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ORIGINAL ARTICLE

Empowering women to breastfeed: Does the Baby Friendly Initiative make a difference?

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Abstract

The *Baby-Friendly Hospital Initiative* (BFI) is currently presented worldwide as the gold standard model of care for promoting and supporting breastfeeding. However, there is a lack of understanding about the ways in which health services, including the BFI, address the cultural change from a disembodied practice (formula feeding) to an embodied one (breastfeeding) in contexts where formula feeding is the norm. We used a qualitative case study methodology to compare the embodied experience of breastfeeding and the maternal experience of breastfeeding promotion and support services between mothers receiving care from institutions with low and high levels of BFI implementation in Québec, Canada. A total of 11 focus groups were conducted with mothers from six institutions–three with high and three with low levels of BFI implementation. We found the flexible approach to breastfeeding duration, characteristic of BFI services in our study, helped to avoid maternal guilt and shame; the shift to focusing on potential barriers and strategies for overcoming them empowered women to negotiate changes in infant feeding with others and self by addressing the embodied experience of a practice that may not feel natural at the beginning. Findings have implications for the concept of *habitus* and the construction of the breastfeeding body; we suggest that *habitus* can change if agents are provided with discursive tools to negotiate this embodied change. Implications for BFI services include the need to implement the 10 steps in a flexible, family-centred way that focuses on empowering women rather than simply reaching outcomes.

KEYWORDS

Baby-friendly Hospital Initiative, breastfeeding, empowerment, evaluation, habitus, maternal experience

1 | INTRODUCTION

As breastfeeding is widely recognized as the optimal feeding method for the health of infants and babies, the World Health Organization (WHO) recommends exclusive breastfeeding for the first 6 months of life and continuation for up to 2 years or longer with appropriate complementary feeding (WHO & UNICEF, 2003). In 1991, the WHO and UNICEF (2009) launched the *Baby-friendly Hospital Initiative (BFHI)* [hereafter called BFI] model of care to promote, support, and protect breastfeeding in health institutions and community settings. However, there is a paucity of understanding about the ways in which health services, including the BFI, take into account the maternal psychosocial and embodied dimensions of breastfeeding (Matich & Sims, 1992; Renfrew, McCormick, Wade, Quinn, & Dowsell, 2012). There is a need to better understand the experiences of mothers exposed to BFI services, as it is presented worldwide as the gold standard model of care to promote and support breastfeeding (Sheehan, Schmied, & Barclay, 2009; McInnes & Chambers, 2008).

1.1 | Problems with promotion and support services

Several studies have underscored that promotion and support of breastfeeding is not received in a morally neutral way (McInnes & Chambers, 2008). For instance, studies on maternal experiences of health services suggest that biomedical discourse promoting and supporting breastfeeding either idealizes the psychosocial impact of breastfeeding (Groleau & Sibeko, 2012) by claiming (without scientific

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evidence) that it favors mother–child attachment (for a refutation of these claims, see Britton, Britton, & Gronwaldt, 2006; Akman et al., 2008; Jansen, de Weerth, & Riksen-Walraven, 2008) or, conversely, constructs breast milk as a commodity, rendering the mother–child relationship invisible (Dykes, 2005). Many have also claimed that health discourses promoting breastfeeding impose a moral imperative that induces feelings of guilt in non-breastfeeding mothers (Trickey & Newburn, 2014; Torres, 2014; Groleau & Sibeko, 2012; Redshaw & Henderson, 2012; Sheehan et al., 2009).

Breastfeeding support services have been noted to be experienced by mothers "along a continuum from authentic presence at one end, perceived as effective support, to disconnected encounters at the other, perceived as ineffective or even discouraging and counterproductive" (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011, p. 49). They have been rebuked for ignoring many of the sociocultural and structural barriers to breastfeeding (Marshall, Godfrey, & Renfrew, 2007; Groleau & Rodríguez, 2009; Groleau, Sigouin, & D'souza, 2013; Groleau & Sibeko, 2012).

1.2 | Background of the study

After breastfeeding was adopted as a public health priority in 1997 in the Canadian province of Québec (MSSS, 1997), provincial breastfeeding initiation rates increased dramatically from 60% (Health Canada, Statistics Canada, & Canadian Institute for Health Information, 1999) to 85% in 2005 (Neill, Beauvais, & Plante, 2006). This has been claimed to be due, in part, to the launch of the provincial breastfeeding policy guidelines (MSSS, 2001), which promoted province-wide implementation of the BFI model of care. However, while Québec's breastfeeding initiation rate reached the Canadian mean of 89% in 2011–2012 (Statistics Canada, 2013), duration rates remain low in many regions, suggesting that formula feeding remains the cultural norm in Québec (Neill et al., 2006).

In this context, there is a need to better understand how models of health services promoting and supporting breastfeeding address the cultural change from a disembodied practice (formula feeding) to an embodied one (breastfeeding). Recent research has illustrated that infant feeding experiences can usefully be examined by building from the conceptual lens of Pierre Bourdieu on social space and embodiment (Groleau & Rodríguez, 2009; Groleau et al., 2013; Amir, 2011). Bourdieu's theory goes beyond the mind–body dualism of Descartes to address the social dimension of embodiment using the concept of *habitus*, defined as a mental disposition expressed in the body, a way of being and using the body that feels natural for the person and close ones (Bourdieu, 1984). For example, in a social space where breastfeeding constitutes a cultural norm, it becomes perceived and experienced as the natural and expected practice. Conversely, when a woman chooses to breastfeed in a context where the cultural norm is bottle-feeding, she and people around her may experience psychological or embodied discomfort that challenges her sense of maternal competency or moral status (Schmied & Barclay, 1999; Groleau et al., 2013; Groleau & Sibeko, 2012).

Bourdieu speaks of social spaces as *fields*, where embodied experiences vary according to an individual's possession of power, defined by their overall *capital* (economic, social, cultural, and symbolic; Bourdieu, 1989; Groleau et al., 2013). Of relevance to the interpretation of our results, *social capital* measures networks of social connections that can be called upon for help and support; *cultural capital* refers to an individual's cultural resources, including embodied (e.g., skills), objectivized (e.g., valued artwork), and institutionalized (e.g., academic qualifications) forms. In this study, we build from the concepts of *habitus*, *field*, *social capital*, and *embodied cultural capital* to guide our conceptual interpretation of mothers' experiences of breastfeeding and services promoting and supporting breastfeeding in Québec.

2 | METHODOLOGY

2.1 | Study question and methodology

The results presented are part of a larger study that aimed to understand the social and institutional processes underlying the unequal implementation of BFI across the province of Québec. We choose a case-study methodology as this qualitative approach has proven relevant for addressing "how" and "why" research questions that require a detailed, real-time investigation of events, especially when it is useful to compare cases across contexts (Yin, 2013). The following research questions guided the study presented in this paper: (a) *What are the subjective experiences of Québec mothers regarding breastfeeding promotion and support services?* (b) *How do these service-related experiences relate to their social and embodied experience of breastfeeding?* (c) *How do these experiences vary according to the implementation level of BFI?*

2.2 | Ethical considerations

This study received ethical approval as a multi-site study from the Ethics Review Board of McGill University.

Key messages

- In a context where breastfeeding is not currently a *habitus*, providing mothers with realistic expectations and discursive tools to negotiate this new embodied experience with themselves and others empowered mothers to overcome breastfeeding barriers.
- Implementation of BFI may be highly effective at helping mothers overcome barriers to breastfeeding if implemented in a flexible, family-centered way.
- Recommendations and institutional initiatives to promote breastfeeding need to focus on how to get to 10 steps while empowering women rather than simply reaching outcomes.

TABLE 1 Matrix of criteria for inclusion of the six cases in the case study

	CSSS < 1000 births/year	CSSS > 1000 births/year	University Hospitals
High level of BFI implementation (HBFI)	Case # 1	Case #3	Case #5
Low level of BFI implementation (LBFI)	Case #2	Case # 4	Case #6

BFI = Baby-Friendly Hospital Initiative; HBFI = high BFI; LBFI = low BFI.

2.3 | Case selection

Six health institutions formed the cases of our study, including four CSSSs and two University hospitals (see Table 1). A CSSS is an administrative unit that unites a hospital with a community clinic. The selection of cases was done to allow comparison between different levels of BFI implementation (high vs. low, hereafter referred to as HBFI and LBFI) across institutions otherwise comparable in size and type of service. We categorized cases as HBFI or LBFI using a BFI implementation score measured in all Québec health institutions by a provincial study (MSSS, 2011).[1]

To maximize the variability among cases, we purposely chose each case from a different geographical region of Québec, a predominately French-speaking province occupying a territory close to three times the size of France, but with many sparsely populated regions (total population: 7,903,001; see Statistics Canada, 2013).

2.4 | Sampling and recruitment of mothers

Mothers were approached by a health professional at the institution they attended for a postnatal visit. Consenting mothers were then contacted by the study coordinator and given details on the study. Inclusion criteria were as follows: (a) having given birth or used postnatal services in a hospital of one of our six cases; (b) having initiated breastfeeding (could have weaned since); and (c) having a baby between 4- and 12-months-old. We made an effort to recruit women with different socioeconomic and language (French or English) profiles in order to maximize variation. A purposeful sample of mothers (Schwandt, 2015), selected on the basis of these inclusion criteria, was then invited to participate in the focus groups.

2.5 | Data collection

The focus group interview, a method commonly used in the domain of health services and policy evaluation and known to facilitate communication and interaction between a moderator and a group of participants, was the chosen method to generate data (Krueger & Casey, 2014). Three domains of experiences relating to breastfeeding were discussed with mothers: (a) exposure to breastfeeding promotion services; (b) breastfeeding support received by family, community, and health services; and (c) emotional, embodied, and social experiences of breastfeeding. Eleven focus groups of 2 hr each were conducted with 53 mothers over a period of 1 year. Two observers took notes at every focus group. Socio-demographical data were obtained from the mothers using a short self-report questionnaire.

2.6 | Data analysis

Focus group discussions and observer notes were transcribed verbatim, coded, and analyzed using ATLAS.ti qualitative analysis software. Thematic content analysis was performed by the team under the supervision of the first author (Miles, Huberman, & Saldana, 2014). Interviews were coded inductively, by looking for naturally occurring emerging themes, and deductively, by looking for parts of transcriptions that corresponded to predetermined codes linked to the research questions (examples of deductive codes: experience of promotion, professional support, family support, social support, embodied experience of breastfeeding, and social experience of breastfeeding). Coders met throughout data analysis to triangulate coding. We analyzed the two sub-samples (HBFI and LBFI cases) separately and then identified commonalities and differences in maternal experiences between the two sub-samples. Interpretation of findings was completed by the first two authors, building from Bourdieu's concepts described in the background section.

3 | FINDINGS

Our sample (n = 52) of mothers was composed of a majority of middle-class French-Canadian mothers with a university degree (79%) who were breastfeeding (87%) at the time of the interview, with close to half of them breastfeeding exclusively (48%). Mother's average age was 29 years, with a sample range of 18–42 years. Family revenue was high in our sample, with close to half of the mothers (45%) living with a family revenue of $80,000 or more, and 25% with a family revenue of $50,000–$79,000. A minority of participants lived with a limited family revenue of $30,000–$49,000 (12%) or a very limited family revenue of $29,000 or less (17%).

3.1 | Maternal experiences of breastfeeding promotion services

3.1.1 | All mothers, regardless of HBFI or LBFI

All mothers in our sample reported being exposed to breastfeeding promotion interventions during their pregnancy or hospital stay. Sources of promotion messages they mentioned included family doctors, nurses providing prenatal classes, and their own personal searches for information online or from books.

3.1.2 | Mothers using LBFI services

Prenatal classes were not always accessible for mothers from LBFI sites. When prenatal classes were accessible and attended, mothers expressed that they did not prepare them well to breastfeed, because too much focus was put on the health benefits of breastfeeding and

[1]A CSSS was assigned "high" BFI implementation if it boasted at least one institution certified as baby-friendly and if the BFI implementation score for each of its institutions was higher than the provincial average. Conversely, a CSSS was assigned "low" BFI implementation if it did not have any institution recognized as baby-friendly and the BFI implementation score for each of its institutions was lower than the provincial average. Since there was no baby-friendly certified university hospital in Québec at the time of our study, we selected case #5 as the university hospital with the highest BFI implementation score and case #6 as the university hospital with the lowest BFI score in the province. For anonymity purposes, we cannot disclose the implementation level of these health institutions, as this information is public and would disclose their institutional identity.

not enough on managing potential difficulties. Mothers from LBFI sites also complained about the lack of information given by their CSSS about formula feeding. The majority considered the breastfeeding promotion materials they were exposed to as being out of date and unstructured, especially compared to the appealing materials and videos used to promote formula. Mothers from LBFI sites were also more likely than those receiving services from HBFI sites to find promotional messages to be conflicting across different health professionals.

> *Prenatal classes say something, the nurse at the hospital said something, the CLSC nurse said something else... I had three different health professionals, three different messages… at a point you start wondering what is happening.* (*mother using LBFI services*)

In a social context where mothers saw the general population and their family members as not being pro-breastfeeding, the breastfeeding promotion messages were experienced as an important issue for mothers. Many mothers mentioned that promotion messages did not prepare them to face negative gazes when they breastfed in public or during familial gatherings. Abandoning breastfeeding in this context was experienced as a failure by mothers served by LBFI services. This experience was accompanied by deleterious psychological effects such as a strong sense of guilt and the feeling of being judged as an incompetent mother.

> *During my mother's time, they [doctors and nurses] would say, it's the bottle, it was fashionable then. Nowadays, everyone promotes breastfeeding but it's good, it's great, I don't disagree, but I feel that at some point, society puts some pressure, and when I wasn't able to breastfeed successfully my first baby, I had a big disappointment, as if it was my fault. (mother using LBFI services)*

3.1.3 | Mothers using HBFI services

In contrast, women who received breastfeeding promotion services from HBFI institutions seemed better prepared to deal with potential breastfeeding technical difficulties and negative reactions of others. The many who actually did encounter breastfeeding problems seemed more likely to find the support needed to overcome those problems, either from health professionals, community organizations, family members or their partner, as shown by the fact that fewer mothers from the HBFI sites had weaned their baby at the time of the interview. For mothers from HBFI sites, sharing the decision to breastfeed with their partner was seen as crucial, as involvement in the decision made fathers thereafter committed to the management of domestic tasks.

> *An advantage of breastfeeding is that it's a task you can't delegate. When the boyfriend is at home, he takes care of the diapers, and must do the rest… But he must agree to the decision, because at some point he will become discouraged. But he wants you to breastfeed, that's the price to pay. (mother using HBFI services)*

Mothers from HBFI sites considered it to be very important to inform their personal network and family members about the decision to breastfeed. Likewise, they stated that it was important to educate society at large that breastfeeding is something normal to do in front of others and that publicity should normalize this practice in public spaces.

3.2 | Mothers' experience of support services

3.2.1 | All mothers, regardless of HBFI or LBFI

Mothers declared having received breastfeeding support mainly from nurses working in various health settings, with support provided by physicians remaining marginal. More than half of the mothers also reported having received breastfeeding support from friends, family members, or their partner. About one third of mothers declared having received support from community groups and peer counselors. Mothers revealed that the overall support they received played a crucial role in their ability to resolve their problems and continue breastfeeding.

Barriers to breastfeeding support mentioned by the mothers were diverse in nature and included cultural, geographic, and institutional barriers. A common observation between mothers from all sites was that, except for a few occasional cases (e.g., female physicians with breastfeeding experience), physicians were not seen as sources of support and were typically described as referring mothers to their local community health clinic when they wanted to discuss breastfeeding.

Cultural deterrents to accessing breastfeeding support derived, in part, from the embarrassment, a few mothers felt about showing their breasts to a nurse or a doctor, and in part, from the perception many mothers had that asking a professional for help was akin to admitting their maternal incompetence. This feeling of shame, coupled with the scarcity of community groups that offered support in some rural regions, exacerbated the problem of accessibility to support. After hospital discharge, some mothers served by LBFI and HBFI sites used the emergency health hotline (i.e., *Info-Santé*) to access nighttime breastfeeding support.

3.2.2 | Mothers using LBFI services

For mothers using services from LBFI sites, many felt breastfeeding support was difficult to access both in the hospital and from community services during the postnatal period.

> *I've found it really difficult at the hospital. I had a lot of problems getting a nurse to come and help me. I think nurses had other priorities. So I did not get much help. I feel that breastfeeding support is something that is missing at the hospital. I would often ring for help and nobody came. So I felt, my partner felt, we really felt neglected at the hospital, really. (mother using LBFI services)*

Furthermore, many mothers considered support services to be inconsistent and insufficient.

> *We saw a difference in the advice they gave me. A nurse told us: 'Give him a little formula while all the others said, no, no, no, here we promote breastfeeding'. I became discouraged. (mother using LBFI services)*

3.2.3 | Mothers using HBFI services

Mothers from HBFI sites declared that both health professionals and community workers were accessible to help them overcome their breastfeeding difficulties, resulting in better continuity of care and greater accessibility of support services in their region. Support interventions aiming to enhance mothers' self-confidence and self-empowerment were more notable in the narratives of mothers using HBFI services. One mother demonstrated her empowerment by strongly asserting her choice to breastfeed, despite opposition from a neonatologist; she described her accessibility to a nurse that offered her support to breastfeed in the neonatal intensive care unit.

> *For my part, she had trouble suckling, this is why I found myself in neonatology. Me, I had to really ask to have that person (nurse) with me because they wanted to give her formula... I was adamant. I said 'There is nothing else than my milk that will enter the mouth of this little baby'. The paediatrician said 'The baby will start to lose weight, it is essential to give him ...' I said, 'No, there was a nurse' ... so eventually she spent all the time and then often called in the room, she said 'Okay go on like this'. Ultimately, that's what started my breastfeeding properly. (mother using HBFI services)*

3.3 | Negotiating the social and embodied experience of breastfeeding

3.3.1 | All mothers, regardless of HBFI or LBFI

The majority of mothers from all sites explained that they had very little exposure to other breastfeeding women. For them, breastfeeding constituted a departure from the social and familial practices of previous generations. While many mothers described family and partner support as crucial to overcoming breastfeeding barriers, breastfeeding negotiation with family members represented an important challenge for many. Many women also faced disapproval when they breastfed in public. Those living in rural areas and first-time mothers stated feeling sensitive to social judgment.

3.3.2 | Mothers using LBFI services

Most mothers from LBFI sites aimed at breastfeeding for a fixed amount of time, generally between 3 and 6 months, as they considered this to be the ideal time recommended by health-care providers. However, mothers using LBFI services described feeling more sensitive to social judgment.

> *I think that was the biggest change in the first month, because I would leave the room and go and do my own thing. You kind of get tired after a while of being on your own (to breastfeed). But no, I do not like it. It isolates me... I see it in the faces, people turn their eyes or make oops wait a bit, even in my family... They are uncomfortable.* (mother using LBFI services)

For some mothers, feeling uncomfortable with exposing their body and feeling obliged to resort to social isolation in order to breastfeed led to interrupting or stopping breastfeeding earlier than intended. However, a few exceptions of empowered narratives did exist in the within this group. These mothers were characterized by being generally either older or more experienced mothers and having more than one child. These were verbal about not feeling limited by the challenge of breastfeeding in front of others.

3.3.3 | Mothers using HBFI services

Many participants from HBFI sites explained having approached their breastfeeding duration decision with flexibility, mainly because they were aware beforehand of the potential difficulties they could encounter. Moreover, most knew in advance where to find appropriate support if problems should arise. Some mothers from a specific HBFI site described how they successfully met their breastfeeding goal, as they had initially set a very low and attainable duration objective, and once attained, renewed their duration goal a few weeks at a time. In the end, most mothers from HBFI sites declared having breastfed either for the duration they had planned or beyond.

In terms of negotiating breastfeeding with others, many participants from HBFI sites reported confronting family members who appeared not at ease with breastfeeding, which in some cases seemed to result in changes in attitudes. These women also voiced a feeling that they contributed to cultural change. These empowered narratives prevailed among mothers using HBFI services.

> *At the beginning, my father, even though I was hiding, as soon as I started to breastfeed he would get up and leave... At one point, after a couple of weeks, I said 'Look, I will probably breastfeed for 6 months so if you hide every time I am breastfeeding, you'll find it long'. He was like, 'Yes'. Now he sits next to me when I breastfeed and he chatters on. He got over it...anyway he sees nothing cause I am careful. (mother using HBFI services)*

Although they generally recognized that breastfeeding is not very well integrated in society, mothers using HBFI services voiced their empowerment while perceiving society as less prone to "attack." They reasoned that lack of exposure to breastfeeding, rather than negative judgment per se, may raise curiosity in other people.

> *We must keep in mind that just maybe people will look. But it is people who perhaps have not had the chance to see a woman breastfeeding before, and they do not realize they are gazing, but it catches the eye because it's beautiful. So sure, it can create some discomfort. If they have the guts to come to you, you must have the guts to tell them that nobody forces them to watch. (mother using HBFI services)*

Hence, most women using services from HBFI sites would consider "*being discreet*"—by using covers or choosing clothing suitable for breastfeeding—as a sufficient strategy to negotiate breastfeeding in public. Finally, mothers from this group voiced

particularly strong opinions about the social images of breasts as sexual objects being imposed by the media, whereas breastfeeding should be considered to be a normal practice. One mother defined it in terms of *doing the switch*: seeing breasts as a body part primarily dedicated to nourishing a baby, with the sexual function of breasts considered a secondary one.

> *I call it 'making the switch'. Until you make that switch, that's it, you feel uncomfortable to breastfeed in public… But if we make that switch, I think that we become comfortable with breastfeeding and breastfeeding goes well, because we are comfortable and the baby does not feel our stress anymore. It is society that made them as a sexual object in the end. I think that those that still have a problem with this, it's precisely because they did not make the switch yet. But the normal thing is that, it's breastfeeding.* (mother using HBFI services)

4 | DISCUSSION

Our results provide insight into the maternal experience of highly educated mothers who received breastfeeding promotion and support from HBFI compared to LBFI services. We found that mothers using HBFI services were characterized by a flexible approach to breastfeeding duration, which helped them avoid maternal guilt and shame. HBFI services with their focus on strategies to overcome potential barriers empowered women to negotiate breastfeeding with others and self. Our results suggest that appropriate breastfeeding support starts before women begin breastfeeding and involves preparing mothers and their partners to face breastfeeding difficulties, with a greater focus on maternal experience than on the health benefits and performance of breastfeeding. Building from Bourdieu's theory, our results suggest that HBFI services contribute to empowering women by enhancing their *social* and *embodied cultural capital* in the *fields* where they breastfeed, including family, community, hospital, and public spaces (Bourdieu, 2011). In the short term, this enhancement of women's abilities to negotiate breastfeeding in social places allows them to overcome the fact that breastfeeding is not currently a habitus in Québec; in the long term, this may support habituation.

Our results demonstrate that HBFI services can increase the *social capital* of breastfeeding women through two routes. First, by increasing accessibility to health-care providers and community breastfeeding support groups, mothers had increased access to technical support for breastfeeding. Second, by encouraging mothers to include their partners in breastfeeding decisions, HBFI services transformed partners into sources of emotional and domestic support that empowered mothers within the *fields* of family and community.

Cultural capital can take various forms, including *embodied cultural capital*, which consists of both consciously and unconsciously acquired forms. In the case of breastfeeding, the majority of women in our study seemed initially, to have unconsciously acquired an aversion to breastfeeding through exposure to this aversion within the family and societal *fields*, suggesting that breastfeeding is not currently a habitus in Québec. These results are consistent with previous research illustrating how the hypersexualization of breasts in western culture, combined with a lack of exposure to breastfeeding, makes the embodied experience of breastfeeding uncomfortable for many women in the Western world (Groleau et al., 2013; Schmied & Barclay, 1999; Boyer, 2012). Our results suggest that empowering mothers to negotiate hypersexualization of breasts with others, as was typical of mothers using HBFI services, is a promising strategy for promoting breastfeeding. The HBFI services in our sample seem to be providing mothers with the skills to think critically about their own culture, providing them with a new framework to interpret their own aversions to breastfeeding and the reactions of others. Moreover, HBFI services seem to provide them with the discursive tools to negotiate breastfeeding in their various *fields*, a form of conscious acquisition of *embodied cultural capital* that helps women overcome the initial acquired discomfort with breastfeeding. However, we still need to know if this would be the case with mothers living in poverty, knowing that their overall access to *economic*, *cultural and symbolic* forms of *capital* is reduced (Groleau et al., 2013).

This is the first study to provide an in-depth, comparative perspective on the maternal experience of breastfeeding promotion and support services, as well as the embodied experience of breastfeeding, in relation to BFI services. While previous research has found that the BFI model of care is not necessarily experienced positively by mothers (Semenic, Childerhose, Lauziere, & Groleau, 2012), our results suggest that the BFI manifests in highly divergent ways depending on how it is implemented. The empowerment of mothers, via enhanced *social* and *cultural capital*, as a key feature of HBFI in this Québec sample is strikingly different from findings on the implementation of BFI in the UK, where BFI has been highly criticized for being too dogmatic (Semenic et al., 2012). Bilson and Dykes (2009) have argued that while the BFI is outcome oriented, the process of implementing BFI may vary greatly and depend on the societal and institutional culture. Many health professionals involved in maternal and child care in Québec have incorporated feminist ideology in their practice (Gendron & Beland, 1992; Fédération interprofessionnelle de la santé du Québec, 2011), and ongoing debate in the Québec media has been critical of health promotion messages imposing guilt on mothers who abandon or reject breastfeeding.[2] We hypothesize that this critical consciousness among health-care providers led to a more flexible and family-centered style of BFI implementation in Québec. The empowering nature of HBFI services in our study also fits with the ideology of family-centered maternity care, which is starting to be of interest in some hospitals of Canada and Québec (Health Canada, 2000). Further studies exploring how the ideology of health-care providers influences BFI implementation are needed to explore these possibilities in the future.

Our findings regarding the maternal experience of breastfeeding have theoretical implications for the concept of habitus and the

[2]For example, see: http://pilule.telequébec.tv/occurrence.aspx?id=1113; http://chantallavigneibclc.qc.ca/tag/culpabilite/; http://blogues.lapresse.ca/mere/2009/10/02/allaitement-information-et-culpabilite/

construction of the breastfeeding body. As a feminist philosopher of the body stipulates: 'No matter how much the individual may wish it or will it, male and female genitals (and other body parts) have a particular social meaning in Western patriarchal cultures that the individual alone—or even in groups—is unable to transform insofar as these meanings have been so deeply etched into and lived as part of the body image' (Grosz, 1994, p. 82). However, our results demonstrate an increasing level of comfort over time among breastfeeding women who received HBFI services, suggesting that habitus can change and that it likely requires a habituation period, in which agents are empowered with *social* and *embodied cultural capital*. While Bourdieu states, "The work of acquisition is work on oneself (self-improvement), an effort that presupposes a personal cost… and investment, above all of time" (Bourdieu, 2011, p. 18), our work shows that, in addition to the personal investment time, BFI services can support acquisition of a new habitus by empowering women to face the challenges that this entails. Some scholars have criticized the concept of habitus for not reflecting the dynamic dimension of reality (King, 2000); however, others have argued that habitus can include flexibility and transformation (Crespi & Bauman, 1992). No author, however, has provided a theoretical discourse that explains the underlying process in habitus change, what we call here "habituation."[3] This complex process of habituation is important to understand, as so many public health programs aim to change a habitus considered deleterious to health, such as smoking or sedentary lifestyles. Our results suggest that one needs to be empowered during a habituation period to negotiate the embodied change with oneself and others in various *fields*.

5 | CONCLUSION

In a context where breastfeeding initiation rates have recently risen to very high levels with duration rates remaining low, our results suggest that breastfeeding in Québec is, in fact, in the habituation phase. With the hypersexual meaning inscribed on breasts in the Western context, this habituation cannot be expected to occur in a rapid time frame. In the meantime, mothers' experiences suggest that HBFI services make mothers aware of this habituation phase by enhancing their *embodied cultural capital*, preparing them with realistic expectations and discursive tools to negotiate this new embodied experience. Our results suggest that this approach not only empowers mothers but also encourages them to act as change agents in the re-inscription of breasts in western society. Health services must recognize that breastfeeding is a social, cultural, and embodied process, not just a decision.

Bilson and Dykes (2009) suggest that successful and sustainable implementation of the BFI requires a level of flexibility, emotional engagement, and critical reflection on the part of health-care workers that may be forsaken in attempts to quickly achieve the BFI outcomes. Health institutions aiming to promote and support breastfeeding need to focus on empowering breastfeeding women rather than simply achieving performance-oriented outcomes.

[3]We use the term more broadly than in behavioral learning theory, which defines habituation as a decrease in response to a stimulus after repeated exposure in which it bears no consequence. Our use of the term habituation encompasses the change in embodied experience over time and space, which could include desensitization to an initial discomfort (e.g., breastfeeding) or an increasing comfort level with a new way of using the body (e.g., through exercise).

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CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

CONTRIBUTIONS

DG led the research project, the qualitative analysis, and wrote the first draft of the paper. All other authors contributed to analysis, writing, and editing of the paper with the authorship rank reflecting their overall contribution.

REFERENCES

Akman, I., Kuscu, M. K., Yurdakul, Z., Özdemir, N., Solakoğlu, M., Orhon, L., … Özek, E. (2008). Breastfeeding duration and postpartum psychological adjustment: Role of maternal attachment styles. *Journal of Paediatrics and Child Health*, *44*(6), 369–373.

Amir, L. H. (2011). Social theory and infant feeding. *International Breastfeeding Journal*, *6*(1), 1.

Bilson, A., & Dykes, F. (2009). A bio-cultural basis for protecting, promoting and supporting breastfeeding. In F. Dykes, & V. Hall Moran (Eds.), *Infant and young child feeding: Challenges to implementing a global strategy* (pp. 32–42). West Sussex: Wiley-Blackwell.

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste*. Cambridge: Harvard University Press.

Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory*, *7*(1), 14–25.

Bourdieu, P. (2011). The forms of capital (1986). *Cultural theory: An anthology*, *pp.*, 81–93.

Boyer, K. (2012). Affect, corporeality and the limits of belonging: Breastfeeding in public in the contemporary UK. *Health & Place*, *18*(3), 552–560.

Britton, J. R., Britton, H. L., & Gronwaldt, V. (2006). Breastfeeding, sensitivity, and attachment. *Pediatrics*, *118*(5), e1436–e1443.

Crespi, F., & Bauman, Z. (1992). *Social action and power*. Oxford: Blackwell.

Dykes, F. (2005). 'Supply' and 'demand': breastfeeding as labour. *Social Science & Medicine*, *60*(10), 2283–2293.

Fédération interprofessionnelle de la santé du Québec. (2011). Pour une approche globale et féministe en santé, *Bulletin du réseau des femmes de la fédération interprofessionnelle de la santé du Québec*, 8(1).

Gendron, C., & Beland, B. (1992). Approche feministe et science infirmiere: Une alliance prometteuse. *Nursing Quebec*, *12*, 34–34.

Groleau, D., & Rodríguez, C. (2009). Breastfeeding and poverty: Negotiating cultural change and symbolic capital of motherhood in Québec, Canada. In F. Dykes, & V. Hall Moran (Eds.), *Infant and young child feeding: Challenges to implementing a global strategy* (pp. 80–98). West Sussex: Wiley-Blackwell.

Groleau, D., & Sibeko, L. (2012). Breastfeeding in the margins: Navigating through the conflicts of social and moral order. In P. Hall Smith,

B. L. Hausman, & M. Labbok (Eds.), *Beyond health, beyond choice: Breastfeeding constraints and realities* (pp. 203–211). New Brunswick: Rutgers University Press.

Groleau, D., Sigouin, C., & D'souza, N. A. (2013). Power to negotiate spatial barriers to breastfeeding in a western context: When motherhood meets poverty. *Health & Place*, *24*, 250–259.

Grosz, E. A. (1994). *Volatile bodies: Toward a corporeal feminism*. Bloomington: Indiana University Press.

Health Canada. (2000). *Family-centred maternity and newborn care: National guidelines* (4th ed.). Ottawa: Health Canada.

Health Canada, Statistics Canada & Canadian Institute for Health Information. (1999). *Statistical report on the health of Canadians*. Ottawa: Health Canada.

Jansen, J., de Weerth, C., & Riksen-Walraven, J. M. (2008). Breastfeeding and the mother–infant relationship—a review. *Developmental Review*, *28*(4), 503–521.

King, A. (2000). Thinking with Bourdieu against Bourdieu: A 'practical' critique of the habitus. *Sociological Theory*, *18*(3), 417–433.

Krueger, R. A., & Casey, M. A. (2014). *Focus groups: A practical guide for applied research* (5th ed.) Thousand Oaks: SAGE publications.

Marshall, J. L., Godfrey, M., & Renfrew, M. J. (2007). Being a 'good mother': Managing breastfeeding and merging identities. *Social Science & Medicine*, *65*(10), 2147–2159.

Matich, J. R., & Sims, L. S. (1992). A comparison of social support variables between women who intend to breast or bottle feed. *Social Science & Medicine*, *34*(8), 919–927.

McInnes, R. J., & Chambers, J. A. (2008). Supporting breastfeeding mothers: Qualitative synthesis. *Journal of Advanced Nursing*, *62*(4), 407–427.

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook*. Thousand Oaks: SAGE Publications.

MSSS. (1997). *Priorités nationales de santé publique 1997–2002*. Québec: Ministere de la Santé et des Services Sociaux.

MSSS. (2001). *L'allaitement maternel au Québec: lignes directrices*. Québec: Ministere de la Santé et des Services Sociaux.

MSSS. (2011). *Rapport d'évaluation: Niveau d'implantation de l'Initiative des amis des bébés dans les établissements offrant des services de périnatalité au Québec*. Québec: Ministere de la Santé et des Services Sociaux.

Neill, G., Beauvais, B., & Plante, N. (2006). *Recueil statistique sur l'allaitement maternel au Québec, 2005–2006*. Québec: Institut de la statistique du Québec.

Redshaw, M., & Henderson, J. (2012). Learning the hard way: Expectations and experiences of infant feeding support. *Birth*, *39*(1), 21–29.

Renfrew, M. J., McCormick, F. M., Wade, A., Quinn, B., & Dowswell, T. (2012). Support for healthy breastfeeding mothers with healthy term babies. *Cochrane Database of Systematic Reviews*, *5*, CD001141.

Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2011). Women's perceptions and experiences of breastfeeding support: A metasynthesis. *Birth*, *38*(1), 49–60.

Schmied, V., & Barclay, L. (1999). Connection and pleasure, disruption and distress: Women's experience of breastfeeding. *Journal of Human Lactation*, *15*(4), 325–334.

Schwandt, T. A. (2015). *The sage dictionary of qualitative inquiry* (4th ed.). Los Angeles: Sage Publications.

Semenic, S., Childerhose, J. E., Lauziere, J., & Groleau, D. (2012). Barriers, facilitators, and recommendations related to implementing the Baby-Friendly Initiative (BFI): An integrative review. *Journal of Human Lactation*, *28*(3), 317–334.

Sheehan, A., Schmied, V., & Barclay, L. (2009). Women's experiences of infant feeding support in the first 6 weeks post-birth. *Maternal & Child Nutrition*, *5*(2), 138–150.

Statistics Canada. (2013). *Table 105-0502 - Health indicator profile, two year period estimates, by age group and sex, Canada, provinces, territories, health regions (2012 boundaries) and peer groups, occasional*. CANSIM database.

Torres, J. M. (2014). Medicalizing to demedicalize: Lactation consultants and the (de) medicalization of breastfeeding. *Social Science & Medicine*, *100*, 159–166.

Trickey, H., & Newburn, M. (2014). Goals, dilemmas and assumptions in infant feeding education and support. Applying theory of constraints thinking tools to develop new priorities for action. *Maternal & Child Nutrition*, *10*(1), 72–91.

WHO & UNICEF. (2003). *Global strategy for infant and young child feeding*. Geneva: World Health Organization.

WHO & UNICEF. (2009). *Baby-friendly hospital initiative: Revised, updated and expanded for integrated care*. Geneva: World Health Organization.

Yin, R. K. (2013). *Case study research: Design and methods*. Los Angeles: Sage publications.

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