the tension that she described between nourishing self and the immediacy of caring and providing for her son was directly related to her perceptions of the quality and quantity of her breastmilk and thus her success with breastfeeding practice. Lee continued,

I never thought of ... you know, my body, barely subsisting on what I put into it having an effect on my ability to breastfeed. Cause I thought I had been doing so much better than that. But ... perhaps I'm not. But um ... I don't know. Old habits really suck. I can go really, really far on caffeine and sugar. I shouldn't. But I can. But there's no nutritional value to it and there's certainly no benefit to him. I need to eat more. I just don't know how. I don't even know how to fit it

in. Even if I had all the food in the world, I even time-wise, I don't know how to fit it into a day. Yeah ...

Jennifer similarly described the tension that she was experiencing in household food management as a direct result of limited financial resources. In our first postpartum interview, I probed Jennifer about her beliefs regarding food security and breastfeeding since giving birth to her son. She stated,

I definitely try and eat more yogurt and fresh fruits and vegetables. I've noticed myself trying to make small changes? Rather than pick up that chocolate bar – let's go for an apple instead ... *What I'm eating I know my son is getting ...* And especially now that he's a person that I'm holding in my arms and I'm looking right at him. When he's in your stomach, it's a bit different. It's ... the oh what's to come? But when you're actually holding him and you're looking at that little person that you've absolutely fallen so much in love with, you want what's best for him. *So knowing that he's getting his nourishment from me? I'm trying to do the best I can to ensure that he's getting the best nourishment possible.*

I interpreted from her response that she was also equating her nutrition and nourishment with having a direct impact on her breastmilk but also she positioned her personal food practices as a component of her subjectivity as a good mother. Jennifer drew on the visibility of her son as an important means for signifying her role as a mother. The subject position of a good mother was reinforced through her ability to 'see' him. This echoed the participants' previous statements pertaining to the importance of the visual in situating meaning for their experience of pregnancy and of breastfeeding (see sections 5.1.3 and 6.1.1).

In our final interview, Jennifer indicated that her household's financial situation was still precarious as her husband was still unemployed. Reaffirming her belief that "healthy food costs a lot of money" she further stated that her family was "cutting corners" and eating foods "that isn't the stuff I wish I could be eating" – specifically relying on foods like Kraft Dinner and canned spaghetti. She continued,

In an ideal world it would be different. But where we're at right now it's [healthy eating] ... just not possible. I don't want to say it makes like a failure because I understand the situation we're in right now. But ... it makes me feel like a failure. *As a mom. I want to be providing...perfect nutrition for my son. So he gets everything he needs. But when I'm not nourishing myself the way that I should be? I know he's probably not getting ...*

In her response, she again reiterated the strength of the discourse pertaining to good mothering and the actions that are required to be constituted as such – namely the normative maternal role of providing for the family healthfully. In her statement she also reaffirmed a child-privileged discourse, prioritizing the needs of her son first and foremost.

In comparison with the other participants, Dawn didn't receive short-term financial support in the immediate postpartum. She indicated that this added financial pressure (things were "hard") for the household as they were awaiting the arrival of the child benefit. Because Dawn was partially breastfeeding due to particular breastfeeding challenges (section 6.1.3), she needed to provide infant formula, which was widely acknowledged by participants as a costly method of infant feeding. When I probed Dawn

about her experience of food management and how this reflected her feelings around food for the household, she replied:

Well definitely worry about the formula first ... definitely yeah for sure ... when we got our cheque, we got formula and we got some diapers and we got some bottles and stuff and ah ... paid our bills and our rent and all that kinda stuff, paid off our loan, and we've got like ... I think it's 65 ... 65 dollars to go get groceries so thank god GST comes out. Fingers crossed that it doesn't get held back and getting adjusted and stuff. So ... when I plan to get groceries is when GST comes out basically. Well we're gonna go and get, 65 dollars worth of groceries today, like later on ... but, other than that, we're just gonna wait till GST comes out. Figured we'd get his stuff first and then ... worry about our stuff later ... Cause the way I see it is ... it's not ... yeah the way I see it is ... they [indicating baby and their pet cat] shouldn't have to suffer for things that ... we do, you know what I mean like ... so ... like he can't ... yeah like he can't go out and get his own food right? So ... and neither can the cat, there's nothing that either one of them can do so ... worry about them first.

Dawn's response indicates how she positioned her own food management and food access relative to that of her son's needs, thus reflecting a child-privileged discourse. However, her statements were also consistent with her earlier remarks whereby her subjectivity as a good mother was reflected within her actions in prioritizing needs within the household. Dawn and her partner would do without, so that her son and her pet cat (also positioned as vulnerable) wouldn't "suffer". Dawn displayed a slightly different perspective on the subjectivity of a good mother. While her subjectivity of a good

mother was an important component of her experience, this subjectivity was constituted through nourishing her son by any means possible, which required that she provide formula above taking care of her own nourishment.

SECTION 6.3 SUMMARY

I interpreted a shift occurred for the participants between the prenatal and postnatal interviews whereby the navigation of early parenting (e.g., infant feeding) and managing their own self-care overshadowed their immediate concerns related to their own excess body weight and their personal experience of income-related food insecurity. Participants all chose their food management practices primarily through the lens of their identity as new parents and more specifically their interpretation of the subject position of a good mother. For all, this meant nourishing their family before themselves. The need to manage excess body weight was constructed through individual practices and self-management of body weight. These were identified as directly impacted by living under resource constraint but were nonetheless important in the subjectivity of the participants.

CHAPTER SUMMARY

The experience of new parenting offered important context for the participants, which further supported their beliefs, values and practices as they pertained to breastfeeding, excess body weight and income-related food insecurity. The beliefs that participants described in their prenatal interviews were largely held into the early postpartum period; however, participants displayed agency in the manner to which they subscribed to these discourses and discursive practices. Tensions were experienced

whereby their practices did not align with their preconceived ideas about health. This had specific and consistent implications for their subjectivity as mothers.

CHAPTER 7 DISCUSSION

This dissertation is an inquiry into how breastfeeding was experienced among women living in Nova Scotia, who were constituted through discourses of excess maternal weight, low-income and food insecurity. Using a feminist perspective, and drawing on Foucauldian concepts, this inquiry revealed the complexity of breastfeeding within the consideration of other contexts, and in particular, highlighting the important role that the ‘good mother’ discourse plays in situating the participants’ experience. While there was diversity in the experiences of the participants, the expectations about, and experience of, ‘mothering’ was a critical position from which participants negotiated their breastfeeding and other health-related practices but also in their interactions with care providers and others within their social networks.

The overall question that this dissertation sought to address was **how do women in Nova Scotia, who are signified as obese, low-income and food insecure, experience breastfeeding?** To address this question, I will, in this final chapter, summarize and discuss the key findings as they relate to my overall research objectives. This discussion corroborates the work of Williamson and colleagues who described that breastfeeding is anything but a “straightforward” or “trouble-free” process (Williamson, Leeming, Lyttle, & Johnson, 2012).

7.1 Discourses of breastfeeding, obesity, income-related food insecurity within the context of mothering

How participants understood mothering and identified (or not) with a normative maternal subject position was a critical component to their experience of breastfeeding

within the context of income-related food insecurity and excess body weight.

Throughout the prenatal interviews (Chapter 5), participants unanimously described their health-related beliefs and justified their practices through their maternal subjectivity. The participants' drew upon constructions of a normative, maternal standard in their constitutions, also with reference to biomedical discourses, an essentialist perspective pertaining to the female body, and child privilege. Foucault's concept of the subject is particularly useful for the interpretation of findings as he defines the subject as one not fixed, but produced through "regimes of power", defined by, and redefining, the limits of what is acceptable or not pertaining to that identity (Bevir, 1999). In this study, the participants signified a good mother as a person who provides for, and nurtures her children through a variety of repeated, socially acceptable activities. The responsibilities of a good mother included providing emotional support, the obligation of protecting their child, and the caring activities of daily living (e.g., feeding the family, attendance to hygiene). This finding closely aligns with the areas governing "maternal practice" as defined by Ruddick (2007), where she defines a mother as an agent concerned with the preservation and maintenance of the life of her children, growth of her children and acceptability of practices to her social group (Ruddick, 2007).

The discursive constructions that were expressed by participants throughout the prenatal interviews were largely maintained as they transitioned from a pregnant physical state to motherhood. However, I noted that there were slightly divergent perspectives as to which activities constituted good mothering, specifically in relation to infant feeding. For example, Dawn and Alice (both of whom experienced challenges with breastfeeding) positioned themselves as good mothers through providing any form of consistent

nourishment for their children, while Lee, Lynn and Jennifer prioritized breastfeeding as a performance of good mothering. This idea extended into household food security whereby participants were largely concerned with the nutritional health and wellbeing of their children at the (potential) expense of their personal nutritional needs; this included making provisions for breast-milk alternatives when breastfeeding success was undermined. Notes Ruddick (2007):

Some mothers are incapable of interested participation in the practices of mothering ... severe poverty may make interested maternal practice and therefore maternal thinking nearly impossible ... As mothers, they are governed by the interests of their respective practices. But the style, skill, commitment and integrity with which they engage in these practices differ widely from individual to individual (Ruddick, 2007, pp. 98-99).

Butler's concepts of power/discourse and their relation to subjectivity is also particularly useful for understanding the fluidity of maternal subjectivity as evidenced within this study. Butler suggests that the power of discourse to subjectivity is "to produce the phenomena that it regulates and constrains" (Butler, 1993, p. 2). In this sense, maternal subjectivity was formed through the participants' engagement in discursive acts – breastfeeding and feeding the family healthfully were important components of participants' *maternal performativity*. Through this performance, I interpreted that participants were identifying with normative social views as a means of maintaining "cultural survival" (Salih, 2007, p. 58) and avoiding the social punishment that ensues when one is not subscribing to normative discursive identities (Butler, 1990, pp.139-40). A clear example of this form of social punishment was during our final interview, when

Tracy identified as a mother, but felt a sense of shame and abandonment by her family and friends when she revealed that she didn't want to continue the "day-to-day" activities of mothering. Additionally, Lee and Lynn felt this punishment in their interactions with health and social institutions, as a form of social control that has been termed "punitive surveillance" (Chin & Solomonik, 2009, p. S-42).

Mother as nature and mother as nurture also continued to form a dominant tension for the participants. I interpreted that the participants' perceptions and constructions regarding an ideal maternal body were based on an essentialist perspective of the female body and signified the physical space through which related discourses (breastfeeding, food security, maternal body weight) were enacted or re-enacted. Successful breastfeeding practice was tied to this essentialist perspective and was reinforced through a biomedical view which privileges the act of breastfeeding, but also takes-for-granted that *all* maternal bodies are capable of the practice; the World Health Organization's position is that "...virtually all mothers can breastfeed..." (World Health Organization, 2017a).

In Chapter 5, participants shared how they believed successful breastfeeding was a natural outcome attributed to having a normal female body. Participants identified their bodies as non-conforming to this normative, female ideal through a variety of ways, including breast or nipple structure (Lynn, Alice, Tracy, Michelle, Dawn) and body weight (all) and described how this might affect breastfeeding practice. In addition, several participants linked the quality of their breastmilk with breastfeeding success; others noted their excess body weight, the types or quality of food available to them (within the context of living with food insecurity), and also their use of particular

medications as having an impact on breastfeeding outcomes, suggesting that health was an important consideration in constituting both the normative maternal body and normative acts related to the maternal self. Some participants not only expressed surprise when challenges to breastfeeding arose (Chapter 6), but they also blamed themselves, conceptualizing their challenges through their pre-existing discursive constructions of an ideal maternal body that can naturally breastfeed. I suggest that this is a finding that merits further exploration for its implications for supporting breastfeeding mothers. While scholars have recently documented the physical breastfeeding challenges experienced among women with excess body weight, there is also evidence to suggest these challenges are not widely understood or integrated within public health practice (Garner et al., 2014; Garner et al., 2016).

I also interpreted that health care providers were implicated in the reification of an ideal, physical maternal body. This observation was supported through the literature review (Chapter 2), which included analysis of Nova Scotia's public health documents pertaining to postpartum care. These documents provide both visual depictions and written statements that, collectively, construct an ideal maternal body and essentialist perspective of mothering. The deployment of medical technologies as a means of *correcting* non-conforming, taken-for-granted maternal practices (e.g., domperidone to augment breastfeeding success or use of psychiatric medications to support better maternal emotional health) or as a means of surveillance in relation to a recognized normative standard (e.g., weight checks for baby and monitoring maternal body weight) are a few examples by which health (as an institution) reified this discourse through the participants in this study. The tension that emerged between breastfeeding as natural but

also requiring surveillance within this study suggests that the tendency within institutions to discipline infant feeding practices by way of pharmaceutical or other interventions casts doubt on the dominant discourse suggesting that female bodies naturally breastfeed.

Scholars have previously noted the critical role that biomedical discourse plays in shaping both social practices, but also the institutional practices in which perinatal care occurs. Because all of the participants gave birth in the hospital environment, they were under the care of medical, nursing and allied health personnel throughout the data collection period. By extension, all of the participants (and their care providers) were exposed to, and situated within, the dominant biomedical discourse that permeates and governs the practices and functions of health, social and related institutions. While the participants all experienced varying degrees of institutional encounters prior to the birth of their babies, in the majority of instances, the hospital was the most intensive, repeated exposure to biomedical discourse and its related practices.

Biomedical discourse played a prominent role in this inquiry to signify the experience of breastfeeding, excess maternal weight and income-related food insecurity. Foucault's *Birth of the Clinic* focuses exclusively on this discourse, describing how it produces and reifies discursive institutional practices such as monitoring and surveillance and produces the subject positions of (medical) expert and patient (Foucault, 1973). Participants spoke about the habitual monitoring and surveillance that occurred throughout their pregnancy and into the postpartum period; activities that Foucault would term the prenatal and postpartum *gaze*. I interpreted that this institutional gaze extended to a form of biopolitics (governmentality), specifically practices and surveillance of the self (Foucault, 1986). This was particularly evident as participants shared their

experiences of living with excess body weight and income-related food insecurity – monitoring and watching their weight and their food practices under material constraint. Their practices of the self signified either good or other health-related practices and were directly related to their maternal subjectivity.

While the perinatal clinic was participants’ most consistent, intensive and repeated exposure to biomedical discourse and its related practices during this study, the deployment of this discourse and its effects were not limited to healthcare. It also infiltrated other social welfare institutions with which participants’ interacted. Notably, Lynn’s story pointed to how this discourse informed her relationship with social and community services and how biomedical discourse was used to invalidate her capabilities of parenting. Lee’s story also demonstrated how biomedical discourse was implicated in her experience as a person living in poverty, her constitution as a “welfare queen” (see Chapter 2) and unfit for parenting by those working in mental health services.

Collectively, their stories form an exemplar case for how biopolitics are deployed and are implicated in institutional force as an apparatus of power (Foucault, 1977). There was evidence that the surveillance of both Lee and Lynn, primarily through their babies not meeting weight-gain standards, led to absolute or threatened involvement to remove their child from their custody.

Culturally, there is great emphasis placed on mothering and its relevance to our society. Perspectives of mothering are not only ubiquitous and historically shaped, but they permeate throughout social life and institutional ideology. The observation that maternal subjectivity played a significant role in the experiences of the study participants was neither a unique nor unsurprising finding; the importance of maternal subjectivity on

health-related practices was presented in Chapter 3 where I argued that circulating discourses of mothering create identities of good and proper mothering and certain parenting practices signify the type of mother you are. Moreover, I also described how institutions shape mothering identities through the manner in which they reinforce understandings of what mothering is about (Chapter 2).

While this finding is *consistent* with my earlier arguments, its existence does not reduce its value or significance to this research study; rather the findings from this study highlight that the discourses of motherhood and good mother(ing) through food provisioning are formulating subject positions and influencing subjectivities even prior to giving birth. It is suggestive of a more thoughtful and deliberate approach to health-related strategies such that a focus on breastfeeding, income-related food insecurity, and excess maternal body weight involves an attendance to the good mother discourse and its implications for maternal experience. The positivist perspectives on health that have traditionally dominated health-related strategies, do little to circumvent the complexities faced when those who identify as mothers cannot adhere to the expectations represented in these strategies.

7.1.1 The experience of breastfeeding within the context of excess maternal body weight and income-related food insecurity

Throughout this study, the participants identified that breastfeeding was their preferred or ideal form of infant feeding, aligning their beliefs with dominant views also held within the public health and medical establishment. Moreover, they associated breastfeed with good mothering practice and I interpreted that, by articulating their desire to breastfeed during the prenatal period, they constituted themselves as good mothers-to-

be. This finding is consistent with previous studies that have explored the concept of breastfeeding and its relationship with good maternal performance (Marshall, Godfrey, & Renfrew, 2007; Schmied & Lupton, 2001; Wall, 2001).

While it was unsurprising that breastfeeding was their preferred form of infant feeding (since all of the participants disclosed intention to breastfeed as a means of study inclusion), what emerged was that this concept of breast is best remained even after participants delivered their babies and experienced breastfeeding challenges and continued to play an ongoing role toward informing their evolving maternal subjectivity. Dominant biomedical discourses coupled with a discourse of autonomy were also present in how they constructed excess maternal body weight and income-related food insecurity, focusing on individualistic approaches to the management of their weight, and continued self-blame for their personal financial situations.

Participants also constructed various health and parental practices as unknown, which extended to breastfeeding practice. This resulted in two things: 1) a reliance on health professional expertise as a means of understanding breastfeeding; and 2) an ongoing questioning of breastmilk itself. A notable finding from this study, which has not been previously documented in the literature, was how the construction of breastfeeding coupled with the invisible composition of breastmilk as was an important defining point for the experience of infant feeding among the participants. When breastfeeding challenges arose, several participants focused on the types and quality of foods available to them (as food insecure women) as a means of justifying the infant feeding challenges that they encountered. Participants suggested that foods of minimal nutritional quality – directly related to their situation of food insecurity – were implicated

in reduced breastmilk quality and quantity; similarly, some participants perceived that their excess body weight (as a visible marker of their physical health), was negatively impacting their breastmilk. Collectively, these concerns were anticipated to result in reduced breastmilk quality and less success with breastfeeding outcomes. For some, this influenced their decision to discontinue breastfeeding (or switch to partial rather than full breastfeeding), acknowledging that the visibility of formula and “knowing” the composition of the food that their children were consuming validated their decision and made the use of formula more attractive for them.

This concept of “inadequacy” has been previously described by Chin and Solomonik (2009) whereby women living in low-income or impoverished circumstances, despite recognizing the importance of breastfeeding, are faced with challenging social circumstances that may factor into physiological mechanisms that may negatively impact breastfeeding practices (Chin & Solomonik, 2009). While the participants from this study continuously labeled themselves, breastmilk or their bodies as inadequate, it was their social conditions or contexts, which ultimately were inadequate and logically impacted on their infant feeding decisions and outcomes.

It is also well documented that insufficient breastmilk supply is a means by which mothers rationalize their transition from full to partial breastfeeding or even discontinue breastfeeding; however, this concept is represented within the medical and public health establishment as a perception rather than a reality (Meedya, Fahy, & Kable, 2010) which has the potential to trivialize the experiences of women who report its existence. Insufficient breastmilk supply as a rationale for discontinuing breastfeeding is reported among women classified as overweight and obese (Kair & Colaizy, 2016; O'Sullivan,

Perrine, & Rasmussen, 2015) and also among those mothers identifying as low-income (Rozga, Kerver, & Olson, 2015). Insufficient breastmilk implies that the *quantity* of breastmilk is unsatisfactory to meet the needs of the nursed baby. The findings from this study suggests that the concept of insufficiency be extended to consider a dimension of breastmilk *quality*, which for some participants in this study, related to their sense of personal health and well-being. Again, this concept of breastmilk quality influencing participants' breastmilk supply was linked with their experience of food insecurity and excess body weight.

Participants acknowledged the day-to-day challenges in parenting (Chapter 6), but they also described seeking ways to learn about parenting and to aim for knowledge about best parenting, drawing on both personal and professional relationships to achieve this. As they shared their stories, the participants' narratives revealed how relations of power shaped their social interactions and relationships with care providers and others within their social network – and how these actors also reinforced and provided a framework for their identities as new mothers.

In this study, I found that participants simultaneously constituted themselves as unknowing, but also constituted health professionals as gatekeepers (experts) in prenatal, perinatal and early postpartum knowledge and care, valuing them for their expertise and perspective. I found it particularly compelling how the participants used clinical or medicalized language (despite not being health professionals themselves) and described related technological practices (self- and other-surveillance, monitoring, scientific benchmarks for baby's weight gain, etc). This suggested the impact that short-term exposures to institutional environments throughout pregnancy and into the postpartum

period had on their subjectivity and early parenting experience. I also interpreted their use of medical technology as signifying a means of legitimizing their respect for health-related guidance, but also a means by which they were adopting and justifying their parenting practices through acknowledging common health related indicators.

It was unsurprising that health care providers were positioned as experts by the participants within this study as scholars have suggested that contemporary Western society health providers have been historically, institutionally and socially constructed as such. Contemporary Western societies, operating within ideologies that include neo-liberalism, are concerned with free-market approaches to the growth and dissemination of wealth and the minimization of the welfare state to support citizens; neo-liberalist ideology emphasizes the rationality and autonomy of individuals, emphasizes keeping well and healthy as important for self, family and the state, and de-emphasizes issues of social justice (Brezis & Wiist, 2011; Navarro, 2009; Nettleton, 1996). The state of knowledge concerning health and wellness that emerged within modern, neo-liberal society resulted in medical, scientific and technological establishments playing an important role in how individuals come to identify and understand themselves and their experiences with others within their social networks (Foucault, 1973). As suggested by Lupton (1997): “individuals lives are profoundly experienced and understood through the discourses and practices of medicine and its allied health professions” (Lupton, 1997, p. 94).

Other studies have suggested the importance of family and friends (Aston, 2002) and the turn to virtual social networks (O'Connor & Madge, 2004) as a means of legitimizing parenting experiences. The impact of informal social support on infant

feeding practices is also well established whereby these networks can influence both intention to breastfeed as well as duration of breastfeeding. In their investigation of factors influencing breastfeeding for women experiencing low-income Humphreys and colleagues (1998) found that health professionals had less influence on infant feeding decisions compared with members of the mothers' immediate social network, with the exception being lactation consultants (Humphreys, Thompson, & Miner, 1998).

While the participants within this study did speak about the experiences of those within their social networks (both face-to-face and virtual) as influencers over their perceptions about infant feeding and parenting, they deferred mostly to the guidance of care providers (physicians, nurses, doulas) and thus demonstrated the importance of medical and public health institutions (and their discursive practices) to their everyday lives, which appears at odds with previous research. While there may be limited pressure to parent in a particular way among informal social networks, it is the institutional involvement which was the fulcrum by which participants made their decisions regarding parenting, by attempting to self-regulate and abide by normative health-related practices, particularly when believed to be under surveillance by these institutions.

The augmentation in discourse related to risk in pregnancy described by Lupton (2012) may provide some explanation for the importance of public health institutions to the health-related decisions and practices among the participants in this study (Lupton, 2012b), describing that the discourses that focus on achieving fetal health through good, maternal responsibility circulate within public health and medical institutions and are also reproduced in broader cultural (lay) milieu. Moreover, the visibility of the pregnant body

creates additional potential for maternal self-surveillance (Lupton, 2012b). One might conclude that because the participants from this study experienced added vulnerabilities of food insecurity and excess maternal body weight (challenges that were identified and discussed with their health providers), this resulted in a heightened awareness among the participants about practices of the self in relation to current health discourse.

7.1.2 Resisting dominant discourses of breastfeeding, excess body weight and income-related food insecurity

A critique of the traditional biomedical discourse pertaining to health is that it diminishes the social contexts and perspectives in which health is practiced. While there was limited evidence regarding resistance to dominant discourses within this study, one of the more notable examples from the participants' experiences pertained to how they reframed and reprioritized health-related practices within their own context after their babies were born. This created particular opportunities for tension when participants were bridging multiple subjectivities – such as patient (self-care) or mother (care for others). In essence, they became their own advocates and focused their practices related to what was useful and possible for them during that particular period of time.

Also, participants demonstrated their agency by aligning their practices in the manner they felt was required to mother in an ideal fashion. For example, when Dawn's experience with domperidone didn't align with her experience of breastfeeding, she exercised her agency and discontinued its use, adopting the position that breastfeeding is not always the best solution.

Lee, Lynn and Tracy were all targeted by health and social institutions based upon occupancy of other subjectivities (i.e., recovering drug addict, foster child, welfare mom)

that, within existing social and historical stereotypes, are understood as incompatible with good mother. As such, they resisted the care of providers to whom they had previously entrusted care. This finding is consistent with previous research describing the normalized surveillance of individuals classified as poor (Maréchal, 2015). The words of Wendy Bach (2014) in her paper on the surveillance of women identifying as poor and African-American also have relevance for the interpretation of the experiences of Lee, Lynn and Tracy from this study; she stated:

... [in] seeking support, [those under surveillance] risk elevate their risk of exposure to more punitive consequences ... the state [whom those under surveillance] encounter not only fails to respond to [individual] needs in any meaningful way, but is instead hyperregulatory, meaning here that its mechanisms are targeted by race, class, gender, and place to exert punitive social control over poor, [African-American] women, their families, and their communities (Bach, 2014, p. 318-319).

In theory, improved perinatal care and support for women living at the intersection of poverty, food insecurity and excess body weight would consider the challenges and complexity of health-related decisions that are made within these contexts and ensure that the needs of families can be met without further punitive consequences for their health-related practices.

7.2 Limitations of the inquiry

The limitations of this inquiry must be considered for their implications in the transferability of findings. First, the group of participants who were recruited for this

inquiry were all from the Halifax Regional Municipality and had access to perinatal services provided by a tertiary care facility and the largest birthing centre in Nova Scotia. This suggests that their types of exposures to the health system and other institutional supports (e.g., charitable food programs) were not only homogenous, but also potentially reflect exposure to services and supports that are absent or limited for pregnant and postpartum women in other (e.g., rural or remote) geographies of Nova Scotia.

Secondly, the demographic characteristics of the study participants may also have factored into the findings of this study. While the recruitment strategy was executed in such a way as to maximize the potential for participant diversity within the study, it remained that the majority of participants identified as Caucasian (6 of 8 participants who began this study); two participants identified as Black Nova Scotian and First Nations, respectively. The cultural homogeneity may have been reflective of the general demographic characteristics of Halifax but nonetheless provide a particular cultural lens through which participants' interpreted their experience and beliefs regarding these health topics. This relative cultural homogeneity fails to account for the experiences and perspectives from other social and cultural groups. Also, half of the participants acknowledged paternal involvement and support, which I interpreted as having impacted on their experience. Despite all the participants identifying as low income, food insecure and struggling with excess body weight, I suggest that being single (Lee, Lynn, Tracy) versus partnered (Alice, Dawn, Jennifer) may have been a stronger influence of those participants' post-partum surveillance as mothers. The red flags surrounding single mothers living in poverty may have placed them under particular lens that is scrutinized by health and social welfare institutions.

Collectively, the geographical and demographic characteristics of the participants formed a particular context through which participants constructed discourses pertaining to breastfeeding, income-related food insecurity, and excess maternal body weight. In addition, the relations that existed between myself, as researcher – constituted as expert and the participants, may also have impacted on what participants' were willing to disclose to me during our interviews. I more strongly identified with their experience as pregnant and new mothers, as opposed to experiencing income-related food insecurity and excess body weight. The topic of body weight was a particularly sensitive topic for all. It was unclear what precluded the sensitivity to this topic; however, I suggest that the dominant discourses pertaining to body weight were central to this sensitivity (see Chapter 6).

The impact of the social, cultural and geographical differences cannot be ascertained for this study. However, the common thread was that of the performance of maternal subjectivity, and in this regard, the findings from this study have the potential to highlight the important role that cultural and social norms play in the daily health-related practices of new mothers.

7.3 Relevance and contributions to practice

Breastfeeding is a relational activity that occurs between mother and child, enacted within prevailing social and cultural discourses. The findings from this inquiry suggest that biomedical discourse plays a dominant role in normative understandings of breastfeeding within the added experiences of excess body weight and income-related food insecurity. One of the most critical questions facing health stakeholders is how best

to address the multiple contextual realities of infant feeding (plus other health-related practices) during the perinatal period to ensure inclusiveness and valuing of the diverse experiences that face women and their families. Taylor and Wallace (2012) suggest that a feminist orientation to the issue of breastfeeding will enable stakeholders to directly confront tensions created through normative and dominant positions, by revealing how breastfeeding practice is constrained through structural inequities and ideological discourses (Taylor & Wallace, 2012).

An improvement over current public health and medical discourse and its practices would be for health professionals and stakeholders working with all pregnant and lactating women to consider the social construction of breastfeeding and understand that breastfeeding practice is not only implicated in nutritional and other health benefits, but also a woman's evolving maternal identity. The first step in this process might be to publically name (rather than marginalize through silence) the diverse challenges experienced by breastfeeding women within pregnancy and lactation public health resources and programs, without the suggestion that these experiences are false, minimally experienced, abnormal or other. The discursive positioning of breastfeeding as both natural and normal throughout medical and public health discourse, is problematic insofar as the potential for a lactating woman to experience, as stated by Lee, "surprise and shock" about issues that arise and feel ill equipped to handle these challenges. Pregnant women, new mothers and their families and support networks should have access to practical infant feeding information in which an array of challenges related to breastfeeding are disclosed and described, with strategies to address these challenges – provided by both other mothers, but also by health professionals. For

example, women should be made aware that human milk production could be negatively impacted by physiological responses to birth and birth-related interventions, body weight, or other postpartum stresses that affect the health and wellbeing of the mother and her baby.

While some experiences may be more commonly shared, for those breastfeeding women who are also experiencing financial and food security challenges, as well as excess body weight, additional, supportive practices and strategies might be necessary. Detailing breastfeeding position options for an array of breast and body sizes would be an important step to ensure that breastfeeding practice can be optimized for women of all body shapes. Another suggestion would be for health professionals to be mindful of the perceived link between a woman's nutritional health and the quality of her breastmilk. Within a dominant discourse that constructs eating well as having a positive effect on the health of the body ('you are what you eat'), it is unsurprising that some participants from this study openly questioned the quality and nutritional value of their breastmilk for their child's wellbeing within the context of them personally experiencing food insecurity and excess body weight. The choice to breastfeed or provide a 'known' nutritional alternative (infant formula) was rationalized through their perception of this association.

Stakeholders who work with this population should attend to the social construction of breastfeeding and understand that this practice impacts not only the nutritional and other health-related 'benefits' of breastfeeding, but also women's evolving maternal identity. Women can engage in multiple ways of being good mothers and this should not hinge solely on their ability to breastfeed their child. This is a particularly important consideration among women who are under consistent

institutional surveillance because of their classification of persons at risk due to resource (income) constraint. Only when these aspects of breastfeeding is more strongly considered can we state that women of all sociocultural backgrounds may have the potential for favourable experiences within the health care system.

The question remains as to whether North American health care systems can espouse a model of person-centred care if women continue to feel the burden to breastfeed at all costs? There is evidence that momentum is shifting towards greater attendance to this consideration. The recently released guidelines from the American College of Obstetricians and Gynecologists (ACOG) imply that the traditional rhetoric surrounding breastfeeding should be modified, suggesting that a patient-centred model of care requires attending to the patient as the central figure in infant-feeding decisions (Committee on Obstetric Practice, American College of Obstetricians and Gynecologists, 2016). Their statement in part reads:

Obstetrician–gynecologists and other obstetric care providers should support each woman’s informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant ... even with comprehensive support, some mother–infant dyads are unable to establish sustained, exclusive breastfeeding. Women who are not able to achieve their breastfeeding intentions report considerable distress, and obstetrician–gynecologists and other health care providers should validate each woman’s efforts and experience (Committee on Obstetric Practice, American College of Obstetricians and Gynecologists, 2016).

Participants within this study provided evidence that they experienced anxiety to breastfeed, using language such as “stress”, “pressure” and expressing feelings of guilt, defeat, “not doing enough” and guilt for the weight and nutrition-related outcomes of their children. A comparable position statement from Health Canada does not explicitly address the *breast as best* position but does acknowledge some mothers may choose not to exclusively breastfeed for a variety of “personal, medical or social reasons” and that all mothers should be well supported by health professionals and related stakeholders in their infant feeding decisions (Critch & Canadian Paediatric Society, Nutrition and Gastroenterology Committee, 2016).

The approach that was followed for this exploration allowed for a fulsome inquiry, allowing considerable depth with each participant over time, and thus, makes a necessary contribution to the field. In the literature, there have been few studies using a repeat, qualitative, in-depth interview structure to explore breastfeeding, to say nothing of breastfeeding within the context of early parenting, mothering, excess maternal body weight, and income-related food insecurity. I observed that the most critical difference between the initial, prenatal interviews and the postpartum interviews was the transition from a pregnant to a mother identity. This shift in subject position was an important component to the interpretation of the participant narratives. I observed that the discourses shaping participants’ understandings of breastfeeding, food insecurity and excess body weight articulated within the prenatal interviews were largely maintained throughout the postpartum period. However, I also observed how these discourses were used in relation to participants’ subject positioning as good mothers and how, in the postpartum period, the good mother position evolved to include other contexts after birth

that were not considered by the participants when they were pregnant. These contexts included their own personal health challenges impacting on breastfeeding and other parenting practices, the health of their infants, and negotiating breastfeeding practice into their daily lives. Some mothers found ways to cope with and justify their inability to do breast is best in the suggested manner, and instead identified with other subject positions as mothers, resulting in a more fluid image of good mother.

As part of my literature review (Chapter 2), I was able to use public health resources currently available within the Nova Scotia public health system as a means of exploring how the prevalent discourses of breastfeeding, new parenthood, body weight and food insecurity position these issues. This exploration proved to be a very useful exercise not because the study participants had described that they relied on these resources tremendously, but because the exploration of these resources revealed some important considerations of how these issues are positioned within the health field, and more notably, what dominant perspectives were present within the institutions in which the participants were negotiating. Both what was present, and what was absent within these documents became an important component of this exploration and adds tangible examples of how discourse is deployed within current healthcare policies.

I intend to disseminate the research approach and findings for this inquiry through traditional academic channels (e.g., peer-reviewed publications, peer-reviewed and health stakeholder conference presentations, etc) in fields such as medicine, nursing, dietetics, midwifery, medical sociology, and qualitative research methods. Dissemination activity is currently underway with a recent book chapter publication (May 2016) based on the preliminary findings of this study and a brief literature review.

Several findings from this study have the potential for further exploration that will fill important gaps in current knowledge. Specifically, the tension experienced between differing subjectivities – maternal or otherwise (patient, employee, etc) within the context of infant feeding would provide some important insight into understanding how infant feeding practices might be affected by the intersection of these multiple, sometimes conflicting, subjectivities. Secondly, I hope to further exploration related to constructions of an ideal maternal body and how this is related to perceived breastmilk adequacy (both quality and quantity). Thirdly is to more closely examine the implications of punitive surveillance on the breastfeeding practices of low-income mothers. Lastly, the findings of this study will also be considered and integrated with findings from a separate, funded research project which explored the experiences of perinatal, family/newborn and public health service areas providing breastfeeding support to women experiencing excess body weight and food insecurity. Collectively, both perspectives will provide more nuanced understanding on how best to provide breastfeeding support within current models of health care practice.

7.4 Personal reflection

Throughout this inquiry, I have explored discourses that frame the health topics of breastfeeding, excess maternal body weight, and income-related food insecurity through the detailed experiences of a sample of participants who identified with these topics under consideration. This inquiry was a means of questioning normative assumptions about these issues, and what is traditionally considered legitimate or truthful about these positions or concepts. These discourses have been illuminated through public health or

medical discourses; the very same exposures have predominantly shaped my knowledge in these areas and what feeds into my position as a dietitian and as a researcher-in-training, and the actions that I undertake within each of these subject positions. The outcome of this exercise is that I have come to realize the complexity of being positioned as a scholar in the health (and now sociological) sciences and a member of a body of experts broadly interested in understanding and improving the nutritional health of the population. This complexity is related to challenging how certain perceptions come to count as valid knowledge in my field, and how this knowledge informs my understanding of health and the understanding of health circulated throughout our discipline. Moreover, it influences the ways in which I attend to research processes.

My intention of entering doctoral studies was to learn and contribute to the advancement of knowledge within my profession. What I have learned through this experience is to interrogate knowledge not just from its taken-for-granted existence, but as something that has been shaped through dominant discourses within my profession and the academy to which I belong. I have now come to realize that our profession, and the health sciences, is dominated by biomedical discourse and this shapes how we come into being as dietitians. States Gingras (2010): “During undergraduate education, dietetic students come to internalize new value systems, philosophies, epistemologies and discourses in becoming recognized as dietitian professionals” (Gingras, 2010, p. 438). The positivist paradigm and empiricist methods of research that use techniques of observation, surveillance, and monitoring are valued. It is these discursive techniques that work to quantify individuals, categorize them, compare them, and create realities and

truths about them that shape subjectivity but also act in a form of governing that defines the boundaries of normal and rational health-related practices.

Poststructural and feminist theory can be used to challenge the universal truths that shape our reality, our knowledge about ourselves and our understanding about the social world. I am struck by how much my training – both as a dietitian and researcher – has, up until my PhD studies, been largely absent of objecting to these universal truths, even while we are challenged to be critical thinkers during our training. What I now see is that the prevailing discourses within the boundaries of what it means to be a dietitian and academic in the health sciences has silenced alternative ways of thinking, pushing them to the margins.

Prior to PhD studies, I understood my professional practice in a different way. I was able to write or conduct presentations about health-related topics. I participated in maintaining the *status quo*, which includes legitimizing knowledge and understandings about these topics. I have perpetuated the dominant discourses that shape mothering, breastfeeding, obesity and food insecurity through my own, uncritical actions, indicating without hesitation that obesity, food insecurity and *not* breastfeeding *will* affect health outcomes, and that mothers are the important vehicles by which we can enable health improvements in families and in the population at large. As summarized by Gard and Wright (2005):

By using terms uncritically, certain truths and stereotypes are established about particular groups of people in that social category as though it is their membership of the category itself that puts them at ‘risk’ of the disease (Gard & Wright, 2005, p. 172).

This inquiry has caused a significant disruption in my knowledge and understanding. Where I once believed I knew truths about breastfeeding and bodies, people experiencing income-related food insecurity or mothers, I now see these positions and concepts in alternative ways. There is a tension when I write or reflect – the words that I previously have taken-for-granted flow with less ease. Where I once read a journal article or other academic publications to validate and legitimize how breastfeeding is linked with good health, I now find myself questioning how the research and the findings are working in a discursive manner to normalize health practices and govern conduct and how these discourses constitute very particular subject positions that are more readily available to some than to others. Further, I can no longer presuppose that the experience of being constituted as obese, food insecure or a breastfeeding mother are universally-shared, or independent of the discourses to which we are exposed. When we operate without critical reflection or a reflexive practice, we continue to fix these realities as fact.

Deconstructing discourses may not provide immediate answers in a traditional scientific manner, but may support a process of social transformation, or create spaces for possible action and change at the societal level. We have the ability to transform social realities, our assumptions about subject positions, and the ways knowledge, authority and expertise are used to discipline and govern within our profession and beyond. Power creates effects, including opportunities for resistance and to challenge the discourses that have shaped not only myself, but others in our social world. Going forward, I will continue to critique and challenge the dominant discourses to which we are exposed, that these are the only truths available to us. I will also focus on how we have come to understand breastfeeding, excess maternal body weight, food insecurity and motherhood

and what those understandings might mean for women actually living in the intersections of those discourses. Rather than silence others, silence alternatives, and push competing discourses and subjectivities to the margins, we need to recognize how discourses shape all of our identities potentially building on and reinforcing existing social inequities.

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APPENDIX A – RECRUITMENT POSTER

We are seeking to interview expectant mothers

Are you?

- Pregnant with your first baby?
- Intending to breastfeed your baby?
- Considered “overweight”?



And:

- Does being short of money keep you from eating the way you want or need to?



We want to talk with women from Nova Scotia about their experiences with breastfeeding, being “overweight”, and struggling to buy enough food or the food they want and/or need.

Please contact 494-8809 or meaghan.sim@dal.ca to learn more.

You will receive \$25 for each interview.

APPENDIX B – PRESCREEN QUESTIONNAIRE

Participant code: _____

Thank you for your interest in participating in this study. We are conducting a study with women in Nova Scotia about their experiences with breastfeeding, being “overweight”, and struggling to buy enough food or the food they want and/or need. Learning about the experiences of breastfeeding from this point of view will help the healthcare system better support mothers in similar situations to breastfeed. Now that you have some more information, are you still interested in participating? (*yes – proceed to next section; no – thank them for their time and interest*)

Before you are able to be in this study, you will have to answer some questions to see if you can take part. This is called pre-screening. This is an important step in the study so that we know we are including women who can speak about the issues that we are exploring. The pre-screen will take just a few minutes of your time.

You may find some of the questions deal with sensitive topics. It is possible that the questions will show that you can't be in the study. Your responses to the questions will be kept private. Your responses to these questions will not impact the standard, usual care you will receive during your pregnancy, birth and after you have your baby and will not be known to anyone other than myself.

At this point, do you have any questions? (*answer any questions*)

Would you like to continue with the pre-screen? (*yes – proceed to pre-screen questions; no – thank them for their time and for their interest*)

1. Are you a resident of Nova Scotia? _____ (*yes, inclusion*)
2. Are you 18 years of age or older? _____ (*yes, inclusion*)
3. Are you expecting your first baby? _____ (*yes, inclusion*)
4. Will you be having your baby at the IWK? _____ (*yes, inclusion*)
5. How many weeks pregnant are you? _____ (*>28 weeks, inclusion, if not, proceed to complete pre-screen to determine inclusion, and schedule consent/first interview when mother is more than 28 weeks*)
6. Do you intend to breastfeed your child? _____ (*yes, inclusion*)
7. When you found out you were pregnant, how much did you weigh? _____

(example: 63.6kg, 140 lbs)

8. How tall are you? _____ (example: 1.6 m; 5 feet, 3 inches)

- BMI: _____ (inclusion based on researcher calculating as overweight or obese, BMI \geq 27, weight (kg)/height (m²))

9. How many people live in your house (total)?

- 1 (self)
- 2
- Over 2 (includes step-children or other family members) _____

What are the first three digits of your postal code? _____ (use with chart below and on the proceeding page to link with low-income cut off per community size)

| | Rural* | CA: < 30,000 pop. | CA: 30,000 - 99,999 pop | CMA: 100,000 - 499,999 pop** | CMA: 500,000+ pop |
|---|---------------|-------------------------|----------------------------------|---|-------------------------|
| After tax LICO per community size | | | | | |
| 2011 | | | | | |
| 1 person | 12,629 | 14,454 | 16,124 | 16,328 | 19,307 |
| 2 persons | 15,371 | 17,592 | 19,625 | 19,872 | 23,498 |
| 3 persons | 19,141 | 21,905 | 24,437 | 24,745 | 29,260 |
| 4 persons | 23,879 | 27,329 | 30,487 | 30,871 | 36,504 |
| 5 persons | 27,192 | 31,120 | 34,717 | 35,154 | 41,567 |
| 6 persons | 30,156 | 34,513 | 38,502 | 38,986 | 46,099 |
| 7 or more persons | 33,121 | 37,906 | 42,286 | 42,819 | 50,631 |

Source: Statistics Canada, LICO 2010/11 Series, June 2012

*choose this column for postal codes starting with B0N (West Hants; outside CMA)

**choose this column for any of the following postal codes starting with: BOJ, B2V, B2W, B2X, B2Y, B2Z, B3A, B3B, B3G, B3H, B3J, B3K, B3L, B3M, B3N, B3P, B3R, B3S, B3T, B4A, B4B, B4C, B4E, B4G, B2T, B3E, B3V, B3Z (within CMA: Halifax)

Source: Canada Post, 2012

Based on this information, I'm now going to ask you about your current household income. Is your after-tax household income (the total amount of income you have per year, after taxes) above or below the following: (use chart to determine cut-off above/below, rounded numbers also given for ease of answering question, research coordinator to record the box used and whether at or below – *at or below cut-off* –

inclusion)

if unable to respond based on year, the calculation of per month is also provided: is the total amount of income you have per month, after taxes above or below the following:

| Community size (as per Census) | 1 person dwelling: after-tax LICO (\$/year) | 2 person dwelling: after-tax LICO (\$/year) | 3 person dwelling: after-tax LICO (\$/year) | 4 person dwelling: after-tax LICO (\$/year) | 5 person dwelling: after-tax LICO (\$/year) | 6 person dwelling: after-tax LICO (\$/year) | 7 person dwelling: after-tax LICO (\$/year) |
|---|---|---|---|---|---|---|---|
| Halifax (CMA); postal code begins with: BOJ, B2V, B2W, B2X, B2Y, B2Z, B3A, B3B, B3G, B3H, B3J, B3K, B3L, B3M, B3N, B3P, B3R, B3S, B3T, B4A, B4B, B4C, B4E, B4G, B2T, B3E, B3V, B3Z | 16,328 | 19,872 | 24,745 | 30,871 | 35,154 | 38,986 | 42,819 |
| | 16,300 rounded | 19,900 rounded | 24,700 rounded | 30,900 rounded | 35,200 rounded | 39,000 rounded | 42,800 rounded |
| | 1 person dwelling: after-tax LICO (\$/mth) | 2 person dwelling: after-tax LICO (\$/mth) | 3 person dwelling: after-tax LICO (\$/mth) | 4 person dwelling: after-tax LICO (\$/mth) | 5 person dwelling: after-tax LICO (\$/mth) | 6 person dwelling: after-tax LICO (\$/mth) | 7 person dwelling: after-tax LICO (\$/mth) |
| | 1361 | 1656 | 2062 | 2573 | 2930 | 3249 | 3568 |
| | 1360 rounded | 1660 rounded | 2060 rounded | 2570 rounded | 2930 rounded | 3250 rounded | 3570 rounded |
| Rural; postal code begins with B0N | 1 person dwelling: after-tax LICO (\$/year) | 2 person dwelling: after-tax LICO (\$/year) | 3 person dwelling: after-tax LICO (\$/year) | 4 person dwelling: after-tax LICO (\$/year) | 5 person dwelling: after-tax LICO (\$/year) | 6 person dwelling: after-tax LICO (\$/year) | 7 person dwelling: after-tax LICO (\$/year) |
| | 12,629 | 15,371 | 19,141 | 23,879 | 27,192 | 30,156 | 33,121 |
| | 12,600 rounded | 15,400 rounded | 19,100 rounded | 23,900 rounded | 27,200 rounded | 30,200 rounded | 33,100 rounded |
| | 1 person dwelling: after-tax LICO (\$/mth) | 2 person dwelling: after-tax LICO (\$/mth) | 3 person dwelling: after-tax LICO (\$/mth) | 4 person dwelling: after-tax LICO (\$/mth) | 5 person dwelling: after-tax LICO (\$/mth) | 6 person dwelling: after-tax LICO (\$/mth) | 7 person dwelling: after-tax LICO (\$/mth) |
| | 1052 | 1281 | 1595 | 1990 | 2266 | 2513 | 2760 |
| 1050 rounded | 1280 rounded | 1600 rounded | 1990 rounded | 2270 rounded | 2510 rounded | 2760 rounded | |

10. Please answer the following questions:

a. Within the past 12 months we worried whether our food would run out before we got money to buy more:

Often True Sometimes true Never true

b. Within the past 12 months the food we bought just didn't last and we didn't have enough money to get more:

Often True Sometimes true Never true

(inclusion based on response of 'often true' or 'sometimes true' to both 10a & 10b)

11. Would you describe where you live as:

a. urban? (city)

b. rural? (country)

12. Are you:

Married Single Partnered relationship (not married)

Thank you for your time in answering these pre-screening questions. Based on your responses, you are (eligible to be enrolled in the study, not eligible to be enrolled in the study).

If eligible to be enrolled:

Are you still interested in participating in this study? (if yes, schedule a time for the review of informed consent and the interview)

If not eligible to be enrolled:

Thank you very much for your interest and time.

APPENDIX C – LETTER OF INFORMATION

Date

Dear XXX:

My name is Meaghan Sim and I am a graduate student at Dalhousie University. I am writing you to let you know about a research study exploring breastfeeding practices among women classified as obese and income-related food insecure, led by a research team from Dalhousie University and the IWK Health Centre. I am contacting you because you are providing care to pregnant women and their families who will have their baby at the IWK Health Centre. I am also asking for you to consider promoting this study in your practice.

This research is being done to learn more about how women experience breastfeeding within the context of excess weight, and socioeconomic challenges which impact on their ability to eat the way they wish or need to (food insecurity). It is part of a larger study that is examining how our health system provides breastfeeding care and support to low-income women with excess weight. Breastfeeding, obesity and food insecurity have been identified as public health priorities in Nova Scotia, due in part to our province having among the lowest rates of breastfeeding initiation and duration, highest rates of obesity and highest rates of income-related food insecurity relative to other areas of the country. As the first known study to examine all of these issues together, the findings have implications for how we can better understand these issues, and as a health community, how we better support mothers and their families in these circumstances.

I am seeking your help to promote this study among your patient population to aid in recruitment. Specifically, I am requesting that you consider placing the enclosed advertisements for this study in a location that is accessible to potential participants – perhaps a patient/family waiting area, washroom, or private assessment rooms.

The study has received ethical approval by the IWK Health Centre (REB protocol 04506). Financial support for this research has been provided by the Danone Institute of Canada, Canadian Institutes of Health Research (graduate scholarship), and the Nova Scotia Health Research Foundation (graduate scholarship). Please do not hesitate to contact me if you have any questions as you read over this material. I can be reached by phone: (902) 488.5409 or by email: Meaghan.sim@dal.ca. The principal investigator for this project is Dr. Sara Kirk and she can be reached at 902.494.8440 or by email: sara.kirk@dal.ca.

Thank you for your time and for your consideration of support.

Kind regards,

S. Meaghan Sim, MScAHN, PDt
PhD (candidate)
Dalhousie University, Faculty of Graduate Studies

APPENDIX D – CONSENT FORM



Information and Consent Form for Research Participants (Mothers)

Research Title: An exploration of breastfeeding practice in overweight, low-income, food insecure Nova Scotian mothers.

Investigators:

Sara FL Kirk PhD

Canada Research Chair in Health Services Research, School of Health and Human Performance
Dalhousie University
Adjunct Professor, IWK Health Centre
Principal Investigator

Sheri L Price, PhD, RN

Assistant Professor, School of Nursing
Dalhousie University
Co-investigator

Megan Aston, PhD, RN

Associate Professor, School of Nursing
Dalhousie University
Adjunct Professor, IWK Health Centre
Co-investigator

S Meaghan Sim, MSc, PDt

PhD candidate (Interdisciplinary)
Dalhousie University
Student working with Dr. Sara Kirk (principal investigator)

Funding Source

Danone Institute of Canada

Canadian Institutes of Health Research (doctoral research scholarship – S Meaghan Sim)

Nova Scotia Health Research Foundation (doctoral research scholarship – S Meaghan Sim)

Introduction and Purpose

You are being invited to take part in the research study named above. This form provides information about the study. Before you decide if you want to take part, it is important that you understand the purpose of the study, the risks and benefits and what you will be asked to do. You do not have to take part in this study. Taking part is entirely voluntary (your choice). Informed consent starts with the initial contact about the study and continues until the end of the study. A staff member of the research team will be available to answer any questions you have. You may decide not to take part or you may withdraw from the study at any time. This will not affect the care you or your family members will receive from the IWK Health Centre in any way.

Background

Breastfeeding is an important way to promote and protect the health of an infant and the mother (including obesity prevention) and is also an important part of food security. Food security is when people have access to and can afford sufficient safe and nutritious food for an active and healthy life.

Ironically, breastfeeding may be particularly difficult for those mothers who experience food insecurity and are overweight. This is for a variety of reasons. Currently women's experience of breastfeeding plays a less significant role than other evidence in informing how we support women to breastfeed.

While these topics may be sensitive to discuss, we need better information about the experience of breastfeeding from those women also experiencing income-related food insecurity and being overweight. This will help us understand ways in which we can better support mothers with excess weight and food insecurity to breastfeed their babies.

Why are the researchers doing the study?

We want to learn about women's experiences around breastfeeding, particularly women who have weight or food insecurity issues. In addition, we are interested in learning more about the experiences of nurses that provide breastfeeding support and counseling to these women. This may help educate the health professionals providing women with prenatal and postnatal care. The research may also help inform health policy directions.

It is hoped that this study will give researchers a clearer picture of the experiences of women who have excessive weight issues and food insecurity and who wish to breastfeed their baby. We want to know what you think and what your plans are for breastfeeding before you give birth. We also want to talk with you after your baby is born to learn about your thoughts and experiences around breastfeeding in the newborn months. Throughout these interviews, we also wish to explore your beliefs and experiences related to being overweight and food insecurity. We hope the information from this study will help us better educate and train health professionals to support all women to breastfeed.

We are also interested in the perspectives of nurses who provide breastfeeding support and counseling to women with excessive weight and food insecurity issues. We will also be conducting interviews with nurses who have experience working with these clients.

How will the researchers do the study?

For this study we hope to include pregnant women aged eighteen (18) years of age or older from Nova Scotia, who are also experiencing being overweight and food insecurity who have come into the IWK Health Centre to have their babies. There will be approximately eight to fifteen (8-15) participants selected for this research. Those women who are eligible to participate will be asked to take part in three (3) separate interviews as outlined below.

We will hope to also include between 10-12 nurses who have experience providing breastfeeding support and counseling to overweight women with socioeconomic challenges (a risk for food insecurity). We hope to include nurses who support women both before and after they give birth. Nurses who agree to participate in this study will take part in only one (1) interview.

What will I be asked to do?

You will be asked to participate in an interview with a researcher just before you have your baby and on two more occasions, shortly after giving birth (between 0-3 months) and when your baby is three to six (3-6) months old. Each interview will take about ninety (90) minutes and will involve asking you about your experiences and expectations about breastfeeding. The interview will take place in a location that you feel comfortable in, such as an office or boardroom, with just yourself and the researcher present. An example of the kind of question might be: “How did you come to the decision to breastfeed?” Questions such as this will tell us about your experience around breastfeeding. You do not have to answer any questions you do not wish to answer.

The interviews will be audio-taped. We will get your permission to audio-tape the interview.

Please see the below table that shows the interview schedule and other details.

| Interview | When interview will be held | Other details |
|------------------|---|---|
| 1 | During the third trimester of pregnancy, before your baby is born | A pre-stamped postcard will be provided to you at the first interview so you can mail this to the research team when your baby is born. This is so we know when to arrange the next two interviews. We will also contact you around the time that your baby is due as a reminder to send in the postcard, or to arrange the next two interviews (if your baby has already been born). |
| 2 | When your baby is a newborn. Within the first 3 months after your baby is born. | This interview will be held even if you stop breastfeeding or decided not to breastfeed after the first interview. |
| 3 | When your baby is between 3 and 6 months of age. | This interview will be held even if you stop breastfeeding. |

What alternatives to participation do I have?

You do not have to participate in this study. If you choose not to participate in the study, this decision will not affect the care that you or your family receives at the IWK Health Centre.

Potential Harms and Burdens

There are risks with this or any study. To give you the most complete information available, we have listed some *possible harms*. We do want to make sure that if you decide to participate in the study, you have had a chance to think about the risks carefully. You may find the interview upsetting or distressing. You may not like all of the questions that you will be asked. You do not have to answer those questions you find distressing. We will provide you with a list of counseling resources available to you in the province and your community. Taking part may be of no help to you personally. It is hoped what is learned will be of future benefit to others.

Can I withdraw from the research study?

You can withdraw from the study at any time. If you choose to withdraw from this study, your decision to do so will not impact your care at the IWK Health Centre in any way. If you choose to withdraw after you have been interviewed, we will not use the information we gathered from your interview in the study.

Costs and reimbursements

There will be no costs to you. You will be paid \$25.00 per interview to be in the study. This will be in the form of cash. This is in order to cover any expenses incurred to you such as transportation or travel, parking, or costs to arrange dependent care. You will receive the \$25.00 honoraria at the end of each interview and you will be asked to sign a form that indicates you have received payment.

How will my privacy be protected?

Any information that is learned about you will be kept private. What you discuss during the interviews will be kept anonymous and confidential. Your name and any other potential identifying information from the interviews will not be included in any way. Any list of names identified as participants will be coded and then confidentially destroyed. Any direct quotes used in any reports will be given a false name and you will be asked for your permission for quotes to be used.

The results taken from this study will be kept in a locked area and only be available to the principal investigator and research coordinator. All information from the study will be stored confidentially for five (5) years after publication in a locked filing cabinet in the office of the Principal Investigator, and then it will be confidentially destroyed. Any audio-recordings will be erased as soon as the study is completed. The results of the study may be used in publications, presentations or for teaching purposes: your anonymity will be also protected in these materials as detailed above.

Taking part in this research will not affect your care at the IWK Health Centre, nor will any health professionals you see at the IWK Health Centre be informed of your participation.

What if I have study questions or problems?

If you have any questions or concerns about the study, please contact: Dr. Sara Kirk at: (902) 494-8440 or email at: Sara.kirk@dal.ca. Dr. Sara Kirk is available during regular working hours.

What are my research rights?

By signing this form, you have agreed to take part in this research study. In no way does this waive your legal rights nor release the investigator(s), sponsors, or the IWK Health Centre from their legal and professional responsibilities. If you have any questions at any time during or after the study about research in general you may contact the Research Office at the IWK Health Centre at (902) 470-8520, Monday to Friday between 8:00 a.m. and 4:00 p.m.

Conflict of Interest Statement

This study is made possible through a partnership between IWK and Dalhousie University, with a grant provided by the Danone Institute of Canada, a non-profit foundation. One of the investigators (S Meaghan Sim) has received scholarships from the Canadian Institutes of Health Research and the Nova Scotia Health Research Foundation to support her training as a student. We do not know of any conflict or interest (ways in which this research is influenced by or benefits any person, researcher, group, company or institution in ways other than for the purposes stated in the background and purpose sections above).

How will I be informed of the study results?

The research findings will be available to you if you are interested in receiving them. Please check one of the boxes below:

- Yes, I would like to receive the results of this study.
- No thank-you, I do not wish to receive the results of this study.

If you checked “yes”, please provide your name and mailing address or email below. This will be stored separately from your consent form to maintain confidentiality. We will keep this on file and send you results once the study is complete. Thanks again.

Name: _____
Street: _____
City: _____
Postal Code: _____
Email: _____

Signature Page: Consent form

I _____ (please print your name) have read about this study and talked with the research coordinator about any questions or issues. I know that participation in this study is voluntary and I can withdraw from the interview at any time.

- Please check this box if you consent to having selected **anonymous** quotations used from information collected during our interview.
- Please check this box if you consent to being audio-taped for this interview.

Signature _____ Date _____

Researcher _____ Date _____

APPENDIX E – SUMMARY OF RESEARCH PARTICIPANTS

Alice indicated that she was in a partnered relationship with her baby's father although her pregnancy was unplanned. Alice's partner was not living locally, so Alice lived with her family. She described herself as unemployed and receiving income assistance. She identified as Black Nova Scotian. Alice disclosed she would be using the support of a birth doula; although at the time of our first interview, she had yet to meet her support person.

Beth identified as being in a partnered relationship with her baby's father and they lived together. Both Beth and her partner received income assistance. Only Beth was present at the time of our initial interview. When I contacted Beth to arrange for our second interview (0-3 months postpartum), she identified that her baby was born stillbirth and thus ceased participation in the study.

Dawn identified as being in a partnered relationship with her baby's father and they lived together. They both received income assistance and her partner was also working towards receiving disability for a past violent trauma impacting his ability to secure stable employment. Dawn supplemented her fixed income by working full-time providing care to young children. Dawn's partner was present during all the interviews.

Jennifer identified as being in a married relationship with the baby's father. They had full-time custody of his preteen and teenage children from a previous relationship and Jennifer's step-children lived with them during the week. She was employed full-time within the health system but her partner had been unemployed for almost a year and she disclosed that although employed, custodial arrangements had significantly impacted on housing costs, putting them into a position of 'working poor'.

Lee's pregnancy resulted from a brief relationship – "unplanned and short notice". She identified as un-partnered and was also working towards securing permanent shelter at the time of our initial interview. Lee was receiving income assistance and recalled a history of being between non-permanent (contract) jobs. Lee also described living with a rare congenital condition that her son ended up testing positively for after birth. Lee disclosed that she would be using the support of a birth doula.

Lynn described a history of living in Children's Aid and group homes. She was not in a partnered relationship and her pregnancy resulted from a brief relationship. Lynn was receiving income assistance and lived alone. Lynn disclosed that she would be using the support of a birth doula.

Michelle was in a martial partnership with her baby's father. They lived and worked primarily overseas; however, she disclosed that she had returned to her home province of Nova Scotia to have her baby and was still considered a Nova Scotia resident. Her rationale for this is that they couldn't afford to have the baby in a safe hospital environment where they lived full-time. At the time of the interview, Michelle lived with her family and was unemployed, but was ineligible for income assistance. She also

disclosed that she would be moving back overseas quickly after their baby was born.

Michelle only participated in the initial interview; I did receive contact with Michelle to arrange a time to re-interview but after attempting to reach her multiple times, I presumed that she had left the country again.

Tracy identified as being recently estranged from a long-term martial relationship. Her pregnancy resulted from a brief relationship with another man of which she was no longer involved. At the time of our first interview, she was employed full-time in the food services industry and was ineligible for income assistance. Tracy identified as First Nations.

APPENDIX F – INTERVIEW GUIDE

Interview/topic guide

Interview #1

- as per methods chapter, first interview guide to be used with participant between weeks 28-40 gestation; these participants have all identified as intending to breastfeed their babies)
- this guide is an example only and is open to change reflecting new lines of inquiry

Preamble: I am interested in hearing about your experiences around impending motherhood, including your intention to breastfeed. I am also interested in your experiences with the health care system and broader community in relation to your pregnancy, your weight and struggles with money which impact on your ability to eat the way you want or need to.

1. Tell me about yourself
2. Can you tell me what brought you here to participate in our study? (probes: motivation, interest in participating?)
3. Can you talk about your overall experience with your pregnancy? (probes: experience in access to/use of healthcare system; relations with other health professionals and support persons; types of healthcare system supports accessed; what have you accessed outside of the healthcare system; joys and concerns about your pregnancy; describe success in eating well during your pregnancy, given your disclosure as not having enough money to eat well)
4. Tell me about your decision to breastfeed? (probes: how did you come to this decision? How does it make you feel? How do you envision it will happen? Where have you received information? what is most important to you about breastfeeding? What challenges do you foresee, if any? Can you describe any experiences you've had with breastfeeding – how did these make you feel? What concerns do you have, if any, about being able to eat well while breastfeeding?)
5. Can you tell me about your overall experience discussing your weight while you have been pregnant? (probes: how do you feel when discussing your weight? With whom did you discuss your weight? What did health professionals or others say? What did you say? What was the outcome?)
6. Tell me about how your struggles with money impact how you eat? (how do you perceive this has impacted your weight? Your pregnancy? How do you feel this impacts your intention to breastfeed? What have others had to say about this, about breastfeeding? (health providers, etc)? have you been referred to programs (CPNP for example, other resources) to support you to eat well during your pregnancy and beyond? What resources to you currently use to eat?)

7. What have others had to say about x [your weight, your infant feeding intentions, food insecurity, providing food for your family, providing for your child] and how does this make you feel? (who says what – describe)

Interview #2

- as per methods chapter, interview to be conducted with participant during the early post-partum, newborn timeframe of 0-3 months

Preamble: Now that you have had [child's name], I am interested in your experiences with breastfeeding. I am also interested in hearing about your experiences with the healthcare system and the broader community in relation to your weight and your struggles with money which impact on your ability to eat the way you want and need to.

1. Since we last spoke [summarize what was discussed], please describe the experiences of the last part of your pregnancy, before birth (probes: is there anything you would like to change/add to your story?)
2. Please describe your birth experience and about bringing your baby home (probes: challenges/facilitators during birth – how would you describe your birth experience; describe your early feeding experience? How did the feeding experience make you feel? Describe your supports – who/what helped or hindered, including what was accessed through the healthcare system?) You were also provided with a care package from public health in the hospital prior to coming home (*show books*) – did you take a look at these? what did you think of them? (how were they used? What was your reaction)
3. Tell me about your experience with breastfeeding your baby over the past x months/weeks? (probes: How is breastfeeding similar or different than what you thought it might be? (if applicable) Describe why you stopped breastfeeding (or did not start in the first place)? Who/what prompted? How does that make you feel? Describe a typical day in your life as a mother (related to infant feeding scheduling, etc) Who supports you to breastfeed and how? Describe any concerns with your ability to eat nutritiously while breastfeeding)
4. Describe your experiences and use of the healthcare system and/or community resources since the birth of your child (e.g. in relation to weight or nutrition) (describe resources used and your experience with them)
5. Tell me about how your struggles with money impact your ability to eat well? (how has this changed since the last interview? How you do perceive it has impacted your weight? How do you perceive it has impacted your child? How has it impacted your decision to continue breastfeeding or not – if not breastfeeding, describe the impact of using formula or other alternative feeding sources on feeding your family? What resources have you used in the community or been referred to?

6. What have others had to say about x [stopping breastfeeding, continuing breastfeeding, your weight, your child's weight/weight gain, food insecurity, providing food for your family, providing for your child] and how does this make you feel? (who says what – describe)

(in addition, clarification of understandings from interview #1 and other lines of inquiry that emerge)

Interview #3

- as per methods chapter, interview to be conducted between 3-6 months post-partum

Preamble: Now that [child's name] is older, I am interested in your experience with feeding [child's name] today (breastfeeding, other feeding practices). I am also interested in hearing about your experiences with the healthcare system and broader community in relation to your weight and struggles with money which impact on your ability to eat the way you want or need to.

1. Since we last spoke [summarize what was discussed], please describe the experiences of mothering over the last few months (probes: is there anything you would like to change/add to your story?)
2. Describe to me how [child's name] is currently being fed? (probes: breastfeeding, other feeding practices, how has that changed for you since we last spoke? If breastfeeding, how is it similar or different? Describe your expectations around feeding [child's name]? If breastfeeding, how long do you intend to continue? If stopped breastfeeding, who/what prompted? How does that make you feel? Describe a typical day in your life as a mother (related to infant feeding scheduling, etc)? Who/what supports you in your infant feeding? Describe any concerns with your ability to eat nutritiously while breastfeeding (do you use the books that were provided to you by public health prior to coming home from the hospital – *show books* – what do you think of them - reaction? How did you use them?)
3. Describe your experiences and use of the healthcare system and resources in your community in the last few months (e.g. in relation to weight or nutrition) (describe resources used and your experience with them)
4. Tell me about how your struggles with money impact your ability to eat well? (how has this changed since the last interview? How you do perceive it has impacted your weight? How do you perceive it has impacted your child? How has it impacted your decision to continue breastfeeding or not – if not breastfeeding, describe the impact of using formula or other alternative feeding sources on

feeding your family? What resources have you used in the community or been referred to?

5. What have others had to say about x [stopping breastfeeding, continuing breastfeeding, your weight, your child's weight/weight gain, food insecurity, providing food for your family, providing for your child] and how does this make you feel? (who says what – describe
(also, clarification of findings in interview #2 and other lines of inquiry)