

THE INFANT FEEDING EXPERIENCES OF MI'KMAW WOMEN: A FEMINIST
PHENOMENOLOGICAL INQUIRY

by

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DEDICATION PAGE

This dissertation is dedicated to my daughter, Michelle, who provided never-ending support, hugs when I needed them, laughter when I was in tears and faith in me when I felt I could not go on. Without her support I would never have gotten here.

This research is also dedicated to the Mi'kmaw women who shared their experiences with infant feeding, which made this thesis possible. I learned so much from these women and sincerely appreciate their commitment to the study.

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ABSTRACT

Although breastfeeding rates among Mi'kmaw women are rising (38%), they remain lower than those of other Nova Scotia women (76%). Increasing the rates of breastfeeding could potentially impact the health of this population in positive ways. It has been reported that approximately 75% of First Nations people are unable to tolerate cow's milk products. The purpose of this study was to explore the lived experiences of Mi'kmaw women with infant feeding, including breastfeeding or non-breastfeeding practices. Positioned within a feminist phenomenological methodology, this research used an interpretive framework, attentive to issues of gender and power, to explore the taken-for-granted experiences of Mi'kmaw women when choosing an infant feeding practice. Twenty-two women participated in the study through conversational interviews and a talking circle. Findings from the study included four themes: 1) *Going it alone—Web of relationships*; 2) *Finding a space...living in poverty. Is anyone listening?*; 3) *Is breastfeeding right for me? It's my choice—respect my choice*; and 4) *Understanding our time*. Analysis of the findings provides an enhanced understanding of Mi'kmaw women's infant feeding experiences. This further supports strategies for the delivery of culturally sensitive, competent, and safe care by health care providers working with Mi'kmaw women and infants. It also offers potential for the development of culturally safe institutional, provincial, and federal infant feeding policies.

LIST OF ABBREVIATIONS USED

AAHRP	Atlantic Aboriginal Health Research Program
AHF	Aboriginal Healing Foundation
CNA	Canadian Nurses Association
FNIHB	First Nations and Inuit Health Branch
JOGNN	Journal of Obstetric, Gynecologic and Neonatal Nurses
NAHA	National Aboriginal Health Association
NAHO	National Aboriginal Health Organization
NWAC	Native Women`s Association of Canada
OCAP	Ownership, Control, Access and Possession
RCAP	Royal Commission on Aboriginal Peoples
RCP	Reproductive Care Program
RHS	Regional Health Survey
SIDS	Sudden Infant Death Syndrome
UNNS	United Native Nations Society
WHO	World Health Organization

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Chapter 1:

Introduction

Aboriginal beliefs about the environment, justice, social well-being, and political life have informed national and regional policy and programs. But despite the significance of Aboriginal issues for our country's past and future, Canadians are remarkably ignorant of Aboriginal peoples. (Warry, 2007, p. 14)

Health, health care, and access to health care have reached a critical point for First Nations people in Canada. First Nations peoples' health has been compared to that of those living in poverty-ridden Third World countries (Dion Stout, Kipling, & Stout, 2001; Warry, 2007). First Nations peoples' history of oppression through colonial tactics has left an immutable imprint on the obstacles, access, and current health status that First Nations peoples face on a daily basis. Cultural, historical, socio-political, economic, physiological, psychological, spiritual, and environmental factors impact on this most human of conditions—health (Waldrum, Herring, & Young, 2006)—for First Nations peoples. Today's reported high infant mortality rates, decreased life expectancies, increasing rates of infection, non-communicable diseases, suicides, family violence, and accidents are all a legacy of such a history (Adelson, 2005; MacMillan, MacMillan, Offord, & Dingle, 1996; National Aboriginal Health Organization [NAHO], 2005).

The birth rate for First Nations women doubles that of other Canadian women; and breastfeeding among First Nations women is lower than that of all other Canadian women (Health Canada, 2005). First Nations children have been reported to have excessive rates of otitis media, respiratory illnesses, iron deficiency anemia, and type 2 diabetes, all of which can be influenced by infant feeding choice (First Nations Regional

Longitudinal Health Survey Team, 2005; NAHO, 2005). Labbok, Wardlaw, Blanc, Clark, and Terreri (2006) reported that exclusive breastfeeding could annually save five to six million children's lives worldwide from infectious diseases. Westdahl and Page-Goertz (2006) state that breastfeeding not only reduces the incidence of these diseases for children but also reduces obesity, benefits maternal health, and economically benefits society at large due to the reduced need for medications and hospitalization of women and children.

Although in Nova Scotia the rate of breastfeeding among First Nations women, in particular Mi'kmaw women, has risen to 38% from the 28% reported in 2002–03, 62% of infants are being fed non-human milk products (cow's milk, cow's milk formulas, soy milk formulas, etc.). Even with this positive increase in rates, the level remains lower than that for other Nova Scotia women, whose rate of breastfeeding is reported at 76% (Mi'kmaq Health Research Group, 2007). Increasing the rates of breastfeeding could perhaps make a positive difference in the health of this population as it has been reported that approximately 75% of First Nations people are unable to tolerate cow's milk products (Berkow & Fletcher, 1992; Pray, 2000). Understanding the factors behind this modest increase in breastfeeding among Mi'kmaw women and developing an understanding of Mi'kmaw women's¹ experiences with infant feeding could lead to improved childhood health and development. It is therefore important to explore

¹ The intent of the study is not to essentialize or recolonize/dehistoricize the experience of all Mi'kmaw women. Importantly it focuses on the narratives of the Mi'kmaw women participants, drawing on many shared social, political, and cultural histories that evolve and change over time as no culture remains static. The voices of Mi'kmaw women are necessary to improve perinatal health for this population.

Mi'kmaw women's daily experiences that influence their infant feeding choice. The current research explored issues that influenced First Nations women's choices in infant feeding practices and identified the relationships and supporting factors surrounding everyday life practices of breastfeeding or non-breastfeeding, depending on the experiences of the women participants in the study. Developing an understanding of these relationships with breastfeeding or non-breastfeeding practices and their influence on perinatal nursing education, practice, and policy was also a consideration of the research. According to Benner (1994),

Narrative accounts of actual situations differ from questions about opinions, ideology, or even what one does in general because the speaker is engaged in remembering what occurred in the situation. Spoken accounts call the speaker to give more details and include concerns and considerations that shape the person's experience and perception of the event (p. 110).

Prior to the introduction of formula, First Nations infants were exclusively breastfed (Ertem, Votto, & Leventhal, 2001). Various cultural, social, political, and economic influences have changed the infant feeding practices among First Nations women. Banks (2003) stated that "First Nations are among the most vulnerable and need creative solutions aimed at protecting human lactation" (p. 3). In order to gain knowledge and understanding of the influencing factors on infant feeding choice, nurse researchers can utilize a holistic approach that considers not only the aforementioned influences on infant feeding practices but also the everyday ebb and flow of life experiences. This approach enables reflection upon these experiences and acknowledgment of their impact on decisions made (Hansen-Ketchum, 2004). While nurses of diverse genders work across the perinatal spectrum of health care, the women in

the study encountered experiences with only female nurses. As such, the discussion that follows reflects the use of pronouns to solely reflect the female nurses who were encountered within the context of the study.

An interpretive mode of research was therefore an appropriate means to discover and recognize the lived experiences of Mi'kmaw women with infant feeding practices. Mackey (2005) stated that phenomenological research views the "human experience as a valuable source of knowledge, and its methodological approaches allow, and indeed encourage, the complexity and depth of human experience to be expressed" (p. 9). Frequently health policies and care provided by health care providers, in particular nurses, do not reflect a cultural understanding of First Nations women and children's lived experiences and frequently lead to ongoing stereotyping and assumptions regarding access to healthcare (Browne & Varcoe, 2006). First Nations women's perspectives on health and health care have often been silenced. While this doesn't suggest that only one narrative reflects the diversity and complexity of all First Nations women, it nevertheless provides recognition that their historical landscape is grounded in colonialism.

Colonialism refers to the period of European post-Renaissance expansion, where the development of colonies and the capitalist system of economic exchange occurred in unison for the benefit of the colonizers (Ashcroft, Griffiths, & Tiffin, 2000; Moore, Skelton, & Walker, 2011). In Canada, colonized First Nations peoples were intentionally constructed to be inferior to the colonizers (Ashcroft, Griffiths, & Tiffin). Oppression, grounded in race and racism, was at the core of colonialism. This suggests a shared

vulnerability among First Nations' women that has positioned them within a prevailing discourse that has not been their own.

The dominant healthcare and scientific means for developing health policies have not incorporated an understanding of how race, racialization, and 'Othering' of First Nations women has impacted women's health (Anderson, 2004; Gandi, 1998; McConaghy, 2000; Reimer Kirkham & Anderson, 2002). Yet, McConaghy (2000) stated that the term *postcolonialism* "does not refer to a period of time, that is, the period in history after colonialism. Rather, the post in postcolonial refers to a notion of both working against and beyond colonialism" (p. 268). Anderson (2004) declared that postcolonialism "brings to the forefront the issue of 'race' and makes explicit how this socially constructed category has been used in the colonizing process, and the effect that this has had on peoples' life and life opportunities" (p. 240). The process of 'Othering' reaches into women's everyday lived experiences, affecting relationships, in particular relationships with health care providers (Anderson). It thus becomes important for health care providers to understand the impact of colonialism on First Nations women and act upon this knowledge. Indifference is no longer acceptable if perinatal outcomes for this population are to improve.

Identifying the successes and concerns regarding infant feeding practices as articulated by First Nations women will support capacity building among First Nations communities. Culturally appropriate perinatal education programs can be developed in partnership with these women. Further, knowledge can be shared with university health care faculty whereby curricula can be changed to reflect First Nations women's needs,

and governmental committees can be lobbied for change to policies that impact the health of First Nations women and children. In order to assure these changes, developers of education programs and health policies that impact upon First Nations peoples may involve First Nations communities, incorporate First Nations definitions of health, develop strong relationships with First Nations communities, and support capacity building within these communities (Reading, Kmetz, & Gideon, 2007).

If these current recommendations and policies are to be relevant and culturally sensitive, competent, and safe, then discernment of the experiences of Mi'kmaw women with infant practices is essential. Understanding the experiences of Mi'kmaw women with infant feeding practices from their everyday stories provides valuable lessons that can illuminate new paths towards meeting and/or changing recommendations and policies in a manner that is appropriate for Mi'kmaw women.

Coming to the Question

According to Eun-Ok (2002), reflective researchers “examine their own values, assumptions, characteristics and motivation to see how they affect the theoretical framework and review of the literature, design, tool construction, data collection, sampling and interpretations and findings” (p. 115). This reflective process makes visible the researcher’s knowledge and understanding before commencement of a study. Lopez and Willis (2004) note that interpretive phenomenology views the knowledge of the researcher as being an effective guide to the inquiry.

As a mother, a perinatal nurse, a lactation consultant, and a nurse educator, I have had a multitude of experiences with infant feeding practices. The knowledge gained from

these experiences has provided a foundation for the research study. As researchers, “[w]e bring to our research our own cultural experiences of race, ethnicity, sexual orientation, gender, and economic status. Instead of striving toward some unattainable objectivity, we need to investigate what role our own subjectivities bring to our research strategies and results” (Shields & Dervin, 1993, p. 67).

As a young mother, I chose to breastfeed my daughter due to a strong family history of allergies, only to be told by my family physician at 6 weeks postpartum that I did not have sufficient milk to nourish my daughter and was advised to start formula feeding. Perceived insufficient amount of breast milk is a common concern of new mothers (Dettwyler & Fishman, 1992; Forman, 1984; World Health Organization [WHO], 1981). I was given no advice on how to increase my breast milk supply or on resources to contact to provide me with information that would have enabled me to make an informed choice regarding my infant feeding practices. In fact, I remember feeling like an inadequate mother because I was not producing sufficient milk and ought to have had my child on formula earlier.

As my nursing career evolved, I discovered how few nurses and other health care providers were educated in infant feeding practices (Howett, Spangler, & Cannon, 2006; Losch, Dungy, Russell, & Dusdieker, 1995). Often the best resources came from formula company representatives promoting their various brands of formula. Perinatal nurses rarely have a clear understanding of the components of formula, the risks or benefits, or the governing body that regulates infant feeding products. I therefore began studying about infant feeding practices, became a Board Certified Lactation Consultant, and

completed my Master's thesis working with Mennonite women learning about their infant feeding practices (Cormier, 1998).

As an educator, I have presented breastfeeding courses throughout the Atlantic Provinces. At such courses I have been able to work with nurses from First Nations communities and learned of the concerns regarding breastfeeding among First Nations women. From these encounters, I hoped to complete my doctoral work with First Nations women to understand their experiences with infant feeding. Charlotte Jesty, a community health nurse and avid supporter and promoter of breastfeeding, encouraged me to think about completing the research in a First Nations community in Nova Scotia. And so my journey began (personal communication, August 24, 2007). I have attended Aboriginal² research conferences, meetings, and have taken a Mi'kmaw studies reading course in order to prepare for the study. As a non-Aboriginal woman I endeavoured to respect and understand Mi'kmaw women's ways of knowing and to explain their reality as articulated to me during the study.

Purpose of the Study

The purpose of this feminist phenomenological study was to develop an understanding of the experiences of infant feeding (be that breastfeeding or non-breastfeeding) as articulated by First Nations women, in particular Mi'kmaw women of Nova Scotia; to look at the imposition of governmental policy on breastfeeding (both

² *Aboriginal* is a collective name for the original peoples of North America and their descendants. The Canadian constitution recognizes three groups of Aboriginal people: First Nations, Metis, and Inuit. These are three distinct peoples with unique histories, languages, cultural practices, and spiritual beliefs (Indian & Northern Affairs Canada, 2009).

benefits and consequences); and to create the opportunity for change related to the effects that such policies have on the lives of First Nations women and children. The knowledge gained from the study provides an understanding of Mi'kmaw women's infant feeding experiences that can support culturally sensitive, competent, and safe care provided by health care providers for other Mi'kmaw women and infants and can enable the development of culturally safe institutional, provincial, and federal organizational policies.

The study enabled Mi'kmaw women to tell stories detailing their physical, emotional, mental, spiritual, and historical experiences with infant feeding. In so doing, their collective stories may increase awareness of how to best support infant feeding practices, be that breast or non-breastfeeding, among Mi'kmaw women, in order to improve the health status of Mi'kmaw women and their infants. Furthermore, reconciliation between policies and experiences was investigated, whereby articulating and contextualizing the tensions between recommended policy and actual experiences related to infant feeding may contribute to the discipline of nursing, particularly in the context of clinical care. This research study was part of the requirements for my Doctorate in Philosophy of Nursing degree, School of Nursing, Dalhousie University.

Research Questions

The fundamental question of the research enquiry was, *What is a Mi'kmaw woman's experience of feeding her infant?* Additional questions that guided the research were as follows:

1. What does it mean for a Mi'kmaw woman to make the choice of breastfeeding or non-breastfeeding her infant?
2. What supported the woman's infant feeding choice?
3. What challenged the woman's infant feeding choice?
4. What recommendations do Mi'kmaw women have for perinatal nurses in regards to infant feeding?

Conversations with both breastfeeding and non-breastfeeding women provided valued information in regards to these questions. This information identified the supports and barriers associated with the mother's infant feeding practice.

Significance of the Research

The significance of the research included 1) increased awareness among First Nations women regarding key concerns associated with infant feeding practices and perinatal health care outcomes, 2) supported capacity-building among First Nations women in developing their own infant feeding strategies, and 3) informed perinatal health care practices that will influence health care policy and curricula development.

Summary

This chapter provided the purpose of the study, the research questions, and the significance of the research to Mi'kmaw women and children's lives, the ways in which the research has impacted upon my own life experiences, and the relevance of the study findings to overall perinatal nursing practice. The following chapter will provide a literature review of the various factors that impact upon First Nations women's choice in infant feeding.

Chapter 2:

Literature Review

*So I think like if First Nations mothers who are mostly doing everything on their own, it would be important for them to have options, to know those options.
(Rebecca)*

Introduction

The supports and barriers for breastfeeding versus non-breastfeeding among other populations have been well documented (Clifford & McIntyre, 2008; Riordan, 2005; Walker, 2002; WHO, 2008) but for First Nations women the supports and barriers to infant feeding choice have not been clearly articulated. Clifford and McIntyre (2008) state that a positive attitude from partners and family members is essential in supporting breastfeeding and that lack of access to breastfeeding support is a major barrier for women.

The following chapter will provide a literature review articulating the history of infant feeding in Canada, as well as Aboriginal women's historical and current health concerns that impact infant feeding choice. The literature review will also include the impact of health policies, the importance of cultural safety, the reality of choice, and the influence of the social determinants of health on infant feeding practices.

History of Infant Feeding Practices in Canada

Until the late 1800s, breastfeeding was considered the infant feeding practice for most Canadian women. Before the development of formula, wet-nursing was the only alternative to breastfeeding one's infant (Baumslag & Michels, 1995). During the 1800s the practice of wet nursing declined as the use of breast milk substitutes became more

popular and accepted by the medical professionals and women of the middle and upper classes (Fildes, 1986).

During the 1900s, urbanization, economic pressures, class conflict, and changing views on “time, efficacy, self-control, health, medicine, sex, marriage, and nature . . . prompted women to doubt the efficacy, propriety, and necessity of breastfeeding” (Wolf, 2001, p. 3). Breastfeeding rates and birth rates fell along with an increase in infant mortality rates (McInnis, 1997). Following World War I, the use of breast milk substitutes increased worldwide (Apple, 1987; Dwyer & Mayer, 1975; Jelliffe & Jelliffe, 1978; Palmer, 2009; Wolf, 2001). Women entered the work force in ever-increasing numbers, frequently leaving rural settings to obtain employment in an urban environment, thereby needing an alternative to breastfeeding when at work (Knaak, 2005).

The invention of the upright feeding bottle and rubber teats, along with an overabundance of cow’s milk and increasing number of infant formulas provided continued impetus for the widespread use of breast milk substitutes. Physicians of middle class and elite women, whose husbands had purchasing power for such substitutes, recommended the artificial prepared milks for their patients (Palmer, 2009). The overabundance of cow’s milk was marketed as sweetened, condensed milk, as milk powders, or as evaporated canned milk (Palmer, 2009; Riordan & Wambach, 2010). The introduction of pasteurization, refrigeration, electricity, and the regulation and availability of sanitary conditions made these breast milk substitutes safer and aided in a reduction of infant mortality rates (Strong-Boag, 1994).

Following the depression years (1929 – 1939) and World War II (1939 – 1945), women sought employment outside the home in ever increasing numbers and the use of breast milk substitutes continued to increase. The Canadian government fully endorsed the use of formula and evaporated milk, providing literature about its preparation to all new mothers (Couture, 1940). While the benefits of breastfeeding were still being espoused by government literature, a change was occurring. Nathoo and Ostry (2009) explained that “unlike the 1920’s breastfeeding was no longer a sign of patriotism or a requirement of good motherhood” (p.89). Additionally, women were bombarded with messages from corporate formula companies and women’s magazines regarding their infant feeding practices (Potter, Sheeshka, & Valaitis, 2000). These factors impacted upon both dominant society’s women and Aboriginal women’s infant feeding practices. According to Palmer (2009), “the term ‘infant formula’ was a stroke of marketing genius” (p. 212) as it turned what was basically cow’s milk into a glorified, scientifically proven safe product.

Canadian breastfeeding rates were at their lowest during the 1960s but have increased since the 1970s due to women’s movements, the La Leche League, and natural childbirth programs (Gorham & Andrews, 1990). Nathoo and Ostry (2009) stated: “The return to breastfeeding occurred in the midst of a range of social, cultural, and political movements” (p. 107). During the late 1960s and early 1970s, women from higher economic and social backgrounds led the increase in breastfeeding across all regions in Canada (Nathoo & Ostry). Working conditions and opportunities had improved for

women due to the feminist movement, but further work needed to occur to support women in making an informed choice concerning infant feeding practices (Boswell-Penc, 2006). Breastfeeding rates were highest among older, white, married, educated, higher income, and urban based women. These factors reflected the influences on infant feeding practices including power, privilege, race, age, orientation (sexual), dis(ability), and class. Thus as Butler (2004) stated: “[s]ocial terms decide our being, but they do not decide them once and for all. They also establish the conditions by which a certain constrained agency, even a decision, is possible on our parts” (p. 117). Indeed such factors can influence the situation of a women’s infant feeding choice. Yet, it is not always the factors that are in place that support breastfeeding; rather, it is the factors that are not in place that have more influence on a women’s choice to breastfeed or not.

As Butler (2004) articulated in the context of truth and trauma: “What remains crucial is a form of reading that does not try to find the truth of what happened, but rather, ask, what has the non-happening done to the question of truth” (p. 156). Butler’s words have relevance to the experiences of women’s infant feeding practices. For example, power and privilege at all levels —individual, community, and societal— provides for, and thus sustains, an enhanced opportunity for choice for a number and yet a detrimental cost for others (McIntosh, 1990). “White privilege” is defined as “a set of unearned advantages, opportunities, and authorities that are based solely on having white skin which confers lifelong increased access to the goods and services of society” (McGibbon & Etowa, 2009, p. 17). Persons separate and thus different from the

dominant culture are often considered problematic, marginalized, and seen as “other.” This othering can take the form of objectification and stereotyping (Westerholm, 2009). *Visibility* of difference is particularly relevant to the process of *othering* (Ang-Lygate, 1996; Liladhar, 1999; Narayan, 1997). Frequently, the social locations of the aforementioned factors intersect and therefore impact on one’s ability for a just choice (McGibbon & Etowa, 2009).

According to Riordan and Wambach (2010), “colonial ruling elites who followed the practices of their social class in their country of origin . . . were more likely to feed their infants artificial milks . . . these colonial elites served as unwitting role models for Indigenous peoples” (p. 61). Prior to colonization, Aboriginal infants in Canada were historically breastfed, a practice strongly influenced by their grandmothers (Banks, 2003). Aboriginal infants were “fed whenever they were hungry . . . women breast-fed their own babies” (Knockwood, 2001, pp. 21–22). Health policy issued by the ruling colonial, elite government continues largely to this day and may impact infant feeding choice for Canadian Aboriginal women. In Northern Canada, for example, women continue to be removed from their home, family, and community for the birth of their infants, taking away the support of women in their community (Moffitt, 2004). Aboriginal women have often encountered racism, discrimination, and further inequalities when admitted for care away from their communities (Browne & Fiske, 2001). This in turn may limit their access to fully informed infant feeding choices.

Historical Past of Aboriginal Women

Prior to colonization, the Mi'kmaw had a matriarchal society (Mi'kmaq Spirit, 2013). Not all Mi'kmaw people agree with this assessment and declare that the Mi'kmaw society was patriarchal (Paul, 2006). Regardless of this debate, Aboriginal women were and continue to be central to the well being of the community and family, with gender relations often being non-repressive. Women's work was seen as being equally valued to that of men's work (Banks, 2003; Leacock, 1991; Paul, 2006);

However, both genders were involved in setting the agenda and dispersing responsibilities for the orderly conduct of the Nation's livelihood. The men were responsible for providing food for their communities by hunting and fishing and for carrying out chores involving heavy work. The women and older children were responsible for such chores as the limited farming the community indulged in, and for collecting, cleaning and preserving produce, game and fish. No demeaning connotations were associated with the assignment of different community responsibilities to each gender. (Paul, 2006, p. 19)

The Elders of the community were the "mental storehouses" for the genealogy of the tribe and would pass on remedies and natural healing traditions that frequently impacted women's health. Aboriginal women were viewed as "caretakers of the culture," and grandmothers held onto their identity as an Aboriginal to pass traditions and ways of being onto future generations (Fiske, 1993). According to Robinson (2005), a grandmother or *ki'ju* is given special status in Mi'kmaw society; she is viewed as "the protector and giver of life, but she is also looked upon as provider of spiritual and physical nourishment and as a source of wisdom and knowledge" (p. 106).

The knowledge of Aboriginal history, cultural practices, and identity are fundamental features of Canada's national identity, but countless Canadians remain

remarkably ignorant of this information (Warry, 2007). Furthermore, the ongoing “belief in the superiority of European values and our ignorance of Aboriginal cultures sustain the structural racism that marginalizes and impoverishes Aboriginal peoples” (Warry, 2007, p. 15). Health care providers require education regarding the present-day concerns of Aboriginal peoples and how they have been adversely affected by colonization (Browne & Fiske, 2001). In so doing, policies and practices—such as the breastfeeding policy of the Nova Scotia Department of Health Promotion and Protection (2006) — will be culturally acceptable for diverse communities of women, including those who are Aboriginal.

Yazzie (2000) wrote that the colonization of Aboriginal people has occurred since the landing of Columbus in 1492. Battiste (2000), a noted Canadian Aboriginal author, defined colonization as “a system of oppression rather than a personal or local prejudice” (p. xvii). According to Warry (2007), the legacy of colonization is one of Aboriginal poverty, illness, and marginalization of people. Colonization has caused Aboriginal women to suffer discrimination and disadvantage based on race, gender, and social class (Browne & Fiske, 2001; Dion Stout, 1996; Gerber, 1990; Voyageur, 1996). Therefore, it becomes prudent to reflect upon how the historical and social impact of colonization has resulted in today’s Aboriginal women’s and children’s health conditions (Browne, 2007; Gregory, 2005; Kelm, 2001).

Additionally, a multitude of hegemonic, colonialist, and paternalistic Canadian laws, policies, and structures have led to hardships for Aboriginal women and caused

changes in their traditional life patterns (Warry, 2007). Emberley (2006) declared that the Indian Act of 1876 is “the most significant form of oppression to shape the lives of Native people in Canada” (p. 395). The Indian Act (Rebick, 2005) and the introduction of Christian beliefs (Banks, 2003) were the principal reasons for disbanding of the traditional matriarchal society familiar to various First Nations people. Relationships between First Nations parents and their children were negatively impacted upon, and maternal infant feeding practices were altered due to these sociocultural changes (Banks, 2003). Colonial practices and ideologies of motherhood have marginalized First Nations women’s traditional practices (Fiske, 1993; Salmon, 2007) for centuries.

The creation of the reserve system by the Canadian government in an attempt to assimilate Aboriginal people created further breakdown in the Aboriginal way of life. Whole communities of Aboriginal people were forced to move to Crown lands set aside for registered Aboriginal people. Aboriginal children were sent away from their parents and sent to residential schools. Attending residential school prevented Aboriginal children from learning about their culture and language in the traditional ways through “the telling of legends that embodied thousands of years of experience” (Knockwood, 2001, p. 17). Young women did not see their mother breastfeeding or caring for their younger brothers and sisters, and parenting skills and traditional ways of feeding infants were often abandoned. Prior to living in residential schools, children viewed their mothers’ breastfeeding as being the norm (Banks, 2003; Knockwood, 2001). The continued inadequate services provided by Canadian federal and provincial governments

to those living on reserves, and the ongoing racist attitudes towards Aboriginal women, further the multiple tribulations faced by Aboriginal women today (Adelson, 2005).

It has been identified that women who are younger, less educated, underprivileged, and underserved tended to have less successful breastfeeding experiences (Dubois & Girard, 2003; Ryan, Rush, Krieger, & Lewandowski, 1991), as they often were unable to participate in breastfeeding education and support programs during pregnancy and in the postpartum period. First Nations women's lives have been politically, socially, and economically structured to fit each of these experiences of oppression, and thereby, impact on infant feeding choice. Without a critical understanding of one's reality, one cannot know that reality (Bruce Pratt, 1984; Freire, 1970; Mohanty, 2003). In various circumstances, First Nations women's identities were affected due to colonization, assimilation policies, language and cultural loss. When one's identity is not recognized, one has no political or historic voice (Mohanty, 2003). It is important for Aboriginal women to tell the stories that reflect their lives in the residential schools and on the reserves, as well as their experiences with health care providers that impact perinatal health care.

Breastfeeding is a feeding method that is greatly influenced by societal norms and behaviours. Historically, Aboriginal people learned through modeling behaviours and skills of others. Wiessinger (1996) writes that in order for breastfeeding to be viewed as the "normal" way of feeding, breastfeeding ought to become a part of our everyday language and information. The loss of infant feeding knowledge by attendance at the residential schools, the ever increasing use of non-breast milk formulas by the overall

Canadian child-bearing women population (Gorham & Andrews, 1990; Potter, Sheeska, & Valaitis, 2002), and the increased movement of Aboriginal women to urban areas (Wagner, 2005) impacted upon infant feeding choice. These socially constructed factors influenced Mi'kmaq women's infant feeding practices as well. Enabling Aboriginal women to share their experiences with infant feeding could support the development of a culturally safe and appropriate model of care that could increase the breastfeeding rates of this population. Discernment of Aboriginal women's historical identity is fundamental in the understanding of Aboriginal women's infant feeding choices.

Health Concerns of Aboriginal Women and Children

The health disparities of Canadian Aboriginal women are not due to inherent Aboriginal traits but are caused by political, social, and economic disparities (Newbold, 1998; Waldram, Herring, & Young, 1995). The current health status of Aboriginal women is entrenched in the oppressed and marginalized position they have often been allotted by hegemonic, White, Christian society (Adelson, 2005; Royal Commission on Aboriginal Peoples, 1996a). Dion Stout and colleagues (2001) have argued that Canadian Aboriginal peoples' health profile is synonymous with people living within the developing world. First Nations communities have reported lower education levels, higher rates of unemployment, and lower pay than First Nations people living away from First Nations communities and among other Canadians (National Aboriginal Health Organization [NAHO], 2005), all of which impact on the health of First Nations women and children.

Canadian non-Aboriginal women's life expectancy is 82 years in comparison with the Aboriginal women's life expectancy of 76.2 years (First Nations and Inuit Regional Health Survey, National Steering Committee, 1999). First Nations women have a higher prevalence of diabetes, obesity, arthritis/rheumatism, high blood pressure, asthma, and heart disease than other Canadian women (NAHO, 2005). Violence at the personal, inter-personal, and community levels is part of numerous Aboriginal women's lives (Royal Commission on Aboriginal Peoples, 1996b). LaRocque (1997) reports that 75% of sex crimes in Aboriginal communities involve women and girls under the age of 18, with 50% of these being under the age of 14, and 25% under the age of 7. Aboriginal women are at high risk of spousal violence involving substance abuse and of becoming homicide victims (Dion Stout et al., 2001).

Canadian Aboriginal women have increased rates of infectious diseases; tuberculosis; hepatitis A, B, and C; gastroenteritis; meningitis; gonorrhea; and chlamydia. The incidence of HIV/AIDS is increasing among Aboriginal people, with Aboriginal women's rates being identified two times higher than non-Aboriginal women (Laboratory Centre for Disease Control, 1999). In addition, substance use of tobacco, alcohol, and both illicit and prescription drugs is another major health concern facing Aboriginal women and their communities (Smylie, 2001).

Hypertension, diabetes, arthritis, heart conditions, cancer, and arthritis are the leading causes of disabilities with Aboriginal communities (First Nations and Inuit Regional Health Survey, National Report, 1999; NAHO, 2005). Cervical cancer is of particular concern for Aboriginal women due to the higher incidence and lower rate of

screening (Calam, Norgrove, Brown, & Wilson, 1999), which leads to increased morbidity and mortality rates. Obesity among all age groups is a major health problem facing Aboriginal people (MacMillan et al., 1996), and diabetes continues to be a significant health problem for Aboriginal women. Statistics indicate that by their mid 30s up to 5% of Aboriginal women will have diabetes. Gestational diabetes is seen in 8 to 12% of Aboriginal women, which increases the rate of fetal macrosomia, fetal hypoglycemia, hyperbilirubinemia, and the need for increased interventions during the birth experience (Bobet, 1998).

Aboriginal women not only have to attend to their own health concerns but also to those of their children. Multiple health problems have been identified for Aboriginal infants and toddlers. Respiratory tract infections, in particular bronchitis, asthma, and pneumonia are frequently diagnosed in newborns (First Nations & Inuit Regional Health Survey, National Report, 1999; Hodgins, 1997; Rhodes, 1990). Otitis media, with complications such as chronic ear perforation and hearing loss is 15 to 60 times higher than the non-Aboriginal population of this age group (Smylie, 2001). The rate of Sudden Infant Death Syndrome (SIDS) is three to four times higher than the Canadian rate. There is a four times greater rate of death due to injury and an increased prevalence of fetal alcohol syndrome/fetal alcohol effect seen among Aboriginal Canadian infants (MacMillan et al., 1996). In addition, the incidence of formula-fed tooth decay averages greater than 50% (Smylie, 2001). The NAHO (2005) reported that the most commonly reported conditions continue to be asthma, ear infections, allergies, and concerns relating to alcohol consumption during pregnancy.

Similar to infants and toddlers, Aboriginal children and youth continue to have health problems related to respiratory tract infections, asthma, and complicated otitis media (First Nations and Inuit Regional Health Survey, National Steering Committee, 1999; The First Nations Information Governance Centre, First Nations Regional Health Survey (RHS) Phase 2, 2008/10). Accidental injuries are three times higher for Aboriginal teenagers; substance abuse of alcohol, marijuana, solvents, and other hallucinogens has a higher reported incidence than non-Native teenagers, with sniffing being reported in children less than 5 years of age (MacMillan et al., 1996). Dental caries continue to be reported as a health concern with this age group; 89% of 12-year-olds and 95% of 6-year-olds were found to have caries (Leake, 1992). Furthermore, suicide rates in Aboriginal youth between 15 and 24 years of age are six times that of the Canadian average (Statistics Canada, 1999). Initial infant feeding practices and the impact of food security greatly influence these health concerns. An understanding of the everyday infant feeding practices of Mi'kmaw women may be a beginning step in alleviating and correcting several of these health concerns.

Breastfeeding and First Nations Women

Approximately 62.8% of Canadian First Nations women living on First Nations communities breastfeed their infants (The First Nations Information Governance Centre, First Nations Regional Health Survey, (RHS) Phase 2, 2008/10). Although this initiation rate is below the average Canadian population initiation breastfeeding rate, First Nations women are found to breastfeed for a longer duration of time. The reasons provided for breastfeeding included higher levels of education, increased income, maternal familial

history of residential school, being in remote communities, and taking part in multi-community transfer agreements (RHS). In Nova Scotia the initiation breastfeeding rate among Mi'kmaw women is 38%, compared to 78% among other Nova Scotian women. Of the Nova Scotian Mi'kmaw women choosing to breastfeed, 32% continued to do so for 6 months or longer (Mi'kmaq Health Research Group, 2007).

MacAulay, Hanusaik, and Beauvais (1989) conducted a qualitative study where 77 Mohawk women in Quebec were interviewed and provided with a questionnaire to complete. The purposes of the study were to find the prevalence of breastfeeding, to verify impressions of increased and prolonged breastfeeding with this population, and to gain knowledge that could potentially improve breastfeeding promotion. The results from the study indicate that Mohawk women chose the method of feeding prior to pregnancy, did not view health care provider's information as important, and identified support as essential from partners, grandmothers and other family members. Those Mohawk women choosing to bottle feed did so mainly so others could feed the baby. Historically, Mohawk women breastfed their infants; grandmothers provided generation to generation knowledge and support for new mothers with their breastfeeding experiences. Storytelling between the generations enabled transfer of knowledge and values. However, societal influences changed the method of infant feeding from breastfeeding to bottle feeding. Recommendations from the research findings included extensive education for family members, community members, and health care providers regarding the benefits of breastfeeding and the need for mother-to-mother support groups if breastfeeding rates were to improve (MacAulay et al., 1989).

A report of a longitudinal survey study between 1962 – 1983 concerning breastfeeding among Canadian First Nations women on-reserve and of women in the Yukon and North West Territory found that the breastfeeding initiation rate increased in this population and is parallel to the findings of other Canadian women (Stewart and Steckle, 1987). However, of these First Nations women, only half continued to breastfeed for the recommended 6 months. Recommendations from the research (Stewart & Steckle) were for governments to assess infant feeding practices; examination of hospital perinatal policies and practices regarding First Nations women; and the creation of new programs supporting breastfeeding, including support for mothers and members of the community, if breastfeeding rates were to increase (Stewart & Steckle).

Neander and Morse (1989) utilized anthropological and ethnographic methodologies of participant observation and unstructured interviews to compare traditional and present-day infant feeding practices of the Northern Alberta Woodland Cree. Twelve women were interviewed from each group. Information relating to traditional infant feeding practices was described. Following delivery, the mother would be given an herbal drink to help with the production of milk; she would be encouraged to keep her breasts warm; her head and feet covered, as cold entering the body through these areas were thought to make her ill. Lactating women were encouraged to rest and nurse their baby frequently. Colostrum was viewed as not good for the baby and was discarded or removed by an older child. Infants were breastfed from 1 to 4 years unless another

pregnancy occurred. Family members supported the care of the mother and infant. The major difference between the two groups resulted from a change from home births to those in hospital. The resulting medicalization of childbirth, loss of social support, and fear of hospital routines were all factors that influenced breastfeeding. The researchers further found that canned milk, rather than infant formula, was widely being used for non-breastfeeding infants at the time the study was conducted (Neander & Morse, 1989). Traditional teaching and support for new mothers was lost with the change in health care practices.

Not dissimilar from the aforementioned findings, a longitudinal study conducted by McKim, Laryea, Banoub-Baddour, Matthews, and Webber (1998) found that the Inuit women of Labrador had a low rate of breastfeeding (18.2%), and that evaporated milk was being used to feed infants. Neither study could identify why, if not choosing to breastfeed, mothers were giving their infants evaporated milk rather than a commercially prepared milk formula. Cost or conveniences were not identified as deciding factors.

Dodgson, Duckett, Garwick, and Graham (2002) investigated the sociocultural patterns that promoted breastfeeding and weaning among Ojibwe women. The factors that impacted breastfeeding included cultural traditions, communication barriers, life circumstances, and social support. These authors concluded that such information is recommended to be considered when developing “breastfeeding programs that are culturally congruent and are based on the needs of those who will be served” (p. 241). An extensive literature review, however, has not been able to locate research studies regarding the infant feeding practices of Mi’kmaw women. Statistical information is

available through various provincial and federal reports, but information detailing Mi'kmaw women's experiences is currently not available. Therefore, the current study is both timely and aids in filling a gap in the current literature.

The Effect of Health Policies

The Canadian Health Care Act, which governs how provinces and territories receive funding for health care, espouses five essential guiding principles for all Canadians: accessibility, comprehensiveness, portability, universality, and public administration (Tang & Browne, 2008). Thus within a democratic Canada, this ideology suggests that all Canadians will be treated fairly and justly and have equal access to health care and health care resources (Riley, 2002). Yet such a framework does not lend itself well to an understanding of how power and privilege impact people coming from diversely constructed life histories (Tang & Browne, 2008) and often renounces “difference and cultural identity” (Sherwood & Edwards, 2006).

The Indian Act of 1876 socially constructed what is now known as status and non-status Indians and thus created an identity for First Nations people. This identity can still be seen in various aspects of First Nations communities today. In particular, First Nations women were most affected by this designation. For example, First Nations women marrying a non-Indian lost their band membership and Indian status, were frequently banned from their communities, were unable to own property on reserve land, and were unable to vote in band elections, to hold office, and/or to participate in public meetings (Voyageur & Calliou, 2000). Not until 1985, when Bill C-31 was passed, could First Nations women and children who had lost their Indian status apply for reinstatement

of their Indian status. This change in legislation did not apply to grandchildren and great grandchildren and did not enable women living off reserve to have votes in band elections. These policies caused irreparable damage to “kinship ties, cultural ties, and participation in governance” (Bourassa, McKay-McNabb, & Hampton, 2004, p. 26).

According to Boyer (2006), “colonization, racism, the Indian Act, residential schools, laws, policies, and regulations that have subjugated Aboriginal women to a lifetime of violence, poverty, and degradation have created the crisis in Aboriginal women’s health today” (p. 19). Due to such policies, First Nations women may be marginalized, further silencing their voices. The Native Women’s Association of Canada (NWAC) (2007b) asserts that

Women’s perspectives must be included in policy development and that an intersectional approach is needed which recognizes that people’s experience of human rights is mediated by multiple identities, including race, class, ethnicity, religion, sexual orientation, gender, age, disability, citizenship, national identity, geopolitical context, and health. (p. 7)

Therefore, when developing infant feeding policies, an increased understanding and awareness of the lived experiences and daily lives of First Nations women, including their diverse histories and complexities, needs to be understood. This can foster collaborative policies to assist in promoting culturally safe care and improved health outcomes (Hunter, Logan, Barton, & Goulet, 2004), for infant feeding practices, including those of both breast and non-breast options.

Cultural Safety

According to Josewski (2011), health care policies cannot be effectively reformed without strategies to dismantle the intersecting dynamics of power between the patient

and the health care provider. Cultural safety is a concept that came from New Zealand nurses in response to interactions between Indigenous Maori and other New Zealanders, whereby the patient's viewpoint rather than the health care system's standpoint became the priority (Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012). The Nursing Council of New Zealand (2005) defined cultural safety as "the effective nursing practice of a person or family from another culture, and is determined by that person and family (p. 4).

Culturally safe health care practices are needed as marginalization, discrimination, and challenge are colonial processes that continue to impact Aboriginal women's lives and health outcomes. The intersection of these processes with poverty, discrimination, substance abuse, and violence contributes to the health conditions of Aboriginal families (McCall, Browne & Reimer-Kirkham, 2009). According to La Rocque (1996):

Colonization has taken its toll on all Native peoples, but perhaps it has taken its greatest toll on women. Racism and sexism found in the colonial process have served to dramatically undermine the place and value of women in Aboriginal cultures, leaving us vulnerable both within and outside of our communities . . . [T]he tentacles of colonization are not only extant today, but may also be multiplying and encircling Native peoples in ever-tighter grips of landlessness and marginalization, hence, of anger, anomie and violence, in which women are the most obvious victims. (pp. 11 – 12)

There is much ambiguity between the understanding of culture, safety, and cultural safety (Browne et al., 2009). Williamson and Harrison (2010) stated that often health care providers approach culture as being "values, beliefs, and traditions of a particular group . . . [that is] static and unchanging" (p. 761).

In Canada the National Aboriginal Health Organization (NAHO) (2008)

developed its own definition of cultural safety:

Cultural safety refers to what is felt or experienced by a patient when a health care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care. (p. 19)

Cultural competence focuses on skills, knowledge, and attitudes of health care providers, while cultural safety requires health care providers to reflect upon their own culture, beliefs, and values, and to reflect upon how these may impact the care they provide, particularly if the beliefs and values differ from those of their patients (Meyst, 2005; Nursing Council of New Zealand, 2005); this type of reflection can increase awareness as well as discomfort. Arieli, Friedman, and Hirschfeld (2012) reported the following challenges for nursing educators when presenting cultural safety information:

- i) making it safe for minorities to present their culture in the majority group;
- ii) dealing with a tendency of groups to deny the existence of conflict;
- iii) making dynamics of oppression discussable, and
- iv) creating conditions in which people can freely define their individual and group identities. (p. 192)

Ramsden (1997) wrote: “Cultural safety . . . gives the power to the patient or families to define the quality of service on subjective as well as clinical levels” (p. 15).

Ramsden (1997) further articulated:

However competent any nurse or midwife may be technically, such skills and experience will not be of use if people do not feel emotionally safe to approach the service or if they approach it too late. If the term ‘safety’ is changed to awareness it immediately shifts the power away from the patient to define their subjective response, and gives it to the service provider. Only the patient is able to say whether the nurse is safe regardless of how many awareness courses the nurse has attended. (p. 12)

When infant feeding practices are being discussed and infant feeding policies are being developed, in order to have them be culturally safe, “voices (from those that are marginalized) become a starting point for enquiry” (Browne, Smye, & Varcoe, 2005, p. 26). As infant feeding policies are being developed, issues of flexibility, power and control, and individual differences have to be addressed by both health care providers and those receiving care, if the policies are to be socially inclusive and culturally safe, affording all women and infants the right to safe health care (Woods, 2010).

The Reality of Choice

Governmental policies for population health are based upon the premise that individuals are self-determining and responsible for their own health, capable of making their own decisions and choices (Tang & Browne, 2008). Economic wealth, access, and distribution of same among members of society are related to the social determinants of health (Wilkinson, 1996), the amount of power an individual has, and the ability for choice among individuals. When government policies take the stance that health is the individual’s responsibility rather than the State’s, the individual can ignore the unequal power relations that have been socially constructed between people in the overall population (Tang & Browne, 2008). When women encounter discrimination, racism, poverty, and fewer opportunities for education, and employment, their choices and health are compromised (Cass, 2004; Smye, Rameka, & Willis, 2006). Power and privilege have the ability to change the life course of all those with or without them (Butler, 1993). Indeed, the current political and economic movements within the Canadian government whereby the wealthy become wealthier and the poor sink deeper into poverty continues

the colonizing process (Ahmad, 1993). Unless one has human freedom, autonomy, and is empowered, choice remains a relative subject (Marmot, 2004b).

In regards to infant feeding practices in Canada, white, Protestant, middle-class women are usually taken as the standard by which government policies are developed (McGibbon & Etowa, 2009; Palmer, 2009; Siegel, 1984). Social class has a direct influence on one's ability to engage in 'good' health practices (Walter, Lenton, & McKeary, 1995). Women of a higher socio-economic status often have increased education and financial resources which provides them with greater choice related to overall health and well being. Younger women with less education and economic security are frequently affected by government policies and waged work policies that impact their infant feeding choices (Boswell-Penc & Boyer, 2007). Peterson and DaVanzo (1992) reported that young, unmarried women, with limited social support and lower educational attainment and income, frequently turned to formula feeding as the choice for infant feeding. Women in such circumstances not only have insufficient resources related to social and financial means but also, with such governmental policies, are increasingly burdened with feelings of guilt and failure as a mother when unable to achieve the recommended ideal of breastfeeding their infants (Knaak, 2006; MacLean, 1990). Governmental breastfeeding policies along with educational and promotional resources for breastfeeding can be a means of "informational manipulation" influencing women's infant feeding choices (Knaak, 2006, p. 414). Improving supports necessary for all women who are mothers, whether they select breast or non-breast feeding, would enable informed choice and healthy infant feeding practices for women and children.

The intersectionality of racism, sexism, classism, colonialism, ethnicity, religion, sexual orientation, gender, age, disability, citizenship, geographic location, national identity, and health state (Native Women's Association of Canada, 2007b) all impact choice and women's infant feeding choice. First Nations women, through colonialist processes have been demeaned, dislocated, dispossessed, and disadvantaged (Said, 1994; Sherwood & Edwards, 2006) in each of these areas. Understanding the lived experiences of First Nations women, who have historically been silenced, is imperative if health policy is to reflect their needs; to be inclusive; and to improve upon health, health care, and health access. If choice relating to infant feeding is to be a reality, the playing field has to become more equal, and social justice for all Canadians ought to become a priority for government-led infant feeding policy.

Social Determinants of Health

Raphael (2009) identified 12 social determinants of health pertinent to all Canadians: Aboriginal status, early life, education, employment and working conditions, food security, gender, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment security. Each of these factors often present as inequalities in the everyday lives of First Nations people and therefore are key elements in First Nations women's choice in infant feeding practices. Boyer (2006) stated that "colonization, racism the Indian Act, residential schools, laws, policies, and regulations that have subjugated Aboriginal women to a lifetime of violence, poverty, and degradation have created the crisis in Aboriginal women's health today" (p. 19).

First Nations women frequently experience poverty; high rates of spousal, sexual and other violence; difficulty in obtaining safe and affordable housing; barriers to employment; loans; and educational opportunities (Native Women's Association of Canada, 2007a). Poverty, according to Marmot (2004a), is not only the lack of financial resources but also involves human dignity, opportunity, empowerment, and security. Poverty is linked with substance abuse, lessened social support, crowded housing, reduced food security, parenting difficulties, narrowed educational prospects (Loppie Reading & Wien, 2009), and social exclusion (Galabuzi, 2004). These factors are influential in women's infant feeding choice.

Canadian governments restructuring of social programs, decreased spending for welfare and unemployment services, privatization, reduced corporate taxes, and increased personal taxes have expanded the level of poverty throughout all of Canada, creating further hardship for marginalized groups such as First Nations peoples by widening the gaps between those with and those living without in the world of poverty and inequality (McIntyre, 2003). Families receiving welfare or social assistance are at high risk of having food insecurity and of being hungry, and Aboriginal people reported hunger four times more frequently than all other ethnic groups (Statistics Canada, 2013). According to the Food and Agriculture Organization of the United Nations (2005), the four essentials for food security are access, availability, utilization, and stability of supply. Modification of First Nations peoples' traditional food supply, contamination, and changing climates have decreased the food supply for many First Nations people (Power, 2008).

Euro-Canadian governmental colonial policies and laws have caused a magnitude of social injustices against Canadians but in particular against First Nations peoples. Such policies often leave First Nations women with either little choice or choice that is made due to injustices and inequalities. When governments take a materialistic approach to policy development, driven by powerful interests, a positivistic approach to science, and the ideology of individualistic response for health, then cuts to social programs, unemployment benefits, public housing, and services for violence against women are made (Raphael, Curry-Stevens, & Bryant, 2008). This environment impacts on health choice, access, and care. Understanding the impact of these life circumstances and the influence that social determinants of health have on policy, on the market force, and on the health of Canadians are essential, as they have bearing on infant feeding practices of First Nations women. It is essential to hear from First Nations women if health policy related to infant feeding is to be inclusive and thereby meet the needs of this population.

Summary

Breastfeeding *may* provide a means for Aboriginal women and children to improve their health status. The current recommendations from Health Canada (2004b) and from the World Health Organization (WHO) (2013b) are for infants to be exclusively breastfed for the first 6 months of life and into the second year with complementary foods. Wiessinger (1996) states “breastfeeding is a straightforward health issue, not one of two equivalent choices” (p. 3). Sterken (2006) reports that the risks of formula feeding infants and children are multiple: increased risk of asthma, allergy, diabetes, chronic

diseases, cardiovascular disease, nutrient deficiencies, infection from contaminated formula, childhood cancers, respiratory diseases, and of reduced cognitive development.

The WHO/UNICEF Innocenti Declaration for the Promotion and Support of Breastfeeding (1990) acknowledged that breastfeeding contributes to women's health by reducing the risks of breast, cervical, and ovarian cancer and by increasing the spacing between pregnancies. In addition, breastfeeding decreases the risks of postpartum bleeding and postpartum depression, enhances the attachment process, causes women to lose weight more easily, and enables insulin dependent diabetic mothers to reduce or remove artificial insulin requirements during the breastfeeding period (Baumslag & Michels, 1995; Lawrence, 1994; Riordan & Auerbach, 1993). These benefits are relevant to the multitude of health concerns confronting Aboriginal women and children. But one needs to question if infant feeding policies are a means for government to place responsibility for infant feeding at the mother's door without accountability for a more experiential approach. Such an approach does not take into account historical context, life circumstance, cultural meanings and living conditions, among other factors. If such policies support the social determinants of health for all and involve state welfare responsibility for ensuring that all women have equal access to the supports needed for breastfeeding, and are culturally safe, then increased breastfeeding rates may be a way to improve the health of First Nations women and infants. A feminist phenomenological framework supported the development of this study. It further endeavoured to develop recommendations for culturally safe nursing practices, policies, and educational programs

to potentially improve the perinatal health outcomes of Aboriginal women and children, particularly in the area of infant feeding practices.

Chapter 3:

Methodology and Methods

Phenomenology is compatible with indigenous peoples, because it is synchronous with holistic indigenous cultural lifeway and values. Phenomenology...assists indigenous people in reproducing, through narrative communication, features of the past, present, and future. In the narrative process, this method elicits significant implicit meaning of indigenous culture and assists with recording the essence of experiences and events of indigenous societies. A product of the telling of narrative stories is the capacity to reflect on change that will enhance health in a holistic and culturally acceptable manner. (Struthers & Peden-McAlpine, 2005, p. 1264)

Paradigms regarding nursing research provide structure to the nature of the research that will be done (Candy, 1991; Monti & Tingen, 1999). The paradigm chosen by the researcher supported and responded to the ontological, epistemological, and methodological questions of the study (Annells, 1996). According to Annells, ontology is “the form and nature of reality . . . and what can be known about reality” (p. 383). The key ontological assumption of an interpretative paradigm is that multiple realities exist. “Multiple realities and perspectives are part of any health-illness experience, and nursing may best be served by maintaining an open acceptance of multiple perspectives” (Polifroni & Welch, 1999, p. 469). These realities are holistic, complex, and dependent on the individual’s context, grounded in one’s experience, and with no absolute truth unlike an empiricist researcher’s ontological assumptions where there is one reality; truth can be established and certainty is feasible (Monti & Tingen, 1999). Stories about lived experiences enable people to understand what it is like to be a person in the world and come to realize what is real for individuals (Streubert-Speziale & Carpenter, 2007).

Epistemology is defined as “the nature of the relationship between the knower (the inquirer) and would-be-knower and what can be known” (Annells, 1996, p. 384). Epistemology from an interpretive viewpoint considers that knowledge originates from experience, art, and ethics. There is a sharing of meanings, observations are value-laden, and experience impacts on what is observed. However, from an empiricist viewpoint knowledge is free from values, reality is verified, and cognition and perception are two individual entities (Monti & Tingen, 1999). According to Polifroni and Welch (1999), the epistemological knowledge development of nursing has grown from “strict rationalism . . . numbers, factual data—toward text, meaning; extracting embedded theory laden in fact” (p. 476). This movement in knowledge development enables nurses to constantly question and seek new information which will help them in their journey to provide care for their patients.

Understanding the ontological and epistemological underpinnings of interpretive and empiricist paradigms enables a nurse researcher to select a methodological approach for answering research question(s). Qualitative research methodologies such as feminist phenomenology support the advancement of knowledge about women’s embodied experiences within patriarchy (Goldberg, 2004; Young, 1990a).

Phenomenological research is a human science that strives to find a way to understand a certain phenomenon and to both describe and interpret the meaning of the phenomenon as it relates to individuals’ everyday life experiences (Bergum, 1989a). This research therefore enabled me, as the researcher, to collaboratively engage with participants to try to find a mutual understanding of the nature and meaning of Mi’kmaw

women's infant feeding practices. Only by reflecting on the context of any given situation is the meaning of the experience understood (Benner, 1985). "Understanding comes not from the subject who thinks, but from the other who addresses me. This other . . . is this voice that awakens one to vigilance, to being questioned in the conversation we are" (Risser, 1997, p. 208). Though conversations with the Mi'kmaw women who participated in the study, relationships were formed, and a transformed understanding occurred regarding their infant feeding practices. The knowledge garnered from the study has potential to contribute to perinatal practices and policies to improve health outcomes for Mi'kmaw women related to their infant feeding practices.

Methodologies

Phenomenology

The ongoing, ever-changing phenomenological movement has been portrayed as three distinct historical phases: the preparatory, the German, and the French (Streubert-Speziale & Carpenter, 2007). During the preparatory phase, the philosophy of Brentano (1838–1917) and Stumpf provided clarification of the meaning of intentionality, whereby a person is always aware or conscious of something (Spiegelberg, 1965).

The German phase was led by Husserl (1936/1970) and Heidegger (1927/1962). Husserl has been called the father of phenomenology (Groenewald, 2004; Koch, 1996), and was interested in the study of consciousness (1931/1965). Husserl was a student of Brentano and was dedicated to understanding "things-in-themselves" and urged researchers to go "back to the things themselves" without presuppositions in order to have a true understanding of the phenomena (Husserl, 1931, 1965). He rejected the

Cartesian rationality of separating the mind from body (object) within an experience and accepted that a person can know about how things appear or present to their consciousness (Lavery, 2003). In order to filter out the essences of a phenomenon, biases and worldly influences must be removed by the researcher, by a means of phenomenological reductionism or bracketing (Lavery, 2003).

Heidegger (1927/1962), a student of Husserl, brought forward the concept of 'Dasein' or 'the situated meaning of the world', whereby a person's lived experience is historically formed through one's background, culture, and ways of understanding (Kock, 1995; Lavery, 2003; Munhall, 1989). To be human was to be able to interpret one's experiences from one's own historical background, within everyday life, and therefore reductionism or bracketing was impossible (Heidegger, 1927/1962). According to Heidegger:

Being is always the Being of an entity. The totality of entities can, in accordance with its various domains, become a field for laying bare and delimiting certain definite areas of subject-matter. These areas, on their part (for instance, history, nature, space, life, Dasein, language, and the like), can serve as objects which corresponding investigations may take their respective themes (p. 29).

This type of interpretive or hermeneutic phenomenological research enables a detailed exploration and perception of the understandings of the everyday unique lived experiences of individuals living in the real world (van Manen, 1997) and of the meanings embedded within these experiences.

The French phase was dominated by the works of Sartre and Merleau-Ponty whose writings focused on embodiment and 'being-in-the-world' (Streubert-Speziale & Carpenter, 2007). Merleau-Ponty's work has particular relevance to this study as his

work provides a research framework that enables a human being to be examined from an embodied understanding; this is in contrast to a Cartesian framework in which the body is objectified (Goldberg, 2005; Merleau-Ponty, 1962). Merleau-Ponty emphasized the need to locate the body in the development of identity and personhood. Thomas (2005) stated, “The nurse researcher who works within the Merleau-Ponty tradition seeks to discover [study] participants’/patients’ perception of their lived experience” (p. 69). Merleau-Ponty’s work spoke only of the male experience, however, and not of what it was like to be a female in the everyday world (Code, 1991). This mindset could render invisible the oppressive influences impacting women. Grosz (1994) suggested that Merleau-Ponty’s work, although insightful in rethinking the body other than through dualism, “remains inadequate for understanding the differences between the sexes” (p. 109). Therefore in a study that focused on the lived experiences of women, a feminist phenomenological viewpoint was deemed appropriate in order to make visible the impact of oppressive, paternalistic powers that women deal with in their everyday life experiences (Young, 1990b).

Feminist Phenomenology

Feminist research is rooted in equality, investigates concerns of women, acknowledges women as “knowers,” represents human diversity, and critiques biases of androcentric and ethnocentric origin (Gillis & Jackson, 2002; Ironstone-Catterall et al., &n.d). As such, feminist phenomenology recognizes the importance of women’s lived experiences (Beauvoir, 1976, 1989; Goldberg, 2004; Young, 1990b) and therefore

provided the methodological framework from which to explore the infant feeding practices of Mi'kmaw women.

Phenomenology enabled an interactive process between the researcher and those being researched which investigated what it is like to be a woman in a patriarchal world (Bergum, 1991). Within the western, patriarchal health care system, feminist phenomenology supports nurses to explore perinatal health concerns of women and children (Goldberg, Ryan, & Sawchyn, 2009; Young, 1990a). Phenomenological research endeavours to provide understanding of the perceptions of human experience with all types of phenomena within their everyday world (Streubert-Speziale & Carpenter, 2003). Phenomenologists pursue the stories of everyday embodied human experiences as they are lived by individuals, whereby one is wholly connected, mind and body, to an actual life (Luijpen, 1966; Merleau-Ponty, 1962). Although Merleau-Ponty provided illumination regarding embodiment, his discussions were central to a male perspective (Grosz, 1994) and provided no clarity or direction for the often oppressed and concealed female perspective of lived experiences.

Feminist phenomenology enables the embodied consciousness of female subjects to be understood from a holistic mind/body viewpoint. A person's embodied self is constructed through his/her social, historical, political, personal, and cultural background (Thomas, 2005; Wilde, 1999). Wilde (1999) suggests that embodiment is "a form of experiencing and understanding the world through the body in lived experiences" (p. 28). Hence, the need for consideration of this study was further framed within a feminist phenomenological perspective (Young, 1990a).

Aboriginal women's embodied experiences have been greatly influenced by the power and control maintained by the dominant European-Canadian structural institutions (Indian Act, residential schools, reserves). Foucault (1980) maintains that why people dominate is not the key issue; instead, it is important for the focus to be on the following:

[H]ow things work at the level of on-going subjugation, at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviors, etc. In other words, rather than ask ourselves how the sovereign appears to us in his lofty isolation, we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc. We should try to grasp subjection in its material instance as a constitution of subjects. (p. 97)

As nurses working with Aboriginal women, when caring for women that are deciding their infant feeding method, it is essential to provide holistic care. In order to do this, as Foucault conveys, nurses require an understanding not only of how the European-Canadian structural institutions (Indian Act; residential schools; reserves) have historically impacted Aboriginal women's lives but also of how they continue to influence Aboriginal women's life experiences, which will ultimately be reflected in their infant feeding decision.

Storytelling plays an important part in First Nations people's culture, language, and history (Poupart, 2003). Struthers and Peden-McAlpine (2005) stated that "Phenomenology is compatible with studying indigenous peoples, because it captures oral history in a holistic and culturally acceptable way" (p. 1264). A feminist, phenomenological methodology supported the stories of the historically constructed,

multifaceted complexities materialized throughout Aboriginal women's embodied life experiences.

There are political and social pressures exerted on all women when choosing an infant feeding method such as breastfeeding. Work environments often do not support women in their breastfeeding efforts, daycare centres are not on work sites, and breastfeeding or pumping rooms are not available. Rather than being valued, breastfeeding is considered an irritant (Palmer, 1993). Breasts are most often viewed as sexual objects placed on a woman's body for the sole pleasure of men rather than embodied parts of her as described by Young (1990a):

Breasts are the most visible sign of a woman's femininity, the signal of her sexuality. In phallogentric culture sexuality is oriented to the man and modeled on male desire. Capitalist, patriarchal American media-dominated culture objectifies breasts before a distancing gaze that freezes and masters. The fetishized breasts are valued as objects, things; they must be solid, easy to handle. (p. 78)

When women's bodies are viewed by society in this manner, breastfeeding becomes a sexual issue whereby women are embarrassed to breastfeed and have concerns that the shape of their breasts may alter with breastfeeding. But breasts may also be viewed as a means of supplying nutrition and health benefits for women and children. These social influences are of particular importance to young women (Wamback, 2004). Aboriginal women often give birth during their adolescent years and endure these pressures regarding breastfeeding at an age when body image is of the utmost importance to a young woman. Breastfeeding one's infant is a rather uniquely embodied experience; it positions women who breastfeed in an incomparable location in a patriarchal society.

This situation challenges society to re-think how breasts are being seen in patriarchy (Goldberg, 2005; Young, 1990a).

Western health care often views the body as being composed of interchangeable, accessible parts which can be dissected and replaced like that of a machine (Gadow, 2000). For many health practitioners, breastfeeding is viewed in this manner. Breasts are not seen as embodied within the woman, but rather as impersonal parts that are either functioning normally or abnormally, in need of repair or of technological support, such as breast pumps. Gadow's (1984) statement seems particularly salient, even 25 years later, in light of how electric breast pumps have become part of the westernized and medicalized support for breastfeeding. She states, "the violation of dignity and autonomy that seems to accompany technology is in reality a result not of the roles of machines in patient care but of the view of the body as a machine" (p. 65). Women's breasts have been measured in size and output ability, and electric pumps are used on women much like those of milking machines in a dairy farm. The embodied breasts of a breastfeeding woman are treated and manipulated like machines without regard for the humanness of the act of breastfeeding.

Prior to colonization and residential schooling, Aboriginal children were taught and nurtured about their culture, historical background, traditions, values, and beliefs through storytelling (Thomas, 2005). Young Aboriginal women would have seen their mother breastfeeding, and each woman's breastfeeding experience may have been shared through storytelling. By telling their stories about infant feeding practice, Aboriginal women may find support for each other that incorporates historical health knowledge

rather than the current hegemonic biomedical model (Dodgson & Struthers, 2005) often provided to breastfeeding women in current practice.

Rather than viewing the body and its parts (such as breasts) as a machine, an embodied view of women that is culturally and socially constructed can be illuminated in phenomenological research (Bergum, 1985; Gadow, 1984; Goldberg, 2005; Young, 1990a), insofar as phenomenology can support Aboriginal women's stories in a manner that will coincide with many of Aboriginal women's traditional health values.

Traditionally, Aboriginal women's health is understood as a holistic balance between the physical, spiritual, mental, and emotional aspects of the person (RHS, 2008/10). Kinship networks, education, parenting skills, and physical environments are encompassed and viewed as impacting their state of health (Saskatoon Aboriginal Women's Health Research Committee, 2004).

Numerous Aboriginal women view mental health as having an inner balance; spiritual health includes, a "strong culture, clean thought, practicing your culture and participating in a spiritual life, asking for help from your Elders or talking to someone, praying and smudging, and healing rooms, sharing, cooking, laughing" (Saskatoon Aboriginal Women's Health Research Committee, 2004, p. 6). Often emotional health is seen as being connected to physical health, women caring for others, laughing and crying together, children being happy, and talking rather than yelling at each other. Physical health means being able to do your own work, having a home that is drug and alcohol free, and where healthy, affordable, fresh, healing foods are available (Saskatoon Aboriginal Women's Health Research Committee, 2004).

Not dissimilar from Aboriginal holistic approaches to health and health care, phenomenology holds promise for fostering Aboriginal women's disclosure of their historical and traditional ways of engaging in health practices. Benner (1994) suggests that "[I]nterpretive phenomenology holds promise for making practical knowledge visible, making the knack, tact, craft, and clinical knowledge inherent in expert human practices more accessible" (p. 124). Thus a phenomenological approach may enable Aboriginal women to share traditional knowledge, skills, herbs, and remedies in regards to infant feeding practices that could potentially impact perinatal outcomes for women and children. By incorporating Aboriginal women's traditional health beliefs into breastfeeding practices, and by interpreting everyday and taken-for-granted experiences of women, an understanding of their lives through their storied narratives can be obtained (Bergum, 1991).

Feminism and Aboriginal studies

There is a diverse collection of literature in regards to feminism and its appropriateness of fit with Aboriginal women's research. Ouelette (2002) contends that feminism is not in keeping with the cultural beliefs of Aboriginal women as traditional values and beliefs are daily passed on through storytelling. Unlike Ouelette, St. Denis (a Canadian Aboriginal scholar) views feminism as a scholarly movement that can change the social and political circumstances that frequently oppress women (2007). In addition, Green (2007) states that Aboriginal scholars tend to be guarded about publicly indentifying as a feminist but insists that Aboriginal feminism is not

a unilateral rejection of cultures traditions or personal and political relationships with me. It is not a subordinate form of other feminism, nor is it a political stalking horse...instead aboriginal feminism provides a philosophical and political way of conceptualizing, and of resisting, the oppressions that many Aboriginal people experience. (p. 26)

Young (1990b) identified five faces of oppression: exploitation, marginalization, powerlessness, cultural dominance, and violence. Aboriginal women have and continue to endure these facets of oppression insofar as they continue to experience poorer health status, lower levels of education, lower paying jobs, poorer housing, and other socio-economic conditions than non-Aboriginal Canadian women and men (Dion Stout, 1996).

Feminism provides a way for women to reach their full potential as human beings (Bennett, 2006). Feminist research is non-hierarchical, interactive, reflective, empowering, and transformative so that participants' voices can be heard (Keddy, 1992). Furthermore, Goldberg (2004) suggests that feminist research that is phenomenological in nature provides a "framework capable of making the invisibility of the female gender visible" (p. 40). Van Esterik and Butler (1997) view breastfeeding as a feminist, women's, and human rights issue, as breastfeeding contributes to gender equality and empowers women. Breastfeeding may strengthen women's confidence and ownership of their own bodies and enhances the potential for women-to-women support (World Alliance for Breastfeeding Action, 1995).

Similar to Green (2007) and Van Esterik and Butler's (1997) understanding, a feminist phenomenological framework is compatible with Aboriginal research in that it provides an illumination of the aspects of Aboriginal women's lives that impact on infant feeding practices. Women's lived experiences are connected to and linked with the past

history of their people (Mohanty, 2003). Understanding Aboriginal women's struggles from a feminist lens may, in fact, act as a healing agent regarding issues related to equality and social justice for women (Evans, 1993). This research sought to provide a means for Aboriginal women's voices to be heard regarding their concerns with infant feeding. A feminist phenomenological methodology provided such a means in the context of this study.

Aboriginal philosophies

In order to pursue research with Aboriginal people, it was important to understand the underpinnings of Indigenous philosophical beliefs. According to Little Bear (2000), Aboriginal philosophy is often articulated as "being holistic and cyclical or repetitive, generalist, process-oriented, and firmly grounded in a particular place" (p. 78). Instilled in Aboriginal peoples' ways of being are deep respects for the Creator's laws, of Mother Earth's powers, and of society's democratic principles. Aboriginal people believe everyone is born equal and that the good of the community comes before individual good (Paul, 2006). Important values taught to children include respect for all people, civility, generosity, truth, honour, courtesy, justice, fortitude, temperance, liberality, harmony with all things (people, environment, and spirits), fairness, tolerance, and persuasion over punishment (Paul, 2010). This is often unlike the hierarchal, mainstream, dominant European concepts whereby people are evaluated according to rank, race, colour, religion, politics, and wealth. Within this framework the individual counts for more than the community.

Principles of traditional forms of education included the beliefs that “a child’s personal autonomy is recognized; learning is interpersonal and communal; learning is contextual and holistic; learning is multi-sensory; and learning is reflective” (Sable, 1996, p. 141). Apprenticeship learning through hands-on experience and storytelling are major components of educating young Aboriginals (Little Bear, 2000; Paul, 2006). Storytelling has been a way for Indigenous knowledge to be conveyed from one generation to the next (Battiste, 2002). The oral tradition of storytelling enables future generations to know of traditional ceremonies, beliefs, histories, and knowledge of environmental and conservation methods long utilized by Aboriginal peoples (Battiste, 2000).

In addition, the traditional viewpoint of Aboriginal health is based on balance. Health and wellness are inseparable from the physical, spiritual, mental, economic, environmental, social, and cultural wellness of the individual, family, and community (Battiste, 2000). By acknowledging these Aboriginal worldviews, health care providers caring for and conducting health-related research studies with Aboriginal people will acquire a richer and deeper understanding of Aboriginal life, including their experiences and meanings associated with their experiences. Struthers and Peden-McAlpine (2005) articulated that a phenomenological methodology is “able to capture the lived experience and illuminate the words of indigenous people themselves and is able to represent, through written accounts, the lifeworld of indigenous peoples” (p. 1267).

Method: Data Collection

According to Bergum (1989a), the goal of phenomenological research is not to produce generalizable results but instead “to ‘interpret’ and ‘understand’ rather than

observe and explain” (p. 46). Phenomenology is concerned with describing the lived experience of a given phenomena (StreuberT-Speziale & Carpenter, 2007). Several methods of data collection were utilized in order to hear, interpret, and validate the voices of the Mi’kmaw women to develop an understanding of the meaning of their embodied lived experiences (Goldberg, 2005) with infant feeding practices. Utilization of several qualitative methods strengthened the study rigour and enhanced credibility of the data obtained (Maggs-Rapport, 2000). These methods included conversational interviews, a *talking circle* (focus group), and reflective journaling. By utilizing a variety of research methods consistent with a feminist phenomenological framework, the opportunity to *discover* and understand infant feeding practices among Mi’kmaw women of Nova Scotia was both revealed in the data and constructed by the researcher.

Sampling and inclusion criteria

Participants for the study were sought through purposeful sampling. Purposeful sampling involves the “selecting and interviewing or observing of participants who have experienced the phenomena of interest” (Gillis & Jackson, 2002, p. 712), is congruent with qualitative research guidelines (Byrne, 2001; Sandelowski, 1991), and added to the study’s credibility. Twenty-two Mi’kmaw women participated in the study. This number enabled the discovering of the rich and varied experiences that support women’s feeding choices, the phenomena under study (Streubert & Carpenter, 1999). Thus, Mi’kmaw women who have birthed and cared for an infant and fed an infant by either breast or bottle were included in the sample. By including both types of feeding methods, multiple perspectives regarding infant feeding practices were garnered.

In my capacity as the researcher of this doctoral study, I have also participated in various conferences and courses with a First Nations nurse and community member who encouraged me to conduct this research with First Nations women. Women who met the selection criteria (p. 54) were informed of the study by either the perinatal nurse working in the community health centre's perinatal clinic or the community health worker. These health care providers were consulted during the development of the study and were informed of the components of the study (See Appendix A). When visiting the community health perinatal clinic, each potential participant was given a letter by one of these women introducing the study (See Appendix B). If the participant chose to participate in the study, she left her name and telephone number in a sealed envelope at the community health center for retrieval by the researcher. These women were then contacted by me, the researcher, at a mutually agreeable date and time for the interview. The community perinatal clinic nurse or the community health worker was not aware of the women who participated in the study.

Inclusion criteria for participants

1. Be of Mi'kmaw descent
2. Have given birth to a live infant having no anomalies
3. Have cared for their infant
4. Be between the ages of 18 and 35
5. Live in the [] First Nations Community
6. Be able to provide informed consent, and
7. Be able to understand, read, write, and speak English

The aforementioned inclusion criteria allowed for a sampling of Mi'kmaw women with diverse experiences across ages and stages of motherhood with infant feeding experiences. Women meeting these criteria provided first-hand knowledge regarding their experiences with infant feeding practices. As the researcher, I sought to get to *know* previously unknown dimensions of these women's life experiences (Crouch & McKenzie, 2006).

Of the 22 women who participated in the study, all had singleton pregnancies, 5 were first time mothers, and 17 had between 2 and 9 children. Thirteen of the participants were single, 7 were in common law relationships, and 2 were married. The ages ranged from 18 to 38 years, and income ranged from less than \$5,000 to \$36,000 annually. Although the criteria stated that the age grouping for the criteria was 18 to 35, when consent was to be signed at the start of a conversational interview two of the women confirmed their age to be 38. As the women had no complications and sincerely wanted to be part of the study, I recognized as the researcher that it would be exclusionary and culturally inappropriate if their voices could not be heard, so they were included in the overall study. Four participants had completed a university degree, five completed 1 to 2 years of university, one completed a business course, one completed a hairdressing course, five participants successfully completed their Grade 12, and the remaining six participants' educational attainment ranged from Grade 9 to Grade 11. Twenty of the participants received social assistance, and two of the participants were employed full time. Six of the women breastfed, 10 provided formulas, and six used both breast milk and formula as a means to feed their infants.

Setting

The setting for the study was a First Nations community in Eastern Canada.

Warry (2007) described the term *First Nations* as the “various communities of Aboriginal peoples in Canada who are not of Inuit or Metis descent” (p. 10). The terms *Aboriginal* and *Indigenous* have been used interchangeably (Asch, 2001; Warry, 2007). Throughout this study the terms Aboriginal, First Nations, and Mi’kmaq will be relevant to Indigenous peoples. The name Mi’kmaq originates from “the word *nikmaq* which means *my kin-friends*” (Davis, 1997, p. 23). Mi’kmaq people have, in the past, occupied land in Nova Scotia, in Prince Edward Island, and in New Brunswick north and east of the St. John River (Davis, 1997), in addition to Anticosti Island, the Gaspé peninsula of Quebec, land in Newfoundland (Steckley & Cummins, 2008b) and in northern Maine (Paul, 2006). According to Paul (2006), the Mi’kmaq land in Nova Scotia, was divided into seven districts: “Kespukwitek, Sipekne’katik, Eskikewa’kik, Unama’kik, Epekwitek, Aqq Piktuk, Siknikt and Kespek” (p. 10-12).

As an assimilation attempt, the Federal Government formed “Bands” of First Nations people, disrupting the traditional governance system. Paul (2006) stated that Section 2(1) of the *Indian Act, 1876* defined the term “band” as

A body of Indians

- a) For whose use and benefit in common, lands, the legal title to which is vested in Her Majesty, have set apart before, on or after September 4, 1951,
- b) For whose use and benefit in common, moneys are held by Her Majesty,
- c) Or declared by the Governor in Council to be a band for the purposes of this Act. (pp. 222-223)

The Federal Government provides monies to the Bands for distribution as each Band determines. The Band is lead by a Chief and councillors, which are normally elected every two years. The community of study had a Health Centre and both an elementary and high school where the Mi'kmaw language was taught. The closest tertiary care hospital was approximately one hour away, and public transportation was not available. The community had a grocery store, a community rink, and an active tourism program. The total population was approximately 4,000 people, and many of the residents were of the Catholic religion. There was a Catholic church, a seniors' meeting place, and a daycare within the community.

Data sources of interpretive inquiry

Multiple ways have been utilized by phenomenological researchers to obtain data in order to reach the goal of understanding the nature of the phenomenon under study (van Manen, 1997). Conversational interviews, focus groups, and journaling, along with feminist, biblical, historical, and literary sources if felt appropriate, were used to further this phenomenological study. As van Manen aptly stated:

The point of phenomenological research is to “borrow” other people’s experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole human experience. (p. 62)

Conversational interviews

The initial method of data collection was conversational interviews with 22 Mi'kmaw women to inquire into their infant feeding practices (See Appendix D). According to Streubert-Speziale and Carpenter (2007), the interview “allows entrance

into another person's world and is an excellent source of data. Complete concentration and rigorous participation in the interview process improve the accuracy, trustworthiness, and authenticity of the data" (p. 95). During the interview process, participants' descriptions of the phenomena were questioned and investigated in order to provide a clear portrayal of their experience (Wimpenny & Gass, 2000) and stories (Kaufman, 1992). The conversational interviews began with an explanation of the study and the signing of the consent form (See Appendix D), followed by talking about the participant's experience, leading into the meaning of the experience for the individual (Seidman, 1991). Information regarding the participants' demographic information was obtained prior to the beginning of the conversational interviews (See Appendix E). This information provides readers with a fuller picture of the women in the study.

The conversational interviews lasted approximately 60 to 90 minutes and were audiotaped and transcribed verbatim by a transcriber who also signed a confidentiality agreement (See Appendix F). As the researcher, I encouraged the women during their storytelling to include experiences with supports (family, emotional, financial, community, social, political) both on and off reserve, gaps in services, impact of institutionalization (residential schools) and colonization, traditional ceremonies (used or aware of), and other factors that influenced their infant feeding practices. Questions were open-ended with prompts such as "Can you tell me more," being used only if the researcher was unable to follow the flow of the conversation (Baker, Wuest, & Stern, 1992). All conversational interviews were carried out at a date, time, and location convenient for the participants. To ensure anonymity, each participant could choose a

pseudonym in collaboration with the researcher, which was used throughout the study for transcription, publication, and presentation purposes.

Talking circle/focus group

A talking circle is a traditional means used for sharing ideas, seeking understandings, and establishing new ways of dealing with everyday events of ordinary peoples' lives (Paul, 2010). This traditional circular meeting format was utilized within a focus group setting with the participants. A focus group is defined as “a semi-structured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic” (Carey, 1994, p. 226). Four to six weeks following completion of the initial conversations, participants were invited to a talking circle/focus group to collect further descriptions of their experiences and to clarify any concerns (See Appendix H; Appendix I). The intent of the talking circle/focus group was to enable a small group of women to meet to discuss the phenomenon (infant feeding) that could further enrich the data being collected (Kitzinger, 1995).

A consent form was obtained (See Appendix J) prior to the start of the focus group discussion. Each participant was given the opportunity to speak or to remain silent during the talking circle/focus group. The duration was approximately 60 minutes, was audiotaped, and was transcribed verbatim by a transcriptionist (See Appendix G). Food was provided for each participant. An opportunity to meet individually with the researcher following the talking circle/focus group was arranged, if desired.

Reflective journaling

Throughout the study, I, as the researcher, kept a reflective journal to store information relating to thoughts, interpretations, sayings, impressions, successes, barriers, etc. According to Gillis (2001), journals are “personally written accounts that promote expression of perspectives, ideas, and feelings” (p. 49). Journaling is a means to connect theory, practice, and self to the research study (Benner, 1994). Hand-written field notes or research notes were part of this journaling. These notes, along with the transcribed verbatim interviews, enabled a more comprehensive and exacting account of the phenomenon under study (Streubert-Speziale & Carpenter, 2003). Notes made in the reflexive journal written after each interview and focus group assisted with data interpretation.

Data analysis: Thematic analysis

“Data analysis requires that researchers dwell with or become immersed in the data” (Streubert-Speziale & Carpenter, 2007, p. 96). The data from this study was analyzed thematically using the phenomenological existentials of body, time, space, and relation (Merleau Ponty, 1962; vanManen, 1990). Utilizing these concepts during the analysis provided for a deeper understanding of the experiences of the Mi’kmaw women. van Manen (1990) indicated that a phenomenological researcher seeks to (1) uncover themes, (2) isolate thematic statements, (3) compose linguistic transformations, (4) glean thematic descriptions from artistic sources, and (5) determine essential themes of the phenomenon under study (pp. 89-99).

A theme has been defined as “an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole” (Desantis & Ugarriza, 2000, p. 362). Once the themes were explicated, they were explored looking through a feminist phenomenological lens to illuminate the lived experiences of Mi’kmaw women with infant feeding. To further interpret the data, existential themes of corporeality, spatiality, temporality, and relationality were further utilized within a feminist interpretation that was conscious of the impact of gender, power, and oppression on women’s lives.

Corporeality (the lived body) is an important aspect of a woman’s infant feeding choice. How a woman views her body or perceives how others view her body can greatly impact if or how she chooses to breastfeed her infant. Further, how her partner, society, and/or media views her body also influences her infant feeding choices (Hannan, Li, Benton-Davis, & Grummer-Strawn, 2005; Ryan, Zhou, & Gaston, 2004; Wambach, 2004).

A woman’s lived space (spatiality) frequently influences her infant feeding practices. van Manen suggests (1990) that “the space in which we find ourselves affects the way we feel . . . a sense of lostness, strangeness, vulnerability . . . we become the space we are in” (p. 102). If a woman’s space, her home, her workplace, her educational institutions, or her community are not supportive of breastfeeding, her infant feeding options are limited (McIntyre, Hiller, & Turnbull, 2001).

Women's lived experiences possess a "strong temporal component whereby the past informs the present, and the past and present enlighten future actions" (Struthers, & Peden-McAlpine, 2005, p. 1269). This holds true with infant feeding practices.

Understanding the teachings of the past and how the past has impacted upon the infant feeding practices will provide a deeper understanding of Mi'kmaw women's infant feeding practices.

Lastly, the term *relationality* refers to the relations women have with others (van Manen, 1990). Infant feeding is influenced not only by the relationship that a mother has with her infant but also by the relationships she has with her partner, mother, relatives, and others in her community (Riordan & Wambach, 2010). Analyzing the narrative text utilizing the existentials of corporeality, spatiality, temporality, and relationality assisted in providing a deeper understanding of Mi'kmaw women's experiences with infant feeding, specifically when viewed through a feminist lens accounting for issues of gender, power, and oppression in their lived experiences.

Ethical considerations

Ethical approval for the study was sought from the Dalhousie University Health Sciences Human Research Ethics Committee. Following this committee's endorsement, approval was sought from from Saint Francis Xavier University Research Ethics Committee and the Mi'kmaw Ethics Watch Committee³, prior to commencement of the

³The Mi'kmaw Ethics Watch Committee, in particular Dr. Marie Battiste, who along with Elder Murdena Marshall provided essential support in amending the title of the thesis and in understanding of the Mi'kmaw language.

study. The principles outlined by the First Nations Centre (2007) regarding ownership, control, access, and possession (OCAP) were adhered to throughout the study. These principles empower the First Nations community, provide a holistic approach to research, ensure relevance of the research to the community, ensure consent and inclusion in the interpretation of findings, insist upon shared community ownership, recognize participants' contribution, protect against stereotyping and stigmatization, and protect traditional knowledge.

The ethical components of the study associated with the Mi'kmaw women participants include informed consent, an understanding of the risk and benefits, and confidentiality/ anonymity. Informed consent was established with all participants in the conversational interviews (See Appendix D) and the talking circle/focus group (See Appendix G) prior to commencement. Participants were advised that they could withdraw from the study at any time and that participation in the study was voluntary.

There were no anticipated risks for the participants associated with this study. If any concerns arose relating to physical or emotional trauma and a participant wished to speak with a professional regarding their concerns, a registered nurse from the Community Health Centre agreed to be a resource. Possible benefits of the study included a deeper understanding of Mi'kmaw women's infant feeding practices and overall health status that could influence nursing practice, nursing education, provincial and federal health policies, and perinatal outcomes for Mi'kmaw women and children. Often, participation is beneficial for participants as it provides voice to their lived

experiences. In keeping with Indigenous research principles, participants were presented with an honorarium (gift) of \$20.00, and food was provided for the talking circle.

All information was kept confidential; the raw data was viewed only by the researcher, members of the dissertation committee, and the transcriptionist (See Appendix G). Confidentiality of conversations taking place in the focus groups could not be assured, although the importance of confidentiality was discussed prior to commencement of the focus group. All information relating to the study is currently stored in a secure and locked cabinet in the researcher's office at Saint Francis Xavier University. Data were entered into a password-protected computer and were anonymized. Knowledge of the participants' involvement in the study was known only to the researcher, unless the participant attended the focus group where anonymity could not be assured. All participants chose, in collaboration with the researcher, an anonymous name. This name was utilized throughout the study and dissemination of findings.

Significance of the Research

As Goldberg (2005) so aptly wrote, "Nurses' and women's experiences provide the very tools for questioning, deepening and changing their own practice" (p. 411). It is therefore incumbent upon nurses to conduct research with Aboriginal women to advance culturally safe, meaningful, gender specific, and realistic perinatal health care. This feminist, phenomenological study provided an understanding of the experiences of infant feeding as articulated by Mi'kmaw women. The research aligns with the suggestions put forward by NAHO (1996) for maternity care with First Nations and Inuit communities:

Identifying a need for gathering and teaching traditional knowledge, inter-agency coordination, and changes of hospital protocols in order to ensure that meaningful healthcare is both provided and received (Westerholm, 2009).

Ongoing cultural learning acknowledges that everyone has their unique and individual lived experience that cannot be based on generalizations regarding ethnicity, location, etc. (Westerholm, 2009). Nurses can gain knowledge about traditional medicines and work with Aboriginal healers to integrate both Aboriginal and western medicalized types of treatment. Conversations between nurses and Aboriginal women are essential for relationships to develop and knowledge to be shared about their lived experiences, in particular for this study related to their infant feeding experiences. Gadow (1994) suggests, “relational narrative requires only the recognition that any situation is a story, a humanly constructed set of meanings that make sense out of phenomena” (p. 306).

Attending and reporting the findings of the current research at Aboriginal conferences and increased inclusion of Aboriginal healers in educational programs and in classroom settings will provide an increased awareness for nursing professionals of the health beliefs of Aboriginal women. The research may also encourage perinatal educators to invite Aboriginal women to participate in the development of perinatal curricula, thereby increasing capacity building with the Aboriginal community. If we are to transform current Eurocentric knowledge “in all levels of education, curriculum, and professional practice” (Battiste, 2000, p. xxi), that transformation begins with the inclusion of Indigenous traditions, knowledge, and heritage.

Enhanced knowledge will thus enable nurses to provide respectful, culturally sensitive (Purnell, 2002), and culturally safe care. Culturally safe care has been described as care that supports healing through the recognition and respect for the rights of others (Wood & Schwass, 1993; Wright, 1995) and by understanding that individuals' life experiences are shaped by a multicomplex web of issues. Trusting in one's nurse enables women to share their storied life experiences (Goldberg, 2008). The lessons learned from these stories with Aboriginal women call for sharing in undergraduate and graduate classrooms, among practicing perinatal nurses, and with community health nurses. The Reproductive Care Program (RCP) of Nova Scotia, which provides leadership for perinatal care, needs also to be encouraged to obtain and distribute information to the various Health Districts of Nova Scotia regarding Aboriginal women and children's health concerns and of their experience with infant feeding. Forms (consents, etc.) required in such programs need to be available in the languages of Aboriginal women, and posters and media presentations could reflect the images of Aboriginal women and children, furthering the idea of Aboriginal people being in control of their own health status. Lack of visibility of Aboriginal people has often been seen as a barrier to health care (Duran & Duran, 2000).

Summary

This chapter provided an overview of the qualitative, feminist, phenomenological framework that was utilized to conduct the study. The nature of the study related to the infant feeding experiences of Mi'kmaw women; it supported relationship building, provided an opportunity for sharing of knowledge, and enabled Mi'kmaw women's

voices regarding their infant feeding practices to be heard. The next five chapters provide information on findings of the study and on final reflections. The four themes in the chapters that follow are 1) *Going it Alone—Web of Relationships*; 2) *Finding a Space...Living in Poverty—Is Anyone Listening?*; 3) *Is Breastfeeding Right for Me? It's My Choice –Respect My Choice*; and 4) *Understanding Our Time*.

Chapter 4:

Going it Alone—Web of Relationships

I would say that if I have to do . . . if the burden is on me to do everything, there's no break for me at all. I think I would just appreciate a break (laughs). But I've been a mother for . . . years, and I've been doing it by myself. I had a husband; I still did it by myself. I had boyfriends; I still did it by myself. You know what I mean? (Rebecca)

As Rebecca clearly articulated in the above narrative, in our lived worlds, despite the relationships that we develop with others, and how they influence the meaning of our lives, there is a sense in which there is a burden to the self. Yet, “[R]elationality refers to lived relationships with others inside shared lifeworlds (mostly women, their partners and their babies)” (Lawler, Sinclair, & Dase, 2003, p. 39). The more support and security that one has in one’s relationships, the more likely one is to be successful in one’s life endeavours.

The overarching literature suggests the Mi’kmaq Nation was a matriarchal society (Hoffman, 1955; Marshall, 1991; Robinson, 2005). Berneshawi (1997) stated, “The social organization of the Mi’kmaq Nation was matriarchal, egalitarian and family centred, where living with extended families was common-place.” (p. 118) Children were taught, tended, and raised by parents, grandparents, Elders, and other members of the community. Grandmothers were seen as members of the community that kept the families together (Robinson, 2002). Paul (2006) stated that “children were raised in an atmosphere of communal devotion” (p. 20). Currently however, repeated victimization of Mi’kmaq families and communities through colonialism, genocide, assimilation, residential schooling, lack of self-determination, poverty, and racism (Bonn, 2002) has

left a lasting and often detrimental physiological and psychological impact on Mi'kmaw people and subsequently their lives and those of their children. These conditions frequently have led to a change from an environment of communal support for growing families to one whereby women are often the sole support for themselves and their children.

In the next chapters (4 – 7), four themes are illuminated with stories of the participants, like those of other Indigenous women, reflecting accounts similar to those of women living experiences of single parenting, abusive relationships, and the use of alcohol, illicit drugs, and tobacco (Janssen, Holt, Sugg, Emanuel, Critchlow, & Henderson, 2003). These situations impact immensely on women's relationships and subsequently on their decision to feed their infants by breast or bottle. For as Cameron (2004) stated, "...what we experience and understand in that moment, we carry with us into the next moment that awaits." (p. 61)

In what follows I discuss the theme, Going It Alone—Web of Relationships, which the women participants in the study encountered on a daily basis within the context of their lived experience with feeding their infants. They spoke of "going it alone," of the relationships with women, men, and health care providers that had an impact on their infant feeding decisions.

Going It Alone

The women in the study were resolved to the situation that they found themselves in, which they lived and embodied on a daily basis. The sense of feeling alone caused

worries for the women. van Manen (2000) described this type of worry that parents often feel:

To have children means that one will never be able to just sleep. Caring for one's children is a kind of worrying mindfulness...I conclude that this caring-worrying is really a very human response to vulnerability in others, it is what philosophers such as Emmanuel Levinas (1993), Jacques Derrida (1995), and Knud Logstrup (1997) have described as the moral ground of human existence. (p. 319)

The women frequently carried the responsibility for this 'caring-worrying' for their infants all alone. They had no preconceived expectations from their partners, unlike countless women in mainstream society who anticipate and prefer their partners to actively participate in their infants' care (Riley & Glass, 2002). The participants often found that they had to care for their infants and make decisions regarding care alone. The word *alone* originates from the Old English saying *eali ana*, meaning "having no one else present; on one's own; without others' help or participation; single-handed" (Oxford University Press, 1984, p. 23). As Samantha, one of the participants stated:

so I think I get more of the responsibility of buying Pampers, clothing . . . and even like personally, I don't even expect my husband to buy anything because it's just assumed that I'm going to get it anyway. So I don't even ask him for help and he doesn't offer to help.

According to Little (2001), single parent mothers living in Canada are progressively being more marginalized and seen as a drain on society. Women living on social assistance funds are frequently seen as lazy, with their only activity as being that of watching television (Little, 2001) or engaging in other social media activities. Blackstock, Trocme, and Bennett (2004) reported that Aboriginal families were more apt to be led by single women and receiving social assistance than any other visible minority

group. Many (See Appendix I) of the participants in the study were single parent mothers and receiving social assistance. Their days were spent mainly in providing care for their infants. If their infant needed medical attention, or if they needed groceries, they walked several miles, out of necessity, with an infant in a stroller to obtain what they needed. While they may have indeed watched television or used social media devices, it was by no means their only activity.

The women participants frequently did without for themselves in order to provide for their children, as Rebecca stated:

Yes, there were times where I didn't eat three times a day just so my kids I mean I wouldn't eat for 3 days because I needed my kids to have enough food to eat. I had to like put . . . I lost so much weight during that time.

It was heartbreaking to sit and listen to stories such as Rebecca's. But during my visits to the participants' homes, I was often offered something to eat or drink. It was humbling to have this hospitality extended to me, when I knew that many (See Appendix I) of the women barely had enough to get by. The women in the study were always willing to share with me whatever they had; I quickly learned to bring juice packs and granola bars to share with the families, in order to feel I was not causing any further burden on these women. Women living under such circumstances may be limited in their ability to fully participate in society at large and to be supported in their choices for infant feeding, which fit with their life circumstances.

For Little (2001), this is the type of sacrifice that lone mothers frequently make in order to provide care for their children. Even when there was food available in the

home, the women agreed that there were several factors regarding women's life choices that impacted upon infant feeding preference, such as certain foods in the diet, smoking, drinking, and other forms of socializing (going to the movies, or to the casino, etc.). Stephanie missed socializing with her friends and clearly articulated how it influenced her life and sense of being alone:

Because there are some people that just stay home and not talk to anybody anymore ever since they have their baby. And you'd be hanging out with so many people, all kinds of people, until you get pregnant and they don't want to see you again. Like they don't want to hang out with you anymore. Like that kind of way.

In order to breastfeed and meet what was considered best for the infant, women considered breastfeeding as an act of "self-sacrifice" (Rebecca). A 'sacrifice' that women alone were to bear. While breastfeeding is often seen as the 'normal' biological way of feeding infants (Murphy, 2000; Sheehan, Schmied, & Barclay, 2010), women have reported "experiences of encroachment of the body/self as a result of the "demands" being constantly made on their body by the practice of breast-feeding" (Williams, Donaghue, & Kurz, 2013, p.98).

The choice for an infant feeding method was often made out of necessity relating to financial concerns or housing conditions rather than that of a personified belief in either breastfeeding or formula feeding. As Elizabeth explained "I was broke and my boyfriend was broke and I didn't know what to do so I just started to breastfeed." Elizabeth did not choose to breastfeed due to the health benefits of breast milk for her infant, or because it was a decision that she made because she wanted to breastfeed. The decision was not one of choice but one made due to her limited circumstances. Goldberg

(2003) stated, regarding choices for women, that “the choices available . . . are often constructed within an oppressive framework” (p. 582). Lack of funds for formula was frequently cited as a reason for starting breastfeeding. When funds became available, some (See Appendix I) of the women’s infant feeding choices changed to a combination of breast and formula or to total formula feeding. Lack of funds for those wanting to formula feed led to a lack of real choice in their infant feeding choice, leading to feelings of isolation, loneliness, and a sense of burden regarding their infant feeding practices and care. As Elizabeth stated, “It [breastfeeding] was hard for me because I felt like I had to do everything, I had to do the feeding and I couldn’t rest . . . it felt like I was just doing everything.”

Rebecca’s and Elizabeth’s infant feeding practices were less about informed choice regarding infant feeding practices and more about the circumstances in which they found themselves. While breastfeeding is body work done by the mother alone (Waring, 1999) — which when done without support can lead to the mother feeling that she is solely responsible for her infant feeding needs—it is important to recognize that infant feeding, regardless of the means, often involves work by the mother. Jillian, who bottle fed, reinforces this when she spoke of her infant feeding experience: “No, no one else had...I was the first one of my friends that had a baby. Yes, basically it’s just me. But my sister upstairs, she’ll...she does a few things but not much. It’s mostly myself.” Rubin (1984) depicted motherhood for many women as a change in self from one of knowing oneself in a known world, to being an unknown in an unknown world.

Shortt, McGorrian, and Kelleher (2012) reported that among low-income women in the Republic of Ireland, key factors influential upon their infant feeding decisions were observation of family members with either breast or bottle feeding; embarrassment of breastfeeding in public and at home, which was seen as a barrier to breastfeeding; balancing the needs of the mother and infant, as breastfeeding was viewed as inconvenient and required tremendous determination; and breastfeeding difficulties with little knowledgeable and experienced support, that utilized a non-pressured manner.

Similar to these Irish women, some (See Appendix I) participants of the study found that breastfeeding their infants left them in a place of social isolation where they were confined to their homes, not feeling comfortable breastfeeding in public domains. Often the participants made it known that when they were breastfeeding, their usual circle of social support changed. As was clearly articulated by Stephanie, “there was really nobody that comes over, and I could just sit on the couch and breastfeed.” It was difficult to listen to Stephanie, when she talked her face was sad with tears glistening, and I could actually feel her sense of aloneness. Her partner was going away to seek work and Stephanie was feeling very much alone for a multitude of reasons. However, I felt our conversation was an engagement, whereby Stephanie had someone present that was listening to how she was. Cameron (1992) stated: “Being there for someone in deep distress, helping to relieve that distress while trying to preserve the dignity of that human being: this call for the nurse to be wholly present” (p. 184). On that particular day, I felt our conversation did this for the participant.

Prior to having an infant to feed, women found that friends dropped over to visit on a regular basis or they were able to go out with ease to be with their friends. Breastfeeding women in the study found that they could not easily leave their infants with kin if they wanted to go out for an evening and that their friends did not want to stay in due to infant needs. When this occurred, young women felt very isolated and deserted by their peers.

Often women who, like Samantha, had partners still felt the need to do everything on their own, even when asked if they had a mother, grandmother, or aunt to call upon for help if needed. The women wanted to be independent but often were overwhelmed with their life circumstances. The combination of trying to manage everything on their own with an infant who was solely dependent on them for nourishment often overcame the breastfeeding mothers. Women who recounted having sole responsibility for a household often discontinued breastfeeding at a much higher rate than those with support (JOGNN, 2004). But even formula-feeding participants voiced their experience of “going it alone,” as explained by a mother of a formula-fed infant “Nobody . . . nobody . . . (the baby) cried a lot, and nobody helped me” (Jessica).

Bondas-Salonen (1998) reported three challenges for health providers caring for new mothers: “to understand the meaning of caring, to involve family and mothers more consciously, and to see the woman as a new mother who needs both to care and be cared for both by her family and friends and by professional carers” (p. 165). If this type of care were provided, women like Jessica may not have felt so alone and without help and support. Gadow (2003) explained that health care providers, in particular nurses,

who engage with their patients to create a plan of care, will define and describe “the good they seek in their situation” (p. 164).

The sense of going it alone in making decisions and in self-sacrificing deeds, as well as truly being alone, all demand a great deal from women both physically and mentally. Lack of support and confidence in one’s choices can impact immensely on a person’s health outcomes (Marmot, 2004a; Wilkinson, 2005) and thereby their family. Although the women regularly had to manage on their own they did provide a portrayal of the complex web of relationships that provided them with support. The women prioritized their sources of support as being women (their grandmothers, mothers, sisters, and female friends), men (partners, grandfathers, brothers), and health care providers.

Relationships with Women (Kin and Others)

Aboriginal kinship supports connection to family, extended family, and the community at large (Cross & Day, 2008). According to McMillan (2011), “kinship networks order all relations past, present and future. They order belief systems, governance, land use patterns, and play a key role in education” (p. 10). Traditionally this type of network supported communal parenting, role modeling, and encouragement of important aspects of everyday lived experiences (Chang & Hayler, 2011). Kin has been interpreted as “an extended family where a mother’s sister is not an aunt but rather a mother, and her female offspring are considered sisters rather than cousins” (Dietsch et al., 2011, p. 59). LeClercq (1910) observed the following regarding the Mi’kmaw kinship relationships, “You will see them supporting their relatives, the children of their friends, the widows, orphans, and old people, without ever expressing any reproach for

the support or the other aid which they give them” (p. 245). Through kinship relationships, children are taught rules and values of the Mi’kmaw people by parents, grandparents, and other members of the extended family (McMillan, 2011). While this kind of support was not always available due to the impact of colonization, residential schooling, and government policies (assimilation, acculturation, and elimination), the women in the study spoke of the assistance they received from their kin, be it mothers, grandmothers, aunts, and sisters in regard to their everyday life experiences, including their infant feeding practices. As noted by Rebecca, both her grandmothers provided advice and shelter when needed:

Yes, both of my grandmothers are passed away. And you’re right, when I look back, I think I really did. I actually did go to my grandmother and mom to get anything from diaper rash to native medicines to anything. And I was allowed . . . like if I needed a place to stay, her house was always open.

Grandmothers and their homes were spoken of as safe harbours for the participants in the study. According to McMillan (2011), following colonization,

Violence in the family escalated and the women spent more time protecting their families from drunken husbands than in preparing the meat, skins, tools, and shelter for them. Alcohol misuse and colonial ideologies, which valued male supremacy and Catholic patriarchy, negatively altered customary attitudes of reverence and respect toward women and disrupted men’s traditional duties to protect, provide for and nurture the family. (p. 38)

Participants spoke of staying with their grandparents, even in their childhood. This was noted by Jessica when asked about her support system. She stated “mostly my grandparents. I was mostly with my grandparents . . . my mom lost her kids and I just kept staying with them.”

According to Kirmayer, Simpson, and Cargo (2003) the continuing transgenerational impacts from the effects of residential schooling include:

[T]he structural effects of disrupting families and communities; the transmission of explicit models and ideologies of parenting based on experiences in punitive institutional settings; patterns of emotional responding that reflect the lack of warmth and intimacy in childhood; repetition of physical and sexual abuse; loss of knowledge, language and tradition; systematic devaluing of Aboriginal identity; and, paradoxically, essentialising Aboriginal identity by treating it as something intrinsic to the person, static and incapable of change. These accounts point to a loss of individual and collective disempowerment and, in some instances, to the destruction of communities. (p. S18)

Jessica further explained that by going to live with her grandparents, she was freed from being placed in a foster home, which often happened and continues to occur in First Nations communities. Foster care and adoption policies enforced by the Federal and Provincial governments during the 1960s, 1970s, and 1980s ended in the placement of many Mi'kmaw children into non-Aboriginal homes (MacDonald, Glode, & Wien, 2005). During the 'Sixties Scoop' Aboriginal children were removed from their homes as a result of these policies, where overcrowding, domestic violence, poverty, and inappropriate upbringing of children (deemed so by the state) were given as the reasons for the children being taken away (Fournier, & Crey, 1997; Kirmayer et al., 2003). It is reported that there are, at present, three times the number of Aboriginal children currently in the care of welfare agencies than were stationed in Residential schools during their highest enrolment (Blackstock et al., 2004). Mi'kmaq Family and Children Services (2010) reported that there were 359 Aboriginal children in the agency's care. In order to prevent Mi'kmaw children from being placed in foster care homes, many of which are non-Aboriginal, the children go with their grandparents.

McMillan (2011) stated that grandparents of Mi'kmaw children continue to be a main source of child-care when parents are unable to provide care due to addiction concerns, attendance at school, or employment. Grandparents often provided that 'safe place' for many Mi'kmaw women and children. Wilson (2010) stated: "A person's perception of a place is as much shaped by adversity, dislocation, longing, trauma, anger, frustration, death, and abandonment as by happiness, freedom, and contentment" (p. 299). There is, however, a paucity of information regarding breastfeeding of fostered children by foster mothers. In the United States, if this issue is brought forward a decision is made on each individual case (Bar-Yam, 2005). Grandmothers in parts of the world have breastfed their fostered grandchildren, although the prevalence of this practice is not found in the literature (Brown, 1978; Marieskind, 1973; Slome, 1956).

While support from her mother was not available and continues to be of concern for Jessica, her grandmother and grandfather provided her with the support she needed growing up. As a young girl, she could recall seeing family members breastfeeding their infants, but—more influential on her feeding choice—Jessica, remembered her grandmother and other family members using canned, evaporated milk. Canned, evaporated milk began being used during the 1900s, and was promoted as easy to store and transport, even during the summer heat (Nathoo & Ostry, 2009) and was widely used by Canadian women. Jessica's grandmother, like many women in Nova Scotia, used canned evaporated milk. And like her, this mother chose not to breastfeed but to use formula for her infants. Grandmothers, mothers, aunties, sisters, and female friends' advice and support frequently had influence on the women's infant feeding choice. If the

mother came from what she termed a “breastfeeding family,” she would more often than not opt to breastfeed her infant. As reflected in the following by Nancy:

Because I had my friends, they like . . . they stopped breastfeeding early because like they had a hard time. Like I almost quit because my baby wasn't latched on right. I think, I was like wanting to quit. Like my mom and my auntie, they helped me and I find they just supported me.

Much like Nancy's words above, women who had the opportunity to be with mothers, other family members, or friends who were breastfeeding had increased confidence with their own breastfeeding experience (Grassley & Eschiti, 2008). Aboriginal women in Perth, Australia indicated that the support of the infant's father, maternal grandmother, and other family members were essential if they were choosing to breastfeed (Binns et al., 2004; Scott, Landers, Hughes, & Binns, 2001). Family members' preference for feeding type, in particular those of the partner or grandmother, greatly influenced women's choices of infant feeding. If the partner or grandmother preferred bottle feeding to breastfeeding, the women opted for the same type of feeding or breastfed for a very short duration of time.

Tension that may occur with kinship relations in regards to infant feeding may relate to how the information provided is often based upon the family member's personal experience rather than on current best practices for infant feeding. When a kin's advice counters what a woman may have read or was given by her health care provider, it can cause frustration for a breastfeeding mother and often leads to the discontinuation of breastfeeding.

The complex web of relationships with varying family members provided support (emotional and financial), mentorship, and education for a variety of infant feeding practices of the participants. Many (See Appendix I) of the women spoke of how grandparents, sisters, and female friends would introduce or encourage feeding cereals to their infants between 2 and 3 months of age. Tea and cheese puffs/cheezies were other food products added to their infant's diet at a very early age (anywhere from 6 to 12 months of age was seen as normal), via family members. Infants like the sweetened tea, and the cheese puffs melt in their mouths without causing any choking concerns. A participant stated "I fed my baby at 6 months [cheezies]," (Samatha), and another replied with this remark:

Or when you leave, a babysitter, they come back with their face all orange. So it's not something I would do but once they're into it, okay, we go shopping or whatever and they start crying for the cheezies. So you just throw a bag in and settle them down. (Stephanie)

The women agreed that children were introduced to 'pop' at birthday parties, usually by the time they were using a sippy cup, and pop was guaranteed to be a beverage served at their children's first birthday party. The following statement by Rebecca encapsulates the concerns the women in the study encountered in their daily lives:

And I mean like I really taught my kids like throughout the years . . . none of my children are obese because I was really strict with how they eat. But on reserve, it's even . . . like they brag about, oh my baby finished . . . even if he's an infant . . . my baby finished 8 ounces . . . and the baby is only like 3 months. Or my baby finished two bottles . . . or even obesity, I find that extremely. Because if you eat one type of food like Kraft dinner or Mr. Noodles, these babies are going to be humungous.

Financial struggles were a concern for all participants in the study, regardless of feeding choice. Women in the study reported that if they were short of funds for infant formula they would either borrow formula from a sister or friend, or would ask an auntie, mother, or grandmother for funds to enable them to purchase formula. Tara stated: “I would call [partner’s] parents . . . or my godmother,” if she ran out of funds for infant formula. Breastfeeding mothers received extra funding from the Band for milk for them to support their diet, but this was often used to purchase milk for children and other family members. The mothers did without the proper nourishment in order to provide for their families. Each participant’s story uniquely told of the lived experiences and circumstances of her life (Bergum, 1988).

When asked what they would do if they felt they had a shortage of breast milk or if they had to be away from their breastfeeding infants, the participants felt that formula would have to be given. They were adamant that they would not have another breastfeeding mother feed their infant (wet nursing) or use another mother’s breast milk and bottle feed. In the past wet nursing was a common practice in many Indigenous cultures (Dodgson & Struthers, 2010). At the talking circle a participant confirmed this practice and told of how her mother and auntie would breastfeed herself and her cousin. If either of the women were away from their infant for whatever reason, they would feed each other’s infant.

Wet nursing other women’s infants may be a means for women to have a break from breastfeeding or provide a means of feeding if women are away from their infants, so that women do not feel they have to do everything on their own. However, while

utilizing other women's breast milk may provide financial savings as compared to purchasing formula or provide a means of support for a breastfeeding mother, it was not something these participants could consider ever doing. So while informational and financial supports were important parts of the close kinship network among the women, providing breast milk to other women's infants was not viewed as a viable option.

During the talking circle Rebecca reiterated this belief, to which others agreed:

I wouldn't be able to do it. Like really thinking about it, I wouldn't be able to have another woman breastfeed my baby or me breastfeed another baby, unless like the baby didn't have bottles and formula and it was a matter of survival.

Not dissimilar from Rebecca, Samantha felt that she would only use another woman's breast milk to feed her infant if there was absolutely no other means to provide nourishment to her infant. She had worries about the content of other mother's milk. Samantha stated, "You don't know these people. You don't know if they're consuming different kinds of medication." Women in the study were worried that mothers may use drugs, smoke, or consume alcohol, so they were not comfortable with utilizing other women's breast milk, even if it had been pasteurized and could be obtained from a regulated breast-milk bank.

Giugliani, Caiaffa, Vogelhut, Witter, and Perman (1994) reported that family and friends' advice regarding infant feeding was more valued than any given by health care providers; a very different relationship in the complex web of relationships occurred with health care providers as compared with kin. What was noted throughout the study was that kin had an investment in the infants and most supported new mothers by providing advice regarding infant feeding methods. The women in the study valued and followed

the advice of their kin in regards to their infant feeding choices, but more importantly, regardless of their infant feeding choice, they valued their infants, as summarized by this poem by Gladys Taylor, an Elder from Curve Lake Reserve, in Peterborough, Ontario (Williams, 2009):

What Are Our Children Worth?

*All people place a value,
On things they call their own,
Their clothes and cars and jewellery,
Their friends, their health and home.*

*The possession of greatest value,
We will ever have on earth
Makes me ponder this question,
What are our children worth?*

*So gather your children around you,
Guard and guide them with hand and heart,
For all too soon will come the day,
When you and they must part.
Then all your days will be lonely,
You will miss their youthful mirth,
All our love and all our life,
That's what our children are worth. (pp. 15–16)*

Indigenous women, indeed women worldwide, have learned how to care for their infants through the relationships and role modeling provided by other women. They teach each other how to survive and care for their own, their families, and their community's needs (Hill, 2009). Additional members in the 'web of relationships' identified by the participants in the support of their infant feeding choice include men, be it husband/common-in-law partner, brothers, or their own fathers.

Relationships with Men (Husband/Common-in-Law Partner, Brothers, and Mother's Father)

When speaking of kin relationships, the participants ranked the level of importance of the various members. According to Brittany, “the bottom [being line of importance for kin support] would be the men” in the hierarchy of importance. Other participants during the Talking Circle agreed with this perspective on the position of men in their relationships. First Nations men and other Indigenous men worldwide face many challenges in their journey of fathering. Colonialism and its effects on the social, economic, and political lives of Indigenous peoples has limited the inclusion of men, put up barriers, and caused difficulties for them that often hinder their engagement in the lives of children and in programs put forward by government for the health of children (Ball, 2009). Barriers to positive fatherhood involvement include “socioeconomic exclusion due to failures of the educational system, ongoing colonization through Canada’s Indian Act, and mother-centrism in parenting programs and child welfare practices.” (Ball, 2009, p. 29)

First Nations men may lack parenting skills as a result of having no role models to follow as they or their parents were survivors of the residential school system (Lawrence, 2004). This intergenerational transmission of trauma has left gaps in the men’s fathering abilities and placed them often in a “role and set of relationships that have little personal resonance” (Ball, 2009, p. 32). Aboriginal men often live in poverty, are homeless or live in poor quality housing, have lower education, higher unemployment, and are incarcerated at a higher rate than other populations (Statistics Canada, 2001; White,

Maxim, & Beavon, 2003). Furthermore, in Canada, compared to other ethnic groups, Aboriginal men have the highest rate of drug dependency, mental illness, and suicide (Kirmayer et al., 2003). Given these challenges, there can be little doubt as to why Aboriginal men may have difficulty in participating in child care decisions and in caring for their infants and older children.

The women spoke of experiences with male kin who had problems with unemployment, addictions, and incarceration. While men may not participate in all activities, the participants told of how relationships with men in their kinship circle impacted their infant feeding decision. The participants told of their taken-for-granted experiences with men in their lives and how their experiences with men influenced many of their decisions and care in regards to their infants.

Amanda, one of the participants, started breastfeeding but stopped as she felt her infant was not getting enough milk, and found the expenses of providing formula and other living expenses to be very hard, even though she had a partner. Her partner was from another Aboriginal Band; therefore, he was not eligible to receive assistance from the Band where he was living. Although Amanda was employed, she was not earning enough to meet her meagre needs. She stated: "Because he's [her partner] not from this Band so he don't get anything from this Band . . . it doesn't do anything. It's costing me a fortune." Amanda's partner did not provide input regarding her infant feeding decision to breastfeed, to discontinue, or to bottle feed. Amanda made the decision to discontinue breastfeeding based upon her concern for her infant. Supports for both feeding options were limited. A decision such as the one made by Amanda due to limited options

becomes an economic decision that associates breastfeeding with poverty in people's minds (Dodgson & Struthers, 2003).

The evidence suggests that women are more likely to breastfeed and to continue breastfeeding if their family, especially their partner, is supportive of their decision (Cardenas, & Major, 2005; Cattaneo, & Guoth-Gumberger, 2008; Clifford, & McIntyre, 2008; Meedya, Fahy, & Kable, 2010; Rempel & Rempel, 2004; Tedder, 2008). For the participants, the choice to breastfeed or bottle feed was a decision that often mirrored that of other women in the kin relationships rather than that of a male partner. Despite this fact, it has been acknowledged that the tension and contradiction regarding the importance of support from men for breastfeeding usually comes from women's perspectives rather than that of the men themselves (Sherriff & Hall, 2011). There is a paucity of information regarding men's experiences with their partner's breastfeeding experiences and the provision of support (Rempel & Rempel, 2004; Sherriff & Hall, 2011). Fathers have been reported to be jealous (Jordan & Wall, 1990) and often embarrassed about their partner's choice in breastfeeding (Henderson, McMillan, Green, & Renfrew, 2011). Furthermore, breasts are often considered to have more importance as sexual objects for men's pleasure than for infant feeding purposes. Caucasian men from a low-income area were reported to view bottle feeding as a much safer and a more convenient means of feeding their infants (Henderson et al., 2011). However, the perspective of Aboriginal men regarding infant feeding choices has yet to be explored. With the diverse and conflicting, cultural, social, political, and health issues confronting

Aboriginal women, if a partner's support is important for the success of breastfeeding, research is required in order to bridge this gap in information.

Some (See Appendix I) of the participants grew up in homes where parents were separated. Of these, a few (Appendix I) of the women continued to have contact with their fathers; a few (See Appendix I) wanted nothing to do with their fathers. However, of the ones who continued to have relationships with their father, he was often the one they turned to for funds for formula, for transportation, and for assistance with finding housing for themselves and their infants. The women in the study did not say why their fathers seemed to have financial resources, but several of the women reported that their fathers knew members of the Band, were employed, owned homes, or were in contact with members of the community who had houses or apartments for rent. The participants' fathers were seen to have more collateral resources than the participants' mothers in nearly all situations. As Halseth (2013) stated, powerful, colonial, gender-based codes and laws have resulted in societal norms among Aboriginal people that constrain Aboriginal women's rights, power, health, education, resources, and decision-making when compared to those of Aboriginal men.

The relationship with brothers was an unexpected finding. Participants repeatedly spoke of the assistance they received from their brothers in funding for formula, provision of housing, transportation, and childcare that often made their infant feeding dilemmas much easier. As stated by Stephanie about her brother: "yes, if I need a sitter, I'll ask him to watch her for me." Another participant, Hilary, affirmed support by

stating: “yes, my brother will automatically just drop off and come if I need him. And I’m getting more support from my brothers than my sisters.”

According to Davis, Wagner, Prosper, and Paulette (2004) there is a unique cultural relationship between brothers and female kin, in particular “but perhaps not exclusively between Sister’s Sons and Mothers’ Brothers” (p. 361). These kinship relations often mean that the brothers share whatever they have with their family members and community (Prins, 1996). The significance of “sharing and reciprocity are of fundamental importance to Mi’kmaw culture and social relations, principles captured by the Mi’kmaw word *utkunajik*” (Davis et al., 2004, p. 361).

The webs of relationships with the males in the participants’ experiential lives are complex yet tightly woven. The bonds of kinship provide support for the women in varying ways. The relationships they have with male kin often provides the support that will enable them to commence and continue breastfeeding or bottle feeding, ensuring that there is a place to sleep, a means of transportation, and funding for formula and other expenses required for their infants. Without this support the women often have to provide care for their infants on their own. Perinatal nurses need to develop an understanding of these complex and diverse relationships if they are to support these mothers in their infant feeding practices, be they breast or non-breastfeeding. For as Benner (2004) stated:

The nurse-patient relationship sets up the conditions of possibility for patients to disclose their concerns, fears, and discomforts. If the nurse is too hurried or too task-oriented to notice the patient’s and family’s experience, then the level of disclosure on the part of the patient or family will be constrained. (p. 349)

Relationships with Health Care Providers

Health care providers were seen as both supportive and detrimental with the participants' infant feeding choice. Health care providers have personal and professional power to either support and positively shape experiences for women, based on connection and respect for difference (Canales, 2000), or to be negative and non-supportive of women's choices. The benefits of breastfeeding have been provided to health care providers worldwide (World Health Organization, 2003). The protection, promotion, and support of breastfeeding have become an international health priority.

The ten steps of the Baby Friendly Hospital Initiative have become the guideline for health care providers throughout Canada (World Health Organization, 2013). Under the ten steps, health care providers are not to teach information regarding bottle feeding to mothers in group teaching sessions (World Health Organization, 2013). This can lead to a void or absence of information and support for mothers choosing not to breastfeed.

The participants in the study placed health care providers into two groups: hospital and community. When speaking of health care providers, the women mainly addressed relationships with nurses, home visitors, and physicians. Thomasna (1994) stated: "A relationship is the most elusive of all realities, yet the most important to human beings" (p. 94). The relationships the women in the study had with health care providers were not always positive. In regards to breastfeeding, the women often felt pressured into breastfeeding by the hospital nurses. As Brittany stated:

I have one friend, she did feel so pressured. And especially she had her daughter after I had my children, and she was there with me when [child's name] was born 5 years ago . . . I'd visit her and I would just stop and breastfeed anywhere. If we

went to [city] together, I just breastfed anywhere. And she always admired it. And she wanted to do it. She really did. And she tried but when she had her baby, she just couldn't. It was just due to milk supply. And it was nobody's fault but she felt really bad. And she felt guilt, she felt ashamed, and she felt pressured. And she even had to come to me and say, "I'm sorry, I can't breastfeed." . . . [Brittany responded] You can use formula. It doesn't make you any less of a mom.

Labbok (2008) stated:

Guilt is defined as the set of feelings experienced when one has done wrong, or has violated internal values. In the psychological literature, shame is a condition stemming from religious, political, judicial, and social control consisting of ideas, emotional states, physiological states, and a set of behaviors, induced by the consciousness or awareness of dishonor, disgrace, or condemnation. (p. 80)

The Convention on the Rights of the Child (1989) declared that breastfeeding is a child's right and therefore parents have to be provided with information regarding the benefits of breastfeeding. This right can then be viewed as burdensome for mothers if supports are not in place. In the construction of this right, it was noted that support from family members, health care providers, policy makers, employers, and society at general was needed if mothers were to be successful with breastfeeding. If this support was not provided, it is these groups that are "guilty," not the mother (Labbok, 2008).

When referring to the benefits of breast milk and the health of infants in a medicalized manner, it can be argued that policies such as the one mentioned above and the Baby Friendly Hospital Initiative (BFI) (Murphy, 2004) provide influential messages about what makes a *good* or a *bad* mother, depending on her infant feeding choice (Murphy, 2004; Wray, 2005), thereby moralizing breastfeeding as the only healthy way to feed infants. Such sentiments can cause significant distress for mothers choosing to formula feed their infants. Ongoing research needs to occur that investigates women's

experiences in the current environment where breastfeeding is clearly being promoted (Lee, 2007). Mothers ought not be labelled as *good* or *bad* or have feelings of guilt or worry about their infants' health in relation to the type of feeding choice they make. As Lee (2007) stated:

An unfortunate outcome of the socio-cultural trend to moralise health may be that it becomes harder in this context for a culture of empathy and trust to develop between women and those responsible for providing healthcare. (p. 1088)

Women require access to information and support that will enable them to make a genuinely informed choice for their infant feeding practices, a choice that is individualized to the life circumstances of the women. Gadow (1980) stated: "Patient agency . . . requires allowing patients to participate, fully and freely, in determinations about their care. This entails access to information about one's condition and options, as well as freedom from coercion in making one's choice" (p. 683). Additionally, Forster and McLachlan (2010) stated that "it is important that care providers are aware of, and sensitive to, the complex personal and sociocultural factors that influence women's decisions about baby-feeding" (p. 116).

Moreover, according to Newman and Pitman (2003), guilt associated with breastfeeding frequently occurs as a result of a deficient knowledge on behalf of health care providers and lack of follow-up support. They further declare that if a mother is made aware of the risks of using formula and opts to bottle feed, then the mother has made an informed choice. The mother, Brittany, portrayed in the above account, obviously did not have the support she needed with her infant feeding decision.

During their hospital stay, mothers in the study told of being given a nipple shield or a breast pump to use by health care providers in order to help them with breastfeeding. According to McKechnie and Eglash (2010), “A nipple shield (NS) is a device that a mother places over her nipple-areolar surface prior to nursing, most often to help the baby latch onto the breast” (p. 309). Breast pumps (milk extraction machines) are often utilized by mothers that have an actual or perceived low milk supply in situations where infants are ill and unable to breastfeed, where breasts may have lesions due to poor latch, if the mother chooses not to breastfeed but wants breast milk for her infant, and upon return to work as a means to extract breast milk from the mother’s breasts so that the breast milk may be given to the infant in a bottle, cup, or other feeding device (Meehan et al., 2008; Sisk, Quandt, Parson, & Tucker, 2010). The participants declared that their infants were unable to latch, they were engorged, or their nipples were so sore they would have stopped breastfeeding if they had not received the nipple shields or utilized the breast pumps. While nipple shields and breast pumps are devices that are used by health care providers to assist with breastfeeding, they should only be utilized following an in-depth assessment of the concern and after trying other interventions. If they are used, they require follow-up assessments (Newman & Pitman, 2003). For some (See Appendix I) of the women in the study, the use of these devices caused embodied turmoil and conflicting feelings regarding such devices. Technology, although often helpful, can be a threat to women’s dignity, particularly with breastfeeding. According to Gadaw (1984):

The reason, then, that technology poses a greater threat to dignity than does less

complex care is related to the experience of otherness. Mundane care and simple apparatus involve measures that persons usually can manage for themselves. But complicated measures and machinery are more disruptive; they can remove the locus of control from the individual by imposing otherness . . . (p. 64).

On occasion the use of a breast pump made the women feel that they were like a dairy cow ('the other') being milked and therefore preferred the use of a nipple shield as described by Rebecca below:

I think that's why I liked the shield. Because the shield is like when people get engorged, when I got engorged, they always tell us at the hospital to use the pump so I will completely empty. But when I used the shield, it did the exact same thing. And I didn't feel like a cow.

As Gadow (2000) stated, western health care often compartmentalizes the body, dissecting it into interchangeable parts much like a machine that can be changed and fixed as needed. Women's breasts, according to various health care providers, have become only a means of providing nourishment for their infants rather than an embodied part of a complete body that makes up the whole of the woman, not just a part. Gadow (1984) further stated that "As long as the body is only a scientific object, decisions about it logically will be based upon external, clinical interpretations, not upon the meanings and values it has for the patient" (p. 65). Women in the study frequently found their breasts to be a part that needed correction in order to function properly in the providers' definition of assistance essential for successful breastfeeding. In both the hospital and in the community setting, women felt that there was too much pressure put upon them to breastfeed. As Brittany stated, "it was constantly breastfeeding, breastfeeding, breastfeeding."

The participants also had concerns regarding the care they received from health care providers during their hospital stay following delivery of their infants when learning how to feed their infants. They expressed how some nurses were not respectful of them as women and new mothers. Nancy stated that she believed the nurses could be more “hospitable” and “make you feel more welcome.” She further articulated, “If you get paid that much money, why don’t you just deal with the fact that you have to do what you have to do?” The women felt frowned upon by the nursing staff if they did not choose to breastfeed. The women, however, never voiced their concerns to the health care providers; they just wanted to get home where they knew that they could call upon relations to assist them with their concerns. The participants were silenced and marginalized as other Aboriginal women have been when seeking care within the mainstream health system (Benoit, Carroll, & Chaudhry, 2003; Browne & Fiske, 2001; Brunen, 2000; Dion Stout et al., 2001; Meleis & Im, 2002; Smye & Browne, 2002). Conceivably due to lack of knowledge, health care providers do not understand how their care and discriminatory attitudes continue to foster the structural violence that so many Aboriginal women have experienced with health care (Browne, Fiske, & Thomas, 2000; Hunter, Logan, Barton, & Goulet, 2004). Health care providers urgently require an understanding of the everyday lives and taken-for-granted experiences of Aboriginal mothers to provide the care essential for best practices in infant feeding choices.

Hospital staff provided conflicting information to the women regarding their breastfeeding and bottle feeding concerns, which caused increased stress for the women. The concern regarding inconsistent information surrounding breastfeeding issues from

health care providers is experienced by women worldwide (Cox & Turnbull, 2000; Moore & Coty, 2006; Simmons, 2002). It is, therefore, imperative that a provincial program be put into place that provides consistent, best practice information for all health care providers that is inclusive of the needs of marginalized populations, including those of First Nations women.

The women in the study had concerns about how health care providers provided them with an over-abundance of education regarding infant feeding practices and overall care for themselves and their infants while in the hospital setting. The women repeatedly told of being given numerous pamphlets about various topics relating to their childbirth and infant feeding practices. Unanimously, the participants agreed that one concise, easy-to-read book that provided information from conception to postpartum, about pregnancy, labour and delivery, postpartum care, and infant feeding was what was needed. More often than not, the pamphlets were left in their carry bags or put into the garbage. They were not seen as any sort of assistance and were rarely, if ever, utilized. The women felt the nurses were rushed and they preferred learning by practicing and having a nurse watch and give advice, rather than the nurse taking over and doing everything. Brittany illustrated this clearly in the following statement:

I think generally everybody wants to be a really good mom but they don't know how. And if it is . . . those pamphlets are definitely not a way to like get the messages across because it's so . . . it probably reminds them of a lot of school work or something. I know I didn't read them. (Brittany)

Although many (See Appendix I) of the participants had been able to obtain a high school diploma, ongoing education had been a difficult journey for many.

Educational material provided in text format was definitely not the most advantageous means of providing information. Unfortunately, this seems to be the most common means of providing educational material to mothers about infant feeding practices within institutional settings.

The women in the study voiced how they would like family members to take part in education opportunities as well but found that many restrictions were often placed on the number of family members who could be present at any given time on the hospital obstetrical units. They agreed that their kin needed to be involved in educational programs. As Samantha stated, “Like we need more hands on learning, even if it is our second child or a third or a fourth.”

Western health care providers often focus on knowledge of the individual and stress the importance of women being able to do everything for themselves (Bengoray & Banister, 2008) and thereby their infants. Whereas, Aboriginal ways of knowing and learning often value relationships with others when making health care choices (Bender & Braziel, 2004). Health care providers ought to develop an understanding of ways that better incorporate illustrations, storytelling, viewing, and active participation in their educational programs involving Aboriginal women in order for them to meet the needs of women and infants (Bender & Braziel, 2004).

A few (See Appendix I) of the women participants declared that they told their community health care providers that they were going to breastfeed because they could receive *milk tokens* as long as they were breastfeeding. Although this extra funding was given to enhance the mother’s diet, this funding was often used to purchase milk for other

children in the family. Cameron (1992) stated: “Being vulnerable is difficult to manage. It makes it difficult to ever disclose your true state” (p. 178). Finances were profoundly difficult, and the women told of how they would tell the community health care providers that they were going to breastfeed in order to obtain extra funding, when in reality they had no intention of breastfeeding. Others told of how they would initiate breastfeeding and continued long enough to have the health care providers think they were going to breastfeed, while in reality they had no plans to continue breastfeeding. When women start breastfeeding and abruptly wean, they can become engorged or develop mastitis, which can lead to a breast abscess. These concerns often make the mother very uncomfortable where she has to endure pain and discomfort, in some cases necessitating ongoing medical care. Breastfeeding is a personal and individual experience for women. It is frequently fraught with challenges even for the most committed of mothers. When one attempts to breastfeed for other reasons, it no longer becomes a fulfilling experience. Rather it becomes something done to meet the need of financial controllers and health care providers.

The participants spoke of the limited support for their infant feeding once they returned to their home community. They felt that if they had more home visits from the clinic nurse or the community home visitor they may have been more willing to continue with breastfeeding, particularly if they had no kin support for breastfeeding. As stated by Rebecca:

I had some problems with . . . latching, tongue tied. And I don't know until it was about almost . . . he was maybe about a month old. So maybe if the nurse had come to see me more often, she could have helped me.

Although the participants wanted more home visits, when questioned about ease of contacting them for visits on behalf of the nurses or home visitors, they declared that it was not always a straightforward thing to do. Many (See Appendix I) women moved for varied reasons (lack of adequate housing, financial concerns, violence in the home, etc.). Health care providers were not notified of the move or forwarding address, and phone contact was often disconnected due to financial constraints. When mothers had to move, it frequently became difficult for women to continue with breastfeeding, as they may not have received the support they needed with breastfeeding concerns. Or they may have had to discontinue breastfeeding and change to formula feeding due to the difficulties associated with relocation. All of these factors made it difficult for follow-up care for the women and their infants. The vulnerability of these women in regards to their perinatal care needs to be further understood if the health care disparities of First Nations women, infants, and communities are to improve.

Overall, participants felt respected by both hospital and community health care providers, although less-than-optimal encounters were described. Many women were so happy to have a break from all the responsibilities at home that they felt fortunate for the care that they and their infants received while in hospital. They commonly agreed that it would have been beneficial in both the hospital and community setting to have more Aboriginal nurses from the area providing care. This would have assisted with any language concerns as well as having a firsthand knowledge of the experiential lives of Aboriginal peoples.

Chapter 5:

Finding a Space . . . When Living in Poverty. Is Anyone Listening?

Poverty is an index of an unjust society, both a sign of failure and a challenge to do better as a community. Poverty is about the stark denial of both hope and freedom. Poverty spawns social exclusion and desperation, and it's the single most significant predictor of individual and community health. (The Honorable late Jack Layton, 2011, p. xiii)

The second theme derived from the research findings illuminated the impact of poverty on the participants' lives and consequently on their infant feeding choices. The experience of poverty among Aboriginal people has been well documented by numerous authors (Lee, 2000; MacMillan et al., 1996; Smiley, 2009; Warry, 2007). It has been reported that Aboriginal women experience an increased dependency on financial support from social assistance and have a much higher rate of poverty (McIntyre et al., 2001). Poverty is particularly hard on families with young children (Esping & Anderson, 2002) and impacts both their current and long-range health outcomes (Raphael, 2011). Although Canada is ranked as one of the elite nations of the world by the United Nations, many Aboriginal people continue to live in conditions of poverty similar to those of Third World countries (Warry).

Within the context of the interviews with participants, concerns regarding safe and affordable housing, safe water, and transportation were continual topics of discussion. Many (See Appendix I) of the women in the study conveyed their frustration and at times anger in their ongoing struggle to ensure that these items were available for their families, thereby having the provision to live in a safe space. This included individual homes or the community at large. If any of these essentials were a concern for

the women, it directly impacted their infant feeding choice. More often than not, all three of these basic life necessities were a problem for the participants, and it took immense effort on the women's part to improve these conditions while living in a state of poverty. According to Baskin (2007), improving these health concerns calls for society as a whole to value the support of "families through equitable access to resources to care for the well being of their children" (p. 40).

The participants frequently recounted stories whereby they found themselves in a position of having to seek assistance for basic needs. This came from family members, the community, the Band, and health care providers. Frequently these requests for assistance, in particular those regarding housing, took years for a response and consistently left the women with the sense that "no one was listening." Their needs for safe housing and improved living conditions (Adelson, 2005) for themselves and their children were thought invisible and ignored by governments and band members. Health care providers, often nurses, may have been able to be the 'someone' who listened. As Cameron stated, "the nurse calls the who to remind and reassure the fragmented person that the who still exists. That person needs to be enabled to cope, to become, and to fulfill his or her unique way of being in the world" (p. 184).

Housing—Locating a Safe Domain

The accessibility and quality of housing created numerous challenges for many (See Appendix I) of the participants and ultimately their choice for infant feeding. The United Nations Society (UNNS) (2001) acknowledged that there is a strong link between children growing up in poverty and living in overcrowded, inadequate housing

or unstable housing and their long-term health outcomes. Furthermore the UNNS stated that this state of housing is rooted in

structural factors such as unemployment, low wages or lack of income, loss of housing, colonization, racism, discrimination (systemic or otherwise), patriarchy, cultural and geographic displacement, and the reserve system. (p. 2)

The space in which one lives and calls home has a profound effect on one's sense of well-being. Home ideally provides a space where one can feel protected and safe (Bollow, 1960; Heidegger, 1971; van Manen, 2007). One's day-to-day experiences occur and are impacted by the relationship that occurs between the individual and the space she or he finds her or himself in, be it home, community, or elsewhere (van Manen, 2007). Memories of a certain space in a home or other place can bring both joy and sorrow to a person. For many of the women in the study, memories of the space they called home were not that of a safe haven but of a space from which the ingredients of nightmares were formed.

When working with First Nations peoples, Larcombe and colleagues (2011) found that protective housing from harsh climates in Manitoba, "would foster human dignity and emotional well-being and . . . would support (rather than undermine) health" (p. 142). However, the participants in this study lived in a variety of home settings that did not always meet the aforementioned recommendations. Only Christina stated that she owned her own home. However, like the other women, prior to owning her home, she had many concerns with housing. She stated:

We lived at my mother's...and in apartments...Yes, it [the last apartment] was too small and...It was just annoying living around other people. Like one of the tenants there, like she did drugs and she did it right in her apartment. And the

smell just went to my apartment and it was annoying . . . we had to borrow a house until our house was done.

The remainder of the participants boarded in family and friends' homes, they "borrowed" homes (homes of family/friends that could be used for brief periods of time), lived in apartments, in one bedroom homes owned by family and other community members, or in Band-owned housing. Bollnow (1961) stated the following regarding the importance of one's house:

He needs the space of the house as an area protected and hidden, an area in which he can be relieved of continual anxious alertness, into which he can withdraw in order to return to himself. To give man this space is the highest function of the house. Even in our profane time the house has a certain *sacred* character... (p.33)

Women in the study told of their struggles in trying to find this 'sacred space'.

Rebecca told of how she had spent years living with her mother prior to obtaining a home that she could rent from the Band. There were at least 14 people living in her mother's home at any given time. This meant that there were not enough beds for everyone, and to achieve any privacy, mothers often stayed in one room with their children. Rebecca spoke of how hard this was. She said:

Like I said before, for single mothers with only one or two children, it's hard for them to find a place of their own. Housing is very difficult. It's more than likely they would board. For breastfeeding-wise, the privacy would not . . . I don't think they would do it because of the privacy issues.

Young (2002) stated:

While values of home do indeed signal privilege today, analysis of those values and commitment to their democratic enactment for all can have enormous critical political potential in today's world. In addition to preservation, those values include safety, individualism, and privacy. (p. 316)

Finding a location to live was of major concern for the women and frequently in their thoughts. Frequently dwellings were procured through family members that knew of an upcoming vacancy in an apartment or a home. Applying to the Band for a home required persistence and patience as it took from 5 to 15 years before some applicants were notified that a home was available, while many continue to wait.

Rebecca went further to provide a depiction of her struggles in obtaining suitable housing for herself and children. At one point in her journey for safe housing, Rebecca and her family moved to a trailer for which she provided the following vivid description:

Like I used to live in a trailer, right. And it was really bad. We had every species of mice living in that house . . . and we had . . . like my son had a swamp project where he had to go to a swamp to get all these like certain kind of bugs, certain kind of plants. We found them in our house! We had nothing but rat holes. Like you could see underneath. You could see outside with the rat holes. And even if we got the foam and stuff like that, they'd just make new ones. And we were living in that kind of condition for about 5 years before they [Band] gave us a house.

As Rebecca recounted this story her facial expression became very sad, and then with resolve and conviction she declared that through her perseverance she was finally able to obtain safe housing for her family. Rebecca's story tells of the strengths that young Aboriginal women often have and of the resilience of these women as they continue to seek out safe environments for their families. What is remarkable in this story is how it points to the broader picture of women having the major responsibility for finding safe environments for their families, which are often single-female headed families. This is further supported by McIntyre and colleagues (2001) in their work with Aboriginal youth between the ages of 12 to 18 years of age: "Impressions of reserve life

to gender revealed quite rigid role definitions for men and women. Both groups agreed that economic factors could overrule male gender dominance. Both groups also recognized that women were responsible for the family” (p. 5).

Returning to Rebecca’s story, one is reminded of how difficult it is to breastfeed when living in overcrowded housing conditions, let alone the conditions she described in a trailer infested with rodents and “swamp” creatures. It has also been well documented that many women have difficulty breastfeeding in public surroundings (Ruowei, Fridinger, & Grummer-Strawn, 2002; Scott & Mostyn, 2003; Spuries & Babineau, 2011). Many participants in the study also confirmed this finding.

While Rebecca had to live for 5 years in unbearable living conditions, while other participants had to wait for up to 15 years for a safe home. Laura told the following of her living conditions:

There were 13 of us at one time. Like we all had . . . like I had my own room downstairs with me and my four kids. Then his [partner] mom would be upstairs, and his little brother would be upstairs. And then his sister came with her little boy, and they were living with us too, and her boyfriend. So they all had their own room. Like it wasn’t so bad . . . everybody accepted it.

These types of living conditions led to despair for some and acceptance for others. When there is no sense of hope for one’s own home, it can foster a cycle of dependency. On the other hand, it can give rise to even further resilience (Helin, 2006), as seen in the case of women like Rebecca.

Overcrowding can lead to violence and family tensions in the home (Robson, 2008). Parenting skills are often not at their optimal in overcrowded situations. According to Cooper (2003), “neighbourhoods in which poor housing is the norm are

also likely [not necessarily] neighbourhoods with few services, higher than average level of violence and so on” (p. 7). As one participant, Brittany, explained:

There’s four of us. There’s his [partner] parents. There’s his brother and his daughter, his sister, her boyfriend and her child. The housing shortage is crazy here. Me and my boyfriend and his brother just had a little drama going on at the house just a while ago . . . we just had to drag them out of the house. Drag all the kids out of the house because they were fighting.

Brittany advised that the family went to her father’s home and that all were safe following this encounter. A few (See Appendix I) of the women spoke briefly and guardedly of experiences with abusive relationships that occurred during their lifetime. They recounted experiences of partners and family members being incarcerated, leaving the women to cope with the family needs. According to McCaskin and Boyer (2009), Aboriginal women are three times more likely to encounter spousal abuse and violence, and may have experienced various forms of abuse as children (Tromé, Knoke, & Blackstock, 2004), when compared with other Canadian women. Family violence negatively impacts all family members but notably the physical and mental health of both women and children (Karmali et al., 2005). By developing an understanding relating to unsafe living conditions, health care providers may understand more clearly the experiential lives of Aboriginal women in relation to infant feeding choice.

Overcrowding may not only lead to increased family tensions but also to a multitude of health concerns. Mold found in numerous Aboriginal homes has been implicated in health problems such as severe asthma and allergies (Berghout et al., 2005; Lawrence & Marten, 2001; Strachan, 2000). A participant, Elizabeth, had mold in her

apartment where she lived with her partner and five children. Elizabeth explained about the mold in the following narrative:

Yes, I got all that. I took pictures [of the mold]. I kept sending it in but they didn't do nothing. But when I got married, I'm looked after . . . I find . . . I see a lot of families that really need a house and they're not with the guy, and their kids are sick and they're sick. I think that they [The Band] should look at it a different way.

Christina, another participant, had similar problems with the mold in her home and with her children becoming ill. In this case the children had required medical attention so frequently that the physician became involved, which eventually enabled her to obtain improved housing for her family. Her recounting of the situation follows in the narrative below:

Well, I say I got my house because one of my kids got sick. We were living in an apartment before, and it was a basement apartment. And it was like full of mold . . . my baby got sick and . . . was seeing a pediatrician and he asked what are your living conditions like? And we told him and he got really mad and starting calling around. Like calling . . . the Band and telling them like you guys, this baby is sick and you guys better do something.

Women told that seeking letters of concern from physicians was the route taken in order to move ahead on the housing waiting list. If their children were identified as having a health problem verified by a physician relating to the housing condition, the Band would try to move them into improved housing conditions more rapidly.

The experiential lives of these women are not unlike many Aboriginal people in Canada who commonly experience health problems linked to poverty in Aboriginal communities. These may include increased infant mortality, elevated rates of communicable diseases, persistence in infectious disease, and a lowering in life

expectancies (Adelson, 2005; Barsh, 1994; Richmond, 2007; Waldram, Herring, & Young, 2006). Several of these health factors can be related to the types of housing that have been provided for the families.

While there is a process (in theory) for submitting an application for housing to the Band committee, there appears to be a hierarchical system in place that determines who gets the homes and when. Scholars Shari M. Huhndorf and Cheryl Suzack (2010) indicated that “although Indigenous women do not share a single culture, they do have a common colonial history. The imposition of patriarchy has transformed Indigenous societies by diminishing Indigenous women’s power, status and material circumstances” (p. 3). From the participants’ accounts, applicants with parents who are financially stable and own housing units have better housing accommodations. Those who have relations on the Band committee may obtain housing more quickly and find out about the availability of housing units sooner, while others have to persevere and even resort to obtaining physician’s reports regarding their children’s health status in order to obtain suitable housing. Even this strategy is not routinely and openly known by all women in the community, as not all of the participants, did not know of the importance of reporting mold in their homes if it was affecting their children’s health. Additionally, the participants felt that it was essential for a woman to have two or more children and be married before she could apply for housing from the Band. Clear and open eligibility criteria for housing that is communicated to women in the community may help reduce many of the stresses women face in finding housing for their families.

During the interviews a range of housing conditions was observed; conditions were in no way homogenous. The quality of the home was another challenge identified by the women. Regardless of the state of the home, wherever I went women generously opened their homes to me while we shared conversations and often pots of tea. Homes owned by the participants' parents seemed to be in an improved state of repair; however, they were often very overcrowded. In other homes—such as apartments, trailers, and old or newly built homes—there was a multitude of repair work, finishing work, or other deficiencies that needed attention. Frequently the steps to the home were badly in need of repair, and handrails on both indoor and outdoor steps were rarely in place. Inside the homes, cupboards were uncompleted, wiring hung from ceilings, and the structures needed new doors, flooring, and paint work.

The federal government does not set specifications for the type of housing that is built on First Nations communities other than the requirement to meet the *Indian Building Code*, which often meets minimal building standards compared with those of the rest of Canada (Public Works Canada, 1985; Tsuji, Iannucci, & Iannucci, 2000), whereby houses may have insufficient kitchens, bathrooms, and electrical services. Furthermore, this building code can only be applied to structures built on First Nations land (Tsuji et al., 2000). Funding for new structures from federal government coffers would be given to First Nations communities in need of housing units due to overcrowding. The various community bands would then have to decide to either build more homes with a lower building code or fewer homes with a higher building code. This may well leave First

Nations communities in a quandary, which may possibly result in homes being built that require ongoing maintenance. This reality was acknowledged by Hilary when she articulated, “yes, most houses, like when they make new houses, they don’t finish all of it. They don’t finish the downstairs sometimes. They don’t finish really nothing.”

While women living in Third World countries may breastfeed their infants out of necessity and from having role models from whom to learn, often Aboriginal women, due to the impacts of colonization, are living in conditions similar to those of Third World countries. Aboriginal women are actually living in a state of poverty in one of the world’s wealthiest countries, living in homes that are below an acceptable standard of safety and living conditions. As Harris, Russell, and Gockel (2007) so aptly stated, “poverty leads to forced compromise” (p. 23). Women’s infant feeding choice is socially, politically, and economically constructed by factors over which they may have limited control.

Women are less likely to choose to breastfeed when their living space is not a safe one. Living in a space influenced by poor living conditions with compromised health and social problems that can cause additional stress and illness for families often shapes women’s choices. In developing and war-torn countries throughout the world, the wounds inflicted on women and infants are similar to those encountered by First Nations women on a daily basis. The United Nations Children Fund (1996) stated:

The disruption of food supplies, the destruction of crops and agricultural infrastructures, the disintegration of families and communities, the displacement of populations and the destruction of educational and health services and of water and sanitation systems, all take a heavy toll on children (p. 32).

Due to the aforementioned factors, women in war-torn countries are left with no choice but to breastfeed, as drinking water is often contaminated and formula is not available. First Nations women often live with food scarcity, poor water and waste disposal systems, and lack of access to educational resources and health care, yet they reside in one of the wealthiest countries of the world. Factors such as housing and safe water supply were of concern for the women in the study; choice related to infant feeding practices was often limited. This limitation could be interpreted as yet another way of continuing to colonize and limit the lives of First Nations women. In summary, finding a safe location to live was of major concern for the women. Frequently, dwellings were procured through family members who knew of an upcoming vacancy in an apartment or a home.

Water—Is it Safe?

In addition to concerns regarding housing inadequacy, many (See Appendix I) of the participants voiced concerns relating to the safety of the community's drinking water. During an interview, Christina, one of the participants was observed preparing a bottle of formula for her infant using purchased, bottled water. When asked about the water, she replied "I just don't like it. I wouldn't even drink it," [water from the tap, connected to the community water system] . . . there's a pump house. So I guess that's where it comes from." Christina therefore buys water for all of her household drinking purposes. When asked about waste disposal and how it may drain into the community water system, she replied, "I don't know. I really don't know." Christina was unaware if there was a community septic system or if she had a private septic system, or if there was a treatment

plant. She felt that all the community's water and waste system could not be trusted and that the current water that came from her household tap was not fit for human consumption. Not only was water a concern for Christiana, but she went on to tell of her financial hardships describing the difficulties many women cope with due to insufficient funds to purchase food for their families, as well as formula, diapers, clothing, and other needs (telephone, internet, etc.). Yet even with these financial concerns, water was routinely purchased, placing an additional expense on tightly, constricted household budgets. The perceived understanding by some participants that the community water was not safe for drinking was a source of tension for several of the participants. Lack of knowledge regarding the community's water, waste, and sewage disposal systems were found to be recurring topics of discussion in several of the interviews.

Following a number of devastating disasters, the 'right to know' has come forward for both community, workplaces, health practices, and environmental concerns, whereby people need to be informed of the risks they may encounter on a daily basis (Baram & Partan, 1990; Hook & Lucier, 2000). Chief Theresa Spence from the Attawapiskat First Nations community went on a hunger strike in 2011, demanding that the Canadian government address the problems of housing and water in her community (Pentland & Wood, 2013), igniting the "Idle No More movement." According to Pentland and Wood (2013), Attatapiskat:

became a symbol of national disgrace when the Red Cross had to step in to provide humanitarian aid to scores of families living without running water in trailers, canvas and plywood shanties, and even tents as winter temperatures plunged. (p. 37)

Lambert, Soskolne, Bergum, Howell and Dossetor (2003), argue that “public health and environmental ethics should be grounded in particular human relationships and our ongoing relationship with the environment” (p. 134). Likewise, women in the study have a ‘right to know’ about their water supply.

The findings related to insufficient housing and inadequate water services and waste disposal systems of both sewage and solid wastes constitute, more broadly, factors previously identified as affecting the health of First Nations people (Robson, 2008; Young, Bruce, Elias, O’Neil, & Yassie, 1991). Access to safe drinking water is critical for all Canadians; however, there have been numerous reports of unsafe water conditions in many Aboriginal communities throughout Canada (Assembly of First Nations [AFN], 2007; Mascarenhas, 2007). Aboriginal Affairs and Northern Development Canada (2012) reported that of the 35 First Nations communities in the Atlantic Provinces, six of the communities’ water supplies were categorized as being at a high level of risk, 19 communities were at a medium risk, and 10 were at a low risk of contaminants, requiring drinking water advisories.

As a result of the *Constitutional Act* of 1867, section 19(24), the federal government has legislative responsibility for ensuring that First Nations communities’ have safe water supplies (Simeone, 2010). Aboriginal Affairs and Northern Development (AAND) provide funding for water services, including construction, upgrading, operating, and maintenance; Health Canada provides water monitoring programs, and Environment Canada regulates wastewater discharge into Canadian waters (Simeone, 2010).

The Honourable Dennis R. O'Connor (2002) noted that the major problems with water supply on First Nations reserves were obsolete, absent, inappropriate or low quality infrastructure; insufficient numbers of certified operators; inadequate testing; frequent contamination; and inadequate distribution systems. The major concerns identified with the disposal of solid waste that may impact upon the safety of water was that much of the waste was burned, buried, or indiscriminately dumped (Young et al., 1991). Following incidents at Walkerton and North Battleford, recommendations for a multi-barrier approach for the maintenance of safe drinking water were provided, which include source protection, adequate water treatment, a safe distribution system, monitoring programs, and response to adverse conditions (Cooper, 2003).

Denny and Paul (2005) provided information regarding potential concerns for drinking water in the community of study. They included “oil furnace tanks, paint thinner substances, paint cans, metal items, appliances, household debris and organic substances” (p. 5). Additionally, the finding of hypodermic needles on the community’s beach was such a concern that one concerned citizen took to raking the beach, as reported by Wadden (2013). The Unama’ki Institute of National Resources (2009) reported the following regarding contaminants found in the water of the community of study:

During 2004, there was one exceedance for chlorine . . . There were no exceedances for E. coli or turbidity . . . In 2005, there was three instances where chlorine was below acceptable limits . . . There were no samples for E. coli, turbidity or total coliforms that were outside the acceptable limits. (pp. 6–7)

Even with these reports being publically available, talking circle conversations reflected that safe water continued to be an ongoing concern due to the worry of

contaminants reaching the community's water supply. Rebecca provided the following description:

I used to buy my own bottled water a lot because everyone thought that the water came up from the mountains. And sometimes there's like garbage up there or somebody dumps a dead (animal) . . . and they feel like they're drinking that as well.

Moreover, when asked about the current solid waste disposal system. Rebecca further added to the conversation:

There is weekly (garbage pick-up) . . . well there's some people . . . like not everybody recycles. So they put everything inside the garbage bag, right. It smells like food. And there's a lot of free roaming dogs . . . and they tear up everything. And then the garbage man won't pick it up when it's torn. So it just keeps getting torn until the next week. And then it just keeps piling up.

When questioned about septic waste disposal, no one could identify how this occurred. For example, Brittany's response was "I don't know where it goes. I hope it doesn't go into the lake." Due to these concerns regarding waste disposal and transfer of contaminants from the waste entering the water system, women did not have faith in the safety of the current community water system, as attested to by Brittany, "people still don't trust it [community water]."

The women were frightened that the ground water in their community may contain contaminants from dead animals, sewage, and solid waste materials, thereby putting their own and their family's health at risk. As Dattaraq (2012) stated, "Safe drinking water and sanitation is central to living a life in dignity and upholding human rights" (p. 45).

To prevent any untoward harm from water contamination, the women used their scarce funding sources to purchase bottled water for consumption purposes. These issues were of concern not only for formula feeding mothers but also for breastfeeding mothers, as numerous reports have been made regarding contaminants in breast milk (Johnson-Restrepo, Addink, Wong, Arcaro, & Kannan, 2007; Landrigan, Sonawane, Mattison, McCally, & Garg, 2002; Mead, 2008; Nickerson, 2006). The Assembly of First Nations (2009) advised that traditional foods be tested for nutrient values and environmental chemical hazards; drinking water needs to be tested for heavy metals and surface water for pharmaceutical metabolites; and it is recommended that the level of mercury in women's bodies be tested among First Nations peoples. While such contaminants have been found in breast milk, the overall health benefits of breastfeeding continue to outweigh the current risks from environmental contaminants (Mead, 2008).

According to Anderson (2000), in the Aboriginal worldview, water is associated with all things related to being female. Fire is equated with males and water with females, both being of importance for survival. Whitehead and McGee (1983) give details of the importance of water to the Mi'kmaw people throughout the ages:

It was along the shores of the bays, coves and rivers that the Micmac found the greatest amount of food and other materials for their needs. Here the people spent the largest part of the year. From the shallow waters they took shellfish: clams, mussels, whelks, periwinkles, squid, crabs and lobsters; and fish: flounder, smelt, shad, skate, salmon and eels. Geese, ducks and other waterbirds fed and nested close by. In deeper water the Micmac fished for porpoise, sturgeon, swordfish and the smaller whales. They hunted seals and collected birds' eggs on nearby islands. (p. 6)

Both the Haudenosaunee and the Anishnabe peoples view the moon as the grandmother, which symbolizes rebirth and renewal (McGregor, 2008). Cook (1992), referring to the moon stated:

She has a special relationship to the waters of the Earth, big and small. From the waters at the doors of life, such as the follicular fluid that bathes the primordial ovum, the dew on the grass in the dawn and at dusk, to the waters of the great oceans, she causes them all to rise and fall. Her constant ebb and flow teaches us that all Creation is related, made of one breath, one water, one earth. The waters of the earth and the waters of our bodies are one. Breastmilk is formed from the blood of the woman. Our milk, our blood and the waters of the earth are one water, all flowing in rhythm to the moon. (pp. 139–140)

According to Collins (2010), the Canadian government neither recognizes internationally or domestically the importance of safe water. Canada was one of the 42 nations that refused to vote on the United Nations General Assembly's resolution on safe water. A safe water supply is of vital importance for First Nations women and their families and has an essential role in their infant feeding choice.

Overcrowding and poor (or lack of) water service and waste disposal for both solid wastes and sewage can lead to health concerns for First Nations peoples, including “shigellosis, hepatitis, tuberculosis, meningitis, measles, respiratory diseases, asthma, diarrheal diseases, intestinal, skin or middle ear infections, eye infections” (Robson, 2008, p. 77). When these health problems occur, women are required to find a means to access health care, which continues to add to their frequently over-tasked and underfunded lives while raising their infants. The concerns they associated with transportation and obtaining health care concerning infant feeding are depicted in the following section.

Transportation—Impact on Access to Health Care

The participants in the study spoke of the difficulties they had in accessing basic needs required for their families' health, which further enhanced their sense of being alone. The difficulties they had in obtaining food supplies, attending community support meetings, or in receiving medical attention were often hindered, and at times impossible due to lack of transportation. Smiley (2009) reported that the inequities in access to society's health resources for Aboriginal peoples are directly linked to colonialism, which in turn is related to the health status of many Aboriginal peoples in Canada.

Starfield, Shi, and Macinko (2005) and Macinko, Starfield, and Shi (2003) indicated that improved access to primary health care and prevention is associated with improved access to immunizations, better prenatal outcomes, and decreased childhood morbidity. However, the community of study, like most First Nations communities reported limited to non-existing access to public transportation to support them in receiving health care (Lavoie, Forget, Prakash, Dahl, Martens, & O'Neil (2010). Access to resources and health care for Aboriginal peoples is often constrained by geographic location, poverty, transportation, and social circumstances.

When interviewed, Tiffany spoke of her infant who was sick and on antibiotics, which caused her to worry greatly about her infant. Tiffany was concerned about obtaining health services (if needed) as there was a feast occurring in a neighbouring community, which meant that everyone would be going, and, as it was the weekend, the Community Health Centre would be closed. Her father had assisted her in finding housing; however, it contained mold which she felt contributed to her infant's illness. As

she or her partner had no vehicle, it was a worry as to how they would get the baby to the hospital if the condition worsened, especially with a large number of the community members being away for the weekend. Until recently, Tiffany had been solely dealing with family issues: housing, pregnancy, and the birth of her infant— her partner had only recently been released from incarceration. Tiffany talks about this time in her life:

Well, we were supposed to get married last June when I was still carrying that little one. And he (partner) got into some trouble. I guess he was on probation or something and he got into trouble. He wasn't supposed to be drinking and he broke his probation. And so he got 6 months. So by the time he came out of jail, I was already ready to give birth.

It has been estimated that 18% of Aboriginal people in Canada are incarcerated in Federal and Provincial institutions; this is a rate 5 to 6 times higher than all other Canadians (Boe, 2012; Quinlan, 1999). Systemic discrimination, severe poverty, as well as physical and sexual abuse endured during childhood have been cited as contributing to these alarming rates of incarceration (Boe, 2012; Johnston, 1997). According to Howard Saper, Canadian, correctional investigator (2013):

Aboriginal offenders serve disproportionately more of their sentence behind bars before first release.
Aboriginal offenders are under-represented in community supervision populations and over-represented in maximum security institutions.
Aboriginal offenders are more likely to return to prison on revocation of parole.
Aboriginal offenders are disproportionately involved in institutional security incidents, use of force interventions, segregation placements and self-injurious behaviour. (p. 5)

These factors may appear to have little or no relevance to infant feeding.

However, when interpreted from the perspective of the participants; it becomes

abundantly clear that such factors embedded in the complexities and challenges of poverty may collectively influence a woman's infant feeding choice.

When Tiffany was asked how she routinely got supplies (groceries, etc.) for herself and her infant without a means of transportation, she summarized how she obtained her groceries as follows:

Well, I have the stroller that has the little bottom part there. So usually when I have to go, I have to make a couple of trips. And I usually fill up the bottom part of the stroller and then I'll bring that home. Then we'll take off again and then we'll go back.

The aforementioned narrative depicts how Tiffany obtained supplies during the good weather months when she would be able to walk the 2 or more kilometres to the community grocery store with her infant. However, she was starting to worry how she would manage as winter approached:

Yes, so if I've got the money, like if I've got enough, if I can get a ride into town then I get like baby food. I get like . . . like all the welfare, like they [Band financial services] say you're supposed to buy groceries and all that. Like it all goes on [the infant]—like for food, pampers, clothing . . . [Winter] that will be another challenge there. But like my sister sometimes helps me out though. Like she has a car seat in the back of her car and that. And she'll take me there and I'll do my grocery shopping. And she'll put it . . . like put the stuff in back. And she'll help me out. But other than that, I haven't thought about winter yet.

Other participants spoke of a 'courtesy van' that could be obtained for helping to get groceries home. The women had to find a means to get to the grocery store, but if the van was not engaged elsewhere, they could get a ride home with their groceries. Even when in labour the women often verbalized how difficult it was to get transportation to the hospital. An ambulance could be called, but it could take considerable time depending on road conditions. This meant that many women had to obtain a drive from a

family or community member. Laura recounts what she did when in labour, which speaks to the resilience and strength of this woman, “I just bummed a friend to take me in. That’s how I got in with all of them.”

In regard to visits to the Community Health Centre, the woman tended to walk, in all kinds of weather, and often being pregnant and managing other children simultaneously. For example, Rebecca stated, “Oh, I can just walk to the Health Centre. That’s not a problem . . . oh, no, I do that all the time.” For booked appointments at health care institutions outside the community, Laura described the transportation that may be available:

We have hospital taxis here too. Like you can call a hospital taxi so that they . . . you know, you just call them and tell them when your appointment’s for and they come and pick you up and they take you there and bring you home. (Laura)

Transportation or lack thereof was of concern for the study participants. Women wished they had their own means of transportation; this was a collective wish from both those who breastfed and those who bottle-fed. The breastfeeding women would have liked to have a vehicle to seek medical attention in a timely manner for such issues as sore breasts, perceived lack of milk supply, and infant weight checks; while the formula feeding mothers would have liked a vehicle for ease in obtaining formula for their infants. However, the participants countered the lack of transportation with varying strategies and did what needed to be done to meet their infants’ needs. A private means of transportation would have made access to health care less and supplies less burdensome for the women. The concern regarding distant medical appointments or

emergency care in a regional centre increased many of these women's already overburdened life experiences.

The United Nations Declaration on Human Rights and the United Nations Declaration on the Rights of Indigenous Peoples declare that health care is a treaty right of all Aboriginal peoples (Lacombe et al., 2011); housing, water, and access are important components of health. Canada was one of the four countries that did not initially sign this Declaration. The Canadian government did not endorse this Declaration until November 2010. Even now, the Canadian government has ongoing concerns regarding the provisions of the Declaration that deals with lands, territories, resources, intellectual property ownership, and the rights and obligations of Indigenous peoples (Government of Canada, 2010). So while on paper the Canadian government supports the Declaration, the government is not providing the policies, funding, and resources needed by First Nations communities to enable health for community members.

The accounts provided by the women in the study provide further evidence that the above-mentioned rights are often in violation. The health of Mi'kmaw women, their infants, and families are daily put at risk due to lack of safe housing, water, and access to health care. This study provides a means to uncover and provide visibility (Benner, 1994) to the often marginalized voices of Mi'kmaw women. It may provide a 'bridge of understanding' for Mi'kmaw women's infant feeding choices. As Austin, Bergum, Nuttgens, and Peternej-Taylor (2006) stated:

The metaphor of a bridge emphasizes, rather than limits, that of connection...The idea of building a bridge involves discovering how to work with the person on the other side to construct the causeway by which to meet. It would be necessary to

have guidelines for the safe “construction” and “engineering” of the bridge. There are many styles of bridges possible to construct, and the choice of type of bridge could be seen as corresponding to the type and quality of the relationship. (p. 86)

Chapter 6:

Is Breastfeeding Right for Me? It's My Choice—Respect My Choice

They need to go...Like how do I explain it? They need more things like traditionally. Like for Mi'kmaw women to pick up the breastfeeding, they would need nurses that, you know, encouraged the breastfeeding, that have gone through the breastfeeding themselves. Teach them what they know about breastfeeding and what benefits it gives to you, not only yourself but the baby as well. Once people really realize the benefits of breastfeeding, I think a lot of people would probably switch to breastfeeding than to be bottle feeding. (Laura)

Laura, in the above narrative, reminds us of the benefits of breastfeeding and the support required by health care providers. Yet not every participant felt that breastfeeding was the best infant feeding choice for them. Many factors influenced the women's infant feeding choice. Foucault (1980) contends that order in human bodies is imposed by society, history, and political controls. He stated: "Let us ask, how things work at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours" (p. 97). This chapter is thus an attempt to understand how the women experienced their bodies in the context of their infant feeding choices.

When discussing the name identified for this theme with participants during the Talking Circle, concern was initially expressed by the women. For participants, the language of "my choice" indicated respecting the right to have a therapeutic abortion. The title did not indicate language related to infant feeding. As discussion evolved, the women commented on potential names related to the initial theme choice (My Body, My Choice). Rebecca, for example, instantly responded with "I don't like that . . . the only reason why I say that is because it sounds like abortion." Therefore, when considering

the name of the theme I had to ensure that infant feeding was clearly evident. The importance of finding a transparent theme that communicated respect and understanding was unmistakably clear for the participants when speaking of women's decisions that impact their bodies. Yet it was essential that the language of the theme did not equate with choices related to abortion. This was clearly not the intent of the research and not the intended theme of the work.

Past experience with colonialism and negative health care experiences have contributed to sensitivities regarding language for Aboriginal women. According to Richmond (2007), it is essential that health care providers be cognizant that women's "choices and opportunities can be masked by features of the broader societal context, many of which are reinforced in the post-colonial setting" (p. 350). Women make the choice to breast or formula feed their infants for a multitude of reasons. Unfortunately for many (See Appendix I) of the participants of the study, health care providers did not always take the time to listen to these reasons and respect their choices. Women often felt forced into breastfeeding when they had no intention of doing so. Many (See Appendix I) who did breastfeed were repeatedly made to feel that their body was inadequate and that devices such as breast pumps and nipple shields were essential if they were to be successful with breastfeeding.

Women's choice regarding health issues for themselves and their families "involves women's emotional, social, cultural, spiritual and physical well-being, and is determined by the social, cultural, political and economical context of women's lives as well as by biology" (Phillips, 1995, p. 507). The conditions in which one lives are often

the factors that have more influence on one's health than do lifestyle choices such as breast or formula feeding, or advice from health care providers (Mikkonen & Raphael, 2010). Health care providers need to be able to understand how the medical model of care that dominates current western health care often accounts for the everyday realities of Mi'kmaw women that may shape their infant feeding choices. According to Lopez and Willis (2004), when these everyday and taken-for-granted experiences of Mi'kmaw women are silenced and/or not considered by health care providers, further oppression, stigmatization, and marginalization are perpetuated.

The participants provided knowledge regarding the influencing factors that had an impression upon their corporeal infant feeding choices. The key areas identified were the body as machine, the disquieted body, the addicted body, the excluded body, and the accepted body. In what follows, I discuss each of the aforementioned in more detail as narrated by the women participants in the context of the study.

Body as Machine

An ongoing tension for the women evolved into a discussion related to how the body was viewed through the biomedical lens, the Aboriginal lens and the technological lens (body as machine). Western health care frequently views the body as a multitude of parts that can be dissected, repaired, or replaced like parts of a machine (Gadow, 2000). The participants experienced this type of attitude when attempting to breastfeed their infants. Their breasts were seen by health care personnel not as part of an embodied person but as parts that were functioning normally or abnormally, in need of repair or technological support, including nipple shields or breast pumps. Gadow (1984) stated

that “the violation of dignity and autonomy that seems to accompany technology is in reality a result not of the roles of machines in patient care but of the view of the body as a machine” (p. 65). The breasts of women are all too often treated as machines measuring size, output etc., with little consideration of the embodied and corporeal act of breastfeeding. Thus the maintenance of dignity is a vital aspect of caring (Gadow, 1985).

Evidence that the body was treated as siloed and disjointed parts was eloquently narrated in the participants’ stories. Some (See Appendix I) of the women were given nipple shields in hospital as assistive devices to their breastfeeding experiences—an experience that can too easily distance the embodied self from the embodied newborn. The women were given nipple shields for a variety of reasons, yet not one of the participants could recall having a complete and thorough breast examination prior to receiving the breast shields. Breast shields can be appropriate with assessment and ongoing follow-up (Hanna, Wilson, & Norwood, 2013) but not as a band-aid solution to a breastfeeding problem.

Technology is not always the most effective intervention. For instance, Alice developed engorgement following the birth of her infant. Engorgement may happen to women in the early days of breastfeeding. The breasts become swollen with milk and are usually hard and painful (Mangesi & Dowswell, 2010). In order to reduce this swelling, mothers are encouraged to nurse their infants frequently. If the infant is not able to successfully latch and thereby relieve the distended breasts, breast pumps can be used to relieve the increasing pressure. However, one needs to be careful when using a breast

pump, as a woman's breast milk supply is very much controlled by a supply and demand system. With too much pumping, increased engorgement may occur.

Use of technology can have negative complications for mother's infant feeding decisions, as illustrated in the following participant's story. Alice was given a breast pump by a hospital nurse to reduce her engorgement. This was not an experience she liked, comparing herself to that of a dairy milking cow when she used the breast pump. Another nurse provided her with a nipple shield. In this instance, Alice found the shield a source of comfort as compared to the breast pump. Alice stated:

I think that's why I liked the shield. Because the shield is like when people get engorged, when I got engorged, they (nurses) always tell us at the hospital to use the pump so I will completely empty. But when I used the shield, it did the exact same thing. And I didn't feel like a cow.

Like Alice, when Brittany was having difficulty with breastfeeding her first infant, she felt the nursing staff was rushed, pushing the baby at the breasts, and grabbing her breasts when attempting to provide assistance. The nurses insisted she use a shield and a breast pump. Brittany described the experience as follows:

Yes, because I was young and I didn't feel comfortable at the time for like breastfeeding. I was sitting there thinking like I was milking like a cow. My boobs were like . . . When they (nurses) wanted me to like produce the colostrums and stuff.

The use of a breast pump made Alice and Brittany feel very much like they were milking machines, like they were dairy cows requiring regular milking. Their breasts and their bodies became synonymous with machines, jettisoning their embodied experiences of feeding their babies via the breast.

However, technology does not always result in negative feelings by all women.

Unlike Alice and Brittany's negative experiences, Rebecca felt that the nipple shield was a "life saver." She described the scenario in which she utilized a nipple shield.

Yes, this last pregnancy I had (the nipple shield) because it was a miserable C-section and I was like not in the right position or whatever and my nipples started getting sore. But they had a shield they gave me at the hospital. They gave me a breast shield. It felt like nothing. It felt like I didn't even have cracked nipples. That would be the best advice I'd give anybody because cracked nipples would discourage mothers because it's so difficult. I used it until I felt better about . . . until I was healed. I found it emptied out my breasts more because when you nurse, when the baby sucks on you, it presses the nipple and it doesn't get the whole . . . like all around. But the breast shield has . . . it doesn't . . . like you can't press down like the baby would, and it just empties everything. Like one time I wasn't engorged on my left side right here. And it just so happened my nipples were cracked and I had no choice but to use the breast shield. And it emptied it out within like maybe three feedings. So I felt better.

The comfort level and the feelings of the mothers towards technological devices greatly influenced their choice for infant feeding. Some women felt the breast shield was helpful for them and that without it they may have abandoned breastfeeding. This was not always the case. As in Jillian's situation, she developed sore nipples and was given a nipple shield; although it helped initially, it ended with the discontinuation of breastfeeding. Jillian stated:

I used a shield when I was with her . . . I got it at the hospital. Yes. Because I guess the first 2 days of trying to feed her, or she was eating, I started getting blistery. So they gave me a shield. And it was so much . . . it was so easy for her to use it so we just kept using it . . . and then once I lost it, we couldn't hack it anymore. Or I couldn't. So we just went to the bottle.

In Samantha's case, her infant had a tight fraenum (tongue tie) and had great difficulty latching. Not only was she given a nipple shield, but the nursing staff gave her breastfeeding infant formula while in hospital. She stated:

The second baby was . . . He had a bit of tongue tie, they call it. So I had a hard time. So they would kind of . . . it wasn't a lot of help. They kind of just told me it would be a little easier, okay, let's give him formula just for a bit until you can get the hang of it. I kind of was too afraid to tell them no and to speak up for myself. So I said it doesn't matter just the first few days in the hospital. I know when I get home I'll try and I'll flush the formula out of his system because of his poor belly. So I just did it on my own at home (Samantha).

Once Samantha was home, the perinatal clinic nurse gave her a nipple shield which she used for 2 months. Samantha stated "It (nipple shield) worked so we kept going with it. And then I finally took him off that and we were able to feed a little better and the milk would come out better without the shield."

As I was listening to these stories, I could see the expressions on the women's faces. Sometimes they shook their heads in dismay, and at other times they laughed, as if they could not believe the absurdity of what had happened to them while trying to learn how to feed their infants. Each narrative provided images of women as objects, as mere parts, and in need of professional care (Gadow, 2000). Aboriginal women have stressed that "good-quality health care for expected mothers and young children is not just prenatal care, delivery, postnatal care and checkups; it involves looking at the woman's life as a whole" (Health Council of Canada, 2011, p. 5).

When appropriate assessments are done, nipple shields can assist with painful, sore breasts, with flat or inverted nipples (Hanna et al., 2013), or with premature infants (McKechnie & Eglash, 2010). When clinically indicated, machines may be able to assist a woman's body but utilized when absolutely necessary and only with follow-up plans in place to ensure that the technology is working properly and being used for as brief a time as possible. What saddened and disheartened me as both a nurse and a Lactation

Consultant was that not one of these women could recall having had a breast or feeding assessment prior to being given either a breast pump or a nipple shield. While I am sure the nurses were well intended, these devices, although helpful for breastfeeding issues, can cause many problems and concerns for others. When women's bodies are seen as various parts and thus disembodied, rather than in their entirety, self-doubt and feelings of inadequacy can develop.

Lack of assessment speaks to the ongoing need for nurses and other health care providers to have current education regarding the best infant feeding practices available which are updated on a regular basis (Chalmers et al., 2009; Levitt et al., 2011).

Knowledgeable nurses need to complete culturally safe assessments that meet the identified needs of the women. Nurses ought to understand the importance of taking time to listen to women's stories in order to comprehend the needs of the women they are assisting, be that of infant care and feeding, clothing for infant, a safe place to return home, and food security—all possible needs identified by the participants of the study.

According to Bergum (2004), nurses have a responsibility to provide care and ongoing education to families for which they are caring. They are not to do this in a hierarchical, authoritative manner, which potentially marginalizes and discriminates clients (Browne & Fiske, 2001; Browne et al., 2005) but rather in a respectful manner where the client's needs, thoughts, and opinions are part of the conversation that develops into a plan of care. Relationships can then occur between clients and nurses that respect both viewpoints (Bergum, 2002), unlike Samantha's situation as noted in the above

narrative. In that situation, she was afraid to voice her opinion about her infant's care, waiting until she was in the safety of her home to put her plan of care into action.

It is essential that when making their infant feeding choices, women receive ethical care from their health care providers. The Canadian Nurses Association's (2008) Code of Ethics for Nursing and Standards for Care indicates that "Nursing ethics is concerned with how broad societal issues affect health and well-being. This means that nurses endeavour to maintain awareness of aspects of social justice that affect health and well-being and to advocate for change" (p. 2). According to McGibbon, Etowa, and McPherson (2008), "Equity in health care refers to the fair distribution of the goods, services and opportunities necessary for physical, psychological, and spiritual health" (p. 24); when equity does not occur, the cycle of oppression continues and health outcomes are affected. It is important for nurses to understand their clients' context in relation to employment, childcare, transportation, and access to health care in order to develop collaborative plans of clinical care related to infant feeding practices.

By listening to the voices of Mi'kmaw women, nurses can potentially utilize technology in a non-oppressive manner. This would potentially empower women thus negating the biomedical tendency that disconnects women from their bodies and reduces them to isolated parts (Goldberg, 2008).

The Disquieted Body

There are a multitude of political and social pressures exerted on women when choosing a means to feed their infants. More often than not, environments do not support breastfeeding. There are few daycares located within the workplace or community,

breastfeeding or pumping rooms are not available, and breastfeeding overall is considered an irritant rather than a healthy and an important means for feeding infants. As Young (1990a) stated:

Breasts are the most visible sign of a woman's femininity, the signal of her sexuality. In phallogentric culture sexuality is oriented to the man and modeled on male desire. Capitalist, patriarchal American media-dominated culture objectifies breasts before a distancing gaze that freezes and masters. The fetishized breasts are valued as objects, things; they must be solid, easy to handle. (p. 78)

When society at large views women's bodies in an objectified way, breasts are not seen as means of providing nourishment for infants but become solely a sexualized issue. According to Wambach (2004), these types of social influences are particularly salient to young women. As such, nurses are often challenged to understand how gender impacts upon women's taken-for granted and everyday lives (Goldberg, 2005).

These social influences were found to also have an impact on the participants' everyday infant feeding choices. When discussing with Elizabeth how she and others (in particular her partner) viewed infant feeding she quickly responded by saying,

I would try to help them (other mothers). Like I'd tell them breastfeeding is good and it's free and it's easy, but from my experience, it's bad. But it's their decision. Nobody can make it for you. I find that when you breastfeed, it's no longer like attractive to your husband. It feels like it's the baby's and you don't touch them.

Surprisingly, she felt like she no longer was attractive to herself or her husband. Like many women worldwide, Elizabeth's partner's opinion regarding infant feeding and her body was of importance to the couple's relationship. Men frequently report feeling left out when women breastfeed their infants and are uncomfortable when their partners

breastfeed in public (Mitchell-Box & Braun, 2012). According to Henderson, McMillan, Green, and Renfrew (2011), “breastfeeding was closely associated or even synonymous with sexual activity and . . . [t]hat breastfeeding in public would be very exposing and might incite negative reactions” (p. 68). Negative reactions to breastfeeding in the public have occurred in Nova Scotia. A mother was asked to leave a retail store in Halifax when she chose to breastfeed her infant (CBC News, 2012a), and a working mother was told she could not breastfeed her infant at work (CBC News, 2012b). The sexual portrayal of breastfeeding is common in many media accounts, leading to increased anxiety for both men and women regarding breastfeeding as an infant feeding choice (Henderson et al., 2011).

The viewpoint of women’s breasts as sexual objects remains apparent in today’s world, with the understanding that the main function of women’s breasts remain a heterosexual one, “body objectification and the sexualisation of breast” (Ward & Merriweather, 2006, p. 712). This objectification of women’s breasts creates even further challenges for lesbian women (Krawczyk, 2013) and trans-gendered men (Karain, 2013) when considering breastfeeding, as both groups report having less social support when making infant feeding choices. Transgender men, for example, have been excluded from taking up leadership positions in La Leache League Canada, for the sole reason that they are not women, despite the fact that they have shared in the birthing experience and breastfed via a supplemental feeding device (Bowman, 2012). While there were no identified lesbian or trans-gendered people among the study participants, this is an acknowledged area for ongoing research.

Another influencing issue on mothers' infant feeding choices identified was the women's own view on the right to choose their infant feeding method. The opinions of the participants varied regarding their infant feeding methods. A few (See Appendix I) of the women felt that the only choice be breastfeeding; while others felt that formula feeding was the only comfortable way to feed their infants. Others felt it needed be a personal choice depending on a person's life circumstances. For example, Brittany felt that women had been given too many choices already and that all women need to currently be encouraged to breastfeed. She stated the following during our conversation:

I don't know if anybody else is trying to bring it (breastfeeding) back or not but I would recommend it. They did it way back then and I don't know why they should stop now. I find women are a little bit too spoiled these days and they just, "Just give me a needle and do this. I'll just bottle feed my kids. It's easier." Like they had no choices back then. And we shouldn't have that many choices now. I don't think we should.

Views about the rights of women's choices were projected onto others. For instance, Brittany went on to describe her experience with advising another mother regarding breastfeeding in the following account:

For women to go to people who want to breastfeed and show them how to breastfeed instead of people that don't breastfeed asking those people to breastfeed. Like I had a . . . my neighbour upstairs, she has a little girl. And she's like, "I'm thinking about breastfeeding but yet I don't want to quit smoking." I was like, "Oh, okay. But I'm just going to show you anyway because it's so much easier and it costs so much less." And so I took her step-by-step on how to actually put it on. And she was like, "Oh my god, but her mouth is so little, I'm afraid she's going to not get anything in. My boobs are so much bigger." But babies are supposed to."

The pressure from health care providers to breastfeed influenced women's choice.

While Brittany was a strong advocate for breastfeeding, many (See Appendix I)

participants stated that breastfeeding made them feel uncomfortable with their body for numerous reasons. They felt their breasts were not the “right size” as indicated in the above account, that they could never be away from their infants if they chose to breastfeed, that they often felt embarrassed by breastfeeding, and that they felt pressured into breastfeeding.

Mary felt that breastfeeding was not the infant feeding choice that met her needs. She felt that there would be no opportunity for her to be away from her infant if she opted to breastfeed. She described breastfeeding as follows: “It [breastfeeding] just didn’t feel right to me . . . I didn’t want to be stuck to my baby all the time.” Similar to Mary, Bethany stated, “I don’t know, embarrassed. I don’t know, embarrassed . . . Yes, I kind of felt like I would be trapped [by breastfeeding].” “Yes, I would have to take them along [her children].” Jennifer explained that if she were to breastfeed she would feel like she would have no time for herself; wherever she went, she would have to take her infant. She was very uncomfortable with the thought of nursing in public and found it embarrassing. Harper (2001-2013) defined “embarrass” to mean: “perplex, thro into doubt, from French *embarrasser* (16c.), literally “to block,” from embarrass “obstacle,” from Italian *imbarazzo*, from *imbarare* “to bar.” In this context, breastfeeding was an obstacle for these women.

Being tied down is another social influence that impacts choice of infant feeding. Others felt that breastfeeding was very taxing on the body and that it was a great deal of work as portrayed by a participant: “It takes a toll on your body. Like I said, in the beginning, it feels like you have to do everything. You can’t rest, you can’t shower,

you've got to feed the baby first" (Elizabeth). This way of thinking about the body was in stark contrast to that of Kelsey: "They say it's [breastfeeding] a lot of work. I always have to be busy with her but I don't mind it."

Both embarrassment and social circumstance shape and constrain choices that have been identified as concerns with breastfeeding among young women and men in Nova Scotia and New Brunswick. Spuries and Babineau (2011) conducted a study with university-educated women and men from these two provinces and found that breastfeeding continues to be viewed as restrictive, with concerns from the young women centering on "disruptions to social relations" (p. 135) and the young men's concerns more on the discomforts of breastfeeding in public. Image is an important social influence. When asked about body image and breastfeeding, Brittany felt that many women did not breastfeed due to the comments that women hear about the breastfeeding body. She stated "They feel like they're cows, you could say [laughing]. Yes, I remember I was told that . . . like, Oh, a cow, that's what it's for. That's what your body is for." Brittany, as previously indicated, was a strong advocate for breastfeeding and these comments did not appear to bother her. She was laughing about the comment and had no problem letting other women know that she felt that breastfeeding was the only choice for infant feeding.

Finally, women depicted how they felt their body was "forced" into making the choice of breastfeeding. They felt that they breastfed for the health care providers, not for themselves or their infant's well being. When describing her breastfeeding experiences, Elizabeth's distress became apparent. I listened intently to her story and

truly hoped that in my time as a nurse and lactation consultant that I have never made a woman feel pressured into one means of feeding over another. Elizabeth stated:

I know breast milk is better for the baby . . . [Perinatal nurse] kept telling me to do it (breastfeed), do it, and it felt like I had to do it so I did it, and [Elizabeth further tells her story about being in the hospital postpartum] They force you to . . . I even . . . I kept telling them, I don't want to. And they said, just latch him on, see if he'll . . . and I felt like he wasn't getting milk, and they didn't show me a proper way to do it, and . . . I find it better bottle feeding because my husband could help me . . . I don't have to rush to nurse . . . I find it better bottle feeding. At least he could do something and I could do something.

Another participant, Jennifer, detailed a similar encounter, "Everything was about breastfeeding . . . yes, because they say how much better it would be for you and the baby and for their health . . . they make you feel guilty if you don't breastfeed." After hearing these stories and having an opportunity to read them repeatedly, they often weigh heavy on my heart. Regrettably, as nurses we often don't realize the impact we have on the lives of others and how our actions have long-lasting consequences for the families that are in our care.

Solchany (2001) stated that pregnant women are constantly "re-evaluating ideas about motherhood and babies, re-evaluating and making role adjustments, and accepting body changes" (p. 31). No doubt such a cycle can also be found when women are making their decision regarding infant feeding. Many factors influence this decision. However, how women's bodies are viewed by others, and more importantly by themselves, is a key element in the decision-making process to breastfeed (or not) their infant.

Naomi Ruth Lowinsky (1992), a noted author, wrote the following about the impact of becoming a mother:

Women who become mothers
find that it is often in the crucible of that experience,
in what in so many ways seems a sacrifice of self,
that she touches her deepest experience of the female self
and wrestles with an angel that at once wounds and blesses her. (p. 66)

Becoming a mother and therefore making infant feeding choices may lead to a multitude of disquieting feelings about one's own body and how others view women's bodies—disquieting emotions that may be reflected in their infant feeding practices, as embodied in those of the women in the study.

Addicted Body

When I initially spoke of the study to participants, it appeared that I would have no problem with obtaining a number of women in a relatively short period of time, as there were a number of births expected. However, it became a concern as it was soon realized that many of the women did not meet the outlined criteria. I was advised that the women delivering were under the age of 18, had high-risk pregnancies, or had infants that required treatment in a neonatal unit. These concerns were often related to drug use issues (personal communication, August 2011).

The participants themselves spoke of their concerns relating to drug usage among women and how drugs impacted infant feeding choice, frequently limiting the option to breastfeed. I will never forget or have never been as humbled as when Lynn shared the following story: Her first child did not live with her but with a relative of her choosing.

She gave her child to a relative to care for rather than have the child put in the foster care system. Thus Lynn stated:

[Child] is with my [relative] because we had like . . . I had problems when I was younger . . . I did it [meaning she contacted Social Services] . . . And then I told them [about her depression and drug usage] . . . Depression and I started hearing things because of the drugs I was doing . . . I was doing . . . I was doing pills . . . Like I only tried hydros like twice. But I was more like on . . . I was taking Valium and I was smoking weed.

As Lynn recounted her story, I could feel the pain the woman felt when she told this story, but also the resolve, fortitude, and resilience she had as she narrated this life experience. She continues to have a good relationship with the chosen guardian of her child and said that she was able to stop the drug usage due to her children and current partner. As a mother I cannot imagine how difficult this decision was for this young woman, but she made the decision with her child's best interests at heart. This woman has turned her life around and from my short but meaningful encounter with her she appeared to be very engaged with and caring for her small children that were currently living with her. She spoke of all her children fondly and tended to them with smiles and frequent hugs and the children responded favourably to their mother's caring hands.

Amanda, another woman from the study stated:

That's why most people around here don't breastfeed, because they smoke . . . smoking cigarettes, yes. Either that or they're drug addicts and they go back to their old habits again. God knows if they're doing it while they're pregnant.

Along with cigarettes it was discovered that the use of chewing tobacco by women was a common practice in the community. June told of her use of chewing tobacco. It was discovered to be a previously unidentified use of tobacco among

lactating women in the community. I spoke with the perinatal clinic nurse following my visit with June and together we called the community grocery store to learn more about the chewing tobacco that June referred to (personal communication, August 3, 2011).

The product is known as *Copenhagen* or “Copen” by the participants. It is loose tobacco leaves that are placed in the lower gum area of a person’s mouth and chewed. Chewing releases the flavour and the nicotine. Nicotine is associated with infant colic, lowered prolactin levels, and earlier weaning (Sick Kids’ Motherisk, 2013). I spoke with Motherisk personnel and they advised that there are no published articles regarding the use of loose tobacco leaves with breastfeeding but they advised that the expected outcomes would be the same as with other types of nicotine (personal communication, May 28, 2013). June then demonstrated how she used the tobacco:

Well, I chewed tobacco . . . That all I did. Yes, just the nicotine . . . I just . . . it’s like . . . I have to show you . . . It smells gross . . . I put it under my lip . . . use it a lot . . . yes . . . but I just got used to it . . . when I’d shower . . . it’s just like when I drive . . . when I play games . . . it’s hard when I pair it with things . . . because like when I wake up, I’ll do it after I eat (she goes through a container of the loose tobacco leafs every 2 days).

Smoking tobacco also limits women’s ability to breastfeed. It has been documented that women who choose to smoke are less likely to breastfeed or even initiate breastfeeding, and if they do attempt to breastfeed it is often for a very short duration (Amir & Donath, 2002). Even though breastfeeding offers protection against respiratory illness among infants, the nicotine does cause a disruption in the sleep/wake pattern of infants, and mothers who smoke while breastfeeding are encouraged in limiting their number of cigarettes (Mennella, Yourshaw, & Morgan, 2007).

A few of the mothers experienced pressures to use substances that are not recommended to take while breastfeeding. June, for example provided an account of her dilemma with regards to substances, including alcohol and tobacco. She was breastfeeding and was encouraged by her friends to have a drink of alcohol. Initially she was frightened to ingest alcohol but eventually had alcoholic coolers. She (June) provided the following account:

Oh, there was another thing I didn't do. Like I was really, really scared . . . Like one of my friends, she had her baby in [month] and I had my baby in [month]. So she's like, "Just have one and then wait a couple of hours . . . But I was scared . . . [As for alcohol] just coolers.

On the other hand some (See Appendix I) women had concerns regarding drug use among family members during pregnancy and following birth. This concern was for the well being of the mothers and infants. For example, Lisa stated, "Well, my boyfriend's sister had a methadone baby, and she was in the hospital for a couple of months. They had to wean her off the methadone." Lisa was clearly concerned about the drug usage within her community and its impact on all community members. This concern is echoed by many Mi'kmaw people, "Today's drugs have become more addictive and more accessible than even 10 years ago. The impact of drug abuse in . . . and other First Nations communities in Atlantic Canada has become widespread" (Eskasoni News, 2012).

The participants strongly encouraged me to do another study among young pregnant women who were using drugs to speak to them about their infant feeding

choices. These women had many concerns regarding substance use and would like to see more services and information made available for those with drug-related concerns.

Excluded Body

For some (See Appendix I) participants in the study their daily breastfeeding experiences frequently caused them to be excluded by family and friends (even in their own homes), by the community at large, and by health care providers. Labonte (2009) stated that social exclusion “is not about categories of people but about relations of power that categorize people” (p. 272). Political and socio-economic powers within women’s everyday circumstances may create experiences of exclusion, in this case of breastfeeding. Therefore, health care providers need to be concerned with such powers and thus become conscious to the ways in which it can perpetuate and sustain such (Labonte).

In the context of the women’s experiences, breastfeeding was not accepted by all family members. As such, it often led to feelings of isolation and exclusion. For example, Mary told of an experience she had with family members while breastfeeding her infant at home. She was breastfeeding her infant when her father unexpectedly arrived home. Mary described her experience as follows:

And my dad got mad once. He got mad at my mom. He didn’t know . . . I was sitting on the bed and I was just breastfeeding. And they came in the door and then in the room, and I was just sitting there. I just told them, “Hi.” And then my dad said, “Jesus Christ, why didn’t you tell me she was in here.” And then they ran out, “I’m sorry, I’m sorry.” They were like that. So I don’t know, I guess everyone is like . . . A lot of people are private, I guess, and you know. But I didn’t mind. Like it didn’t bother me, like, “Oh my god, get out, get out,” or whatever.

While Mary had no concerns with breastfeeding openly in her home, it was a problem for her family members. This in turn caused her concern because it upset her father. The participants spoke of using a small blanket or a shawl for privacy when nursing among family or in public settings. The use of the small blanket enabled mothers to be comfortable breastfeeding in public and made it possible for them to be included in family functions.

The degree of acceptance by community members also influenced women's breastfeeding experiences. Women had concerns when trying to breastfeed in the community setting. When speaking of breastfeeding in the community at large, Rebecca stated:

No, not . . . like when I first started nursing that was kind of . . . you did stuff like that in private. I mean like to go shopping at [department store], there's the dressing room where you could nurse. I mean there was only one incident that one of the workers asked me to nurse the baby in the bathroom. And then I asked her, "You're serious? You want me to nurse my brand new baby on a toilet?" And she opened the dressing room. And that's the only incident out of the whole amount of years that I had that weren't supportive of nursing [breastfeeding]. . . . I think that's a personal choice [breastfeeding in public] . . . because nowadays, they have that cover. And at the time, I used to use a blanket. But . . . And I used to nurse my baby going to town or nurse my baby . . . You know what I mean?

Although Rebecca had an unfortunate incident with her infant in a department store she was quick to point out that in her home community supported breastfeeding. Thus, Rebecca further stated, "It's [breastfeeding] not frowned upon. If you're asking that question. I think more people are supportive of those who nurse. Like when I nurse, people say how tough I am."

Despite challenges, mothers reported that they were “tough” and continued to breastfeed. *Tough* in this context represented a type of resilience against all odds (poverty, lack of housing, transportation, social exclusion, etc.). The word *tough* is defined as “able to endure hardship; hardy; stubborn; vicious; a ruffian” (tough, 1984, p. 796). Similarly, Harper (2001-2013), defined ‘tough’ etymologically from: “Old English *toh* “difficult to break or chew,” from Proto-Germanic *tankhuz*. Its figurative sense of “strenuous, difficult, hard to beat” is first recorded c. 1200; that of “hard to do, trying, laborious” is from 1610. Rebecca was determined to breastfeed her infants. Rebecca described her use of the word *tough* to mean

More like kind of an encouraging kind of way. You know what I mean? Like I already know when I nurse my babies that I’m going to nurse for over a year. I don’t like . . . Even though it was hard, even though there is time where it’s hard, either you’re sick or whatever what’s going on, but I always know I’m going to nurse for a year.

As Rebecca spoke you could see on her face the pride she had in herself for breastfeeding her children. She spoke of the difference she could see in the health status of her children who were breastfed. She stated the following about her children:

Yes. Like I notice their body shape in between my two older ones and the others. I call them [the younger children] my breastfed babies. My two older ones, they’re not as built and healthy as my other ones. They’re a lot more, I don’t know, skinnier, I would say . . . there’s a difference . . . they [the breastfed children] are healthier, their bodies are different . . . and then all my other . . . my two older ones, they need glasses. The rest of them have above average eye . . . what do you call it? They can see better than normal vision. Breastfeeding is hard. Like I did give up going to the movies and stuff like that. But to me it’s worth it. My baby is number one. I’ll wait until the baby is like 6 months and eating solid foods and able to have like apple juice on his own in order for me to leave. And if I do leave, it’s not more than 2 hours. Because you have that bond. Like even now, if I have a babysitter and I take off, I leave for like to the movies,

I'll miss my baby. I'm longing for my baby. And just to come home and smell and kiss him. (Rebecca)

While Rebecca found strength in breastfeeding and standing up for her rights to breastfeed in public, Elizabeth found public disapproval of breastfeeding too uncomfortable and felt that formula feeding was a better option for her infant feeding choice. She stated:

I find that people look at you funny [when breastfeeding in public] . . . They look at you with a face, a weird face expression, that makes you feel uncomfortable . . . And I could do it [formula feed] anywhere. I just need to heat it up and give it to him without anybody looking at me weird. (Elizabeth)

Similar to Rebecca, Amanda had friends comment on her attempting to breastfeed “They were saying, ‘You’re tough. You’re tough. That’s the toughest thing to do.’ They said, ‘We tried . . . They tried for a week.’ And they said the first week is the hardest.” (Amanda). Language is “a special and unique process since, in linguistic communication, a ‘world’ is disclosed” (Gadamer, 1989, p. 446). In order to breastfeed these women all too often had to endure hardship and be stubborn. They were seen as a nuisance rather than as a determined woman trying to provide nourishment to her infant. Had these women submitted to the exclusionary actions and negative or unsupportive comments of family, friends, and community, they may never have breastfed their infants at all.

The use of the word *tough* draws attention to the need to understand language. Bergum (2004) wrote that if a woman were to write her own story about the care received by health care providers, it would “have a different emphasis and language” (p. 486) than that told by health care providers. It would include not only the physical

concerns that tend to be those focused on by nurses and other primary care providers but also the personal, social, and psychological issues of their daily lives. This is equally true for Mi'kmaw women's experiences and how their infant feeding choices have been shaped in the context of their health care encounters.

Rebecca gave the following account of her childbirth experiences and of her experiences of provider care:

I was robbed of my baby at birth . . . Yes. At the beginning, I think it was at [hospital], they used to take the baby out of the room after you had just given birth. And they go clean the baby or whatever like that. And like even at night-time, you wouldn't be able to room in with your baby. But at the [another hospital], and I guess times have changed, but you could take your baby right from birth and you be the one to clean the baby the day after . . . Well, as soon as the baby is born, they plunk the baby on your stomach. And then they have to do whatever—snip, snip, stuff like that. And of course they take the baby to . . . I guess you're holding the baby for a little bit while they're doing the snip, snip stuff. And then while you pass the placenta and stuff. And then they go weigh the baby, of course. They do that. And with the eyes and the drops. Yes. And then the baby is still dirty, warm in that nice blanket. They give you the baby and the baby's hungry. [Laughs]. . . . My babies were born hungry. They were like [crunching sound].

Unlike Rebecca's experience noted above, current perinatal policy recognizes the importance of ensuring postpartum mothers and newborns are provided care that supports early breastfeeding and bonding. The Baby Friendly Hospital Initiative encourages mothers to place their infants at their breast as soon as possible after delivery (Breastfeeding Committee of Canada, 2012) in order to support early breastfeeding. While this is written as institutional policy, it is not always occurring in practice. It has been common practice for infants to be weighed and bathed before they were placed at the breast—which is not reflective of best practice for nursing care. Additionally, the

National Aboriginal Health Organization (2005) states that, “an integration of Aboriginal women’s perspectives is critical to all policy discussions” (p. 4). In order to provide culturally safe care for Aboriginal women, Foster (2006) stated that the mother-baby pair need to be considered in a holistic manner: physically, mentally, spiritually, emotionally, historically, and culturally. The participants of the study voiced that their perspectives were understood when their decisions were respected, when they truly felt that they were part of the infant feeding decision, when health providers spent time with them and individualized their care, and when family members as a group were welcomed by health care providers.

Health care providers can also fail to recognize women’s infant feeding needs. Nurses both in the hospital setting and in the community were found to be both helpful and of concern to the participants. Mary, for instance, had concerns related to feeding her infant in the hospital and made the following comment about nursing care:

Yes, I find it was alright. But at the time when I had my son, there were so many women coming in having their babies that nobody couldn’t really help me. It was just me and my boyfriend really . . . I just didn’t get as much help as I wanted . . . because all of the nurses were busy, too busy . . . I don’t even know if they were helping anybody else. (Mary)

Due to Mary’s lack of support in the hospital, she was not given the information she needed in regards to formula preparation. It wasn’t until she was at a friend’s home that she realized she was preparing the formula incorrectly. Fortunately, the infant did not become sick, but this was a grave concern for her regarding her infant’s health. Mary recalled the following:

And I didn't know that you're supposed to add it with water. And then I took my baby to my best friend's house because they wanted to see the baby. And they told me, "is there water in these bottles? And I was like, "No." And they were like "You're supposed to put water in them."

Insofar as evidence suggests that nurses are committed to the provision of equitable and quality care, the aforementioned concerns are likely the result of staff shortages and patient acuity and not a conscious attempt to discriminate on the basis of race and class. When there are differences, however, in race, class, ethnicity, sexual orientation, etc. there is potential for tension to occur relating to the balance of power inequities (Browne, 2007; Reimer Kirkham, 2003). Thus, Emma's desire for more Mi'kmaw nurses made me ponder the quality of care the participants might have received. Emma felt she would have been more understood if she had been cared for by a Mi'kmaw nurse. She stated, "Yes. It's more understanding. I mean because . . . Well, all these high words and everything but we're like, Huh? Like can you explain that again? Huh? . . . Well, if there was big words, I'd be like what does that mean?"

It is imperative that health care providers understand language is of the utmost importance in supporting women with their infant feeding choices. Thus, Emma's comment is telling in many ways. In particular, it sheds light on the ways in which providers can use language in exclusionary ways that distance themselves from patients in their care. Gadamer (1989) stated that, "language has its truth being only in dialogue, in coming to an understanding" (p. 446). Words obtain their meaning through the conversation that takes place. Helpful conversations between health care providers and women involve a reciprocal and relational discussion and an understanding whereby a

collaborative agreement about infant feeding practices occurs. Returning to Emma, she felt that Mi'kmaw nurses would be able to understand her needs better and would explain things to her in a manner that she could understand. She felt excluded when explanations were given to her using difficult medical terms by the nursing staff. Tang and Browne (2008) maintained that Aboriginal peoples' health care is often negatively affected by health care providers just for being visibly Aboriginal.

On the other hand, the participants identified experiences where the nursing care was very helpful. Amanda spoke of the care received from the Perinatal Clinic nurse.

She stated:

It was [Perinatal Nurse] that helped Amanda to try breastfeeding. Her friends told her the perinatal nurse was a great support "Yes, and everybody said she's good." [Laughing Amanda stated that] She [Perinatal Nurse] convinced me. My nipples were sore. It felt like she wasn't getting enough and what helped was that the perinatal nurse came to visit . . . I think that's why everybody gives up, because they're not supportive enough. (Amanda)

Foucault's (1979) notion of normalizing judgments is evident when women and others, including health care providers, are judged as good mothers or not, depending on the choices they make. This type of normalizing judgement can be particularly salient for single mothers, mothers with disabilities, and other marginalized women (Knott & Latter, 1999; Peckover, 2002; Thomas, 1997). Many (See Appendix I) of the mothers felt judged by health care providers about their infant feeding choice. It is essential that health care providers become aware of their privileged position and of the situational power they can wield on a mother's decision regarding infant feeding. The provision of evidenced-based knowledge is a necessity for mothers to enable and to support informed choice. If this is

not done, women are often excluded and isolated, and their own health and that of their infants is placed in jeopardy.

Additional factors that impacted infant feeding choice were those of geographic location and access to health care agencies. Women often had great difficulty in getting help with their feeding difficulties relating to their location and the distance to health care facilities. While there is a Health Centre in the community, it is not accessible in the evenings, weekends, or holidays. The Canada Health Act (1985) is in place to ensure that all Canadians have reasonable access to hospital and medical health services (Health Canada, 2008). It became readily apparent that these services were not readily available for the participants in their community, and that they also had difficulty in accessing health care in the closest regional health care facilities due to transportation concerns. The women advised that they frequently had to pre-register for a taxi if they had an appointment for themselves or their infants in the regional health centre. Jillian described what she had to do in order to get to the hospital for her caesarean section:

And we got a hospital taxi for the section . . . The hospital taxi . . . you just call . . . the hospital taxi, you just call someone, you make an appointment with them to drive you into the hospital or something. They get this slip and they just get it stamped . . . I think it's like \$30.00 a trip.

Not only did Jillian have to book a taxi in order to go to the hospital to have her baby but lack of transportation also has impacted her other child's learning opportunities. She stated, "I couldn't even get [child] to Head Start because we had no ride. Head Start is like practice before kindergarten" (Jillian).

According to Lavoie and colleagues (2010) “access to care constrained by geography” (p. 722) is all too frequent for many Aboriginal people. Funding for health services does not meet most Aboriginal peoples’ needs. Government cutbacks, increasing demand, limited public transportation, and delays in approval all impact the everyday experiences of Aboriginal peoples’ access to health care (Health Canada First Nations & Inuit Health Branch [FNIHB], 2005; Lavoie et al., 2010).

Accepted Body

An interesting finding in the study entailed that none of the participants expressed dissatisfaction with their body shape and size. The participants were aware that postpartum women lost weight much more rapidly if breastfeeding, but this method of feeding was not routinely utilized for this purpose by the participants. In fact, the promotion of weight loss as a benefit of breastfeeding was of concern for Jessica, a participant in the study. When Jessica spoke of concerns regarding weight loss and breastfeeding, she stated:

I would say if the mother is unhealthy, guarantee would be one. If the person had an addiction problem, would be two. Oh, there’s another thing that bothers me. People think that just because they’re breastfeeding that no matter what . . . This is what really bothers me. I’m really upset about this, I just remembered. One of my friends stopped eating and thought that just because the baby still nurses . . . the baby wasn’t getting enough milk and the baby wasn’t growing. My baby grew like double its size, and this baby was still in infancy. The baby was, I think, only 8 pounds while my baby was 16. They were born at the same time. And she wasn’t eating, thinking that the breastfeeding and the not eating was going to make her lose her weight more quickly. But the baby wasn’t developing. She thought that just because the baby’s growing . . . just like . . . what was her response to me . . . she said that babies in third world countries still grow . . . I think a pamphlet should say if you’re intending on losing weight, if your only goal is to lose the weight than it’s better to not breastfeed.

As a practicing nurse, I have heard mothers express their concern regarding the loss of their pregnancy weight and dissatisfaction with their bodies. However, in this study the women did not express concern about their bodies and appeared to be accepting of their bodies. In a study exploring stress among on-reserve female youth in Nova Scotia, it was found that:

While the Aboriginal females preferred smaller body shapes as did mainstream females, they preferred body shapes that were larger than the shapes preferred by mainstream females. This difference may be due to cultural differences in what is considered attractive. (McIntyre et al., 2001, p. 17)

Additionally, Marchessault (2004) found that among suburban Aboriginal women, a heavier perceived body weight was seen as acceptable and suggested that this may be based on the women's belief that a heavier, not obese, body weight may be more achievable, rather than on ideas or beliefs of attractiveness. The hegemonic construct of the female body as outlined by Ussher (2006) as nurturers, good or bad, or needing self-renunciation may not be as salient among Mi'kmaw women in the study, or constructed differently as other women. Perhaps these findings provide an explanation for the participants' acceptance of their bodies, but ongoing research is required as one cannot generalize this finding to all Mi'kmaw women.

The theme, *Is Breastfeeding Right for Me? It's My Choice—Respect My Choice*, provided information on how infant feeding practices impacted on the Mi'kmaw women's bodies, their health, and their infants' health. Austin (2001) stated "Health as a universal right means equal opportunity of access to quality health care, regardless of gender, race, social, economic and geographical facts" (p. 186). All too often health care

providers still provide disembodied health care grounded in a Cartesian model of medicine: “So long as the mind-body dichotomy is accepted, suffering is either subjective and not truly real . . . not within medicine’s domain . . . or identified exclusively with bodily pain” (Casell, 1982, p. 640).

First Nations women’s embodied experiences have been greatly influenced by the power and control maintained by the dominating European-Canadian structural institutions (i.e., the Indian Act, residential schools, reserve systems, health care systems). Nevertheless, Foucault (1980) reminded us that actual power and domination are more in keeping with

How things work at the level of on-going subjugation, at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours, etc. In other words, rather than risk ourselves how the sovereign appears to us in his lofty isolation, we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc. We should try to grasp subjection in its material instance as a constitution of subjects. (p. 97)

First Nations women deserve to have culturally competent and culturally safe professional care with all their health care needs. McGibbon and Etowa, (2009) define cultural safety as “the provision of quality care for people of ethnicities different than the mainstream” (p. 212). In order to achieve this, mainstream health care providers need to engage in “cultural humility and/or assess actual practice” (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). Through an increased understanding of Mi’kmaw women’s views on the body as machine, disquieted, addicted, excluded and/or accepted, nurses in collaboration with Mi’kmaw women may develop educational programs and activities

that would improve upon each of these areas, thereby enabling other Mi'kmaw women to make an informed decision regarding their infant feeding choice. The final theme of the study, *Understanding Our Time*, is described in the following chapter.

Chapter 7:

Theme Four—Understanding Our Time

And people have got to understand [regarding time] that it's not just an easy thing to pick up and go for folks... You know, it's not a matter of saying okay, at 10:00, I'm going to be there because I may not have a car, I may not have transportation. There's not taxis everywhere. And I've got 3 kids to try to get sorted out to get there. (Rebecca)

Rebecca clearly provided a portrayal of the many factors that may impact on Mi'kmaq women's daily experiences of time. Halsema (2011) wrote of how time affects how women understand themselves, how women adapt over time to experiences, and of how women perceive and define themselves. Only through my studies have I come to understand how much I do not know about Mi'kmaw women. Finding words to adequately describe their embodied lives has indeed been a journey over time, one often experienced in moments of stillness and at other times in moments of speed, thus racing by in the blink of an eye.

Although Western society has multiple ways of perceiving time, it is nevertheless often understood in a linear fashion in a series of *nows* (Leonard, 1994). Heidegger (1975), described these *nows* as “free-floating, relationless, intrinsically patched onto one another and intrinsically successive” (p. 263). Thus linear time tends very much to be concerned with the *nows* in our lives and yet creates difficulty in being able to link how the *now* integrates with the past and the future experiences in our lives (Leonard, 1994). To alleviate the tension caused by linear time, Heidegger (1975) used the term *temporality* rather than time. For Heidegger this term enabled time to be directional and relational, rather than linear. “The not-yet and the no longer are not patched onto the now

as foreign but belong to its very content. Because of this dimensional content, the now has within itself the character of a transition” (Heidegger, 1975, p. 249), suggesting that peoples’ lives and time are constituted from times of the past and of the future.

While linear time, which is chronological and of a specific duration (Janca & Bullen, 2003), dominates our western thinking, in reality it is not the singular discernment of time (Barton, 2004). Biological, cosmic, human, natural, psychological, individual, collective, ecological, and seasonal are other aspects of time that complexly and diversely compete for women’s experiences of time (Adam, 1990, 1995, 2004). Insofar as time can be construed as gendered, Adam (1989) argues that feminists need to develop an understanding of time that can do the following:

[G]enuinely connect experiences, context, pattern, process and events; one that can simultaneously account for continuity and change, the influence of the past, the visions and interests of the future, and the constitution of the present, without losing sight of social relations of power. (p. 463)

Understanding experiences phenomenologically requires one to be able to express, interpret, and translate everyday life events (Barton, 2004), inclusive of one’s historical and cultural experiences (Heidegger, 1962). According to van Manen (2007), lived time (temporality) is “subjective time as opposed to clock time” (p. 105). Not unlike van Manen’s description of lived time, *Indian Time* has been described as “time that progresses through events, rather than minutes on a clock” (Klemm Verbos, Kennedy, & Gladstone, 2011, p. 51).

In light of the aforementioned, there appears to be robust similarities between phenomenological understandings of time and Aboriginal worldviews of time,

specifically how they are depicted in the sacred medicine wheel—which speaks to the relational understanding of events in people’s lives. As Bird (1993), a First Nations woman stated:

[The sacred circle is a] major paradigm of Native thought: life, time, seasons, cosmology, birth, womb, and earth are intrinsically located in the symbology of the circle. Within this circle we are returned to beginnings to consider how far we have come as Native [peoples] . . . the Native literary tradition . . . encompassing and reflexive, a reciprocal meeting of beginnings and possible futures. (p. vii)

For study participants, time was not about numbers on a clock; it was very much about relationships and the value of their day-to-day relationships. The events of the past, present, and future intertwine, encircle, and influence Mi’kmaw women’s experiences and the relationships they form in their lives. The events and relationships that occur over time are of importance to their infant feeding practices and significantly influence the women’s choices in the context of their embodied experiences.

Lost Time

While completing the conversational interviews, the participants frequently related how important their kinship relationships were to their infant feeding choice as discussed in chapter 6. While speaking of their kinship relationships, the participants reported that they had very little understanding of their relatives’ past experiences in residential schools and were hesitant to engage in conversations with their family members regarding their experiences. In fact when the topic of residential schooling became part of the conversation, the participants without fail had a prolonged pause in the conversation. As time lapsed, the silence was often uncomfortable and some (See

Appendix I) of the participants declared that most people did not like talking about that time in their lives.

These emotional silences were perhaps not unlike what Bar-On (1995) termed as “the untold story” (p. 20) when writing of the trauma endured by Holocaust survivors. The untold stories have been seen as being very significant in the intergenerational transmission of Holocaust trauma (Bar-On, 1995). The untold horrors were too much for the survivors to communicate to others; survivors frequently resorted to unrelenting storytelling of their ordeals or of profound silences (Baranowsky, Young, Johnson-Douglas, Williams-Keeler, & Mccarrey, 1998). Either way, communicating the horror that was endured by Jewish people left scars on many generations to come, just as the traumas that occurred in residential schools have left intergenerational effects on Aboriginal people.

Jessica, in remembering her grandparents, told of what they did to protect their children from going to residential schools: “they [her grandparents] hid their children. Like whenever the bus went by, like some families hid their children. From what I was told anyway, they hid and they wouldn’t let them take them.”

Similar to Jessica, Christina talked of how her grandfather prevented children from going to the residential schools:

Yes. And he himself stopped a lot of children from going there really. Like he would take the children as his own and he would adopt them. Like if there were a lot of children that were . . . if they were well taken care of by their own parents, and the only option they had was the residential school, he would take them. But I guess he wouldn’t take the hardened ones. Like the ones that were in trouble, like the ones that were getting into trouble, I guess he wouldn’t take those ones.

But I heard stories about him like claiming a lot of children just to stop them from going there.

Other participants were very adamant that family members would not speak of their time spent in residential schooling. Samantha remembers the following:

I don't really know because you don't really . . . like if someone was in residential school, you don't ask and you don't talk about it and bring back these traumatic memories.

Others were just learning about their family members' time spent at residential schools. As June stated, "I think my grandmother went [to residential school]. They just told me like a couple of weeks ago. No. She hasn't . . . like she don't like talking about it." Foucault (1980) stated:

Silence itself—the things one declines to say, or is forbidden to name, the discretion that is required between different speakers—is less the absolute limit of discourse, the other side from which it is separated by a strict boundary, than an element that functions alongside the things said, with them and in relation to them within over-all strategies. There is no binary division to be made between what one says and what one does not say; we must try to determine the different ways of not saying such things, how those who can and those who cannot speak of them are distributed, which types of discourses are authorized, or which form of discretion is required in either case. There is not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses. (p. 27)

It was unsettling to hear the young women speak of the knowledge regarding their family members' attendance at residential schools. They themselves were uncomfortable speaking of that time, and there was always hesitancy in their response; this raised many questions for me as to how they were just learning of these experiences and of their understanding of the consequences and the internalization of the colonizing practices on their current life circumstances. Brown (2013) stated:

Silence is evident in uncertainty, yet uncertainty immediately reveals both speaking and declining to speak. The posture of discretion about speaking is not innocent, but shaped by how cultural discourses and meanings determine particular ramifications associated with telling stories of trauma . . . While uncertainty is ripe with possibilities, and may offer the safety of appearing “neutral,” detached, or non-positioned, it is not innocent. It can enable movement, agency, resistance as well as an abundance of caution and self-protection. (p. 22)

In light of the Truth and Reconciliation talks that have been taking place throughout Canada, lack of attendance at such events by any of the participants of the study may reflect the ongoing struggle for many Aboriginal people between past and present life events. The mandate of the Truth and Reconciliation Commission of Canada (2013) is articulated in the following passage:

There is an emerging and compelling desire to put the events of the past behind us so that we can work towards a stronger and healthier future. The truth telling and reconciliation process as part of an overall holistic and comprehensive response to the Indian Residential School legacy is a sincere indication and acknowledgement of the injustices and harms experienced by Aboriginal people and the need for continued healing. This is a profound commitment to establishing new relationships embedded in mutual recognition and respect that will forge a brighter future. The truth of our common experiences will help set our spirits free and pave the way to reconciliation. (p. 1)

The outcomes of the Truth and Reconciliation Commission meetings (2013) may reveal and bridge this gap in understanding and knowledge enabling healing for several generations to come. In my naivety I had expected that at least one or so of the participants would have participated in the discussions or had a family member who participated. However, no participant disclosed that they had attended any such meetings. There was indeed limited disclosure regarding the residential school experiences during our conversations. The ‘silence’ may have been a strategy of

resistance regarding the discourse surrounding residential schooling or a means of protecting themselves from the events that unfolded during residential schooling. While making note of the concerns regarding residential schooling, the intent is not to say that all students experienced injustices or harm while attending residential schooling.

The intergenerational impact of residential schooling on infant/child rearing practices has been reported as affecting First Nations families whether they attended these schools or not (Dion Stout et al., 2001; Hanson & Rucklos Hampton, 2000; Ing, 1991; Morrissette, 1994). Between 1860 and the early 1980s (Lafrance & Collins, 2003), the residential school system in Canada removed children as young as 3 years of age from their families and communities, which led to forced loss of language, loss of understanding of the ways of being with the land, and for many a taught and learned hatred of Aboriginal identity (Royal Commission on Aboriginal Peoples, 1996b). Due to the separation of children from their families, “the disruption in the transference of parenting skills from one generation to the next through the absence of 4 or 5 generations of children” (Willows, Hanley, & Delormier, 2012, p. 7) occurred. The intergenerational traumas and colonizing forces may have impacted and altered First Nations women’s knowledge regarding infant feeding practices. Women’s experiences with residential schooling would require a case-by-case indepth investigation to bring such an assumption into theory and thus into acknowledged fact.

Breastfeeding was the norm for Aboriginal women prior to residential schooling. Le Clerq (1910) told of the duration of breastfeeding among Aboriginal women of that time, “our poor Indian women have so much affection for their children that they do not

rate the quality of nurse any lower than the mother. They even suckle the children up to the age of four or five” (p. 91). He further told of how in the 1900s Aboriginal women “suffered” breastfeeding for extended periods of time and did not use wet nurses as was common in his home country. First Nations youth who attended residential schools endured:

loss of parental and sibling bonding, loss of parental role models, loss of extended family and community contact, loss of family values, loss of culture and traditional teachings, loss of language, loss of identity, and loss of childhood and childhood friendships. (Dalseg, 2003, p. 95)

Forgiveness for these losses does not come easily, and this multitude of losses continues to cause harm to generations of First Nations families. After leaving the residential schools, many First Nations people felt that they did not fit into either world and often could not get along with their parents when they returned. According to the Aboriginal Healing Foundation (2009) “many of those who went through the schools were denied any opportunity to develop parenting skills and lost the ability to pass these skills on to their own children” (p. 25). Traditional knowledge regarding maternal health concerns is passed down from woman to woman (Battiste, 2011). “As life givers, women bring the children into the world, and for this they have traditionally commanded a great deal of respect” (Anderson, 2000, p. 164).

Generational effects of residential schooling (Benabed, 2009) have severely disrupted the “teaching coming from the women’s realm” (Battiste, 2011, p. 114). Researchers have reported that breastfeeding is often learned through watching other women breastfeeding, and this has more influence on a woman’s decision to breast or

bottle feed than does educational programs or written material (Hoddinott & Pill, 1999; Holman & Grimes, 2003; Meyerink & Marquis, 2002). Furthermore, familial exposure to breastfeeding leads to positive feelings regarding breastfeeding (Dykes, Moran, Burt, & Edwards, 2003; Goulet, Lampron, Marcil, & Ross, 2003; Holman & Grimes, 2003; Meyerink & Marquis, 2002) and supports the *normalization* of breastfeeding (Dykes et al., 2003). Conversely, women with lower exposure to breastfeeding, where bottle feeding is viewed as the norm, tend to have a lower rate of initiation and an earlier rate of cessation of breastfeeding (Scott & Mostyn, 2003). Lost generations of modeling of breastfeeding due to residential schooling have left a gap in women's knowledge and in the sharing of infant feeding practices.

In keeping with much of the above evidence, study participants provided personal accounts of their experiences, not unlike current findings. Tara, for example, was bottle fed and subsequently bottle fed both of her children. She was mainly raised by her grandparents and has a difficult relationship with her mother. As residential school survivors became adults and had children of their own, the loss of modeling for parenting and their experiences in the residential schools often had devastating consequences for their own families. Their children were frequently removed from their care and in many cases were brought up by their grandparents. Tara told of how she lived with her grandparents as a young child: "mostly my grandparents. I was mostly raised with my grandparents . . . my mom lost her kids and I just kept staying with them." Tara's mother has had great difficulty with alcohol addiction and when Tara spoke of her mother, she just rolled her eyes and shrugged. She wants a different way of life for her two children.

While I was with her she constantly smiled, hugged, and gave kisses to her baby, who engaged with her mom very happily.

Rebecca recounted that her mother, father, and step-father had all gone to residential schools. In telling of her story, Rebecca stated: “He [step-father] regretted not giving us attention and affection, like hugging and kissing. But he’s very affectionate to my children, his grandchildren.” She reiterated how family members kept memories of time spent in residential schools very private: “No, they [family members] don’t. They never talk to me about it, nor have they talked to each other about it. It’s private, whatever went on. In my own family anyways. I have no idea about others” (Rebecca).

Laura spoke of her experiences with family members and residential schooling. Her grandfather attended residential school, and she felt that this impacted her parents’ parenting abilities. Laura stated:

I believe it did. I believe that this next generation, like the generation that . . . Once they had kids, the ones that went to the Shubie school or the ones that . . . they had kids . . . Whatever happened to them, I feel stayed. They taught it to their children and then those children had children . . . it was like a horror story all over again, pretty much . . . I mean, they would probably do things a lot different. Like to be honest, I think they would probably want to hold their children more because they didn’t get that affection and stuff like that. But you know, a lot of emotional things, and mean and cruel things that happened to those people . . . so they’ve held a lot of grudges inside too so that, you know.

In January 1998, The Aboriginal Healing Foundation (AHF) was established in Canada with the following mandate to address the legacy of residential schools. The mission of the AHF (2009) was

To provide resources which will promote reconciliation and encourage and support Aboriginal people and their communities in building and reinforcing sustainable healing processes that address the legacy of physical, sexual, mental,

cultural, and spiritual abuses in the residential school system, including intergenerational impacts. (p. 19)

Prime Minister Stephen Harper offered an apology to the Aboriginal peoples of Canada in June 2008. Then in March of 2010, the same government completely eliminated all funding to the AHF (AHF, 2013, Hulan, 2012). As Ricoeur (2004) stated, “giving obliges giving back; giving secretly created inequality by placing the givers in a position of condescending superiority” (p. 481). By stopping the funding for such a vital organization, the colonizing effects of government continues and will continue to wreck havoc on those in vulnerable positions. It would seem that the government does not learn, as Brown (1994), in a report to RCAP, stated:

If a dominant society controls, overshadows or wipes out this fundamental institutional function then it also takes control of the cultural constructs that become the defining characteristics of the smaller society. As a result, the smaller culture becomes sapped of its traditions and its autonomy—in short, it loses touch with its life blood and a period of social disease ensues. This has been the partially effective strategy behind the Canadian government’s relationship with Aboriginal peoples. The impact of these phenomena are numerous; most notably Aboriginal people feel immense rage and shame that has been internalized (within the individual, the family and the community) through a long-term process of racist victimization. These feelings are apparent in the symptoms of depression, family violence, suicide and addictions that prevail in Aboriginal communities and are described as a dark period in the cultural development of Aboriginal peoples by numerous writers. (p. 16)

Isabelle Knockwood, a noted Mi’kmaq author and survivor of the Shubenacadie residential school, eloquently stated:

I keep thinking about that time when I found the little girl sitting underneath the stairs—the nuns had sent her there for punishment and then forgotten about her and she’d been there all day. For a lot of the survivors of the school—it’s like that—that child is still there and has to be rescued. (2001, p. 174)

Prime Minister Harper and other government officials would do well to learn from Isabelle Knockwood's words, taken from her text, *Out of the Depths*. What happens in the past is indeed circular in its momentum, continuing in taken-for-granted ways, an undercurrent of power, impacting the understanding of women's current choices regarding infant feeding and health care practices. Mi'kmaw women and health care providers alike need to comprehend and reflect on how history influences present-day practices and future decisions regarding infant feeding choices. Collaborative and relational understanding may thus enable the development of culturally safe infant feeding supports, programs, and policies.

Experiences with Health Care over Time

The difference(s) in understandings of time sometimes led to a disconnect between the participants and health care providers. There is the linear/industrial understanding of time for many, in Western society, that is driven by the scientific/technological paradigm. This in turn entails that everything be completed within a designated timeframe. According to Waring (1988), health care providers often do not value the multitude of demands placed on women's time, particularly regarding infant feeding practices:

Women who do not breast-feed and women who breast-feed for "too long" or for "too short" a time are seen by health specialists in multilateral aid agencies as problems. Women who breast-feed in accordance with the best practice for the health of mother and child are simply expected to get on with it, to continue their valueless productive and reproductive activity in their own time. (p. 210)

Regrettably, this too often makes breastfeeding in need of interventions where efficiency is constantly monitored. This has meant that breastfeeding is viewed by many

women as demanding work and an intensive event (Dykes, 2006), instead of a relational encounter between a mother and her infant. From practice, I have noted that breastfeeding for women may be viewed as demanding work but also has a rewarding relationship between women and their infants. Additionally, the medicalization of infant feeding practices over time has contributed to the need for numerous encounters with health care providers by women, including the Mi'kmaw women in the study. Not all of their encounters resulted in successful outcomes.

When health care providers work with Aboriginal women, an understanding is needed of the cultural accounts of time and how embodied time may involve the work a woman does to provide care for her family against a gendered backdrop that differs from that of men (Davies, 1990/1996). Not to essentialize the work of either women or men, however, there are gendered differences that account for the lives of women and how they are embodied over time, inclusive of family life, reproduction, and health. Bartlett (2010) suggested that “[m]any women struggle to accommodate the time it takes to care for babies into their already established regimes of temporality” (p. 120). Furthermore, an Aboriginal understanding of time, which is multidimensional and not viewed in hours and minutes but in *time* circles inclusive of life events, takes priority over the daily clocks of western lives (Janca & Bullen, 2003). This can be seen in the words of Jessica, as she expressed concern regarding time and health care appointments:

You know, it's not a matter of saying okay, at 10:00, I'm going to be there because I may not have a car, I may not have transportation. There's not taxis everywhere. And I've got 3 kids to try and get sorted out to get there . . . you can word it by saying maybe something like you'll do it when you're ready or you'll leave when you're ready, not when the clock tells you to.

Developing knowledge of how these multi-faceted understandings of time can influence Mi'kmaw women is essential if health care practitioners are to be of assistance with infant feeding practices. Boyer (2006) stated that "colonization, racism, the Indian Act, residential schools, laws, policies, and regulations that have subjugated Aboriginal women to a lifetime of violence, poverty, and degradation have created the crisis in Aboriginal women's health today" (p. 19). Passing time has not erased these concerns for many Aboriginal women. Aboriginal women continue to be marginalized and have difficulty in accessing health care services (Benoit et al., 2003; Browne & Fiske, 2001; Brunen, 2000; Dion Stout et al., 2001; Meleis & Im, 2002; Smye & Browne, 2002).

Examples of similar challenges to accessing health care were evident in the research. Women told of how they had difficulty in developing a relationship with the physicians in the Community Health Centre, as [the physicians] change frequently and therefore the women often ended up going into the city to receive care at the emergency department. Similar findings were reported by Battiste (2011) in her study of Mi'kmaw women, whereby mothers had concerns relating to rotating doctors; to lack of consistent, personalized care; and to relationship building with their health care providers.

Participants also spoke of how difficult it was to get an appointment with health care providers and of how they really didn't understand the struggle it was for women to get to appointments. Stephanie stated: "It's very difficult to get an appointment even if you really need it. And it's easier to go to the walk-in clinic or Emergency in Sydney than it is to come here [Community Health Centre]." Similarly, June said "I had to go for

a pap test. I think that's when I was pregnant. I made an appointment like over four times. They [clinic personnel] had to cancel it and change it." Obtaining appointments for their infants was a problem for many (See Appendix I) of the mothers as articulated by Elizabeth:

Yes. Like today, my daughter's 2 months, and today is the day I just got a 6 week check-up. So it's that crazy here. It's hard. By the time you make an appointment, they'll give you next week, 2 weeks time. You're better by then. It's crazy . . . They should have a doctor on-call here weekends.

Making and changing appointments is not an easy issue for many Mi'kmaq women. As Rebecca declared, "We don't have babysitters. We don't have licenses or can't find anybody to take us there." She further went on to say: "You can word it by saying maybe something like you'll do it when you're ready or you'll leave when you're ready, not when the clock tells you to. Yes. If we're on time, everything just went totally completely smooth."

Tiffany had a sick infant when I was there to complete our conversational interview. The infant had been diagnosed with an infection and was on antibiotics. However, Tiffany was very concerned about her infant and felt that she would need to find a means of transportation to take her ill infant to the regional hospital, an hour away. It was a Friday afternoon, and the Community Health Clinic was closed necessitating a trip to the emergency department of the regional hospital, stretching her already extremely tight budget. Tiffany's main concern was about her child, and as we spoke it seemed to be a relief to her to have someone to talk to. Her infant was asleep the entire visit but had a very vigilant mother worrying over the bedside. Tiffany stated:

[The infant]) not sleeping well . . . started not to eat. So I was thinking about taking her in later to the hospital. And just fever. Like I gave [the infant] Tylenol and the fever comes back in 4 hours. So it's every 4 hours. But Doctor ___ said to give her Tylenol every 4 hours until she doesn't have a fever. So I've been doing that . . . Yes. I'm just getting a little worried because she's not really eating. She'll have two or three bites and that's it. She'll nurse but she won't eat.

A concern brought forward by participants was a shortage of Aboriginal nurses to provide care for them and their infants. Aboriginal nurses may have an enhanced understanding of the issues relating to time for Aboriginal women and may be able to advocate in a known language when providing teaching opportunities, booking appointments, etc. Laura stated:

More Mi'kmaq should be hired as nurses for the Natives at the hospital. Because there are a lot of reserves here, and I don't really see very many Native nurses there that can speak Mi'kmaq to help others out . . . It would be very important because some of us do not know how to speak English.

Stephanie, another participant, reiterated this concern: "Sometimes I was scared to speak it [Mi'kmaq language]. I was scared that one of the nurses might think I'm talking about them or something. That's what I was scared of. So I just spoke English." The effect of colonization continues when women feel that in order to manage and thrive in the health care system, they are required to conform and utilize the dominant language of the health care providers.

While many (See Appendix I) participants desired to have more Aboriginal nurses to provide their care, some (Appendix I) felt that if the nurses were from their community, confidentiality about their medical needs could be of concern. Samantha stated: "It would be but . . . with myself, I wouldn't mind it but I know with other people, they're concerned about confidentiality and privacy. So they kind of would rather have

someone they don't know [speaking about having Mi'kmaw nurses]". Thus, at any given time choice regarding care givers might be a hindrance or a benefit to mothers when deciding on their infant feeding practices.

The linear and rigid tick-tock of the clock did not meet the time structure for the participants. Priorities of life often caused deviations from western conventional time. Finding a means of transportation and childcare usually entailed having a family or kin member arrange to take the mothers to their appointments. Lack of transportation often caused the women to be late for appointments, as a family situation would take precedence over a health care appointment so the family member would come to pick them up when able to do so, not according to the time of the appointment. Health care providers don't always understand the convoluted and complex planning that many Mi'kmaw women may have to make in order to be *on time* for a scheduled health care appointment. The linear timeframe mandated by health care agencies does not fit easily into circular time where events are the priority rather than hours on a clock, as is the case for many of the Mi'kmaw women.

The pervasive power structures and social inequities of the West continue to marginalize health care and health care access for Mi'kmaw women and their families. This, in turn, creates oppressive barriers that lack the ethical and relational space needed to thrive in health care (Ermine, 2007). Ethical space is "formed when two societies, with disparate worldviews, are poised to engage each other" (Ermine, 2007, p. 193). Such a space was not always present for many of the participants when seeking assistance with infant feeding concerns.

Health policies, including those related to breastfeeding put forward by the Nova Scotia Department of Health Promotion and Protection (2006), encourage exclusive breastfeeding for the first 6 months of life and into the second year of life along with complimentary foods. Perinatal providers caring for mothers and babies are educated to promote, protect, and support breastfeeding and encourage the mandate of this policy. However, without a full understanding of women's environments at any given time, such a policy can limit women's choices regarding infant feeding. Samantha stated:

I don't know about a policy. It seems strict, just the word policy maybe. It seems very strict and it maybe seems like you don't have a choice and you have to do what they say. But myself, I could have breastfed for 2 years but I chose because of going back to work, I stopped at a year.

Similarly, Emma felt a policy that advised mothers of a recommended time for breastfeeding would be constraining on women. She stated:

I mean, Jesus, what if your kid gets to four and they start going to school, and you know, [the child says] . . . Mom, I want your nunu . . . You can't get off work and go feed two at school, right? So it'd be a tight lockdown for you too at the same time for being that old.

Along with concerns regarding health policy, the participants also spoke of their contact with community health nurses. "No, she never came at all. They told me she was going to come but she goes to _____ street and goes to look for me, and I don't live there. And they tell her that I lived over there but she couldn't find me" (Stephanie). The complexity of this concern was one I encountered as a researcher as well. Similar to community health nurses, a time for a visit would be arranged with the mother, but locating the mother was often difficult. Often due to housing conditions, women moved and stayed with different family members or moved to a new location. The change of

address was not forwarded or changed on their health care records. Significant time was then lost in trying to locate the mother and new infant. As well, due to financial constraints many women purchased cell phones with limited time on them. Therefore their telephone numbers frequently changed, making it difficult to reach them. The time spent on the women's part waiting for a visit from a nurse and the time lost on the part of the nurse trying to locate the women caused frustration on all sides. This can result in a poor outcome for all concerned. If the nurse does not reach the breastfeeding mother when assistance is needed, all too often the mother changed to bottle feeding for her infant.

The lack of 24-hour health care services 7 days a week in their own community was a hardship for the participants. Rebecca stated: "My God, wouldn't that be awesome! [24 hour doctor service]." The shortage of round-the-clock health coverage in their community where there is no public transportation only exacerbates the already reported negative outcomes First Nations people encounter with health care services (Zehbe, Maar, Nahwegahbow, Berst, & Pintar, 2012). Janca and Bullen (2003) stated that family and friends are of utmost importance, and appointments, even scheduled ones that are of importance to the person, may be seen as less important if another family or community concern was to occur. This understanding of time adds another layer of complexity in the provision and access to quality health care services.

While in acute care hospital settings, the participants voiced varying encounters with health care providers that influenced their infant feeding experiences. Samantha, for

example, recounted her experience with hospital nursing staff while learning to breastfeed her baby. She stated:

And she [a nurse] helped a great deal. And where my husband was sitting there and I told him, okay, watch everything she does so you can do this when we get home. And he did. And he watched how she latched the baby on and held the baby's head, and then she stayed throughout the feeding. But the other nurses didn't. And she came in I think maybe once. Maybe the most important thing is to have patience, especially with a new mother. That would be the biggest thing . . . and doing more showing rather than doing themselves and then leaving.

Christina told of her experience following a caesarean section delivery with health care providers:

Well probably just that one time when I had my first one. Like that was my very first section, and I was having a hard time getting around. And when I asked the nurse for like assistance, she just said like, "oh, you should learn now to take care of your baby on your own," Like . . . I can't really remember but I remember she was saying something like that. But not long after that, that nurse was never there ever again. I guess she did that to a few of the women and I guess they complained about it.

Participants expressed their concern of how they were taught and helped by the nurses to care for and feed their infants, be it bottle or breastfeeding. The women were frequently given an abundance of literature regarding breastfeeding but a scarcity of hands-on help. All too often health providers, due to lack of time, used pamphlets as a shortcut for teaching. This method of teaching does not reflect the importance of how time spent with patients is an indication of valuing the women and infants. Furthermore, written material does not reflect an understanding of the oral cultural-based way of learning utilized by Mi'kmaw people. Jessica stated: "Yes, sometimes they [the nurses]

gave me pamphlets which really didn't help with the . . . like we need more hands on learning, even if it is our second child or a third or a fourth.”

Similar to Jessica, another participant declared: “They [the nurses] go over them [books/pamphlets] but like kind of fast . . . they'd [the nurses] just help me latch on and out the door” (Nancy). Additionally, Stephanie told of how she felt regarding the literature she was given by the hospital nursing staff: “They [the nurses] gave me a bag of books and stuff but I just didn't look through it . . . I think people have that kind of way. It's easier for them to learn off other people than reading. I don't know, I think that's how they are. I'm not sure” (Stephanie).

Tiffany provided further insight into how she would prefer the nurses to have assisted her with learning how to feed her infant as she stated:

Yes. Detail and maybe explain and show. Yes. Like if you can explain everything, probably some of it you'll take in. But if you were to show then you'll remember everything. So if somebody else . . . say like somebody else didn't know what to do, you can go and show them yourself too. Like pass it along.

Other participants spoke of the nurses' care and time spent with them while learning how to feed their infants. Jennifer stated: “They [nurses] should put more care in their patients . . . be more gentle. They [nurses] just like rushed . . . No. I just stayed there to be alone because that's all they left me there for . . . like they'd come every now and then but” (Jennifer). Jasna reinforced this attitude and care of providers by stating:

No, it wasn't enough time. I don't find they [the nurses] helped a lot. Like through breastfeeding, they [the nurses] weren't helping me enough. I didn't know what to do really. So they were just like they were [in a hurry].

Amanda had a similar experience when she was learning to breastfeed her infant.

The nursing staff would just quickly check on her and she stated:

Yes, okay, the baby's okay, and then they [the nurses] were gone . . . I think that's why everybody give up [breastfeeding], because they're [nurses] not supportive enough . . . You've [(nurses)] got to give them [mothers] time and to work with them [mothers], not scare them away. Like, you can't do this.

Elizabeth, not unlike Amanda's experience, not only felt rushed but forced into breastfeeding by nursing staff as she stated:

I kept telling them [nursing staff] I don't want to [breastfeed]. And they said, just latch [the infant] on, . . . and I felt like [the infant] wasn't getting milk, and they didn't show me a proper way to do it . . . I tried for about 3 weeks . . . it was hard for me because I felt like I had to do everything. I had to do the feeding and I couldn't rest. And I had to get up, feed the baby. I felt like I was just doing everything . . . it was easier [bottle] feeding.

Thus the participants repeatedly spoke of feeling rushed, not cared for, and of not having sufficient time with the nursing staff to learn what they needed in order to successfully learn how to feed their infants. Traditionally, Aboriginal children were taught through modeling any given skill that needed to be learned. Whitehead (1988), in her book titled *Six Micmac Stories* told the story of a little boy who was lost and was taken in by a mother bear that kept him warm and taught him how to catch food to eat and ways to keep himself alive and well. Children and adults alike learn by trying to do things and by watching others do the tasks. According to Harris (2006) "it is also important to recognize that traditional learning processes are holistic, that learning and healing go hand in hand, and that learning is based on watching, learning, and doing" (p. 125).

While recognizing that Indigenous world views are diverse and complex, Little Bear (2000) stated the following regarding Aboriginal peoples' worldview on education and learning:

For the most part, education and socialization are achieved through praise, reward, recognition, and by example, actual experience, and storytelling . . . Teaching through actual experiences done by relatives: for example, aunts teaching girls and uncles teaching boys. (p. 81)

In order for the linear, western, medical model worldview and the Aboriginal worldview on time to be more integrative rather than at cross purposes, it is imperative for health care providers to develop an enhanced understanding of varying philosophies regarding time. Perhaps this can be accomplished by borrowing from Elder Albert Marshall's *Two-Eyed Seeing* approach to learning. "Etuaptmumk" or two-eyed seeing refers to learning from one eye with the strengths of Indigenous ways of knowing and knowledge and with the other eye from the strengths of Western ways of knowing resulting in knowledge that improves outcomes for all (Bartlett, Marshall, & Marshall, 2012; Hatcher, Bartlett, Marshall, & Marshall, 2009). Bartlett and colleagues (2012) describe the lessons learned from utilizing two-eyed seeing:

1. Acknowledge that we need each other and must engage in a co-learning journey.
2. Be guided by Two-Eyed Seeing
3. View "science" in an inclusive way
4. Do things (rather than "just talk") in a creative, grow forward way
5. Become able to put our values and actions and knowledges in front of us, like an object, for examination and discussion.
6. Use visuals.
7. Weave back and forth between our worldviews.
8. Develop an advisory council of willing, knowledgeable stakeholders, drawing upon individuals both from within the educational institution(s) and within Aboriginal communities. (p. 334)

Health care providers would do well to incorporate these learned lessons when providing information regarding infant feeding practices: more visuals could be used; women could be shown how to prepare formula or have other women demonstrate various breastfeeding techniques; and support groups could be formed that include Elders, experienced mothers, and health care providers.

By incorporating the mothers' identified ways of learning and by improving access to health care, best practices for infant feeding could occur. Broadening health care services and improving cultural security where women feel safe and can develop trusting relationships with health care providers is essential if the gaps between Aboriginal and mainstream health care is to be closed (Taylor & Thompson, 2011). When collaboration between these two worldviews occurs, women and infants may be more apt to receive the care they need in the appropriate time so that choices will not be suppressed and an improved harmony with health care providers may occur for First Nations people. The importance of celebrations is also another significant time issue for Mi'kmaw women that have influenced their infant feeding practices.

Celebration Time

As I completed the conversational interviews and the talking circle it became abundantly clear how important celebrations, pow wows, and various feasts and gatherings were to the lives of Mi'kmaw women and families. Every participant had stories to tell of the importance of these meetings to the survival of Mi'kmaw culture, values, stories, and beliefs. Being unaware of an important community feast often meant

that interviews could not be completed, that the Health Care Centre was closed, and the community took on the appearance of a ghost town.

According to Battiste (2011), young women were “socialized to believe that having children was an important part of any woman’s life as children enabled the survival of language, customs, culture and community” (Battiste, 2011, p. 66). In past years, young Mi’kmaw women would be present at moon ceremonies to “receive teachings: this is where they would hear the sex education and the parenting skills and the basic life skills. How to take care of themselves and to respect themselves as women” (Anderson, 2000, p. 166).

Bollnow (1989) described the significance of celebrations in our everyday lives:

The festive celebration is more than a mere outer adornment of life or a break after a period of hard work. Rather, we need to grasp the notion of celebration in its deeper significance, as a necessary function in human life. We experience it best in the results of the mood of celebration, in the festival itself . . . in its relationship to the world and to other people. . . . The human being moves out of the isolation of his or her everyday existence into a situation of great bliss and finds himself or herself accepted into a new communion. It is not just that the experience of this communion brings the person into deep happiness; it is, on the contrary, that the enhanced mood of the festive situation allows her to experience this communion. (pp. 69–70)

According to Battiste (2011), “Mniku,” the Feast at St. Anne’s Mission is a spiritual gathering and meeting and a time in which Mi’kmaw people gather to renew ties to one another and reaffirm sense of community, to celebrate the patron Saint Anne, and to hold Grand Council meetings. St. Anne was adopted as the Patron Saint of the Mi’kmaw people in 1628. Annually on July 26th, the Feast of St. Anne is held throughout many Mi’kmaw communities, with the largest celebration occurring at the St. Anne

Mission in Chapel Island, Cape Breton. Mi'kmaw people come to this small island to pray, feast, and celebrate with each other and to celebrate their culture. This celebration is attended by all members of the community who can possibly be there. With numbers as large as four to five thousand people in attendance, the event is seen as important to Mi'kmaw people (Robinson, 2012, 2005). Families go in campers, tents, and/or stay with relatives and kin. Children and infants are very much a part of these celebrations. June, for example, spoke of how important it is for her and her family and kin to meet for these celebratory times throughout the year and of the traditional foods they share during these gatherings:

All of us [come together for feasts and celebrations]. Yes, everything. Like when it comes to Thanksgiving or Easter, Christmas, birthdays, they're here. Meta Lodge . . . Feast of Saint Anne . . . we tried moose meat . . . but I've never tried anything else . . . she [her infant], yes, she tried lobster. Her dad gives her everything. (June)

Another participant, Emma, spoke of how she makes bracelets for all family members from cloths that are used to wash the statue of St. Anne. Emma stated:

And people bring me the cloths that was washed from St. Anne . . . the cloth . . . they did the . . . they wash St. Anne's, the statue, the face . . . and you make a little bracelet . . . it's supposed to help you . . . it supposed to help you with whatever you need.

Emma further articulated other important ceremonies that her family participate in on a daily basis:

Yes. Yes, we have that. Or mom does. She has sage and sweetgrass. Like we all believe in that. Right? It keeps the evil spirits away . . . It's good. It heals you, it gets all the yuckiness out of you . . . Yes, that's what it is. That's how it is. If anybody's sick, anybody has it, they go to them, they smudge them and pray. There's bear root too . . . usually every day we use it . . . tobacco offering [used

for health as well] usually it's all in a . . . we've got to get a shell, like a clam shell, and you put the sweetgrass and tobacco and the sage in there . . . yes, but you feel good after that.

Bollnow (1989) stated that a celebration cannot be experienced passively but “requires a spontaneous participation. Only through one’s participation can one submerge oneself in this special mood which is so different from the consciousness of everyday life” (p. 72). It appears that the joy of feasts, holidays, and such celebrations comes through the participation and sense of communality and time spent together, Little Bear stated that: “Renewal ceremonies, the telling and retelling of creations stories, the singing and resinging of the songs, are all humans’ part in the maintenance of creation” (2000, p. 78).

Not unlike Little Bear, Battiste (2000) affirmed the importance of Aboriginal ceremonies for the benefit of their Peoples:

The summer resounds with the healthy sounds of our peoples as we converse to honour our teachings, our elders, and our ancestors in ceremonies and gatherings, sharing around campfires, at feasts, pow wows, potlatches, and multiple ceremonies. Our traditions, . . . preserve and sustain us. (p. xxiv)

During these times of meeting and celebration, mentoring and teaching often occurs. Women share stories of childrearing and of their own concerns and solutions. This helps and supports other women. While the participants took their infants to these celebrations, there were varying opinions about breastfeeding infants while celebrations were being held. Laura stated: “Well, at the pow wow and stuff that we have here, like you know, you can breastfeed anywhere. It’s like we don’t have a problem with that.” In contrast, Jessica had the following to say about breastfeeding at a pow wow: “Probably a

separate area. Like I find most mothers, they go into the trailer to breastfeed or in a room.” Jillian agreed with this sentiment regarding breastfeeding at social events: “I think . . . I don’t know, I think they would cover themselves. Like with a sheet or something . . . it’s [breastfeeding] private.” Another participant stated: “They [women] probably feel like they have to go off somewhere . . . because people around here are shy . . . [women] probably would feel uncomfortable and wouldn’t even try it [breastfeeding]” (Elizabeth). While Rebecca felt the breastfeeding at public functions was an individual mother’s decision: “I think that’s a personal choice. Because nowadays, they have that cover. And at the time, I used to use a blanket” (Rebecca).

Regardless of whether the mothers breastfed in public or in private at the various celebrations, or if they chose to bottle feed their infants, time spent at the celebrations was important sharing time with family and kin. Traditions, knowledge, and cultural values were learned and passed on during these times. At the various events the Mi’kmaw language was prominent, and this was important for the participants. From being outlawed from having traditional celebrations by the *Indian Act*, to being forbidden to speak their language at the residential schools, regaining the language and openly sharing customs and values at celebrations was of utmost importance for the Mi’kmaw women and families. Language is important as peoples’ identity is closely entwined with their language, which unites people from the past to the present. The participants commonly used the word *nunu* for infant feeding. They frequently interchanged this word for both breast and bottle feeding. The participants did not identify a specific Mi’kmaw word for breastfeeding or for bottle feeding, but interchanged the word. Nunu

was an action that involved feeding infants, regardless of the method. The importance of celebration time was clearly evident and provided a means of support for women and their infant feeding choice.

Future Time

Lack of housing, employment, transportation, access to health care, and improved activities for their children were the main items of concern for the participants' future. Concerns over these issues relating to the social determinants of health impact Mi'kmaw women's infant feeding choices. Throughout the conversational interviews, regardless of the circumstances, the participants remained very positive about the future and had many hopes and wishes for future time.

Many (See Appendix I) of the women wanted to be employed. Tara stated: "Anywhere, I'll work anywhere." Likewise, Tiffany declared that: "I'd like to be working again . . . and I'd like to have my own vehicle." They felt that if they were employed they would be able to have maternity leave and have funds to provide for themselves, including a means of transportation. Having a vehicle would make it much less difficult to access health care services when and where they were needed. Elizabeth asserted, "I would have been breastfeeding" if she had a safe home in which to live. She is hoping that the future holds a new home for herself and her children.

Women that were engaged in feeding their infants spent a great deal of time worrying about the future of their infants and their older children. Participants felt that there were not enough activities for older youth in the community and felt that funding was only available for those involved in hockey or ballet lessons. The women worried

that their children would become involved with drugs or become pregnant at a very young age. Laura articulated the concern:

Like teenagers are disrespectful. Like my parents used to also have a garden on the side of the house. And as time went on, like as soon as we got like into the teens, and that was like 20 years ago, that kids started coming like in the middle of the night and just uprooting stuff just for the fun of it . . . The teenagers. Because it's the teenagers that are going to be disrespectful. If they learn how to appreciate . . . like there's a lot of stuff for young people but there's not stuff for teenagers. It's like they don't have a place to belong until they become moms. They don't have a place of their own. They don't have something to call their own until they become parents, and then they're with the parents. But the teenagers, they don't have like nothing to be proud of. No accomplishments. Because not everybody is a hockey player, right? There's only . . . There's only funding for hockey players and for ballerinas. And if you don't fit those two there's nothing for you.

Many (See Appendix I) participants felt that in order for breastfeeding to become the norm for young Mi'kmaw women, breastfeeding classes would be very helpful. June, a participant, said that she would really like to see classes occur that would be co-facilitated by breastfeeding moms. She stated: "Yes, that would be cool. And also like pregnant women that want to do it. I think like breastfeeding moms would like to help too."

Bethany, another participant, had another perspective and stated: "Like they [nursing staff] should have like a course of like how to make . . . properly how to make your infant formula and how to clean your bottle, bottle care." Mi'kmaw women want to be part of the solution regardless of the infant feeding choice and to have their voices and suggestions heard.

If best practice in infant feeding is to be a goal for health care providers, those working with and caring for Mi'kmaw mothers and infants need to develop an

understanding of time according to the mothers' voices: lost time, health care over time, celebration time, and future time. Perhaps in the work of being reflexive, providers will acquire the initial tools for understanding variations in time as embodied by Mi'kmaw women. Barge (2004), for example, suggested that reflexivity is: "the interconnectedness among persons by recognizing the interplay between communication, context, meaning, and action" (p. 70). Reflecting on these aspects of Mi'kmaw women's lived experiences may make a difference in health outcomes for women and their infants. Carrying out the taken-for-granted and day-to-day business as it is currently being done across the health care system may continue to have negative consequences for at-risk populations, including Mi'kmaw women and families. Colonialism has silenced Aboriginal voices for too long. It is essential for the voices of Mi'kmaw women to be included in health care partnerships in order to improve infant feeding practices. Aboriginal women show great strength and resilience as they cope with their everyday life experiences. Aboriginal women are pushing forward, from grassroots levels, to press for legal and policy changes that will alleviate the health inequities encountered by many Aboriginal women. When women's mental, physical, spiritual, and emotional health are in balance, infant feeding practices, occurring in ethical spaces, will support informed choice, be that breastfeeding or non-breastfeeding.

Chapter 8:

Final Reflections

There are many other descriptions of [infant feeding practices] that could and should be heard so that appreciation and understanding the complexity of human life can be sustained—understanding the particular rather than the general. By only focusing on one aspect, and giving that aspect a place of importance in such a way as to be neglectful of other ways of knowing the world...In lived life there is never any experience that is exactly like the other so that individual persons must forge their own understanding of life. (Bergum, 2003, p. 124)

The study has portrayed the many ways that Mi'kmaw women's everyday experiences with infant feeding impact on their lives; often fragmenting or pulling women in many directions. With an enhanced understanding of Mi'kmaq women's infant feeding experiences, perinatal nurses may be able to more fully support women with their infant feeding practices be that breastfeeding or non-breastfeeding. Feminist phenomenology provided the descriptive, interpretive and critical lens from which I examined how the Mi'kmaw women's voices illuminated their everyday experiences with infant feeding. The four themes from the study included: 1) *Going it Alone—Web of Relationships*; 2) *Finding a Space...Living in Poverty. Is Anyone Listening?*; 3) *Is Breastfeeding Right for Me? It's My Choice—Respect My Choice*; and 4) *Understanding Our Time*. These themes enriched the conversations regarding perinatal care with Mi'kmaw women, in particular those conversations regarding infant feeding practices. From the analysis of the stories shared by the participants critical implications related to the impact of socially constructed policy and culturally safe care on the participants' infant feeding choice were revealed. When the themes were brought together, a critical

shift in my thinking and understanding of the factors that impact infant feeding choices occurred.

It is not enough to have the Federal Breastfeeding Committee of Canada, the Canadian Paediatric Society, the Dieticians of Canada (Health Canada, 2012), and the Nova Scotia Provincial Government (Nova Scotia Department of Health and Nova Scotia Department of Health Promotion and Protection, 2006) recommending a particular infant feeding direction for *all* women in Canada. Central to the critical discussion regarding the themes was the impact of public policy and cultural safety. This understanding revealed further implications for and a shift in perinatal practice and policy. Health care providers need to develop an understanding of how poverty, housing, transportation, relationships, choice, and time from Mi'kmaw women's perspectives impact their infant feeding choice. By listening to the women, ways of teaching can potentially be revised to address the women's needs. Family members, as the women request, can be included in health care activities, as the kinship relationships are a vital component in women's lives. Provincial programs need to provide greater access for at-risk mothers who have little access to home visiting programs. For example, programs could be developed in collaboration with new mothers, Elders, and health care providers to develop infant feeding support groups. Additionally, health care providers need to collaborate with women in the community to discuss issues of housing, water supplies, and transportation to work towards improved access to the essentials to optimize good health and health outcomes. In recognition of the time factors that impact Mi'kmaw women's lives, health care providers could change clinic hours to later in the day, with weekend coverage at the

community health centre. Additionally, nurse practitioner position(s) in the community could add in the consistency of health care in the community, perhaps enhancing trust within the health care system.

I am humbled with the knowledge and understanding that I gained regarding the lives of Mi'kmaw women and the Mi'kmaw people in the context of the research. The resilience, strength, and kinship relationships that I witnessed and came to understand from the Mi'kmaw women's storied experiences regarding their infant feeding choices have had an immense impact on my perinatal nursing and teaching endeavours.

The central purpose of the study was to provide a feminist, phenomenological understanding of the experiences Mi'kmaw women encounter in their everyday lives when making their infant feeding choices. My fundamental aim in utilizing a feminist, phenomenological framework was to provide a forum for Mi'kmaw women's voices to be heard and made visible. This would potentially offer better understanding and care by health care providers, in particular perinatal nurses.

In Chapter 4, I delved into the first theme: web of relationships that may impact upon Mi'kmaw women's infant feeding choices. The relationships that one encounters and develops throughout a lifetime provide meaning and purpose to one's daily existence (van Manen, 2007). Understanding the complex relationships that Mi'kmaw women have with women (kin or otherwise), men (kin or otherwise), and health care providers was the focus of Chapter 4.

In Chapter 5, the second theme, I discussed the impact of poverty on the lives of Mi'kmaw women and their children, and poverty's influence on infant feeding choice.

The long-term health outcomes of children have been strongly linked to the type of living conditions in which they have been raised (United Native Nations Society, 2001).

Housing, water supply, transportation, and access to health care were identified as concerns for the participants of the study. The stories of the participants and descriptions of their encounters with poverty were outlined throughout Chapter 5.

Is Breastfeeding Right for Me? It's My Choice—Respect My Choice was the pivotal and third theme of Chapter 6. According to Phillips (1995) choice in regards to health care is influenced by the social, cultural, political, and economical background in which women are located. This theme disclosed four key points of discussion of the body as being: the inadequate body, the addicted body, the excluded body, and the accepted body. Understanding how the participants encountered these embodied experiences is elucidated throughout Chapter 6.

Chapter seven, the final theme, Understanding Our Time, illuminates the ways in which events in time and understanding of time have influenced the participants' infant feeding choices. The key components of time revealed through this theme were: lost time, experiences with health care over time, celebration time, and future time. The impact of residential schooling, culturally unsafe health care experiences, cultural celebrations, and hopes for a brighter future were discussed. Elder Albert Marshall's Two-Eyed Seeing and the Aboriginal Medicine Wheel were useful tools to give voice to Mi'kmaw women's experiences and bring about change in perinatal nursing policy and practice which impact their infant feeding decisions.

Social Constructed Policy

The purpose of the Canadian Charter of Rights and Freedom of 1982 legislation is to ensure that *every* Canadian has the right to be treated equally under the law (Canadian Human Rights Commission, 2013). According to Tang and Browne (2008), the Canadian health care system espouses five essential guiding principles for *all* Canadians: accessibility, comprehensiveness, portability, universality, and public administration. Both of these foundational Canadian directives focus on the fundamental principle that all Canadians have equal access to services regardless of their historical, political, or social background. However, similar to the Maori people of New Zealand (Human Rights Commission, 2011; Oda & Rameka, 2012), the obstacles faced by Aboriginal people, and in this case Mi'kmaw women, when trying to access health care and health services are frequently ignored or overlooked.

The World Health Organization (2007) introduced the 10 Steps to Successful Breastfeeding for organizations and community services providing perinatal care for families. These have been endorsed worldwide and updated by the Breastfeeding Committee of Canada to meet Canadian requirements (2012). These updated requirements include the following:

1. Have a written breastfeeding policy that is routinely communicated to all health care providers and volunteers.
2. Ensure all health care providers have the knowledge and skills necessary to implement the breastfeeding policy.
3. Inform pregnant women and their families about the importance and process of breastfeeding.
4. Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as

- long as the mother wishes: Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.
5. Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.
 6. Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.
 7. Facilitate 24 hour rooming-in for all mother-infant dyads: mothers and infants remain together.
 8. Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
 9. Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).
 10. Provide a seamless provision of services provided by the hospital, community health services, and peer support programs. Apply principles of primary health care and population health to support the continuum of care and implement strategies that affect the broad determinants of health that will improve breastfeeding outcomes. (pp. 1–2)

Recommendations such as these do not always take into account women's historical, political, and/or social everyday and taken-for-granted experiences when they are deciding on a way to feed their infant. Or as suggested in Step 10, incorporate the social determinants of health. The Nova Scotia Provincial Government (Nova Scotia Department of Health and Nova Scotia Department of Health Promotion and Protection, 2006) put forward a breastfeeding policy that incorporates the 10 Steps. Yet, to date, no institution or community in the province has met all of the requirements in order to achieve a *baby friendly* designation. With health care cutbacks, organizations often do not designate sparse funds to provide breastfeeding education to all health care providers. Further, based on my experience of delivering breastfeeding education throughout the Maritime Provinces, accommodations and needs for attendees are often overlooked. However, when co-presenting with a First Nations nurse, she ensured such

accommodations were provided, including: accessibility of location, travel, food and educational materials—as relevant to community needs. I thus learned from the First Nations nurse the many factors to be considered in making an educational program, effective, culturally safe, and a sharing experience among all attendees.

Martens (2000) found that when breastfeeding education was provided to nursing staff an increase in breastfeeding initiation rates occurred. Increased breastfeeding initiation rates and a decreased weaning rate occurred in a Sagkeeng First Nations community when nursing staff and peer counsellor(s) worked in collaboration with women in the community (Martens, 2002).

These findings address the importance of increased education for health care providers and the importance of collaboration and inclusion in program development for women in the First Nations community—particularly if infant feeding programs and policies are to be put in place. In their development and dissemination, infant feeding programs and policies cannot ignore the social determinants of health including: poverty, housing, employment, justice, and access to health care. According to Palmater (2011), federal policies stemming from the Indian Act have resulted in chronic poverty in First Nations. The provision of inequitable funding to First Nations by the Federal Government has led to “desperate living conditions, poor health, barriers to education and employment, social dysfunction, over-representation in jails and children in care, and premature deaths in First Nations” (Palmater, 2011, p. 116).

Many Canadians have limited knowledge about First Nations poverty and its historical origins and therefore are influenced by media reviews that blame First Nations

people for their state of affairs, rather than societal factors (Hasnain-Wynia, Pierce, & Pittman, 2004; Steckley & Cummins, 2008; Varcoe, 2011; Warry, 2007). Such factors lead to ongoing racism, exclusion, victimization, and continue the cycle of poverty and violence that so many First Nations women experience on a daily basis. It is therefore important for health care providers to reflect upon and develop a more in depth understanding of the history of Canada's First Peoples, of the Aboriginal social determinants of health, and of the impact of policy upon this population if this type of blaming is to be reduced.

When policies such as the breastfeeding policy in Nova Scotia are brought forward without ensuring equity and inclusivity for all, choice may not be an option. Unfortunately, such a policy potentiates a dictatorial-like policy, which can lead to the creation of false dichotomies, including women being seen as “good” or “bad” mothers, depending on their infant feeding choice. This falsely constructed dichotomy needs to be addressed by collaborating with Mi'kmaw women to develop infant feeding policies that meet their identified needs. As the National Chief of the Assembly of First Nations (AFN) Shawn Atleo stated: “right now, decisions are made for us and we live—and die with the consequences” (2011, p. 2). Many First Nations are now taking a stand and are developing success in their communities by “addressing federal control, inequitable funding, and discrimination prevalent in federal policies” (Palmer, 2011, p. 123).

Culturally Safe Care

Hunter and colleagues (2004) found that nurses frequently do not include cultural understanding into their nursing care. These authors further stated that by incorporating

both traditional healing and western medical care, the patient-nurse relationship was both strengthened and enhanced. Retelling the stories of Mi'kmaw women's infant feeding practices provides a means to shed light on their experiences that may bring forth a deeper comprehension and consequence that may result in improved culturally safe perinatal practices and policies (Sandelowski, 1996).

Bergum (1989b) refers to pregnancy as “a mysterious union, a comingling, an entangling, an interlacing” whereby the mother and infant are “an indissoluble whole, and yet two, a mother and child” (p. 53). This could extend to the mother-infant feeding relationship. Mothers make their infant feeding decisions based upon what will meet their own and their infants' needs in their particular situation. Based on my clinical expertise, I have witnessed this fundamental relationship between mother and infant be negatively compromised when mothers have difficulty with infant feeding. If a mother does not want to breastfeed and is strongly encouraged to breastfeed by a partner or by health care providers, the mother may attempt breastfeeding. However, feeding often becomes a time of dread for the mother rather than a time of joy, potentially causing negative consequences for the mother-infant relationship. As Shaw (2004), stated that for a number of women:

the rewards for breastfeeding their infants are too few and/or impossible to achieve...overly romanticized images of mother—infant affinity can, in fact, carry with them an emotional and affective burden too heavy for some women to bear. (p. 104).

As well, when mothers really want to breastfeed yet due to challenges (latch, mastitis, lack of milk supply, infant anomalies, etc.) they are not able to successfully

breastfeed, mothers frequently feel inadequate, a sense of guilt and less of a mother (Shakespeare, Blake, & Garcia, 2004; Shaw, 2004). Both of the above examples demonstrate how infant feeding concerns can impact the mother-infant relationship and the mother's feelings associated with "good" and "bad" mothering by herself, her partner, and health care providers. Non-judgmental care by health care providers whereby mothers are supported in their choice of infant feeding, independent of breastfeeding or non-breastfeeding is essential if healthy relationships are to be encouraged between the mother-baby pair.

When a woman is given information about the benefits of breastfeeding, this should not lead to expectations that she will automatically chose to breastfeed. Women's beliefs about their own bodies and what they expect of their bodies do not disappear because they have given birth (Young, 1984). Women's experiences, and specifically those of infant feeding choice, are constructed through social, political and economic systems (Scott, 1992). It is important that health care providers learn to listen and understand the multitude of factors that impact upon women's infant feeding choices and respectfully support those choices. Mi'kmaw women are resilient, and even in the face of health care providers' power and policies, forms of resistance such as false compliance, foot dragging, and pretended ignorance (Scott, 1985), may be utilized when women's infant feeding choices are not respected. Moreton-Robinson (2000), an Aboriginal scholar states that Aboriginal women resist power relations in discreet but not necessarily passive ways. She stated: "Our resistances can be visible and invisible, conscious and

unconscious, explicit and covert, partial and incomplete, and intentional and unintentional” (p. xxiii).

Without understanding, an opportunity for redressing power imbalances between health care providers and clients could be lost, which may continue to cause concerns for Mi’kmaw women.

Cultural awareness and cultural sensitivity have left the power of understanding with nurses and primary care providers, rather than that of the patient. According to Ramsden (1997):

However competent any nurse or midwife may be technically, such skills and experience will not be of use if people do not feel emotionally safe to approach the service or if they approach it too late. If the term ‘safety’ is changed to awareness it immediately shifts the power away from the patient to define their subjective response, and gives it to the service provider. Only the patient is able to say whether the nurse is safe regardless of how many awareness courses the nurse has attended . . . [Cultural safety] insists that nurses and midwives become experts in understanding their own diversity within their own cultural outlines as well as their potential for powerful impact on any person who differs in any way at all from themselves. (p. 121)

Ramsden (2003) further separated cultural safety into cultural awareness, cultural sensitivity, and cultural safety. Culturally safe care is inclusive of acceptance, awareness, understanding, respect of the client and their life circumstances, and in the provision of care that *empowers the client* to make choices that meet their needs (Walker, Cromarty, Kelly, and St. Pierre- Hansen, 2009). While this is the goal of culturally safe care, it has been reported that changes in health care delivery (Spitzer, 2004) put one more layer of difficulty on reaching this goal. The concern arises when in many Canadian health care facilities increased workloads and models of care have developed a bureaucratic mindset

of economy of care. Thus, as Spitzer (2004) articulated, Canadian nurses working with minority birthing mothers:

Felt compelled to avoid interaction with patients deemed too costly in terms of time. Overwhelmingly, these patients were members of culturally marginalized populations whose bodies were read by nurses as potentially problematic and time consuming. As their calls for assistance go unanswered, visible minority women complained of feeling invisible. Taken in context of historical and contemporary interethnic relations, these women regarded such avoidance patterns as evidence of racism. Obstetrical nurses, too, understood that the new economy of care wrought by health care restructuring has altered nursing practice and patient care to the detriment of minority women. (p. 490)

This mindset speaks to how policy continues to marginalize and perpetuate the inequities faced by women who are a minority and of how cultural safety may perhaps become a priority for *all* health care providers. Jones (2000) stated, “Institutionalized racism is often evident as inaction in the face of need” (p. 1211). Policies, linguistic barriers, and avoidance techniques utilized by health care providers are no longer acceptable. “White bodies” are not the only bodies that require equity of care—not equality, but equity, whereby everyone receives the care required to ensure equivalent outcomes for all (Spitzer, 2004).

Inequities in health care may occur in a *relational space* between the client and the health care provider (Bergum & Dossetor, 2005). According to Bearskin (2011), relational space is “the point at which self-awareness and self-consciousness of power in the health care system begins” (p. 553).

Culturally safe care is complex and multidimensional; it is care that empowers women to be those in the position of power rather than the health care providers. This is the type of care required for mothers making decisions regarding their infant feeding

choice. Mi'kmaw women and health care providers need to work together to develop policies, educational programs, and community programs that will support the voices of the women and their identified needs rather than those dictated solely by policy. As Barksin (2011) stated:

Nurses have a moral responsibility to engage with individuals, families, and Communities; and ethical action needs to start with the nurse-client relationship in an attempt to understand the other person's situation, perspective, and vulnerability. (p. 553)

Significance of the Research to Perinatal Nursing

The current initiation rate for breastfeeding among Aboriginal women in Canada (81.2%) is slightly below that of other non-Aboriginal women (88%). The rate of exclusive breastfeeding at 6 months is 18.7% for Aboriginal women and 25% for non-Aboriginal women in Canada (Statistics Canada, 2013).

There is a paucity of research detailing Mi'kmaw women's experiences regarding infant feeding choice. This study explored infant feeding choices from the narratives of Mi'kmaw women from a First Nations community in Nova Scotia. Feminist phenomenology provided the methodological framework that enabled the women to narrate and provide the in-depth text of their everyday experiences with infant feeding. This framework provided a platform for the women's voices, where they could speak of their concerns relating to relationships, housing, water, respect for infant feeding choice, impact of time, and recommendations for future perinatal care. This is not to say that every Mi'kmaw woman's experience is the same, as it is critical not to generalize or essentialize all Mi'kmaw or Aboriginal women's experiences as being the same. There

are complex differences among each of the women's stories. The intent of the research is to show the extent to which the women share important experiences related to infant feeding practices.

The research thus provided insights into the relationships that were important to the Mi'kmaw women in the study, how the social determinants of health impacted infant feeding choice, how their bodily encounters affected infant feeding choices, and how understanding time influenced choice. As the dissemination of the findings of the study commence, it is anticipated that changes may occur in perinatal (institutional) policies and educational programs that will promote improved, culturally safe, accessible, and equitable perinatal care for Mi'kmaw women. Knowledgeable, culturally safe care can assist Mi'kmaw women to make informed choices regarding their infant feeding practices.

However, nurses may initially be challenged with how the stories told by the participants reflect nursing practices and encounters which continue to colonize Mi'kmaw women. These stories may give pause to nurses encouraging them to reflect further upon their practices with Mi'kmaw women, resulting in opportunities to develop best practices in perinatal nursing. van Manen (1997) spoke of how research findings can affect people involved in phenomenological research:

The research may have certain effects on the people with whom the research is concerned and who will be interested in phenomenological work. They may feel discomfort, anxiety, false hope, superficiality, guilt, self-doubt, irresponsibility—but also hope, increased awareness, moral stimulation, insight, and a sense of liberation, a certain thoughtfulness, and so on. (p. 162)

van Manen's (1997) words resonate as I too had many of these feelings while completing the study. At times I felt overwhelmed, anxious, uncomfortable, and guilty. I was raised as a child in Shubenacadie and had no comprehension of the atrocities that occurred at the residential school. At various meetings that I have attended during my doctoral studies, even mentioning my home town's name upset many Aboriginal attendees. At one such conference we had to introduce ourselves and say where we were from. A pregnant woman got up and left once I said where I was from. It upset her greatly, and she felt there were bad spirits in the room. I felt terribly saddened, shocked, and did not know what to do. This study has increased my awareness of white privilege, given me further insight into Mi'kmaw women's lives, and enhanced my knowledge so that I can collaborate in a more culturally safe manner with women in the perinatal and educational settings.

Feminist Phenomenology

The application of feminist phenomenology, both substantively and methodologically, provided the framework for understanding the embodied experiences of Mi'kmaw women's infant feeding practices in the everyday context of their lives. Feminist phenomenology provided a means for the women's stories to be told and voices to be heard. According to Battiste (2000), stories offer a means to understand us as human beings both individually and collectively. St. Denis (2007), also a Canadian Aboriginal scholar, suggested that a feminist framework can provide a means to understand Aboriginal peoples' historical, political, cultural, economic, and social oppressions. Additionally, Goldberg (2004) indicates that feminist research that is

phenomenological in nature provides a “framework capable of making the invisibility of the female gender visible” (p. 40). The conversational interviews and the talking circle employed in the study afforded opportunities for the participants to recount their experiences, to question, and to clarify understandings. Both of these venues enabled relationships to develop and a sense of trust to grow.

Implications for Practice

Health care providers often have limited knowledge regarding the lives of Canadian Aboriginal peoples. The Canadian Nurses Association (2012) declared “it is the professional and social responsibility of nurses to take a strong leadership stand on behalf of Canadians” (p. 1). The following are the key issues that were brought forward in the study, for which Mi’kmaw women and practicing perinatal nurses could work together to improve care for Mi’kmaw women and their infants:

1. Improve perinatal nurses’ knowledge of culturally safe practice and of culturally competent care. Guidelines such as those utilized by the Registered Nurses Association of Ontario (2007) regarding best practices for cultural competency could be utilized. For example, nurses ought to be encouraged to reflect upon their own beliefs and values and discuss these with peers. Nurses also need to recognize and address inequitable, discriminatory, and or racist behaviours, individually, collectively, and institutionally.
2. Perinatal nurses could lobby alongside Mi’kmaw women to improve or make available public transportation to enhance accessibility to health care and health care resources.

3. Perinatal nurses and Mi'kmaw women need to work together to develop proposals to put forward to the Band Councils and Government agencies to once again reinforce the need for improved housing and the impact this has on the health and well being of their families and communities.
4. Nurse practitioners may be added to the health care team. They may provide a source of consistent health care for Mi'kmaw women and enable an expanded timeframe for access to health care services.
5. Health care providers, in particular perinatal nurses, must learn to talk less, listen more, be comfortable with silences, participate in community events, and understand how important celebrations and events are to many Mi'kmaw women's lives as part of their daily practice. (Kelly & Brown, 2002)
6. The participants in the study would like perinatal nurses to work together with them to form an informal group that could meet on a regular basis in a community location where refreshments could be served and where Elders and women could talk and learn from each other regarding infant feeding concerns.
7. Perinatal nurses need to lobby for funds to increase community health representatives (CHR). People in this role liaise with the community and health care providers, listen to concerns, and do home visits (McCulla, 2004). Mi'kmaw women identified CHR's visits as being very helpful but would have liked more frequent visits and visits from the same care provider.

8. Mi'kmaw women and perinatal nurses could work together to develop programs, meetings, do job shadowing, mentoring, etc. which would support Aboriginal students to consider entering nursing programs.
9. Nursing educators can also engage with identified Aboriginal nursing students in both informal and formal ways by attending student Aboriginal events, making themselves known to Aboriginal students, and being available for assistance.
10. Participants identified the need for Aboriginal nurses. Increasing the admission and graduation of Aboriginal nursing students is a priority.

Implications for Policy

Existing infant feeding policies in Nova Scotia may be examined and evaluated by Aboriginal women along with policy makers to ascertain their appropriateness and fit with Indigenous lived experiences. Perinatal policies need to attend to the social determinants of health (Raphael, 2007) that impact women's opportunities for choice or lack thereof regarding their infant feeding practice. The social determinants of health as identified by Raphael (2009) include income and income distribution, housing, race, gender, social exclusion, health services, education, unemployment, Aboriginal status, and food insecurity. As Loppie Reading and Wien (2009) stated, "Without equitable distribution of the determinants of health Aboriginal peoples cannot realize the same possibilities of health" (pp. 22–23). Perinatal nurses and other health care providers can work with Aboriginal women to develop and campaign for policies that incorporate an understanding of the political, sociological, economical, and historical lived experiences of Aboriginal women (Hall-Long, 2009).

The participants in the study identified the following issues as being important to the choice they made relating to their infant feeding practices: support, role modeling, housing, safe water, transportation, funding, and access to health care. Infant feeding policies ought to incorporate these political, sociological, economical, and historical issues identified by the participants.

All too often health care policies and programs have been put into place without feedback and input from Aboriginal people (Bartlett, 2005). When developing health policies for Aboriginal women and children, it is essential to incorporate all aspects of health as seen through the lens of Aboriginal peoples. According to Loppie, Reading, and Wien (2009), "Health is not only experienced across physical, spiritual, emotional and mental dimensions, but is also experienced over the life course. A life-long trajectory of health begins during gestation, with the health profile and social determinants affecting the health resources for pregnant women" (p. 3). Health care involves caring for all aspects of women and their families' lives (Health Council of Canada, 2011).

Moreover, policies that impact infant feeding practices need to be gender-sensitive; in Canada this frequently is not a consideration (Native Women's Association of Canada, 2007b) with policy development. Several of the women had concerns accessing health care due to transportation and/or childcare issues and chose not to breastfeed due to the use of tobacco and other addictive products. There was no public transportation in the community of study, and women often had to rely on kin for transportation in order to access health care. This delayed treatment for breastfeeding

concerns. Women then stopped breastfeeding and went to formula feeding. Several of the participants spoke of problems with finding childcare. There is a daycare in the community, but many of the women were unable to afford the cost of daycare. The current system was unable to accommodate the occasional needs of mothers for medical appointments. Assistance with childcare depended on kin being able to attend to children in the event that the mother needed to access health care treatment. The women in the study had worries about the amount of drug use in the community and the number of teenage pregnancies. They felt that many women may choose to formula feed their infants due to drug exposure and suggested that additional drug awareness programs need to be established in the community. Gender-based policy, “integrates a gender perspective into the development of policies, programs, and legislation, as well as planning and interaction with the health care system” (Health Canada, 2006, p. 1). The concerns related to transportation, childcare, and drugs are concerns that have significant impact on Aboriginal women’s daily lives. Aboriginal women’s insights into these important issues, from a women-sensitive lens, could provide suggestions regarding ways to improve public transportation, daycare programs, and drug awareness and rehabilitation programs in their communities.

Study Strengths and Limitations

Using feminist phenomenology as the framework for the study and using conversational interviews and a talking circle as a means to collect the information shared by the women fostered a method to hear and understand Mi’kmaw women’s everyday life events regarding their infant feeding choices. Many of the women voiced how

important this work was and that it was time for someone to hear about their experiences regarding infant feeding. Several women suggested the need for the study to be repeated with a younger population. The women had concerns regarding the amount of drug use and number of teenage pregnancies in their communities. The participants thus felt that the younger women's concerns needed to be explored and identified in order to understand the lived experiences impacting the infant feeding choices of the younger women in the community.

Through my many visits to the community, to the health centre, and to various homes, I felt that people in the community began to know me and could trust me to come into their homes. Initially, as I began the study, I knew that I was being watched in each home. Someone would be in another room and wouldn't leave the home until I left, or someone would be outside sitting on the steps in a nearby home watching until I left. As the women in the study began to know me, text messages would be sent to others to join the study, meals were offered, tea was shared, and on one occasion members of the community came to push me out of a snow bank. They knew me as the "big woman with the cane" and would describe me to others when advising other women of the study. I believe these are examples of trusting and respectful relationships that developed between the researcher and participants that may open the doors to ongoing research projects.

Trust is vital to relationships between Aboriginal people and health care providers. All too frequently, Aboriginal people fear and mistrust the health care system and do not consider treatment due to this lack of trust; mistrust that has developed due to

personal experiences and recounted experiences. From this study, I have learned from the participants that Mi'kmaw women need and deserve to have health care from providers who truly care about them, treat them with dignity and respect, and understand what is important to them, their values, and the value they place on family and land. Colonization has often left Mi'kmaw women feeling disempowered and non-trusting of health care providers. My hope is that this research has provided a measure of trust to the participants in knowing that I cared and will do my best to share their stories regarding their experiences with infant feeding.

A limitation of the study was the age grouping of the participants. The women in the study age ranged from 18 to 38. Women suggested that this study needed to be repeated with younger women. It was difficult to obtain the 22 participants in the study—as the inclusion criteria required that there could be no anomalies or birth complications, and many of the births in the community occurred with women under the age of 18 who had complications in the pregnancy, with birthing, or postpartum. The younger women had infants who were admitted to neonatal intensive care units with complications due to immaturity, drug addictions, or other congenital anomalies. Teenage pregnancy, drug usage, and infants requiring intensive care treatments warrant ongoing research, as these are identified concerns of the participants.

Furthermore, the fact that the researcher could not speak the Mi'kmaw language may have been a limitation of the study. The women in the study were fluent in the English language and, while many could speak the Mi'kmaw language fluently, they could not all readily write in the Mi'kmaw language. For ongoing research, a co-

investigator that could speak and write the Mi'kmaw language would be beneficial.

Recommendations for Future Research

There is a recognized need for this type of research to be done with younger Mi'kmaw women, but there is a need for this study to be done with many other Mi'kmaw women: Mi'kmaw women with disabilities, women who are not solely heterosexual, those struggling with addictions, and those living in urban areas and other Mi'kmaw communities. Voices regarding infant feeding practices need to be heard.

Collaborative studies with Mi'kmaw women and perinatal nurses relating to improved educational methods that incorporate Aboriginal worldviews of teaching and learning (Battiste, 2000; Wilson, 2001) may be developed in regards to infant feeding practices. According to Getty (2010), non-Aboriginal researchers ought to “be more respectful of the strengths and insights of First Nations people, to understand better the injustices that have been perpetrated on them” (p. 8). Research that is conducted with First Nations people needs to be collaborative and engaged in the struggle to rise above the colonial practices that have oppressed Aboriginal people (Friere, 1970; Smith, 2005).

Additionally, while this study has centred on Mi'kmaw women's experiences with infant feeding practices, much could be learned if a similar study was completed with Mi'kmaw men. Furthermore, interdisciplinary research is necessary as physicians, dieticians, social workers, and perinatal nurses often utilize each other's policies regarding infant feeding in their everyday practices when engaging in care with childbearing women. These policies are often developed in a biomedical environment, where power often rests in the hands of the health care provider rather than being shared

with the client. As Goldberg (2004) stated, “The perinatal relation is an intersubjective relation that promotes practices based on power *with* the Other, as opposed to power *over* the Other” (p. 166).

Final Thoughts

This qualitative study, framed by feminist phenomenology, illuminated the many aspects of Mi'kmaw women's everyday experiences that impacted their infant feeding choices. It is essential to social justice, education, and inclusive health care that the women's voices through their storied experiences be heard, understood, and inspire action by other Mi'kmaw women, Mi'kmaw communities, health care providers, and policy makers. The study was, at times, overwhelming due to the vast expanse of knowledge I needed and was learning throughout the context of the research. It is with humble gratitude that I express my awe and admiration to the Mi'kmaw women that so willingly shared their stories. I am committed to continue ongoing research with Mi'kmaw women to develop infant feeding programs (be that breast or non-breast feeding) or with other aspects of Aboriginal women's lives that are identified as concerns.

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Appendix A

Letter of Information to Community Support Persons

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
School of Nursing, Dalhousie University
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
School of Nursing, Dalhousie University
Phone: (902) 494-2988

Community Support Persons:

[Community Support Persons]

Dear [Community Support Persons]:

The following is a description of the study I will be providing for participants in the above-mentioned research. Your devotion and hard work supporting mothers of young infants has been an inspiration for this research. I hope the findings will support culturally appropriate care for Mi'kmaq women's infant feeding practices.

Purpose of the study:

The purpose of this study is to bring about new knowledge about Mi'kmaq women's infant feeding practices. The study will provide an enhanced understanding of Mi'kmaq

women's infant feeding practices that will support culturally appropriate care provided by health care providers for other Mi'kmaq women and infants. This research study is part of the requirements for my Doctorate in Philosophy of Nursing degree.

Procedure:

Mi'kmaq women between the ages of 18 and 35, which have given birth to an infant, cared for an infant and live in the [] First Nations community, will be asked if they would want to take part in the study. Women will be asked to have one conversational interview lasting 60 to 90 minutes about their experiences with infant feeding. The talks would take place at a time and location chosen by the participants. The talks will be audio-taped and a written copy of the audio tape will be made.

Within four to six weeks of completing individual conversations with several Mi'kmaq women, all would be invited to participate in a group meeting to have further discussion. Participants will be given further information regarding this group conversation.

Benefits and Risks:

Women often find it helpful to talk with other women about their infant feeding practices and learn from each other's experiences. Findings from the study may help perinatal nurses provide improved support and care for other Mi'kmaq women with their infant feeding practices. There are no identified risks from participating in this study.

Participation:

It is entirely up to each woman to choose to participate in the study. If a woman decides to enter into the study, she is free to stop at anytime with no concern for herself.

Confidentiality:

The real name of participants will not appear on the study in any form. Instead, a made up name will be chosen or given to each participant. All information will be stored and locked separately and only the researcher will have access to these locked areas.

Should the results of this study be published or presented at conferences participants' names would not appear on any material. If you have any questions or concerns about this study you can contact me or my supervisor at any time.

Thank you for supporting and encouraging me to complete this study regarding infant feeding practices with Mi'kmaq women. Please do not hesitate to contact me via telephone or email at jacormie@stfx.ca if you have any questions or concerns.

Sincerely,

Judith A. Cormier, RN, MN, IBCLC, PhD (c)



Appendix B

Letter of Information and Recruitment

Title of the Research Project: ‘Tikanagan’ Feeding Experiences of Mi’kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
School of Nursing, Dalhousie University
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
School of Nursing, Dalhousie University
Phone: (902) 494-2988

Hello:

My name is Judy Cormier and I am a registered nurse and a graduate student in the PhD nursing program at Dalhousie University. I invite you to participate in a study titled *‘Tikanagan’ Feeding Experiences of Mi’kmaq Women: A Phenomenological Inquiry*. I am interested in understanding more about the experiences Mi’kmaq women have with infant feeding. In the past, health care providers have made suggestions for infant feeding practices without understanding the many factors that may influence a mother’s infant feeding choice.

Purpose of the study:

The purpose of the study is to find new knowledge about Mi'kmaq women's infant feeding practices. The study will provide increased understanding of Mi'kmaq women's infant feeding practices that will support culturally appropriate care given by health care providers for other Mi'kmaq women and infants. This research is part of my requirements for my Doctorate in Philosophy of Nursing degree.

If you are between the ages of 18 and 35 and have given birth to an infant within the past two years, have cared for the infant, and live in the [] First Nations community, I would like an opportunity to meet with you to discuss your experiences with infant feeding practices. Our conversation would last about 60 to 90 minutes, and be at time and place of your choosing. The talks will be audio-taped and a written copy of the audio tape will be made.

Within four to six weeks of completing individual conversations with several Mi'kmaq women, all would be invited to participate in a group meeting to have further discussion. You will be given further information regarding this group conversation. An honorarium will be provided for your time.

Benefits and Risks:

Women often find it helpful to talk with other women about their infant feeding practices and learn from each other's experiences. Findings from the study may help perinatal nurses provide improved support and care for other Mi'kmaq women with their infant feeding practices. There are no identified risks from participating in this study.

Participation:

It is entirely up to each woman to choose to participate in the study. If you decide to enter into the study, you are free to stop at anytime with no concern to yourself. Your real name will not appear on the study in any form. Instead, a false name will be chosen or given to your information. All information will be stored and locked separately and only the researcher will have access to these locked areas.

Should the results of this study be published or presented at conferences, your name would not appear on any material. If you have any questions or concerns about this study you can contact me or my supervisor at any time.

If you would like to talk to me about participating, please call me or return the bottom part of this form (sealed in the enclosed envelope) and leave at the Health Centre for either [Community Support Person]. I will then obtain the signed forms and will contact you. Thank you for considering being part of this research project.

Sincerely,

Judith A. Cormier, RN, MN, IBCLC, PhD (c)

Phone Number (902) 867-5174

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:
A Phenomenological Inquiry

Name:

Address:

Phone:

Best time and day to contact you:



Appendix C

Conversational Interview Guide

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
School of Nursing, Dalhousie University
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
School of Nursing, Dalhousie University
Phone: (902) 494-2988

Orientating Statement:

Before the conversation begins I would like to thank you for agreeing to take part in this study. The information you share will provide valuable knowledge that may assist nurses in providing culturally appropriate care for other Mi'kmaq women and infants.

Breastfeeding has been promoted as the best way to feed an infant without fully understanding the many factors that may influence a mother's infant feeding choice. Rarely, have nurses explored with women what it means to them, as an embodied person, mind, body, and spirit, to make an infant feeding choice. It is important for nurse to uncover these lived experiences so that we can improve health outcomes, improve

nursing practices, and influence policies to reflect the identified needs of the population intended. Could we start by having you tell me about yourself?

Interview Guides:

1. Tell me about yourself.
2. Tell me about your baby?
 - a. How old is she/he?
 - b. What was your pregnancy like?
 - c. Did you have any worries during your pregnancy?
 - d. Did you think about how you would feed your baby during pregnancy?
3. Who provided you with support during your pregnancy (Mother, Sister, Aunt, Grandmother, Friends, and Partner)?
 - a. What did this support look like?
 - b. Did any of your supports tell you stories or provide teachings about infant feeding during pregnancy?
4. Do you know how you were feed as an infant?
 - a. How do most women in your family feed their infants?
 - b. Before you had your infant, did you discuss how you would feed your infant with anyone?

5. During pregnancy did you receive any information about infant feeding from medical persons (Doctor, nurses, etc.)?
 - a. Was this information helpful?
 - b. Would something else have been more helpful?
6. Did you have any problems receiving or accessing medical care during your pregnancy?
 - a. Was transportation or financial worries ever a problem in getting medical care?
 - b. Was childcare ever a problem?
 - c. Did you feel like the medical people provided you with good, safe, respectful care (meeting your needs and questions)?
 - d. When having your infant did you feel supported by the medical people?
 - e. What would you like to see changed that would have made the birthing process better for you?
 - f. Was your family able to part of the whole birthing experience?
7. Did you during your years in school ever receive any teachings about infant feeding?
8. What kinds of things do you think have impacted upon women's infant feeding choices?
 - a. If women are receiving social assistance, do you think additional funding for formula feeding impacts on their feeding choice?

- b. Do you think the use of drugs impact on their feeding choice (tobacco, alcohol, marijuana, hydromorphine, etc.)?
 - c. Do you think that family violence may impact upon infant feeding choice?
9. Do you think that young women would see breastfeeding as a means of providing food security for their infant?
- a. Is food security, having enough to eat for everyone in the household a worry for many women?
 - b. Do you think that breastfeeding may be seen as a means to return to more traditional ways of feeding used by Mi'kmaq ancestors?
10. Do you think that working outside the home or going to school has an impact on infant feeding choice?
- a. Which method would seem easier for you?
 - b. Why might this be so?
11. Do you think that how a woman chooses to feed her infant has anything to do with how she or members of her family views breastfeeding and women's breasts?
12. Do you think that young women have an understanding of the benefits of breastfeeding for themselves and their babies?
13. Do you think that mothers are encouraged to hold their babies skin-to-skin or in carriers?
- a. Have you seen traditional cradle boards being used in your community?
14. Did you ever see anyone in your family breastfeed as a child?

- a. How do you think members of your family and community feel about breastfeeding?
 - b. Do you think breastfeeding is support in your community?
 - c. Are there cultural factors that may impact on breastfeeding?
15. What do you think health care workers need to know in order to be able to help Mi'kmaq women make an informed choice about infant feeding?
16. Do you have any questions for me? Is there anything else you would like to add?



Appendix D

Consent for Conversational Interview

Title of the Research Project: ‘Tikanagan’ Feeding Experiences of Mi’kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
Dalhousie University School of Nursing
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
Faculty of Nursing, Dalhousie University School of Nursing
Phone: (902) 494-2988

Introduction:

I invite you to take part in a research study titled: ‘Tikanagan’ Feeding Experiences of Mi’kmaq Women: An Phenomenological Inquiry. Your participation in the study is completely voluntary and you are free to withdraw from the study at any time with no impact on you or your infant’s health care. The following will provide a description of the study.

Purpose of the Study:

The purpose of this study is to find new knowledge about Mi’kmaq women’s’ infant feeding practices. The study will provide an increased understanding of Mi’kmaq

women's infant feeding practices that will support culturally appropriate care provided by health care providers for other Mi'kmaq women and infants. This research study is part of the requirements for my Doctorate in Philosophy of Nursing degree.

Study Design:

An interpretive, qualitative approach drawing upon feminist phenomenology, which explores the experiences of Mi'kmaq women with infant feeding practices, will be used for this study.

Participation Involvement:

If you are a Mi'kmaq woman between the ages of 18 and 35, have given birth to a live infant within the past two years, have cared for the infant, and live in the [] First Nations community, you are invited to participate in this research study. You will be asked to participate in a one-on-one in-depth conversation, that will be audio-taped at a time and location that is convenient to you. The conversation will last for about 60 to 90 minutes. Approximately 15 to 20 Mi'kmaq women living in the [] First Nations community will be involved with the study.

Once the conversations have been completed the researcher will share with the participants the findings in a focus group discussion that will enable further dialogue, clarification of findings, and accurate interpretation of the results. If you are unable or choose not to attend the focus group discussion the researcher can meet with you privately. There is no preparation is required by participants for either the initial conversation or the focus group discussion.

Participation in the study is voluntary and you are free to withdraw from the study at any time.

Possible Risks and Discomforts

There are no predicted risks to being a participant in the study. If at any time you feel uncomfortable answering any of the questions posed you are free to not answer the question or withdraw from the study without any consequences. In accordance with Canadian Law, any disclosure of information regarding child abuse or information that indicates an immediate threat to you will be reported.

Confidentiality and Anonymity:

Confidentiality will be stressed throughout the study; your name will not be used in the study or on any documents produced from the study, instead a pseudonym (made up) name will be used that has been decided in collaboration with the researcher. All information from the audio-tapes will be securely locked in a safe area, and signed confidentiality agreements with both translator and transcriber will be obtained. Only the researcher and the research supervisor will have access to this information for the purpose of preparing the research thesis.

Reimbursement for Participants:

An honorarium will be provided for each participant for the one-on-one discussions, and for the focus group discussion. Refreshments will be provided for the focus group discussion.

Contacts for Questions of Concerns:

Comments and questions are welcome at any time throughout the study. If you have any questions or concerns please contact Judith A. Cormier at (902) 867-5174 (Principal Investigator) or Dr. Lisa Goldberg at (902) 494-2988 (Thesis Supervisor).

Participant Consent:

I hereby consent to be a participant in this research study; have my conversational interviews audio-taped; and, give my consent to the use of direct quotes in the research report, publications, and conferences, knowing that no identifying information will be disclosed and that pseudonyms (made up names) will be used. I am aware that I am free to withdraw from the study at any time. I have been given an opportunity to ask any questions I might have about the study, and have received a copy of this information and consent form for my files.

**Study Title: ‘Tikanagan’ Feeding Experiences of Mi’kmaq Women: A
Phenomenological Inquiry**

Participant (print name): _____

Participant (signature): _____

Date: _____

Please indicate if you would like a copy of the study results by circling the appropriate answer.

Yes

No

Please provide your mailing address if you have answered yes to either of these requests.

Statement of Person Obtaining the Consent

I have explained the nature of the study to the participant and am of the opinion that they are consenting to participate voluntarily and are aware of their right to withdraw from the study at any time without consequence.

Researcher (print name): _____

Researcher (signature): _____

Date: _____



Appendix E

Demographic Data of Participants

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
School of Nursing, Dalhousie University
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
School of Nursing, Dalhousie University
Phone: (902) 494-2988

The following additional information would help the researcher understand the findings of the study. All information you provide will be confidential and will be included in the final report so that you cannot be identified. Any questions you do not wish to answer can be left unanswered.

Age: _____

(In the following sections please circle one area)

Status of Relationships:

Single
Married
Common law

Separated
Divorced
Widowed

Status of Employment:

Employed full-time
Employed part-time
Unemployed
Receiving Disability income
Receiving Social Assistance income

Education Attainment

Elementary school
Junior High school
Graduate of High school
Community College
University
Other

Yearly Income

Less than \$ 5,000.00
\$ 5,000.00 – 10,000.00
\$ 11,000.00 – 15,000.00
\$ 16,000.00 – 20,000.00
\$ 21,000.00 – 25,000.00
\$ 26,000.00 – 36,000.00
\$ 36,000.00 – 50,000.00
Over \$ 50,000.00

Age of First Pregnancy: _____

Number of Pregnancies: _____

How did you feed your infant(s) (breast or bottle)? _____

If you breastfeed your infants(s), for how long? _____

How were you fed as an infant (breast or bottle)? _____

Language(s) Spoken: _____

Do you live in your own home? _____

If not, in whose home do you live? _____

Overall, how do you see your health?

Poor Fair Good Very Good Excellent

Overall, how do you see your infant's health?

Poor Fair Good Very Good Excellent



Appendix F

Confidentiality Agreement for Transcriber

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
School of Nursing, Dalhousie University
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
School of Nursing, Dalhousie University
Phone: (902) 494-2988

I, _____ have agreed to keep all information contained within the audiotapes for this research study strictly confidential. I will not disclose any portion of information or discuss the contents of this study with anyone except the researcher, for purposes of transcription.

Transcriber (print name): _____

Transcriber (signature): _____

Date: _____

Researcher (print name): _____

Researcher (signature): _____

Date: _____



Appendix G

Information Letter for Talking Circle/Focus Group Participants

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
School of Nursing, Dalhousie University
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
School of Nursing, Dalhousie University
Phone: (902) 494-2988

Purpose of the study:

The purpose of this study is to find new knowledge about Mi'kmaq women's' infant feeding practices. The study will provide an increased understanding of Mi'kmaq women's' infant feeding practices that will support culturally appropriate care provided by health care providers for other Mi'kmaq women and infants. This research study is part of the requirements for my Doctorate in Philosophy of Nursing degree.

Participants:

If you are a Mi'kmaq woman between the ages of 18 and 35, have given birth to a live infant within the past two years, have cared for the infant, live in the [] First Nations

community, and participated in the previous one-on-one interview process for the study, I would like to invite you to participate in a focus group meeting.

Procedure:

Based on the findings from the one-on-one interviews, I am inviting you to participate in a focus group meeting which will be held in the [] First Nations Community Health Centre to discuss in further detail the things I heard and learnt from the interviews.

Who will be conducting the Focus Group?

The focus group will be conducted by the principal researcher, Judith A. Cormier (myself), an experienced perinatal nurse. I am completing this study as part of her Doctoral of Philosophy (Nursing) Degree at Dalhousie University.

What will you need to do?

If you have agreed to participate in the focus group you will join with other women for a group conversation lasting for approximately two hours. During the discussion, the principal researcher will present information found during the earlier conversations and ask questions to determine if she has interpreted the data correctly and that it fits with the experiences you have shared. Questions will be asked for clarification purposes and to validate key areas identified during the previous conversations. If a study participant does not wish to join in the focus group, the researcher can arrange to meet with her privately.

Possible Risk and Discomforts:

There are no foreseen risks to participating in this study. If at any time participants feel uncomfortable discussing their experiences or answering questions during the focus group they are free to refuse to answer and may withdraw from the study at any time with no repercussions. Each participant will be reminded that everything discussed during the focus group is to be kept in strict confidence. Participants must be aware that although confidentiality will be discussed the researcher can not guarantee that this will occur in a group setting. In accordance with Canadian Law, any disclosure of information regarding child abuse or information that indicates an immediate threat to you will be reported.

Possible Benefits:

This study may enable you to gain insight into your own infant feeding practices and may benefit other Mi'kmaq women by adding to the knowledge of infant feeding practices.

Confidentiality and Anonymity:

Your identity will be kept in strict confidence at all times during the study and the pseudonym (made up name) chosen during the initial conversation will be used on all study reports and documents. The file connecting the made up name to your true identity will be known only to the researcher. Although confidentiality will be stressed to all participants of the focus group there is always a risk that it may not always occur and you are therefore encouraged to discuss only those things you feel comfortable about sharing with a group. The audio-tape of the group discussion will be transcribed but the transcriber will have no knowledge of the focus group participants' names. All

information will be stored and locked separately and only the researcher will have access to these locked areas. Should the results of this study be published or presented at conferences, your name would not appear on any material.

Reimbursement for Participants:

An honorarium and refreshments will be provided for the participants of the focus group discussion.

Contacts for Questions of Concerns:

Comments and questions are welcome at any time throughout the study. If you have any questions or concerns please contact Judith A. Cormier at (902) 867-5174 (Principal Investigator) or Dr. Lisa Goldberg at (902) 494-2988 (Thesis Supervisor). Thank you for considering taking part in the focus group.

Sincerely,

Judith A. Cormier



Appendix H

Talking Group/Focus Group Consent Form

Title of the Research Project: 'Tikanagan' Feeding Experiences of Mi'kmaq Women:

A Phenomenological Inquiry

Sponsor: Aboriginal Health Research Program of Nova Scotia

Researcher: Judith A. Cormier, PhD (Nursing) Student
Dalhousie University School of Nursing
Phone: (902) 867-5174

Supervisor: Dr. Lisa Goldberg, Assistant Professor
Faculty of Nursing, Dalhousie University School of Nursing
Phone: (902) 494-2988

Do you understand that this Talking Circle/Focus group is part of a research study?

Yes No

Have you been given a copy of the Information letter?

Yes No

Have you had the chance to read the Information Letter?

Yes No

Do you understand the benefits and the risks of taking part in this research
study Talking Circle/Focus Group?

Yes No

Do you have any questions about the study?

Yes No

Do you understand that you can refuse to take part in the study or leave the study at any time?

Yes No

Have you received an explanation as to how your information will be kept in confidence and of how your name will not appear on any papers or in the research reports?

Yes No

Do you understand that if any information is told in regards to an abusive situation of a minor child (under 18 years of age), the researcher is legally required to report the information to the authorities?

Yes No

Participant Consent:

I hereby consent to be a participant in a Talking Circle/Focus group for this research study; to have the conversation audio-taped; and, give my consent to the use of direct quotes in the research report, publications, and conferences, knowing that no identifying information will be disclosed and that pseudonyms (made up names) will be used. I am aware that I am free to withdraw from the study at any time. I have been given an opportunity to ask any questions I might have about the study, and have received a copy of this information and consent form for my files.

Study Title: 'Tikanagan' Feeding Experiences of Mi'kmaq Women: A Phenomenological

Inquiry

Participant (print name): _____

Participant (signature): _____

Date: _____

Statement of Person Obtaining the Consent

I have explained the nature of the study to the participant and am of the opinion that they are consenting to participate voluntarily and are aware of their right to withdraw from the study at any time without consequence.

Researcher (print name): _____

Researcher (signature): _____

Date: _____

Appendix I

Commonalities Among Participant Experiences

The following table provides clarity re: commonalities among participant experiences when the language of “few,” “some,” and “many” is used in various contexts throughout the research text.

Experiences	Few <25 %	Some 25-50%	Many >50%	Total Number	Percentage	Page
Single Parenting		Many		13/22	59%	69
Financial Struggle		Many		20/22	90%	69
Changing Feeding Practice		Some		10/22	45%	71
Social Isolation		Few		3/22	14%	72
Introduction of Solids		Many		15/22	68%	79
Separation of Family		Some		7/22	32%	86
Relationship with Father		Few		5/22	22%	86
No Relationship with Father		Few		2/22	9%	86
High School Graduates		Many		16/22	72%	94
Milk Token Use		Few		4/22	18%	95
Location Concerns		Many		12/22	54%	97
Housing/Water/Transportation		Many		20/22	90%	98
Housing		Many		21/22	96%	99
Abusive relationships		Few		3/22	14%	104
Water Safety		Many		17/22	77%	109
Encounters with Health Providers		Many		15/22	68%	123
Medical Device Use		Some		7/22	32%	125
Feeding Choices		Few		2/22	9%	125
Pressured to Breastfeed		Many		16/22	73%	133
Drug Use		Some		7/22	32%	140
Exclusion		Some		8/22	36%	141
Judgement of Choice		Many		14/22	64%	148
Impact of Residential		Some		7/22	32%	156
Access to Health Care		Many		15/22	68%	168
Need for Aboriginal Nurses		Many		14/22	64%	169
Confidentiality Concerns		Some		7/22	32%	169
Employment Needs		Many		17/22	77%	182