

Open Research Online

The Open University's repository of research publications and other research outputs

Is breast best?: breastfeeding, motherhood and identity

Book Section

How to cite:

Earle, Sarah (2003). Is breast best?: breastfeeding, motherhood and identity. In: Earle, Sarah and Letherby, Gayle eds. Gender, identity and reproduction: social perspectives. London: Palgrave, pp. 135–150.

For guidance on citations see [FAQs](#).

© [\[not recorded\]](#)

Version: [\[not recorded\]](#)

Link(s) to article on publisher's website:

<http://www.palgrave.com/products/Catalogue.aspx?is=140390281X>

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's [data policy](#) on reuse of materials please consult the policies page.

oro.open.ac.uk

SECTION II

CHAPTER 8

Is Breast Best? Breastfeeding, motherhood and identity

Sarah Earle

Introduction

Breasts and breastfeeding have long since been the locus of political struggles concerning femininity, motherhood and childrearing, yet although breastfeeding is a contemporary personal and political issue, the battle between breastfeeding and other forms of infant feeding is not new. For example, between the 18th and early 20th Centuries, wet-nursing was common in Britain, France, the Southern States of America and the British Colonies (Carter 1995) and as Evans (1995:vii) writes: ‘Once upon a time all babies in Western societies were breastfed [but] they were not, necessarily fed by their mothers’. Although wet-nursing is no longer commonplace within these societies, breastmilk now competes with the mass manufacture, marketing and distribution of formula milk.

Many people will agree that ‘breast is best’. However, many women only breastfeed for a very short time, and some do not breastfeed at all. This could be interpreted in one of two ways.

It could be argued that women who breastfeed are empowering themselves by doing what comes ‘naturally’ and taking advantage of the various benefits afforded by

breastfeeding (these will be discussed in more detail below). It could also be argued that women who formula feed are being duped by the manufacturers of baby milks who place commercial interests above those of women and babies. On the other hand, it could be argued that women who formula feed are positively rejecting the view that babies are the sole responsibility of women and they are making a positive choice about how to feed their babies in the context of their own lives and relationships.

In this chapter, the advantages of breastfeeding in both developing and developed societies will be explored and the considerable socio-economic and cultural variations in breastfeeding rates will be examined. Within the context of this, I will draw on a qualitative study of the body in pregnancy, childbirth and early motherhood in the UK to explore the perceptions and experiences of women who do or do not breastfeed and to consider the question: is breast best?

Is breast best? The advantages of breastfeeding

There can be no doubt that breastfeeding is advantageous for women and babies. In 2001, the World Health Organisation carried out the most extensive and systematic review of the literature on infant feeding to date, and concluded that, with rare exceptions, exclusive¹ breastfeeding is recommended for 'about six months' (WHO 2001). The advantages of breastfeeding are also widely documented elsewhere and there is substantial evidence to suggest that breastfeeding has significant biopsychosocial benefits for women, babies, and society as a whole.

In the developing world, the rate of breastfeeding is strongly correlated to both infant mortality and infant morbidity; that is, countries with higher rates of breastfeeding tend to have lower rates of sickness and death in infants (Booth 2001). This point has been made repeatedly by organisations campaigning against the marketing of formula milk in developing countries where the means to safely prepare formula milk are not available – for example, the longstanding campaign led to boycott Nestlé products. Research has also identified the disadvantages of formula milk even in developed countries (Walker 1993; Gerstein 1994) leading many health organisations, such as the United Nations Children’s Fund (UNICEF), to stress that breastmilk is both superior to, and not equivalent to, formula milk.

In the developed world, breastfeeding is thought to protect babies from various forms of ill health. There is evidence, for example, that breastfeeding may offer protection from sudden infant death syndrome (Golding 1993), juvenile onset diabetes (Park 1992), and even eczema (Lawrence 1995). There is also some evidence suggesting that babies who are breastfed may be at a reduced risk of both viral and bacterial gastrointestinal, respiratory and urinary infections (Howie *et al.* 1990) and that breastfeeding may enhance neurodevelopment in infants (Crawford 1993).

Women who breastfeed may be protecting themselves from various diseases, in particular, premenopausal breast cancers (Newcomb 1994) and certain types of ovarian cancer (Rosenblatt 1993) and it is thought that breastfeeding may also protect against reduced bone density in later life (Cumming & Klineberg 1993). Some researchers have also suggested that breastfeeding has psychosocial advantages, for example, it can increase self-confidence and encourage ‘bonding’

(Lawrence 1995). Arguably, breastfeeding is also free and convenient and, therefore, cost-effective for women, families and society and is, for some women, an enjoyable, sensual and empowering experience (Kitzinger 1979; Rodriguez-Frazier and Frazier 1995).

The prevalence of breastfeeding: an international perspective

It has traditionally been difficult to build a global picture of breastfeeding trends because different countries have applied various definitions and measurements when collating breastfeeding statistics. However, the WHO maintains the Global Data Bank on Breastfeeding which collates data on 94 countries, using internationally accepted definitions and indicators to enable comparisons between countries over time. Globally, breastfeeding rates are lowest in countries within the African Region – for example, Nigeria has the lowest rate of exclusive breastfeeding - at only 2 per cent (WHO 2000). Some of the highest rates of exclusive breastfeeding can be found in the Americas, for example: Colombia has a rate of 95 per cent and Ecuador, 96 per cent (WHO 2000).

An analysis of breastfeeding rates in 30 European Member States shows that in spite of the widely acknowledged biopsychosocial advantages of breastfeeding in industrialised countries, rates of breastfeeding in the UK are the lowest in Europe and, indeed, one of the lowest in the developed world (WHO 1999). In Sweden, the rate of babies ever breast-fed is 98 per cent, the rate at four months is 90 per cent and at 6 months, the rate drops to 64 per cent (WHO 1999). In the UK, the rates are 66 per cent and 27 per cent respectively, dropping to 14 per cent at 6 months (Foster, Lader & Cheesbrough 1997). The UK also has lower breastfeeding rates than Canada

and the United States. For example, in the U.S., breastfeeding rates at 6 months are twice those in the UK (U.S. Department of Health & Human Services 2000).

In 1990, the *Innocenti Declaration on the Protection, Promotion, and Support of Breastfeeding* was adopted by the WHO and UNICEF in recognition of the importance of promoting breastfeeding. Building on this, in 1992, WHO and UNICEF launched the Baby Friendly Hospital Initiative as a strategy for further promoting breastfeeding. The foundations for this initiative are the *Ten Steps to Successful Breastfeeding* (see Figure 1).

INSERT FIGURE 1

In the UK, the Office for National Statistics performs its Infant Feeding Survey every five years. The most recent Survey was carried out in 2000 and early indications suggest that there has been a statistically significant increase in the incidence of breastfeeding. For example, in 1995, the initial incidence of breastfeeding in the UK was 66 per cent, whereas in 2000, this rose to 69 per cent (DoH 2001). Recent research also suggests that rates of breastfeeding have begun to increase in other countries that have adopted the Baby Friendly Hospital Initiative, particularly in Australia, Canada, China and USA (WHO 2000).

Social variations in breastfeeding rates

Although increases in breastfeeding rates are encouraging, there are still considerable socio-economic and cultural variations both in the UK, and elsewhere. In the UK, the results of the most recent Infant Feeding Survey (DoH 2001) confirm the

associations seen previously between breastfeeding and the age, educational level and social class of the mother. For example, older women are more likely to breastfeed than younger women and women who remain in education beyond the age of 18 are the most likely to breastfeed, whereas those who leave full-time education at age 16 years are the least likely. Social class is also strongly associated to breastfeeding, with women in Social Classes I and II having the highest breastfeeding rates overall (see Figure 2).

INSERT FIGURE 2

There are also significant national variations in breastfeeding rates within the UK. England and Wales have the highest initial incidence of breastfeeding (70 per cent), followed by Scotland (63 per cent) and then Northern Ireland, which has the lowest rate (54 per cent) (DoH 2001). The Infant Feeding Survey conducted in 1995 (Foster, Lader & Cheesbrough 1997) also revealed considerable geographical variations. For example, breastfeeding rates in different postcode zones in Glasgow varied between 9 per cent and 75 per cent. In the US, there are considerable ethnic variations. For example, the rate of White women who breastfeed their babies in the early postnatal period is 68 per cent, whereas the rate of Black or African American women who do so is only 45 per cent (U.S. Department of Health & Human Services 2000).

Breastfeeding, motherhood and identity: a study of infant feeding in the UK

Whilst national surveys and international comparisons of infant feeding can give us a good overall picture of breastfeeding trends, they do not really tell us what motivates women to breastfeed, nor do they tell us why some women decide that breastfeeding

is not for them. A more qualitative approach to research can, however, allow us to explore these issues in more depth, as Raphael (2000:355) points out:

The increasing popularity of qualitative methods is a result of a perceived failure of traditional methods to provide insights into the determinants – both structural and personal – of whether people pursue or do not pursue health-promoting actions.

The rest of this chapter draws on a qualitative study of women's experiences of the body in pregnancy, childbirth and early motherhood in the UK, focusing specifically on data exploring women's perceptions and experiences of infant feeding. The first section explores the issue of researching women's experiences of infant feeding and the remainder of this chapter considers the various factors that influence women's decision to breastfeed or not.

Researching women's experiences of infant feeding

The data discussed below formed part of a larger research study conducted between 1994 and 1998. 19 women, who were pregnant for the first time, were recruited to a study group via 12 antenatal clinics in the West Midlands. The ages of women in the study group ranged from 16 to 30 years; two participants were below the age of twenty, but the majority were aged between twenty and twenty-nine. Similarly, there was a broad range of women in relation to occupation, including those women who were in both professional, non-manual and manual employment, women who were unemployed and those not seeking work. Except for one participant who described herself as 'Asian', all participants described themselves as 'White'.

A series of in-depth interviews were conducted with each participant at specific stages of the pregnancy and following childbirth. The 1st stage interviews were conducted as soon as possible after the confirmation of pregnancy (between six and fourteen weeks), the 2nd stage interviews were conducted towards the end of the pregnancy (between 34 and 39 weeks) and the 3rd stage between six and fourteen weeks after childbirth. In-depth unstructured interviews were used to generate 'rich' descriptions of women's experiences, allowing each participant to establish her own agenda for discussion, within broadly defined research themes. This method also ensured that the data was reflexively generated and grounded in women's own personal experiences (Jones 1993). Initially, open questions were used to pursue research themes, which were then followed up using the participants' own words and phrases as a means of generating further data.

All interviews were conducted in the participants' homes and the interviews were audio tape-recorded with the consent of each individual and then transcribed *ad verbatim*; the interviews ranged in length from 30 minutes to two and a half hours. The interview data were analysed using a 'grounded theory' style, which involved sorting the data into analytical categories by 'breaking down, examining, comparing, conceptualising and categorising data' (Strauss and Corbin 1990:61). These categories of data were then compared and contrasted to generate themes; some of these themes form the basis for the analysis and discussion below.

Lay and medical discourses on infant feeding

Some writers would argue that it is, in practice, very difficult to distinguish between lay and medical discourses of health and ill-health because lay concepts can be

influenced, and are in part determined, by medical discourse (Blaxter 1990) and this is certainly true in relation to discourses of breastfeeding. Although the UK has the lowest rate of breastfeeding in Europe, the data from this study indicate that health promotion campaigns have been extremely successful in educating women about the benefits of breastfeeding. Some of the women in the study group strongly echoed health promotion messages, for example:

The emphasis is always on breastfeeding ... yes, breast is best!

[Kelly, age 23, laboratory assistant, formula feeding]

Other participants were able to construct fairly accurate accounts of why they considered breastfeeding to be better than formula feeding, reflecting the generally accepted biomedical view on the advantages of breastfeeding:

The only thing that is really making me think is should I be breastfeeding is this immune system.

[Linda, age 28, financial administrator, formula feeding]

It is more natural to breastfeed ... I know it is better, and the antibodies and everything else.

[Alison, age 21, unemployed, formula feeding]

I just felt that it was better to breastfeed for the first few months or as long as you can. Because I have read it before, it prevents infections and things like that.

[Pam, age 30, factory assembler, breastfeeding]

Other participants were more likely to emphasise the psychosocial benefits of breastfeeding, putting emphasis on the importance of emotional fulfilment and bonding. For example,

When I did try [breastfeeding] I thought it was absolutely wonderful, for the first three days, I think it creates a bond, a really special bond.

[Gayle, age 27, legal executive, breastfeeding]

I don't know what it will be like. I would imagine at times it is going to be painful, but I would hope quite fulfilling, I hope very natural.

[Jill, age 28, police officer, breastfeeding]

The data indicate that, regardless of whether they breastfed or not, the women in the study group were aware of the various advantages of breastfeeding. Previous research in this area supports these findings – for example, in her study of infant feeding, Murphy (1999) argues that women who formula feed are very unlikely to

claim that formula feeding is the 'best' method and will frequently acknowledge that 'breast is best'. So, although some of the research participants agreed that 'breast is best', they did not always believe that it was best for them.

Breastfeeding, breasts and femininity

Unlike other parts of the world, in contemporary Western societies such as the UK, it is now extremely uncommon for women to have visual experiences of breastfeeding until they, themselves, become mothers, and it has been argued that that this influences both the likelihood of initiation and the duration of breastfeeding (Dykes and Griffiths 1998). Only one participant in the study group had experience of seeing a baby breastfed:

My mum breastfed all of us, I was twelve when my little brother was born, so I actually had some experience of seeing a baby and it being breastfed.

[Hannah, age 24, not seeking work, breastfeeding]

This was extremely atypical and it was more common for women, both breast and formula feeders, to have little, or no, experience of seeing a baby being breastfed and to express ambivalence about breastfeeding. For example, some participants talked about breastfeeding as something that could be regarded as 'embarrassing' or 'disgusting':

I wanted to [breastfeed] but wasn't sure if I felt comfortable about it ... with my family it's something we got embarrassed about ... but as I have changed during the pregnancy I suppose, relaxed more and things like that. I have always wanted to do the right thing for the baby, it was a struggle with my own emotions. But I have decided and I haven't looked back.

[Jill, age 28, police officer, breastfeeding]

I thought it sounded like the most disgusting thing in the world, the thought of it. I didn't like the thought of it. The funny thing now I think of it as the most natural thing in the world, but before not having children, not trying it before, I was just horrified at the thought of it.

[Gayle, age 27, legal executive, breastfeeding]

The actual action of doing it wouldn't bother me at all. I would feel embarrassed in front of his family, I would. Say I was in the middle of town and you get these mothers that ... breastfeed them.

[Alison, age 21, unemployed, formula feeding]

Others highlighted the dichotomy between the private and the public where breasts were perceived, by them and by society, as something that should not be publicly exposed:

I wouldn't do it in public, I just couldn't get my body out anywhere, for anybody. It is more private, isn't it?

[Rebecca, age 23, assistant buyer, formula feeding]

I just didn't fancy the idea of breastfeeding, the inconvenience of it really ... I just couldn't breastfeed in front of anybody, no way, some people can, but I don't think I could. It was that, that made my mind up.

[Linda, age 28, financial administrator, formula feeding]

Well I couldn't do it in public like some people, you know some people don't have a problem . . . I'd just feel uncomfortable I think. It's the way society looks at it as well, the way people see things like that. They'd think it was wrong, I think. A lot of people think you should do that sort of thing in private.

[Kelly, age 24, laboratory assistant, formula feeding]

However, within the popular press, in glossy magazines, on television and on billboards, breasts are everywhere. Breasts, Carter (1995) argues, are highly symbolic both to feelings of femininity and to the social processes which construct femininity within modern, industrial Western societies. Women's ambivalence towards breastfeeding reflects the tension between what breasts are for, and what

they represent: an organic source of food for babies or a potent symbol of sexuality within society. One participant highlights this particular tension:

I suppose it is a case of that they [breasts] are there for him [the baby], I am not in the least bit shy of breastfeeding him in a restaurant or anything like that. Before I would have been extremely shy about bearing my breasts on a beach or anything like that, because I would feel uncomfortable about it.

[Hannah, age 24, not seeking work, breastfeeding]

Infant feeding and men's role

Previous research has highlighted the significance of men's role within infant feeding decisions, emphasising, in particular, that women are unlikely to breastfeed if they do not have the support of their partner (Freed and Fraley 1993; Earle 2000; 2002). However, the data from this study suggest that men's role is more integral than this. There is an increasing expectation that fathers-to-be will be involved in the preparation for parenthood (Draper 1997), and that fathers will participate fully in childcare (for example, see Freeman, this volume). Contemporary parenting manuals depict an image of conjugality, which although may be little more than rhetoric, establishes an ideal model for paternal participation (Murphy 1999). These images of partnership and sharing were represented in some of the comments women made about infant feeding. Formula feeding was perceived as an opportunity for allowing men equal access to, and participation in, early childcare. For example:

I think really it's nice to be able to share that responsibility with your partner.

[Laura, age 24, insurance clerk, formula feeding]

I haven't discussed it with my midwife. That is just one of the things, at least Luke will be able to help. I think that it's nice for him to get involved, to share everything, to see Billy grow up.

[Alison, age 21, unemployed, formula feeding]

Other participants were more likely to regard formula feeding as an escape from the daily grind of early motherhood, allowing both parents (and others) to share the load of early parenthood. For these women, breastfeeding was perceived as an avoidable 'tie' to the baby, as articulated below:

You can share the feeds easier and things like that. Share the load.

[Kelly, age 23, laboratory assistant, formula feeding]

Well, it will not only be me having to get up in the middle of the night.

[Rebecca, age 23, assistant buyer, formula feeding]

I think it is important for my husband to be able to feed him ... I don't think I could stand being tied down every single feed. At least my husband can feed him at weekends and nights. We both seem very tired and I just can't imagine having to feed him every time.

[Linda, age 28, financial administrator, formula feeding]

Although participants were, therefore, prepared to accept that breastfeeding was the 'best' method of infant feeding, this did not always fit into their expectations of early motherhood. Some participants wanted the baby's father to share in the experience of early parenthood whereas others were simply not prepared to shoulder the burden of caring for a new baby by themselves.

Women, breasts and self-identity

Motherhood, and the process of becoming a mother, is often depicted as a joyous and fulfilling experience to which all women should aspire. However, for many women, becoming a mother is associated with a loss of status, freedom and self-identity (Oakley 1979). Since breast is considered best, breastfeeding is often associated with being a 'good' mother. Indeed, previous research suggests that formula feeding is stigmatised and women who choose not to breastfeed can be perceived as deviant (Carter 1995; Murphy 1999). The women in the study group were well aware of the association between formula feeding and maternal deviance, as highlighted by the following formula feeding participants:

I think there is a bit of a stigma attached to it [formula feeding]. I think it is your conscience. I think as well with formula feeding you are left to it. I don't think they gave it to breastfeeders, they give you a sheet and you have to fill it in how much feed they have, and the midwives come round and have a look at it. But with the breastfed babies, the midwives were there, telling them how to do it, I suppose it is because you are left alone, you sort of think 'Oh I am one of the naughty ones', so they let you get on with it.

[Linda, age 28, financial administrator, formula feeding]

All the leaflets I have had as well, say it is best for baby, and you're a horrible mother if you didn't do it. That is how it feels...

[Alison, age 21, unemployed, formula feeding]

Some of the breastfeeding participants also expressed feelings of stigma and guilt, particularly when they had not managed to breastfeed for as long as they had expected to. For example:

I wasn't really happy with it because I think no matter what people say you do feel a bit guilty if you can't do everything you plan. I hadn't anticipated having a caesarean I thought everything was going to be OK. You have all these plans of what you are going to do and I saw breastfeeding as being a good thing and something I wanted to do, and I felt a bit of a failure that I didn't feel up to doing it all of the time.

[Gayle, age 27, legal executive, breastfeeding]

I always said I would breastfeed for twelve weeks and that would be it, but up until the last few days I really didn't want to formula feed, I couldn't stand him near me when we started to formula feed at first, I thought I was totally failing him by giving him a bottle. I never dreamt I would feel like that. I am not anti-formula feeding at all, I think it is your choice and you do what you want to do.

[Trudy, age 29, university lecturer, breastfeeding]

However, in spite of the very strong health promotion messages promoting breastfeeding and the feelings of stigma, guilt and failure associated with formula feeding, some of the women in the study group chose not to breastfeed. For these women, breastfeeding was often associated with a (further) loss of self-identity and many of the formula feeding participants expressed a powerful desire to re-establish their lives outside of the context of pregnancy and motherhood:

I don't know why, breastfeeding isn't something that I had ever thought about, given the choice, and seeing how much he drinks I am glad I decided to formula feed him . . . it was not something that I would like to give a go, just, no, I am not doing it . . . the thought of having somebody hanging off you when you are in that much pain anyway. I thought no, forget it. You have suffered enough, I am not going through that as well.

[Judith, age 23, civil servant, formula feeding]

I have thought about it a lot . . . I always get the impression that they're permanently latched there. I want to get out and about and do other things.

[Charmaine, age 23, administrative assistant, formula feeding]

About eighteen months ago my sister-in-law had a baby and she seemed to be feeding all the time. She was always up in the bedroom feeding, to me it was as if she lost her identity, She was this baby's feeding machine.

[Linda, age 28, financial administrator, formula feeding]

Is breast best?

The advantages of breastfeeding are generally undisputed, yet many women choose not to breastfeed their babies. The UK has one of the lowest rates of breastfeeding in the developed world, although 92 per cent of women in Social Class I will breastfeed

in the early postnatal period (DoH 2001), a figure rivalling those of countries with the highest rates of breastfeeding worldwide. Survey data highlight strong socio-economic and cultural variations in rates of breastfeeding in the UK, and in other countries, yet the data presented here illustrate few differences between the experiences and perceptions of breastfeeding and formula feeding women and, certainly, no evidence of a clear-cut dichotomy between women who breastfeed and women who do not.

Health educators have been successful in promoting the view that 'breast is best'. However, it would appear that this success has been at the expense of demonising formula milk and the women who choose to feed it to their babies. Whilst women are encouraged to think of breastfeeding as a free 'fast-food' for babies the reality is that, for some women, breastfeeding can sometimes be difficult, painful, boring and inconvenient, and as Oakley (1979:177) argued over 20 years ago, 'the pain and the difficulty that many women experience with breastfeeding at first conflicts with the rosy romantic image of the "nursing couple"'. It could also be said that breastfeeding carries hidden unrecognised costs, such as the need to buy nipple pads and nursing bras, often not acknowledged by health promoters. It also determines, to some extent, what women can wear, where they go and for how long. It must be recognised that biomedical 'truths' must be deconstructed and that breastfeeding has become fashionable in many societies where women's experiences of reproduction are increasingly medicalised. As Carter (1995:234) has argued:

...although 'choice' of breast or bottle offers women a way of managing their lives, it does not tackle the mechanisms of control and the lack of

resources which limit, rather than expand, women's choices in relation to how they care for their children, and how they use their bodies.

Concurring with Carter, there is no doubt that we live in a society which has sexualised breasts, turning them (and women) into objects of (male) sexual desire and commodification. It is also true that we live in a society in which women have little, or no, visual experience of breastfeeding and where it is hard to find a space to breastfeed, should we choose to do so. When I carried out the research on which this chapter is based, I had no personal experience of breastfeeding. I have, subsequently, given birth to a child and breastfed him. It was a fulfilling experience, but sometimes a boring one. It was a pleasant experience, but often uncomfortable. Sometimes it was inconvenient but, so too, was formula feeding. Throughout my experiences, both personal and in relation to my research, writing and teaching, I have been overwhelmed by the emotional zeal with which health promoters, often midwives, approach the topic of breastfeeding, and the subsequent guilt felt by the women who cannot, or choose not to, breastfeed their babies. So, albeit with some reservations, I argue that just as women who breastfeed are empowering themselves, so too, are the women who embrace formula milk in their positive rejection of the view that babies are the sole responsibility of women.

¹ 'Exclusive' breastfeeding is defined by the WHO, and other international organisations, as no other food or drink, not even water, or formula milk, to be given for at least 4 and if possible 6 months of life, but allows the infant to receive vitamins, minerals and medicines as required.

References

- M. Blaxter, *Health and Lifestyles* (London: Routledge, 1990).
- I. Booth, 'Does the duration of breastfeeding matter?' *British Medical Journal*, 322 (2001) 625-626.
- P. Carter, *Feminism, Breasts and Breastfeeding* (London: Macmillan, 1995).
- M. A. Crawford, 'The rôle of essential fatty acids in neurodevelopment: Implications for perinatal nutrition', *American Journal of Clinical Nutrition*, 57 (1993) 7035-7105.
- R. G. Cumming and R. J. Klineberg, 'Breastfeeding and other reproductive factors and the risk of hip fractures in elderly women', *International Journal of Epidemiology*, 22 (1993) 684-691.
- Department of Health, *Infant Feeding Survey 2000: statistical press release* (London: HMSO, 2001) <http://www.doh.gov.uk/public/infantfeedingaug01.pdf>.
- J. Draper, 'Whose welfare in the labour room? A discussion of the increasing trend of fathers' birth attendance', *Midwifery*, 13 (1997) 132-138.
- F. Dykes and H. Griffiths, 'Societal influences upon initiation and continuation of breastfeeding', *British Journal of Midwifery*, 6:2 (1998) 76 - 80.
- S. Earle, 'Why some women do not breastfeed: formula feeding and fathers' role', *Midwifery*, 16 (2000) 323-330.
- S. Earle, 'Factors Affecting the Initiation of Breastfeeding: Implications for breastfeeding promotion', *Health Promotion International*, 17:3 (2002) 206-214.
- M. Evans, 'Foreward'. In: P. Carter, *Feminism, Breasts and Breastfeeding* (London: Macmillan, 1995).
- F. Foster, D. Lader and S. Cheesbrough, *Infant Feeding Survey 1995* (London: HMSO, 1997).

- G. L. Freed and J. K. Fraley, 'Effect of expectant mothers' feeding plan on prediction of fathers' attitudes regarding breast-feeding', *American Journal of Perinatology*, 10:4 (1993) 300-303.
- H. C. Gerstein, 'Cow's milk exposure type I diabetes mellitus. A critical overview of the clinical literature', *Diabetes Care*, 17 (1994) 13-19.
- J. Golding, *Breastfeeding and sudden infant death syndrome: Report of the Chief Medical Officer's Expert Group on the Sleeping Position of Infants and Cot Death* (London: HMSO, 1993).
- P. W., Howie, J. S. Forsyth and S. A. Ogston, et al., 'Protective effect of breastfeeding against infection', *British Medical Journal*, 300 (1990) 11-16.
- K. B. Jones, *Compassionate Authority: Democracy and the Representation of Women* (London: Routledge, 1993).
- S. Kitzinger, *The Experience of Breastfeeding* (London: Penguin, 1979).
- R. Lawrence, 'The clinician's rôle in teaching proper infant feeding techniques', *The Journal of Paediatrics*, 126:suppl (1995) 112-117.
- M. Murphy, "'Breast is best": Infant feeding decisions and maternal deviance', *Sociology of Health and Illness*, 21:2 (1999) 187-208.
- P. A., Newcomb, B. E. Storer and M. P. Longnecker, et al., 'Lactation and a reduced risk of premenopausal breast cancer', *The New England Journal of Medicine*, 330 (1994) 81-87.
- A. Oakley, *From Here to Maternity: Becoming a Mother* (Oxford: Martin Robertson, 1979).
- G. Palmer, *The Politics of Breastfeeding* (London: Pandora, 1988).
- P. Park, 'Cows' milk linked to juvenile diabetes', *New Scientist*, 22 August (1992) 1835-1839.

- D. Raphael, 'The question of evidence in health promotion', *Health Promotion International*, 15:4 (2000) 355-367.
- R. Rodriguez-Frazier and L. Frazier, 'Cultural Paradoxes Relating to Sexuality and Breastfeeding', *Journal of Human Lactation*, 11:2 (1995) 111-115.
- K. A. Rosenblatt, 'Lactation and the risk of epithelial ovarian cancer', *International Journal of Epidemiology*, 22 (1993) 192-197.
- A. Strauss and J. Corbin, *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* (London: Sage, 1990).
- U.S. Department of Health & Human Services, *HHS Blueprint for Action on Breastfeeding*. (Washington, D. C.: U.S. Department of Health & Human Services, Office on Women's Health, 2000).
- M. Walker, 'A fresh look at the risks of artificial infant feeding', *Journal of Human Lactation*, 9:2 (1993) 97-107.
- World Health Organisation, *A Comparative Analysis of the Implementation of the Innocenti Declaration in WHO European Member States: Monitoring Innocenti targets on the protection, promotion and support of breastfeeding* (Geneva: WHO, 1999) <http://www.who.dk/document/e63687.pdf>. [last accessed 17 January 2002].
- World Health Organisation, *Global Data Bank on Breastfeeding* (Geneva: WHO, 2000) http://www.who.int/nut/db_bfd.htm [last accessed 16 January 2002].
- World Health Organisation, *The Optimal Duration of Exclusive Breastfeeding: Results of a WHO systematic review* (Geneva: WHO, 2001) <http://www.who.int/inf-pr-2001/en/note2001-07.html> [accessed 11 January 2002].

Chapter 8

Is breast best? Breastfeeding, motherhood and identity

Sarah Earle

Figure 1 Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their babies.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practise rooming-in, allowing mothers and infants to remain together for 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

Figure 2 Incidence of breastfeeding by social class¹

Social Class	%
I	92
II	83
III Non-manual	79
<i>All Non-manual</i>	83
III Manual	65
IV	60
V	59
<i>All Manual</i>	63
All babies	69

Source: adapted from DoH (2001).

¹ based on current or last occupation of husband/partner.