

Breast/chest Feeding Support: Critically Analyzing a Canadian Policy Guiding Nursing Practice

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Abstract: The World Health Organization has identified the importance of improving the rates of breast/chest feeding for population health. Canadian health organizations have put public health resources toward breast/chest feeding support. Despite statements of purpose describing health promotional interventions to be focused on improving overall population health, many times these methods are based only upon biomedical knowledge and fail to adequately address the needs of diverse populations. Thus, in this paper we critique a Canadian policy providing clinical guidance to care providers through the application of a relational inquiry framework. We draw on the first author's experience as a Public Health Nurse delivering breast/chest feeding support within the scope of these guidelines to further illustrate the point. The results from published evidence are integrated within this critique to provide an evidence base for policy improvement recommendations to improve the social, cultural, and political components of breast/chest feeding typically overlooked in current standards.

Cite as: Deo, H., Ojukwu, E. & Boschma, G. Breast/chest Feeding Support: Critically Analyzing a Canadian Policy Guiding Nursing Practice. *Witness: The Canadian Journal of Critical Nursing Discourse*, 5(1). pp 17-30. <https://doi.org/10.25071/2291-5796.147>

Keywords: Breast/chest Feeding, Health Promotion, Public Health Nursing, Health Policy, Health Equity

Introduction

Public Health Nurses (PHNs) provide breast/chest feeding support and education to perinatal individuals with the ultimate goal of improving overall population health and wellbeing. The World Health Organization (WHO, n.d.) identifies breast/chest feeding as a necessary factor for improving the health and survival of children. The WHO (n.d.) recommends all infants are exclusively breast/chest fed until six months of age. The Canadian province with the highest reported rate of exclusive breast/chest feeding until six months is British Columbia (BC) at 49% (Statistics Canada, 2022), raising questions regarding the potential barriers for the remaining 51% of postpartum individuals. Perinatal Services British Columbia (PSBC) provides guidance to nurses in BC with the 2015 policy document titled "Breastfeeding Healthy Term

Infants." We argue that this guiding document could be enhanced to better support parents. The purpose of this article is to conduct a critical analysis of this Canadian policy document through the application of a relational inquiry framework to uncover gaps that fail to meet the needs of all parents and subsequently provide recommendations for quality improvement.

Evidence from published literature reveals the inequities present in current breast/chest feeding promotional practices. Campbell (2021) asserts that "regardless of overall improvements in breastfeeding rates, disparities continue to exist related to racism; socio-economic social determinants of health including poverty, income, and food insecurity; and geographic location" (p. 79). Critiques of current breast/chest feeding culture suggest specific groups of individuals have not been appropriately addressed (Revai & George, 2021). Breast/chest feeding support tends to be

focused on achieving higher rates through messaging of health benefits with the assumption that the decision to breast/chest feed is primarily an individual choice. This view fails to recognize the social, political, and economic factors that may be restricting the agency of an individual to make the choice to breast/chest feed (Smith, 2018; Taylor & Wallace, 2012). Breast/chest feeding outcomes have macro-level causes beyond the choices made at the individual level, including socio-political constraints affecting micro-level feeding choices made by individual parents (Taylor & Wallace, 2012). Based on the results of an integrative review of Canadian studies related to the contents of the PSBC policy, we articulate a similar critique (Deo et al., in press). The evidence cited ranges from studies exploring the experiences of perinatal individuals to the perspectives of care providers. The first author also includes influences from their practical experience working as a PHN providing breast/chest feeding support in BC within the PSBC guidelines.

Background

Theoretical Framework: Relational Inquiry

Through a critical lens, relational inquiry can be applied to support PHN practice through the understanding of structural inequities and the potential impacts on health outcomes (Doane & Varcoe, 2021). A relational approach to breast/chest feeding centres the unique experiences of the individual, with meaningful consideration of context and situation (Revai & George, 2021). This framework addresses diverse aspects of the breast/chest feeding experience beyond the physical act itself (Revai & George, 2021; van Wijlen, 2019). Many individuals do not reach the ideal of 'breast is best,' and many of these individuals do not simply 'choose' to bottle feed. There are often circumstances beyond the individual's control that affect this 'choice' (Smith, 2018). The critical shift towards relational practice counteracts the philosophy in which current breast/chest feeding practice is rooted. Critiques against current policies argue the Western approach to breast/chest feeding has been shaped through the view of Cartesian dualism, which is

a separation of the mechanical and biological aspects of the physical body from the emotional and psychological aspects (McBride-Henry et al., 2009; Regan & Ball, 2013; Spencer, 2008; van Wijlen, 2019). This view essentially reduces the perception of the childbearing person's body to that of a machine and furthers the objectification of the breast present in society (McBride-Henry et al., 2009; Spencer, 2008). Relational inquiry seeks to challenge the Cartesian knowledge dominant in Western healthcare practices and integrate different ways of knowing (Doane & Varcoe, 2021). Critical explorations of the concept of breast/chest feeding allow for the interrelationships between the various aspects of the human experience through the rejection of Cartesian dualism, in addition to the integration of the impact of the larger social and political structures and influence of the social determinants of health (SDoH) to construct a more embodied, holistic, and critical understanding of breast/chest feeding support. To analyze how the framework of relational inquiry and existing critiques relate to current breast/chest feeding education and support in BC, we apply this lens to an in-depth review of the PSBC guideline document that is used by PHNs in practice.

Practical Experience

As a PHN in BC, I (the first author) have practiced within the constraints of the PSBC guidelines, as both a witness and active participant in the health promotion of breast/chest feeding. PHN practice follows the Community Health Nurses of Canada (CHNC) standards of practice, which lists the standard of incorporating health equity into practice, inclusive of integrating the SDoH into practice and advocating for changes in health policy (CHNC, 2021). However, I do not think the broad application of these policies represent an equity-oriented approach for diversity in the psycho-social and contextual needs of all Canadian parents. I have facilitated prenatal breast/chest feeding classes with the content provided to me by my healthcare organization, consisting of the benefits of breast/chest milk over formula use, encouraging parents to make the right 'choice', and the physical act of putting baby to breast/chest. I have hesitated with the

term ‘natural’ in reference to breast/chest feeding and sharing the potential harms of using formula. Postnatally, I have found that not all parents are equipped with the resources and education needed to exclusively breast/chest feed, nor do they all have the ability to do so, thus listing off the harms of formula is not an effective solution. Parents have expressed guilt and questioned their parenting abilities due to their perceived failure at meeting their feeding goals. They have also shared feeling an intense pressure to exclusively breast/chest feed while also balancing the demands of parenting other children or having limited social and financial supports. When discussing the challenges of providing breast/chest feeding support with colleagues, other nurses have fiercely defended the need to increase breast/chest feeding rates, referring to ‘breast is best’ and ‘breastmilk is liquid gold’, with others countering this message with ‘fed is best’, often stemming from their own personal experiences. I do not agree with either polarized view. Rather, I argue that the complexities of breast/chest feeding should not be over-simplified with captivating language that tends to be remembered due to the words that rhyme. Instead, we should aim to critically address the conflicting discourses that exist at the practice level through deeper inquiry into the health promotion of breast/chest feeding and through the consideration of the expanding evidence we use to inform our practice. I believe that conversations with parents should begin with an assessment of their overall infant feeding support needs, and the subsequent messaging provided should be based upon addressing those needs as best as possible. Despite the guidance from PSBC (2015) instructing providers to remain positive in the promotion of breast/chest feeding, in practice the beliefs of individual nurses that I have worked with are not always reflective of this policy. The perspectives of both the providers and recipients of health promotional messaging of breast/chest feeding will be explored in this article to frame the policy and education gaps for nurses needing to be addressed.

Policy Description

In BC, the health promotion guidelines to which PHNs refer for breast/chest feeding

education and support are the “Breastfeeding Healthy Term Infants” resource from Perinatal Services BC (PSBC) (2015). The PSBC (2015) “Breastfeeding Healthy Term Infants” guidelines state that the guidelines were written to be: consistent with the *Canadian Baby-Friendly Initiative*; the recommendations of the BC Ministry of Health; Perinatal Services BC (PSBC) education *Breastfeeding: Making a Difference*[®]; the *BC Baby-Friendly Network Resource Binder*; and the Canadian documents, *Nutrition for Healthy Term Infants and Family-Centred Maternity and Newborn Care: National Guidelines*. (p. 3)

With the PSBC guidelines being consistent with national guidelines, the guidance in BC should also align with other provinces within Canada.

The stated purpose is:

To facilitate optimum and consistent lactation care to women and their infants by all health care professionals in both hospital and community settings. To increase the number of infants who are exclusively breastfed from birth to hospital discharge and for the first six months of age with introduction of nutritious and safe complementary foods with continued breastfeeding for up to two years and beyond. (PSBC, 2015, p. 3)

Upon review of the 52-page document outlining the health promotion of breast/chest feeding in BC, much of the content provides clinical guidance for the physical act of breast/chest feeding, ranging from the challenges with neonatal jaundice to the parental concerns of inverted nipples (PSBC, 2015). Throughout the guideline, the concept of breast/chest feeding is framed as a decision made by the parents, and the role of the healthcare provider is to encourage informed decision making and to “[...] respect parent’s decision making when it is based on accurate knowledge” (PSBC, 2015, p. 6). Recommendations for education by PHNs are based upon the understanding that “the decision to breastfeed is influenced by the woman’s life experiences, beliefs, culture, and the attitudes and views of family and friends” (PSBC, 2015, p. 7). Still, with little guidance on how such education should take place, nurses are

advised to maintain a positive attitude towards breast/chest feeding, assess parental support systems, and to “show sensitivity to cultural influences and views but address cultural perceptions which may be incorrect” (PSBC, 2015, p. 7). The guidelines do not go into detail regarding what level of knowledge is required for informed decision-making and whether that knowledge encompasses factors outside of the health benefits of breastmilk. There is a lack of guidance in the interventions following the assessment of the influences listed or how to ‘sensitively’ address cultural perceptions.

PSBC (2015) states that healthcare providers should draw upon principles of adult education when providing health education for parents. Desjardins (2017) notes the need to be critical of the evidence used for policymaking in adult education, specifically whether there is diversity in the perspectives that influence the research being done. Policies are often based on quantitative data, which can create a foundation for further exploration, however these methods alone result in a fragmented picture, and lack the depth required for decision-making (Desjardin, 2017). Research in breast/chest feeding interventions is often focused on assessing outcomes through quantitative approaches, and the opportunity for qualitative methods to investigate the interpersonal processes leading to these outcomes is underutilized. For example, research in the technical, biomedical process of lactation is vast with the dominant narrative being the need for medical intervention to manage a women’s body (Dietrich Leurer and Misskey, 2015; Spencer, 2008). Qualitative approaches building on the current biomedical views of breast/chest feeding may provide the contextual understanding needed to address the barriers that are preventing ideal outcomes from being met (Leeming et al., 2017; Spencer, 2008). For example, are the barriers related to a lack of education in the technical aspect of latching baby to the breast or is there a larger social norm preventing individuals from breast/chest feeding their baby in certain settings? Overall, PSBC provides guidance for healthcare workers in the promotion of breast/chest feeding through an evidence-informed, biomedical approach that begins to involve more holistic components of breast/chest feeding. However, this perspective

has limitations and would benefit from expansion of the social, cultural, and political dimensions of breast/chest feeding. According to the PSBC website (n.d.), guidelines which are older than 5 years should only be used for historical reference only, and not utilized for clinical guidance. At the time of this review, the currently published PSBC (2015) guidelines are seven years old, with the last revision being March 2015. Upon review of the PSBC website, no updated guidelines were found, and this version remains in the current guidelines section. These dates suggest a need for an updated revision to the current PSBC guidelines that, we argue, should incorporate new insights. From the preliminary review of recent literature, it appears that contextual perspectives of breast/chest feeding are being explored through qualitative methods, thus affirming the need for a revision of the current policies to integrate best practices and a combination of qualitative and quantitative literature. In this paper we critique current breast/chest feeding policy with recommendations for such revisions through discussion of this literature.

Discussion

Integrating Social Determinants of Health

In Canadian policy, the current approach taken by various levels of health officials to improving breast/chest feeding rates has failed to adequately recognize the SDoH as intersecting components affecting infant feeding outcomes. The dominant narrative has been the need to educate individuals on the benefits of breast/chest milk to provide the information required to make an informed choice. This narrative places the burden of responsibility on the perinatal individual. If exclusive breast/chest feeding is not achieved, it is simply the result of their individual choice. This narrative is evident in the PSBC (2015) guidelines, while it has no explicit statements acknowledging the involvement of the SDoH or structural barriers. This narrow view fails to address or even recognize the barriers potentially preventing a childbearing person from having the required agency to make such a choice (Groleau & Sibeko, 2012; Taylor & Dowling, 2021). Writing breast/chest feeding policies through a

critical lens widens the field of view to include the power differentials at play in the overall environment, ranging from the power relations between individuals to the structures that affect power dynamics, and the ways individuals use their power (Doane & Varcoe, 2021). This lens should include the application of a trauma and violence informed care (TVIC) approach, described by Browne et al. (2015) as the recognition of past interpersonal and/or structural trauma or violence potentially experienced by individuals and the subsequent impacts to their health. Interdisciplinary TVIC education provided to primary health care providers has been found to challenge the biomedical paradigms entrenched in the culture of primary care clinics (Levine et al., 2021).

The Government of Canada (2020) considers the SDoH to include the social and economic positioning of an individual within society affecting their opportunities for healthy choices, with specific attention given to groups of individuals that have been affected by discrimination, racism, and historical trauma. Furthermore, health care provision itself has the potential to have adverse effects if it perpetuates harmful misconceptions or racist stereotypes. Writing policy from a TVIC lens would include deliberate considerations of strategies to minimize the potential for re-traumatization (Levine et al., 2021). When referring to trauma that may complicate the choice to breast/chest feed, Campbell (2021) reviews historical practices that have affected childbearing persons to include the lack of bodily autonomy, the objectification and sexualization of breasts, and violence against women's bodies. Colonization and globalization have also impacted infant feeding choices in a profound way that require a greater understanding from nurses (McFadden & Erikson, 2020). In addition to the gendered discrimination faced by individuals, systemic racism has harmfully impacted the ways perinatal persons have been treated within the healthcare system (Campbell, 2021). A survey conducted with 2323 women in BC found autonomy in maternity care during the perinatal period was reduced amongst women with decreased education levels or when they perceived being racially discriminated against by their healthcare providers (Vedam et al., 2019).

Studies have also revealed the ways SDoH affect the breast/chest feeding experiences of different lactating individuals, including the racialization of Chinese parents (McFadden & Erikson, 2020), the stigmatization of HIV-positive parents (Greene et al., 2015), and the barriers faced by lower-income parents (Francis et al., 2020). These groups are a small fraction of various populations living in Canada, thus the experiences of other groups of individuals also warrant further investigation.

The PSBC (2015) guidelines acknowledge the potential impact of past experiences and the socio-cultural forces affecting breast/chest feeding, but simply state that these factors influence the individual's decision rather than providing guidance around how these factors could restrict the agency of the individual from making the decision to exclusively breast/chest feed. Clear, explicit guidance is needed for PHNs to address the socio-cultural differences among different groups of childbearing persons and how they can be empowered within their infant feeding experience despite the structural barriers they may face (Gillis et al., 2013; Greene et al., 2015; Groleau et al., 2017). McFadden and Erikson (2020) recommend an expansion of nursing theory "to help the nurse navigate and understand both the nurses' and client's local histories as well as individual-to-systems level constraints and supports that may impede, or promote, a mother's ability to breastfeed" (p. 11). This could include the integration of a TVIC lens, which calls for an acknowledgement of structural forms of violence (Levine et al., 2021). In practice, Vancouver Coastal Health's (2020) guideline on trauma informed practice states that care providers are required to have a baseline awareness of trauma, including the rates of prevalence, the effects of trauma from the individual to the organization levels, and the potential for interactions with the healthcare system to cause re-traumatization. An example would be requiring PHNs to undertake education that includes such awareness to potential breast/chest feeding trauma. However, a key point to recognize at the practice level of applying a TVIC lens is the emphasis on the *potential* for past trauma to affect the breast/chest feeding experience on

individuals/communities/organizations rather than requiring an individual to disclose their personal experience with trauma and violence. As well, PHNs could provide referrals to community resources and programs that may address constraints as part of their overall infant feeding support interventions. For example, in situations of food insecurity affecting the lactating person's ability to produce breast/chest milk, the PHN may examine referring the family to accessible and low-cost nutrition services.

In the Margins

Dominant narratives in breast/chest feeding policy and discourse tend to centre certain individuals with others left in the margins. Examples of peoples relegated to the social margins include lactating individuals with contraindications to breast/chest feeding such as those living with HIV (Greene et al., 2015), parents who do not meet the "good mother" identity that is defined by meeting the moral imperative to breast/chest feed (Groleau et al., 2012), and childbearing persons that do not meet heteronormative standards (Farrow, 2015).

Breast/chest feeding has been tied to parenting identity, with Groleau et al. (2012) describing the link as a moral imperative. There are multiple reasons parents may be unable or choose *not* to breast/chest feed. Regardless of whether they do or do not, all parents require support with infant feeding free of judgment. One specific example is the contraindication of persons living with HIV to provide their breast/chest milk to their infants. Greene et al. (2015) raised concerns with the dominant messaging of breast/chest feeding being the optimal nutrition for all infants in relation to HIV. They note how perinatal parents living with HIV reported the stigma associated with bottle feeding in a culture that expects childbearing persons to breast/chest feed if they want to provide the best for their children, a message that is prevalent in healthcare settings promoting 'breast is best'. Within the PSBC (2015) guidelines, there is a '*Potential contraindications to breastfeeding*' section acknowledging that while contraindications are rare, HIV-positive persons in Canada are advised against breast/chest feeding and will likely require emotional support. This guidance

begins to address the emotional *impact* of perinatal persons being advised against breast/chest feeding due to their medical status, however there is no further discussion in the guidelines on how these emotional challenges may be a result of pushing the 'breast is best' ideology. Neither is there a discussion on the emotional *support* needed by parents that do not achieve exclusive breast/chest feeding standards for reasons outside of medical contraindication. PHNs may have the best of intentions when framing breast/chest feeding as "normal" and "best", but the potential unintended consequences are individuals feeling as though they have failed at providing the "normal" and "best" care to their infants if they are unable to breast/chest feed, such as in the case of parents who are HIV-positive.

Heteronormative language is commonplace in breast/chest feeding policies and support from healthcare providers (Farrow, 2015). Kitzinger (2005) defines heteronormativity as "the mundane production of heterosexuality as the normal, natural, taken-for-granted sexuality" (p. 1). Such language is evident in the PSBC (2015) guidelines, with descriptions of lactating individuals and parents being limited to "mothers" or "women". Individuals that do not fit into these narrow, gendered identities are thus excluded, or considered to be part of the "other" rather than the norm, creating an additional barrier to appropriate breast/chest feeding support (Farrow, 2015). In my experience as a PHN providing support guided by PSBC (2015) policy, I used these gendered terms countless times, and prior to my seeking out additional education on the topic, I did not question my exclusionary practice. Guidelines and health authorities should update their practice documents with gender-neutral language to encourage PHNs to use inclusive terms at the practice level. Of note, the recommendation is not for there to be an additional section added for Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, and Asexual (2SLGBTQIA+) parents; instead, they should be incorporated throughout the guidelines as part of the norm as advocated by Farrow (2015).

PHNs and those providing breast/chest feeding education and support should be challenged to explore their own beliefs regarding infant feeding and use such reflection throughout the knowledge and care they provide, to promote more conscious awareness of potential biases being translated into the care provided. Infant feeding policies need to go beyond the margins of simply stating contraindications to breast/chest feeding and a potential associated emotional impact. Policymakers should further address the impacts and the ways in which these individuals can be better supported to mitigate potential harm with more fully developed guidelines.

Beliefs and Ambiguity in the Application of Policy

Individual beliefs and awareness of ambiguity when applying the guidance provided in health policy to practice have the power to impact the culture of healthcare settings and the messages given to clients. For example, an ethnography of PHNs conducted by McFadden and Erikson (2020) revealed an inaccurate understanding of cultural practices related to infant feeding in Chinese culture. The PHNs reported their awareness of a stereotype in Chinese culture that women with smaller breasts do not have enough breastmilk and therefore their infants would require additional formula. The PHNs believed they were being culturally sensitive by assuming the parents would not exclusively breast/chest feed and thus, providing less breast/chest feeding support compared to parents that were not Chinese. This finding represents the ambiguity present in the concept of cultural sensitivity and a limited understanding of the notion of cultural safety and the application of this knowledge in the setting of infant feeding support.

Upon review of the PSBC (2015) guidelines, among the entirety of the 52-page document, only two statements acknowledging culture are made, specifically in the '*Prenatal Care*' section, recognizing "the decision to breastfeed is influenced by the woman's life experiences, beliefs, culture, and the attitudes and views of family and friends" and the guidance for care providers to "show sensitivity to cultural influences and views but address

cultural perceptions which may be incorrect" (p. 7). There is no further expansion upon the topic of culture or on the contextual factors on which understanding of cultural sensitivity should be applied. The statement merely conveys that simply being culturally 'sensitive' is enough as a guiding principle for PHNs, without acknowledging the potentially problematic nature of this view. The statement invites one to simply perceive 'culture' as a set of fixed characteristics and practices that identify a certain person as being from a particular ethnic group that should be acknowledged (Doane & Varcoe, 2005).

It overlooks conveying the importance of the more recent notion of cultural safety and of showing cultural responsiveness to a range of contextual factors influencing a person's circumstances and life experience. The guidelines do not refer to recent insights and nursing theories around providing care that applies the concepts of cultural safety and cultural humility. Without any further guidance about the limitations of cultural 'sensitivity', and without being offered insights on culturally safe care, the care provider is then challenged to determine the best approach when cultural responsiveness and humility is warranted, especially as the guidance states addressing potential misperceptions related to culture. The guidelines should explain cultural safety as "[...] requiring actions that a) recognize, respect, and nurture the unique and dynamic cultural identities of all people and families, and b) safely meet people's needs, expectations, and rights given the unique contexts of their lives" (Doane & Varcoe, 2021, p. 270). Such an explanation would enhance guidance for nurses that aligns with current insights, rather than using the potentially problematic concept of cultural sensitivity. McFadden and Erikson (2020) advise caution with the application of cultural sensitivity theories in nursing practice, with some theories representing culture as static and ineffective in addressing the effect of inequities and other frameworks being too complex to realistically put into practice. Further critiques have been made against the use of cultural competence in healthcare settings due to the reality that cultures are complex and vast; the belief that 'competency' concerning a culture

has been achieved may result in the perpetuation of harmful stereotypes (Wambach & Spencer, 2021). An example of this harm was present in the racializing of Chinese women by the PHNs in McFadden and Erikson's (2020) study, reporting how the PHNs believed they were providing culturally competent care but in reality their knowledge of Chinese culture in relation to breast/chest feeding was based on stereotypes that they imposed broadly upon on the perinatal individuals being cared for. Wambach and Spencer (2021) suggest an alternate view of cultural humility, a concept that requires the recognition of culture being viewed and valued in different ways by individuals and groups. Additionally, enacting cultural humility involves an iterative process of self-reflection of one's own beliefs and values as a health professional and the potential for these beliefs to impact the care they are providing (Wambach & Spencer, 2021). The concern with the specific guidance from PSBC (2015) for care providers to correct any cultural misperceptions of breast/chest feeding is the positionality of the provider as the expert in the client-provider relationship. This statement also privileges biomedical ways of knowing over any other forms of knowledge and over the insights and experiences of perinatal individuals themselves. Rather than simply (if not superficially) referring to potential cultural perceptions that deviate from the Western approach to breast/chest feeding, the concepts of cultural safety and humility should be clearly stated and better explained in the guidelines to further unpack the beliefs present and encourage understanding how these beliefs fit into the breast/chest feeding experience. For example, in the situation of the Chinese parents, rather than making assumptions of the potential feeding choices made by this racialized group, a culturally safe approach would advise for the PHNs to assess the cultural practices of the individual parents and provide support based upon that assessment. Addressing the concepts of context and culture more fully would provide more substantial guidance for PHNs in practice.

Gillis et al. (2013) examined the application of health literacy in care providers' promotion of breast/chest feeding, a concept which is key to adequately delivering health messaging. They revealed that varying

interpretations of health literacy were present, thus health literacy was applied in different ways, with different approaches being used depending on the care provider, rather than a fulsome, consistent application of the concept. The theoretical basis and concepts applicable to health promotion need to be explicitly stated in the guidance provided to care providers to prevent these ambiguous interpretations that lead to inconsistency and a potential perpetuation of stigmatizing or racializing beliefs and practices. The inconsistent messaging from care providers was noted in several Canadian studies exploring breast/chest feeding health promotional messaging with the study participants including both providers and parents (Chabot & Lacombe, 2014; Dosani et al., 2016; Francis et al., 2020; Gillis et al., 2013). The ambiguity and individual beliefs present throughout the continuum of care in breast/chest feeding promotion call for a pragmatic approach to the knowledge used to inform practice guidelines. In the application of relational inquiry, this pragmatism is a process of continual inquiry and self-reflection on the part of the healthcare provider, with the value of knowledge being assessed in relation to the consequences of applying such knowledge (Doane & Varcoe, 2021).

Realities of Unmet Expectations

Canadian studies by scholars such as Dosani and colleagues (2016), Groleau and colleagues (2017), Brockway and colleagues (2020), and Francis and colleagues (2020), which all explore experiences of postpartum individuals, reveal a large discrepancy between expectations of the feeding experience and reality. These scholars note how the postpartum period is marked with vulnerability. Becoming aware of the difficulties associated with their plan to breast/chest feed during the postpartum period is not the most opportune time to learn of these challenges, as is understanding how to best overcome them (Dosani et al., 2016; Groleau et al., 2017). Rather than waiting for this reality to hit shortly after giving birth when the infant needs to be fed breast/chest milk, prenatal individuals should be made aware of the challenges and difficulties they may face and should be encouraged to prepare for such challenges (Dietrich Leurer & Misskey, 2015).

In qualitative studies, lactating individuals have identified feeling as though the prenatal education was too saturated in health benefits with the goal of encouraging the decision to breast/chest feed rather than the education needed to overcome the potential challenges they might face when attempting to follow through with that decision (Groleau et al., 2017; Francis et al., 2020). In a Canadian study conducted by Dietrich Leurer and Misskey (2015), parents who expressed understanding the importance of breast/chest feeding, but ultimately did not meet their infant feeding goals due to challenges that arose, stated feelings of regret, sadness, and guilt. In another study, researchers found some parents were left feeling judged as being incompetent in their parenting skills (Groleau et al., 2017). One study found parents of late-preterm infants expressing frustration and anxiety over feeling unprepared for the challenges of breast/chest feeding (Dosani et al., 2016). Prenatal education regarding infant feeding should also extend past just breast/chest feeding to include individuals that may be unable to breast/chest feed due to contraindications or may choose a different option rather than exclusive breast/chest feeding. Parents must be supported to take on the social and emotional consequences that come with the medical recommendation of bottle-feeding (Greene et al., 2015). Aside from medical reasons, there may be a variety of reasons a family may choose to use formula rather than breast/chest feed. It is also important that all families are supported in their infant feeding journey with relevant, non-judgmental care. Additionally, breast/chest feeding education should not be limited to perinatal individuals but also include the overall population of any people that may interact with perinatal individuals. Building of breast/chest feeding self-efficacy, which relates to a parent's level of confidence in their ability to meet their goals of breast/chest feeding, increase the chances of postpartum individuals persevering through challenges they face (Dennis, 1999). Therefore, increasing self-efficacy should be a goal of health promotion. Breastfeeding self-efficacy (BSE) theory should be incorporated into formal education for PHNs providing breast/chest feeding support and utilized when designing prenatal education

programs. A systematic review and meta-analysis conducted by Brockway and colleagues (2017) found that interventions aimed at improving BSE were linked to higher rates of breast/chest feeding of full-term infants. The 'prenatal care' section of the PSBC (2015) guidelines touches on the need to explore parental and family attitudes and beliefs regarding breast/chest feeding, but does not expand upon the role of the care provider in the prenatal period beyond that of acknowledging and assessing these views.

The Links between Breast/chest Feeding and Shame

The concept of shame has been raised in multiple studies exploring the experiences of perinatal individuals. Whether it was due to seeking professional support for challenges (Groleau et al., 2017), expectations for breast/chest feeding not being met (Dietrich Leurer & Misskey, 2015), or being unable to breast/chest feed for medical reasons (Greene et al., 2015), the parents felt a sense of failure in relation to their parental abilities. Breast/chest feeding has been tied to being a 'good mother' and given the 'breast is best' culture prevalent in Western society, anything short of 'best' may be perceived as a failure of motherhood if the standard of exclusive breast/chest feeding is not met (Dietrich Leurer & Misskey, 2015). Parents who achieved their breast/chest feeding goals found the 'breast is best' messaging encouraging, whereas parents who were unable to meet their goals reported feelings of guilt being induced by this 'breast is best' culture (Brockway et al., 2020; Dietrich Leurer & Misskey, 2015). Taylor and Wallace (2012) argue the shame associated with infant feeding has been in part a result of breast/chest feeding promotional strategies because the ideal image "[...] of motherhood that inflexibly insists that the good mother is a breastfeeding mother, regardless of other social, cultural, economic, or even medical considerations" (p. 200). This argument aligns the biomedical view of breast/chest feeding with the prioritization of the infant needing breast/chest milk over the needs of the parent providing this milk (Taylor & Wallace, 2012). The benefits of breast/chest milk for the overall health of infants and

ultimately the health of populations is well documented (WHO, n.d.), however the means to achieve this health outcome may be resulting in poor emotional and mental health from a perspective of holistic wellbeing. A critical lens calls on the uncovering of contextual factors affecting healthcare, including the language and discourses present (Doane & Varcoe, 2021). The application of a moral imperative for parents to make the right ‘choice’ through the language used by nurses may undermine the role of a parent in caring for their child. Therefore, to decrease the potential of internalizing a failure of exclusive breast/chest feeding as a shortcoming of parenthood, a recommendation of this critique is to praise parents on their attempts of breast/chest feeding their infant regardless of the amount of breast/chest milk provided. This praise should also extend to parents that appropriately provide care to their infant regardless of their infant feeding practice.

Within the PSBC guidelines (2015), providers are encouraged to exhibit a positive attitude towards breast/chest feeding to influence or impact patient perceptions. However, the PSBC guidelines do not address the potential for bias and beliefs held by the providers to impact the way the care is perceived, nor do they address the power differentials present in the patient-provider relationship. The encouragement of providers to portray a positive attitude committed to breast/chest feeding may be perceived as pressuring to the families receiving this care. In one study, there were reports of lactation consultants being overly enthusiastic and prioritizing breast/chest feeding outcomes over the wellbeing of the lactating individuals (Brockway et al., 2020). The emotional and mental wellbeing of parents specifically related to their experience with breast/chest feeding should be considered a routine assessment in breast/chest feeding support, with the understanding that some parents may not enjoy this experience (Dietrich Leurer & Misskey, 2015). Taylor and Wallace (2012) propose the need for a conceptual shift in breast/chest feeding health promotion to counteract the guilt or shame prominent in the culture of ‘breast is best’, suggesting the primary goal of the promotion being to support parents. This shift can be achieved by first collecting data

from perinatal individuals to determine what their needs are and identify any constraints preventing them from achieving their infant feeding goals. Identified constraints can be the focus of evidence-informed interventions, and using appropriate strategies to overcome these hurdles should result in better health outcomes (Taylor & Wallace, 2012). The underlying radical assumption in this approach is the belief that in most cases, parents will choose what they believe is best for their child. This belief underscores the goal of supporting parents as a means of supporting their infants (Taylor & Wallace, 2012). The PSBC (2015) guidelines list as the goals of health promotion to “facilitate optimum and consistent lactation care to women and their infants by all health care professionals” and “increase the number of infants who are exclusively breastfed from birth to hospital discharge and for the first six months of age” (p. 3). We recommend reframing these points to state the support of the overall health of the parent and infant as the primary goal, with increasing rates of breast/chest feeding as a secondary goal. Such prioritization values the holistic wellbeing of perinatal individuals over the production of breast/chest milk.

Conclusion

The goal of this critique was to identify potential gaps in the current guidelines outlined by PSBC (2015) and make recommendations for quality improvement informed by evidence. Using a relational inquiry framework underpinned by critical theory, we have demonstrated areas of the practice guidelines for breast/chest feeding support that fail to adequately meet the health needs of all childbearing persons. Drawing from the first author’s experiences as a PHN delivering health messaging and education based upon the PSBC guidelines and a recent integrative review which examined breast/chest feeding experiences of care providers and breast/chest feeding persons in Canada (Deo et al., in press), we highlighted critical areas of improvement. Upon review of Canadian studies, critiques on the dominant discourse in breast/chest feeding promotion guidelines in Canada ranged from overlooking the SDoH, continued exclusion of populations

that are often left in the margins, and the difficult emotions arising from this health promotion. Including the framing of breast/chest feeding as a 'choice' made by a lactating individual seems oversimplified and lacking the acknowledgement of the larger structures that may be limiting the agency required by perinatal individuals to make such a choice, while also placing judgment on those that do not make the 'right choice.'

The outcomes of health promotion messaging are important to acknowledge. Beliefs of individual care providers affect the care they provide, and misunderstandings of context and cultural safety can lead to groups of individuals receiving a poorer level of care. The 'breast is best' narrative has resulted in unintended feelings of guilt and shame among individuals that do not meet the moral imperative of exclusively providing breast/chest milk to their infants. Parental identity formation is largely influenced by the social, cultural, and political views of breast/chest feeding and the role of a childbearing person. This narrative of 'breast is best' needs to be challenged by nurses from a policy perspective to improve not only the quality of breast/chest feeding health promotion, but also infant feeding education as a whole, especially to those that may lack the social and cultural capital required to make the decision to exclusively breast/chest feed, or those who may experience other reasons that result in an alternative feeding plan to exclusive breast/chest feeding. These contextual forces and their impact need to be explored and assessed by PHNs prior to and as a basis for information of sensible interventions and advice. The SDoH are largely neglected in the ways in which they affect the overall infant feeding experience. There is a need to fully address these determinants through a pragmatic approach, guidance around which should be included in the PSBC guidelines.

The recommendations proposed throughout this critique aim to promote a more just, equitable narrative in the promotion of infant feeding, including understanding the impact on parental identity. The biomedical model and 'breast is best' culture present in Canadian infant feeding practices need to be challenged and reframed through a more holistic

model of care that equally values the expressed experiences of perinatal individuals and the scientific knowledge currently forming the evidence base for current guidelines and policies. The evidence informing the 2015 practice guidelines are primarily quantitative in nature and lack discussion of the unique experiences of perinatal individuals across the spectrum of socio-cultural backgrounds present in Canada. There is opportunity for improvement by enhancing the level of depth to be applied to guidance around the social, cultural, and political aspects of infant feeding. The PSBC (2015) guidelines touch on the topics of social and cultural aspects that may be related to the breast/chest feeding experience, but there is no mention of how the SdoH may impact breast/chest feeding outcomes. Of the 52-page document, the PSBC (2015) guidelines contain a few sentences that point towards a critical understanding of breast/chest feeding, but these mere statements do not provide enough guidance for care providers when applying theory to practice. The PSBC (2015) guidelines cited in this critique provide one example of practice guidance. However, it is important to note that a larger macro-level shift is required for health promotional initiatives to appropriately address all the concerns raised within this critique. There are specific interventions that can be undertaken from policymakers, such as utilizing an equity-orientated lens, in addition to using inclusive language to improve quality of care at the practice level.

Addressing these challenges based on the recent evidence and use of relational inquiry will require a collective effort through several avenues, with the quality improvement of promotional guidelines being one of these paths. As such, recommendations have been made for improvement in the health promotion guidelines used in BC, however these recommendations are transferrable to other guidelines that follow the same biomedical principles of infant feeding in Canada. Future research and policy development need to incorporate the unique range of experiences with breast/chest feeding promotion, specifically focusing on individuals with diverse socio-cultural backgrounds.

Note: The authors declare no conflict of interest. No funding was received for this manuscript. Ethics approval was not required for this policy critique.

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