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Power to negotiate spatial barriers to breastfeeding in a western context: When motherhood meets poverty

Danielle Groleau [a,b,*], Catherine Sigouin [b], Nicole Anne D'souza [a,b]

[a] Division of Social and Transcultural Psychiatry, McGill University, Montreal, Canada
[b] Culture and Mental Health Research Unit, Jewish General Hospital, Montreal, Canada

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ABSTRACT

Although breastfeeding is beneficial to the health of babies born into poverty, rates have remained consistently low among this group. This paper presents findings from a study conducted with poor French Canadian women, who were exposed to breastfeeding promotion. Analysis of 31 qualitative interviews suggests that the 'good mother' imperative in context of poverty and the western hypersexualization of breasts acted as major deterrents to breastfeeding. Poor mothers, lacked access to the power required to negotiate these barriers in their social space. Public health should prioritize the transformation of social and public spaces when promoting breastfeeding to poor mothers.

Numerous studies have shown that breastfeeding provides optimal health benefits for newborns and mothers (Kramer and Kakuma, 2002). The World Health Organization, recognizing breast milk for its nutritional advantage and immunological properties, has been vocal in its advocacy of this infant feeding option, releasing pro-breastfeeding statements in the 1980s and 1990s (WHO, 1981; WHO/UNICEF, 1989, 1990, 1992). This culminated in their *Global Strategy for Young and Infant Feeding* (WHO, 2003), a resolution recommending exclusive breastfeeding for the first 6 months of life, and further breastfeeding up to a minimum of 2 years of age. These efforts to encourage breastfeeding appear to be working as overall breastfeeding rates, since the 1970s, have been increasing in the United States (Wright, 2001), Canada (Millar and MacLean, 2005), and Europe (Yngve and Sjostrom, 2001).

Despite these promising trends, breastfeeding rates have remained consistently low among low-income women of Western countries, even if these women have been exposed to breastfeeding promotion activities (Callen and Pinelli, 2004). This trend is seen in the Canadian province of Québec, the location of this study, where overall breastfeeding initiation and duration rates have remained low among women living in poverty despite a dramatic rise in overall provincial rates in the initiation of breastfeeding from 45% in 1995 (Levill et al., 1995) to 85% in 2006 (Neill, 2006). This is a particularly pressing problem for Western countries in general, because children born into poverty have been shown to have limited access to a nutritional diet and are known to be more vulnerable to diseases (Baker et al., 1998). Thus, children born into poverty constitute, by far, the social group that benefits most from being breastfed (Giugliani et al., 1996). Nevertheless, the reasons why low-income mothers in Western countries tend to reject breastfeeding are not completely clear, but it is likely that structural and economic factors contribute to the problem. In the USA, for example, low-income mothers are eligible to receive free infant formula through the Special Supplemental Nutrition Program of Women, Infants, and Children (WIC) and need not rely on exclusive breastfeeding (Ryan et al., 2002). Low-income women are also less likely to have the flexible work schedules and maternity leave that allow breastfeeding a child (Heinig et al., 2006).

Many studies have also indicated that along with these structural and economic deterrents, a correlation exists between low breastfeeding rates in mothers and their low levels of education (Celi et al., 2005; Mitra et al., 2004). For example, a study in California found that the education level of both parents was more important in predicting breastfeeding compared to parental income and occupational status (Heck et al., 2006). As shown in Fig. 1, compared to the general population in Québec, exclusive breastfeeding rates have remained low among mothers with low income (< $20,000.00) and even lower among those with low level of education (< 11 years) (Neill, 2006).

Studies among disadvantaged Western-born women consistently show the rejection of breastfeeding in relation to young age,

* Corresponding author. Tel.: +1 514 340 8222x3989; fax: +1 514 340 7503.
E-mail address: danielle.groleau@mcgill.ca (D. Groleau).

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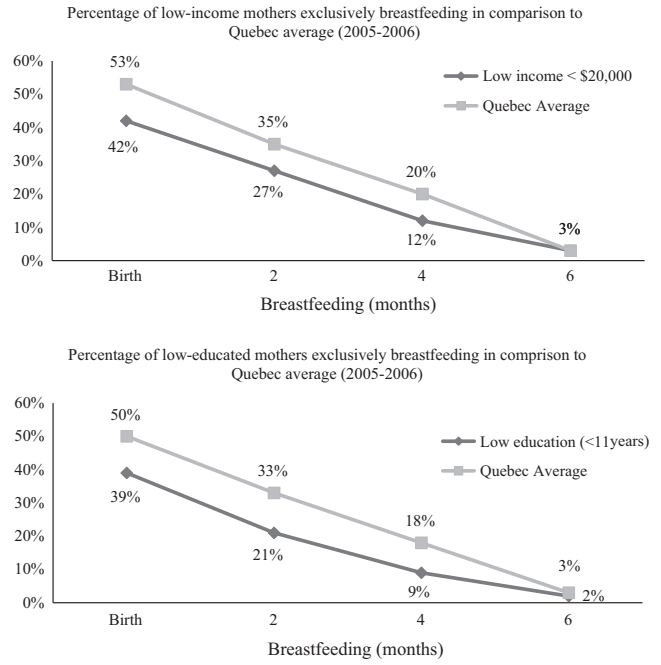

Source: Neill (2006)

Fig. 1. Exclusive breastfeeding rates in Québec according to income and education (2005–2006).
Source: Neill (2006).

low income, and low education. Few studies, however, have attempted to understand the meaning behind these factors and the corresponding social processes taking place. There is a need to understand this complex phenomenon so that health policy and public health programs may better respond to the needs and worldviews of poorly educated, low-income women of Western countries. Therefore, the goal of our study was to better understand the subjective experiences and meaning linked to the rejection of breastfeeding among Québec-born women living in context of poverty.

1. Background

Breastfeeding is a health behavior that can significantly contribute to reducing health disparities known to affect children born into poverty. Understanding why poor Western-born mothers tend to reject such a beneficial health behavior even if exposed to promotion activities requires the need to address how this infant-feeding choice also reflects a social context that structures the production of a health inequality. Since breastfeeding has been known to vary through space, time, ethnicity and economic level (Shaw, 2004; Groleau et al., 2006) there is a need to better understand the complexities underlying this social practice in a way that adequately addresses the relationship between agency and structure as well as the role played by lay knowledge (Popay et al., 2008). While post-structural theorist have been criticized for having produced relatively little critical discussion regarding breastfeeding (Adkins and Skeggs, 2004; Dykes, 2006), there has been recent claims that using concepts developed by Pierre Bourdieu can enhance our understanding and interpretation of breastfeeding (Amir, 2011; Groleau and Rodriguez, 2009; Groleau and Sibeko, 2012; Shaw, 2004). Bourdieu indeed argues that "food and eating is much more than a process of bodily nourishment: it is an elaborate performance of gender, social class and identity" (Bourdieu, 1984). Since Bourdieu's approach to examining social structure has been productively applied to research on health inequalities in other areas of marginality (Gatrell et al., 2004; Veenstra, 2007), we chose to build from his critical theory of *social space* (1984, 1985, 1989) to examine, in a novel way, the full complexity of the social mechanisms underlying the rejection of breastfeeding.

The social world according to Bourdieu's offers several dimensions where agents or groups of agents are defined by their relative position and access to power. Within this perspective, *social space* can be described as being made up of *fields of power* relations that impose themselves on those who enter them. Agents, according to Bourdieu, engage with others within these *fields of power* according to the overall *capital* they hold.

> "These [forms of capital] are, principally, economic capital (in its different kinds), cultural capital and social capital, as well as *symbolic capital*, commonly called prestige, reputation, renown etc., which is the form in which the different forms of capital are perceived and recognized as legitimate (Bourdieu, 1985, p. 724)."

Bourdieu (1985) thus states that access to power is determined by the totality of one's capital, including cultural, social, and symbolic forms. While Bourdieu (1990:118) has argued that *symbolic capital* has been underestimated as a source of power to the benefit of other sources of capital, this seems particularly true in the literature of social sciences of health. Recognizing and identifying the role played by *symbolic capital* in the understanding of health behaviors that contribute to health inequality is of particular importance (Stoebenau, 2009). *Symbolic capital* is defined as a form of power that comes with social position, affords prestige, and leads others to pay attention to the agent holding such capital. While *symbolic capital* is often associated with economic capital in the Western world, it also exists outside affluent circles. The notion of *symbolic capital* is particularly relevant to understand how poor mothers engage in *fields of power* because, as Attree (2005) states, poor women have "few alternative sources of capital and ways of legitimizing their role in society" (p. 236). For mothers living in poverty, the rearing and health of their children become key sources of *symbolic capital and* power (Groleau and Sibeko, 2012) and, as such, their infant feeding choice may be experienced differently depending on the *field of power* they engage in.

The *field of power* is thus expected to vary according to the *social space* the mothers engage in, such as a hospital setting, a village, a public space, a family gathering or any social group with its own rules to accessing power. The *field of power* concept is important when studying marginalized populations for whom "the general community significantly determines social and economic opportunities and constraints" (Stoebenau, 2009: 2046). For example, while discussing infant feeding with a health professional in the social space of a hospital, the *field of power* will not be the same for a mother with a university degree as compared to an uneducated mother. In this social space, a young and uneducated mother may not feel she has as much *symbolic capital* and thus power, to negotiate requests and recommendations with health professionals. Thus as argued by McNay (1999) *fields of power* are autonomous by their functioning and internal logic but individuals also hold the possibility to participate in a proliferation of differentiated *fields* of action in various social spaces which holds both the potential to have negative and positive effects.

Habitus, another critical concept of Bourdieu's theory of *social space*, is a useful concept that helped interpret our data. *Habitus* corresponds to a mental disposition that is experienced as the expected, normal and appropriate embodied behavior to adopt within defined *social spaces*. Habitus is shaped by the conditioning of agents over time through their participation in different *fields*

from specific locations (Bourdieu and Wacquant, 1992). The notion of *habitus* "is considered to lead to a more dynamic theory of embodiment than Foucalt's work which was criticized as failing to think the materiality of the body" (McNay, 1999: 95). When examining the rejection or adoption of breastfeeding, the body becomes essential to consider because of the embodied nature of the practice. Bourdieu claims that large-scale social inequalities are not always established at the level of institutional discrimination but through subtle inculcation of power relations upon the bodies and dispositions of individuals. The notion of *habitus* thus, is key to help capture the incorporation of the social into the corporeal (Bourdieu, 1990). For example, breastfeeding is considered normal and is the expected way to behave in some social spaces, such as on the street in many African countries, while it may not be in other places such as in a shopping center in North America.

Drawing on Bourdieu's theory of *social space*, we propose that if breastfeeding constitutes a traditional practice in a specific cultural context, as it does in many countries of the developing world, it is then considered an *habitus*, or a natural and expected disposition to feed one's infant based on an expected way to use one's body. For much of the Western world, the initiation and continuation of breastfeeding has been discouraged by a complex interplay of culture, social support and economic status and we cannot assume that breastfeeding constitutes a *habitus* in this context. The WHO and health authorities of many Western countries have tried to restore breastfeeding as the normal and expected way to feed one's infant regardless of the social space. However, we suggest that promoting breastfeeding not only involves promoting a change in behavior, but it also involves a change in *habitus* that needs to be understood within the *fields of power* women engage in when they participate in various *social spaces*.

In this study we build from the critical concepts of *field*, *habitus* and *symbolic capital* to interpret the infant-feeding choice and experiences of Québec-born mothers living in poverty. We will thus build from Bourdieu's theory of *social space* to explore how health inequalities reproduce themselves through bodily dispositions of women engaging in *fields* of power in various *social spaces*. This critical conceptual framework will highlight the importance of place in structuring infant feeding choice and behaviors of Western-born poor women and later support the argument that policy and programming need to refocus on the structuring role of various social and public spaces when promoting and supporting breastfeeding to Western-born women living in poverty.

2. The study

2.1. Research population and sample

The results of this study were drawn from a larger longitudinal study (Groleau et al., 2009; Groleau and Rodriguez, 2009) on infant feeding in the context of poverty in Québec, Canada. The sample of the larger study consisted of 62 low-income French–Canadian mothers living in various regions of the province. To reflect geographical variation, pregnant mothers were recruited from urban, suburban, and rural areas of the province. Mothers from our sample were recruited by nurses through perinatal nutritional programs for low-income mothers. The sample was purposive and mothers were selected according to the following inclusion criteria: born in Canada, living in Québec, identifying French as their first language (majority of the population in the province); non-attainment of a high school diploma (less than 11 years of schooling); eligible to attend a local perinatal nutritional support program because of their low income. In addition, all mothers had been exposed to intensive breastfeeding promotion during pregnancy and during their hospital stay. While the sample of the larger study was composed of 62 mothers who opted for various infant-feeding methods, the sample of the present study consisted of 31 formula-feeding mothers either from birth or a few days after birth.

2.2. Recruitment

Mothers in the study were recruited by health professionals working in local community service centers (CLSCs) in various regions of Québec. Among other services, these organizations offer medical and perinatal services involving the distribution of nutritional supplements during pregnancy through provincial (e.g., OLO) or regional (e.g., PRINCIP) programs, as well as community services to respond to the needs of low-income mothers during pregnancy. The programs offer no financial benefit to mothers who formula feed or breastfeed. Recruitment took place over the course of 26 months. The research project was approved by the research and ethics committee of the Jewish General Hospital (Montreal, Canada), and all mothers read or were read a consent form that they signed prior to being interviewed.

2.3. Methods

Three data collection methods were used in the larger study: focus groups, conducted in community center meeting rooms; two individual ethnographic interviews, completed at two separate times in the homes of mothers; and a quantitative socio-demographic questionnaire, completed by telephone. Focus groups were conducted at two different times, prior to the first individual ethnographic interviews and following the analysis of the two ethnographic interviews. The first sequence of focus groups aimed at enhancing the cultural validity of the individual ethnographic interviews questions, since no previous knowledge existed in the literature on the sociocultural determinants of infant feeding in this population. The second sequence of focus groups were conducted with mothers sharing similar socio-demographic characteristics in order to validate the results from the individual ethnographic interviews. Results from all the focus groups were presented in a previous paper (Groleau et al., 2009), and results from the second ethnographic interview, focusing on barriers to continued breastfeeding for 6 months postnatal, were presented in another paper (Groleau and Rodriguez, 2009). The present study examines the results from the first individual ethnographic interviews, focusing on the sociocultural determinants of formula feeding.

We used a questionnaire with close-ended questions to gather standard socio-demographic data during the first telephone contact with mothers. The first individual ethnographic interview was completed by the second author (CS) and a professional interviewer at 1 month postnatal. The interview allowed mothers to produce the narrative of their pregnancy, labor, and early postnatal period, their understandings of their health and symptoms during these periods, their infant-feeding choice and experience, the social support they received from family and friends, and the values and concerns that dominated their perinatal experience.

2.4. Analysis

Interviews were transcribed and analyzed using the qualitative data management software ATLAS Ti (v.6). The second and first authors coded the interviews and completed a thematic content analysis (Miles and Huberman, 1994). Interviews were coded for emerging themes and were summarized individually. Analysis of the interviews was then conducted to identify common

representations among the mothers. To make sense of the mother's experiences and their decisions to formula feed, interpretation of the data was completed by building from the concepts of *field*, *habitus* and *symbolic capital*.

3. Findings

Following a brief description of the socio-demographic characteristics of the participants, the reasons mothers gave to explain their decision to reject breastfeeding, will be examined. Participant's perceptions of their social environment, their support and the opinions of their loved ones regarding best infant-feeding practices will also be examined. Finally, since it emerged as an important theme in the mothers' narratives, the question of the acceptability of breastfeeding in public will also be explored. Re-entering the workforce was not discussed as a barrier to breastfeeding as all the mothers from our sample had access to a one-year paid maternity leave offered on a universal basis, to all citizens of the province of Québec.

As seen in Table 1, the majority of mothers who participated in the study were young (16–26 years, 77.4%), first-time mothers (61.3%), and living with their partner (61.3%). Of the 31 mothers interviewed, 20 formula fed their infant immediately after birth (Group A), and 11 (Group B) attempted breastfeeding at birth but resorted to formula feeding within a few hours or days following birth.

3.1. The breast: nutritional or sexual?

The reasons presented in this section were extracted from the mother's narratives and thus are not mutually exclusive. The most common reason given by mothers who chose to formula feed since birth (Group A) was that they did not perceive their breasts as having a nutritional function (52.6%). This is surprising considering that all the mothers were exposed to breastfeeding promotion and knew of the health benefits associated with breastfeeding. Mothers who formula fed since birth (Group A) explained that they had always intended to bottle feed and had never imagined themselves breastfeeding. For many of these mothers, the breast had too sexual a connotation to be a source of nutrition for the baby. Certain mothers spoke of the need to preserve this part of their body to remain attractive. They feared that on top of the toll that pregnancy had already taken on their bodies, breastfeeding would deform their breasts, the symbol of their attractiveness (Table 2).

> I'd tell you that especially for me… because I told myself, if I had to put the baby there… already when you give birth, sexually, you're finished, exhausted… I told myself, it's the only thing I've got left… that I find a bit sensual, sexual. If I also have to put my baby to it … I would feel as if I were the bottle. And I wouldn't have wanted my husband to touch it anymore, you understand? For me it was like that, I didn't feel good doing it—I'd have always felt like…the milk coming out—I wouldn't have liked that. I tell myself, it's the last thing that belongs to me. I give them my soul, I give them my life, I give them my love. That's the only thing I want to keep (Group A mother).

Others voiced their general discomfort with feeding the infant. One mother described this feeling with humor: "Breasts are sexual. It's not supposed to go in my baby's mouth! It's supposed to go in my man's mouth! [laughs]" (Group A mother). Later, she added more seriously: "I wouldn't be able to go to a shopping center and breastfeed! No, no—never! No, I'm not for that. I find that disgusting! I find it like a form of abuse… a form of sexual abuse of your infant" (Group A mother).

As illustrated in the above excerpt, for some women in Group A, breastfeeding represented a form of sexual abuse towards their baby, and this idea dissuaded them from breastfeeding. For one woman of this group, the image of her baby's head on her breast had a bestial aspect that she found disturbing:" I didn't want to do it because I told myself, "Dogs do it; dogs breastfeed; animals breastfeed." So it seemed to me that it didn't suit humans" (Group A mother).

3.2. Preservation of energy

The second most important reason given by mothers in Group A (36.8%) to explain their choice of formula feeding over breastfeeding was the great amount of energy breastfeeding required. A smaller proportion of mothers in Group B (18.2%) adhered to the same explanation. Mothers of Group A spoke about breastfeeding as something that would have exhausted them. Protecting their energy level was important for them to take good care of their baby, and breastfeeding was seen as jeopardizing their ability to do so. While the mothers' perception of breastfeeding as

Table 1
Sociodemographic variables of formula feeding low-income French Canadian with < <11 years education.

	Formula fed ($n=31$)	
	n	%
Age		
16–21	15	48.4
22–26	9	29
27–31	5	16.1
32–36	1	3.2
>37	1	3.2
Parity		
First child	19	61.3
Second child	6	19.4
Third child or more	6	19.4
Living situation		
In a couple	19	61.3
Single	9	29
With family member(s)	3	9.7
Geographic location		
Urban	11	35.5
Semi-urban	12	38.7
Rural	8	25.8

Table 2
Comparison of reasons for formula feeding for 30* low-income French Canadian with <11 years education.

Reasons extracted from narratives (non-exclusive categories)	(Group A) Formula fed since birth ($n=19$)		(Group B) Formula fed after trying to breastfeed ($n=11$)	
	n	%	*n*	%
Breast does not have a nutritional function	10	52.6	0	0
Preservation of energy; exhaustion	7	36.8	2	18.2
Baby not taking the breast; perceived lack of milk	0	0	8	72.7
Too painful; breast sensitivity	4	10.5	2	18.2
The importance of autonomy/interdependence	2	21	0	0

* One mother was excluded because she was unable to produce milk due to her milk ducts being destroyed by surgery.

potentially exhausting appeared to be related to lack of support, the narratives of Group A mothers generally revealed satisfaction (78.9%) with the emotional and domestic support provided by their partners. Furthermore, only a small proportion of mothers from Group A (37%) and Group B (18%) were living without their partners at the time of the interview. However, in both groups, those mothers who cited lack of support from their partner also reported being distant from their families and friends, who, since the mothers' maternity, were "no longer on the same wave length" (Group A mother). For these few women, the feeling of being on their own was marked:

> With the second child, since it wasn't going well with his dad, and I left…I didn't have time. I was taking care of both of them and doing nights all alone… I was too tired. With the third child, I would have like to [breastfeed], but since my boyfriend, Pierre [not the father], was going to school, I was still doing nights all alone, all week, and I had to get up at seven in the morning to get the other one ready for school, so it [breastfeeding] wasn't working at all. But I would've liked it (Group A mother).

Morevover, for women not living with their partners, their concern about their energy level affecting their ability to be good mothers was compounded by them being the sole caretaker of their baby:

> I find there's already enough stuff to do in taking care of an infant than having to think of that [breastfeeding] as well, and you know, it doesn't always work… I saw women at the hospital having trouble… You already have enough to deal with being alone, so to deal with having trouble with that as well…I have to protect my energy level, you know, you have to take care of that (Group A mother).

While the fear of losing energy to take good care of the baby, and not seeing the breast as having a nutritional function were the main reasons mothers chose to formula feed (Group A), most mothers who initially attempted breastfeeding (Group B), in fact, experienced unresolved technical problems leading them to abandon breastfeeding prematurely.

3.3. Unresolved technical problems

Technical problems related to breastfeeding (e.g., baby not taking the breast, perceived lack of milk, pain and sensitivity) were the most cited reasons given by nearly all mothers of Group B (90.9%) for abandoning breastfeeding within a few hours or days following birth. More precisely, the baby not taking the breast and insufficient milk were the most common reasons given for switching from breastfeeding to formula feeding. In all cases, the urgent need to feed a hungry baby was cited as the main reason for switching to formula, many times after only a few hours of fruitless effort:

> My baby was having trouble taking the breast. It was hard. He was trying to take the milk, the breast, for hours, and it wasn't working. He was in a crisis, struggling so much that he was crying. And I felt awful inside. I told myself, "You already have problems with your baby. You're not able to feed him" (Group B mother).
>
> I cried a lot over it. I went back to my room and I cried. I cried like a baby. I felt so low. Because it was clear for me: I wanted to breastfeed, and the baby didn't want to. He had trouble with it… he was putting his tongue like he should, but he wasn't taking it. I took that personally. I told myself, "I'm not a good mother" (Group B mother).

Mothers who had unresolved difficulties with breastfeeding almost systematically had a deep sense of guilt. Such feelings called into question their competence as mothers. For those who had tried breastfeeding and rapidly resorted to formula feeding (Group B), they cited pain as a cause due to cracked and bleeding nipples, the baby sucking too hard, or thrush. These unresolved technical problems were evoked by almost all Group B mothers (90%), a situation which speaks to the lack of technical support for mothers who are open to breastfeeding but do not have access to health services or family members who are knowledgeable about solving such technical problems:

> It's when I got home that I started my milk flow. And it was really sensitive. It was really too painful. Even if I wanted to, I wasn't able to touch my hard nipples, because I wanted to try it [breastfeeding] anyway. Unfortunately, it didn't work (Group B mother).
>
> The baby got thrush, and then gave me thrush. It was so painful that I didn't let him drink. I stopped him before he was finished drinking (Group B mother).

3.4. The importance of autonomy and independence

This relates to both the mother and the baby. We grouped both components together because they contained similar elements as reflected in the mother's discourse, namely, the importance of learning how to manage alone, to take charge, to be free. Only two mothers in Group A used this reason to explain their decision to formula feed from birth. No mothers of group B spoke of these issues. Group A mothers voiced their need for freedom, a need that was hampered by the arrival of their child:

> I was working in a bar. I was supposed to go back to school. When I found out I was pregnant, I had to cancel that. It's just that before, I was… non-committal. I made the most of my youth. Now, well… family life dictates (Group A mother).

These women cited the value of independence and autonomy to explain their feeding choice. One mother explained that she had intended to return to work as soon as possible and that breastfeeding would not give her that option: "I wanted to go back to work soon, and it would have been tough to coordinate with breastfeeding" (Group A mother). One mother from Group B who initially tried breastfeeding explained her choice for switching to formula as a means for her child to learn to be autonomous and not become too attached and spoiled. The special relationship with the mother during breastfeeding was described as something that should not persist so that the child could become more independent:

> She would always want to be on me, you know, with someone she gets used to. She would always be in my arms. I told myself it's not good. You know, yeah, affection, it's nice, but having her in my arms all the time… and she's wailing because she wants to be in my arms… is not right (Group A mother).

3.5. Infant-feeding preference of kin

The difference between mothers of Groups A and B on the basis of this theme is striking. A high proportion of Group B mothers (81%) had received divergent opinions from their kin about the best feeding method. The following example of a partner who endorsed breastfeeding and a stepmother who found it too complicated illustrates the divergent and conflicting discourse to which the mothers were exposed:

> For me, at home, my parents, my mom didn't breastfeed me. As for my stepmother, she said to breastfeed a little. As for my own

parents, everybody was reluctant. They didn't want me to breastfeed. But for me it was important. So I didn't get a lot of support from them (Group B mother).

On the other hand, over half the mothers in Group A (52.6%) had unanimously pro-formula-feeding entourages, and none of these mothers received pro-breastfeeding support from their kin. For example, one respondent explained that not a single member of her family or step-family had breastfed their children. Having such models invalidated the argument of the purported superior health benefits of breastfeeding, because everyone she knew who had been formula fed were in good health. Although the mothers who bottle-fed had been informed about the benefits of breastfeeding, their families and friends told them about the many difficulties involved and the exhaustion it caused. Because formula feeding was widely used in the entourage of these mothers, and because they had never observed its negative effects on the health of others and themselves, formula milk seemed to be the logical choice:

I wasn't interested. No. Even if they say it's better for the baby and everything. I told myself I was raised with bottle-feeding and I'm not dead. I… it depends on how you think about it, your ideas of people. But for me, it wasn't important (Group A mother).

3.6. Breastfeeding in a public space

The mother's narratives also portrayed a negative social judgment of breastfeeding in public. Most mothers from Group A described themselves as "too modest" and could not imagine themselves breastfeeding in front of others (73%). In comparison, mothers from Group B were a bit less embarrassed about breastfeeding in front of others, with a smaller proportion describing modesty as a deterrent to breastfeed in public spaces (54%). However, a minority of mothers in both groups judged other women who breastfed in public negatively:

I find it unacceptable from my point of view. Because it's, like, personal; it's a part of you that you're not supposed to show. You take it out in front of everybody… I find it… I find it horrifying! You don't do that. You don't arrive in front of everybody and take out your breast and feed the baby, even if you say it's something natural. Because that's part of you, that you don't show (Group A mother).

"For me, if I see women fully breastfeeding in a restaurant, I tell myself that they could do it in the washroom" (Group B mother).

The issue of breastfeeding in public was an important barrier to breastfeeding. The mothers felt subjected to social pressure and the disapproving look of others, and although many mothers did not agree with such judgment, it was strong enough to dissuade them from breastfeeding.

4. Discussion

While all the mothers from our sample were informed by health professionals that breastfeeding was the optimum infant feeding choice for their baby's health, they still opted for formula feeding or abandoned breastfeeding rapidly after giving birth. As for any qualitative study using purposive sampling, our results cannot be generalized to all French-Canadian or Western-born mothers living in poverty. However the use of qualitative interviews provided insight into the complex social process occurring in relation to these infant-feeding decisions. Since French-Canadian women living in poverty likewise other Western-born women living in poverty, are less prone to initiate and sustain breastfeeding (Neill, 2006), our interpretations discussed here can be used both as hypotheses to be tested in larger studies and as an understanding of the central role played by *social space* to guide policy and intervention. In our discussion, we build from Bourdieu's (1984, 1985, 1989) theory of *social space* defined earlier, to discuss how the experiences of this group of women needs to be understood in a Western social and cultural context, so that we may propose pathways to promote and support breastfeeding in ways that address the spatially grounded needs of Western born women living in poverty.

The perception that breasts did not have a nutritional function and that breastfeeding in front of others was too sexual to be acceptable, was the main barrier to adopting breastfeeding for the women of our sample that formula-fed from birth on. The limits imposed on breastfeeding in social and public spaces has been identified as a barrier by other studies conducted in Western countries such as Boyer (2012) in the UK, who highlights that "breastfeeding in public destabilizes prevailing understandings about how public space should be used" (Boyer, 2012: 559) and that "the sense of shock, disgust or embarrassment of others—can mark the limits to belonging in public space" (Boyer, 2012: 557). While we agree with Boyer (2012), we argue that some groups of individuals, such as poor women, may have less power than others, in the Western culture, to negotiate and resist the gaze imposed on women breastfeeding in social spaces.

Our results suggest that the poor women in our study tend to have less access to sources of power that would support them in challenging a prevailing cultural phenomenon of the Western world: the hypersexualization of breasts and sexualization of breastfeeding. We will develop our argument first by explaining how the sexualization of breastfeeding is inseparable from the hypersexualization of the breast in Western cultural imagery found in public space. And second, by discussing how women living in poverty tend to have less power via their *total capital* to challenge and negotiate the gaze of others when they engage in *field of power* of different public spaces. In the following sections, we will also discuss the other reasons evoked by mothers for rejecting breastfeeding namely technical breastfeeding problems and their preoccupation with fatigue and energy. Finally, we will discuss these predicaments in the light of mother's need to respond to the "good mother" expectancies in order to preserve their symbolic capital.

4.1. Breastfeeding and the importance of power to negotiate the sexual body in the field of public space

Sexualization of breastfeeding in social space, a cultural phenomenon of the West. The sexualization of breastfeeding is inseparable from the hypersexualization of the breast in public spaces (Hausman, 2003; Smyth, 2008), a Western world phenomenon recognized to have begun in twentieth century Europe (Stearns, 1999; Yalom, 1997) and North America (Dettwyler, 1995). Hypersexualization of the breast has remained a highly Western construction, since breasts are not considered to be as sexual in non-Western countries such as several African countries where men tend to give more importance to the sexual appeal of other parts of the woman's body such as the hips, the buttocks, and the face (Dettwyler, 1995).

Interestingly, hypersexualization of the breast emerged in historical times when fertility rates drastically dropped in the Western world (Guyer et al., 2000; McInnis, 2000). Beginning in the 1960s, many developed countries experienced a sharp and rapid drop in fertility (Roy and Bernier, 2006). The province of Québec, the place of this study, may be considered the epitome of such a phenomenon, where fertility rates dropped from 3.8% in

1960 to 1.4% in 2000 and continue to remain low, varying between 1.45% and 1.48% (Roy and Bernier, 2006). This phenomenon is inseparable from the "Quiet Revolution" which took place in Québec during the 1960s, when society embarked on a rapid process of secularization and the population massively rejected the Catholic church's imposition of large families (Groleau et al., 2010). As found in other western countries, women changed from occupying a predominantly maternal role, to having fewer children and participating in the labor force even after childbirth. This drop in fertility rates has led to a situation in which the visual imagery of the breast that is linked to its nutritional function has been rapidly evacuated from public spaces. The resulting shift in the definition of femininity has also been reflected in the public space of Western societies, in which sexual elements became more overt in the public space of visual medias between 1964 and 1984 (Soley and Kurzbad, 1986). Today, female nudity and erotic content have become commonplace, and women's bodies, in particular their breasts, have become negotiable commodities that help sell consumer goods (Rodriguez-Garcia and Fraizer, 1995).

However, although middle-class women in Western countries live in the same "hypersexualized" world as their low-income counterparts, this does not prevent many of them from adopting breastfeeding and perceiving their breasts as having both a maternal and a nutritional function alongside its sexual dimension. This difference raises the possibility that poor Western-born women may actually negotiate the hypersexualization of breasts differently than middle-class women. Our results indeed suggest that most women of our sample who rejected breastfeeding from birth have internalized the idea that breasts are only sexual and do not have a nutritional function.

Poverty as lack of access to power to challenge the hypersexualization of the breasts. The internalization of the idea according to which breasts are only sexual, may be explained by the low levels of education that tends to characterize women living in poverty (Callen and Pinelli, 2004; Heck et al., 2006). Many studies have identified a significant correlation between low maternal education and the hypersexualization of breasts as an important barrier to breastfeeding (Celi et al., 2005; Mitra et al., 2004) and yet the social process behind this correlation has remained unexplained. The narratives of the mothers in our study suggest that their low-levels of education (<11 years school) may make them less critical toward the Western reductionist hypersexualization of the breast and the more general comodification of women's bodies.

Adding to this predicament, our results suggest that poor mothers do not rely predominantly on scientific knowledge to guide their infant-feeding decisions but tend to rely more on competing experiential knowledge of their family and peers, including the prototypical infant feeding experiences of their families such as that found in many immigrant or non Western populations (Groleau et al., 2006; Groleau and Sibeko, 2012). Conversely people with high levels of education tend to value scientific knowledge in general (Knaak, 2010), which is the epistemology, or type of knowledge, that supports breastfeeding as the optimal feeding choice. It could thus be argued that because mothers living in poverty have less education, they adhere less to the more general scientific discourse that would provide them with the discursive power to challenge the sexualization of breastfeeding. Knowledge, as stated by Foucault, is a central form of power to be exercised in social spaces through discourse (Foucault, 1980). Foucault uses the term "power-knowledge" to signify that power is constituted through accepted forms of knowledge, scientific understanding and "truth". However, our results suggest that the cultural norm of hypersexualization of breasts is interiorized by the mothers of our study beyond perception—causing them to discipline themselves without any willful coercion from others, a phenomenon Foucault calls *disciplinary power* (Foucault, 1977). In that sense, while women of our sample were informed of the documented benefits of breastfeeding as supported by scientific discourse, their low levels of education may have contributed to the fact that they nevertheless internalized and embodied the idea that breastfeeding was sexual and inappropriate, thus becoming a deviant practice. Building from Bourdieu's notion of *habitus*, we thus argue that formula-feeding has become a *habitus* for poor women that reflects "a sense of one's place and a sense of the place of others" (Bourdieu, 1989:19). When considering such a *habitus*, one needs to ask what are the social conditions that make such a common judgment possible, such as the one that links breastfeeding to sexuality? Indeed middle-class women have different social conditions than women living in poverty. The former tend to have higher education levels which also gives them access to more valued paid occupations, higher social class and income, that provides them with more sources of *symbolic capital*, and thus power and confidence to challenge both, the "sexualizing" gaze of others when breastfeeding in public, as well as the embodied emotional discomfort some may anticipate or experience when putting a baby to their breast. Thus, we posit that while the hypersexualization of breasts is a cultural phenomenon present in Western public spaces, it creates an important challenge to introduce breastfeeding in public spaces where the expected *habitus* is to formula-feed babies. Poor mothers like any other socialized agents, are perfectly capable of perceiving the relation between a practice- such as breastfeeding- and its adequacy with their position in social space (Bourdieu, 1989:19). However, since poor women tend to have less access to *symbolic capital* and *power-knowledge*, they have less power to challenge and negotiate the sexualizing gaze of others if they opt for breastfeeding. Our interpretation of the rejection of breastfeeding using Bourdieu's theory of *social space* adds to the sociological research that posits that "women's respectability is closely linked to norms of sexuality, expressed through the body and ranked by social class" (Smyth, 2012: 188). Our results also support the idea that embodied social relationships are central to sociospacial processes as argued in previous literature (Lefebvre, 1991).

4.2. Breastfeeding and power to negotiate the "good mother" expectancies in their social space

Technical problems such as the baby not taking the breast, perceived lack of milk, and anticipation that breastfeeding is painful, were cited as important reasons for mothers rejecting breastfeeding after trying it briefly. These reasons speak to the lack of information and support women received from health professionals, community and family. One may expect that family members did not have the knowledge to help mothers resolve these technical problems considering this embodied practice is not a *habitus* in their intimate *social space*. However, these results also suggest that while health professional succeeded in convincing some mothers of our sample (11/31) to try breastfeeding, the majority of these mothers (10/11), were not provided with adequate information and support to resolve their breastfeeding problems, an issue well documented in the literature (Groleau and Rodriguez, 2009).

Nevertheless, the sexualization of breastfeeding, fatigue and the need to preserve one's energy, constituted the most important reasons evoked by mothers to formula-feed. These reasons were mainly couched in the mother's desire to be able to take good care of their baby. While postpartum fatigue has been documented in the literature as being an important barrier to breastfeeding (Gardner and Campbell, 1991; Milligan et al., 2000) our results suggest that this barrier needs to be understood in the context of

the limited sources of power that are accessible to poor women. An important source of power for poor women when engaging in the *social space* of their family and peers, is the *symbolic capital* (Bourdieu, 1984, 1985, 1989) they acquire by becoming what their milieu considers a good mother (Groleau and Sibeko, 2012). Conversely, as stated before, middle-class women have more varied sources of *symbolic capital*. Therefore, for a mother that lives in poverty, becoming a "good mother" (Marshall et al., 2007) represents a central source of power in the *field of power* she shares with her family, friends, and community. The mothers of our study, reported the importance of not subordinating their own needs to those of their babies. Mothers considered that their first duty was to protect their own energy level to be able to take good care of their baby. Rejecting breastfeeding in this context has implications regarding identity for mothers who were committed to being defined as a "good mother" by their families and peers with whom they shared the same *social space.* This situation is contrasted with that of middle-class women who are known to have more varied sources of power and tend to rely more on expert-guided medico-scientific knowledge of parenting to determine their maternal competence (Knaak, 2010). Conversely for middle-class, educated women, their maternal competence is known, to be often "couched in terms of the benefits of the baby's health and the subordination of their own needs to those of the baby" (Marshall et al., 2007: 2,156), a phenomenon that corresponds to what Hays (1996) calls "intensive mothering". Our results thus suggest that the notion of "intensive mothering" does not apply, as such, to the women of our study. The good mother expectations changes, according to the *social space* of mothers, where middle-class women are expected to focus on the needs of their baby (Holloway, 1999; Marshall et al., 2007) while our results suggest that the low-income women tend to focus on themselves in the aim to preserve their capacity to protect their baby in the challenging context of poverty.

The compliance of poor mothers with the normal expectations of the *social space* of their family and close ones in terms of infant-feeding choice conveys important meaning that speaks to their expertise as "good mothers" but also corresponds to their access to *symbolic capital* and power. Our interpretation thus corresponds to the work by others such as Shaw (2004) that acknowledges the ways in which bodily practices, such as infant-feeding choice, mediate and constitute an ethical identity. While Shaw used Foucault's notions of ethics and subjectification to interpret breastfeeding practices, we interpreted the mother's narratives with a concern over the role of power in inequalities of health and integration of the body that we believe, was better served using the theory of *social space* of Bourdieu.

Rejecting breastfeeding in this context needs to be understood as a reasonable decision poor mothers take in order to protect their moral self while reflecting an embodiment of the *social spaces* they engage in, both intimate and public. Our results thus support the Bourdieusian argument that *social space* tends to function as symbolic space, where different lifestyles that reflect dispositions and taste that characterizes groups (Bourdieu, 1989: 20). In this context, promoting breastfeeding as "breast is best" to poor women without seriously engaging in social action to alter the infant-feeding *habitus* of their *social space*, would equate in asking them to adopt a highly stigmatized behavior, corresponding to what Bourdieu qualifies as symbolic violence.

The interpretation of our results using Bourdieu's theory of *social space* (1989) suggests that his theory usefully adds to our understanding of why breastfeeding rates remain so low in a Western context of poverty and correspondingly why public health interventions promoting breastfeeding in Western poor populations have failed. In our study, the notion of embodiment is understood as the incorporation of the social into the corporeal that we approached building from Bourdieu's concept of *habitus*, *field and symbolic capital*. However, as suggested by Crespi (1989:122), the notion of *habitus* reflects a generative phenomenon of the body- rather than a determining structure. So a *habitus* of infant-feeding, while being embodied in *social space*, remains permeable to change, both coming from the social and the individual (Bourdieu, 1992:133), a phenomenon that could explain why breastfeeding rates vary according to place, time and socio-cultural groups.

Therefore, before promoting breastfeeding to mothers living in poverty, public health action needs to transform their *social spaces* in a way that represents breastfeeding as a normal and morally acceptable behavior, while giving poor mothers better access to sources of power to negotiate this change. This type of action takes time, but nevertheless needs to be prioritized over the promotion of breastfeeding done individually to poor mothers, if public health wishes to avoid engaging in actions that can potentially generate symbolic violence to a group of women that already live in the margins.

5. Conclusion

While many studies report large-scale epidemiological correlations between low breastfeeding rates and variables such as low-income, young age, negative attitudes toward breastfeeding, and low levels of education, they cannot explain how these associations might work. Without an understanding of the underlying social processes found in a Western context of poverty, it becomes challenging for breastfeeding promotion and support programs to address the special needs of mothers living in poverty. As seen in developing countries where breastfeeding constitutes a traditional practice for women living in poverty, our results strongly suggest that it is not poverty per se that keeps poor Western-born mothers from adopting breastfeeding, as epidemiological studies of the western world could suggest. Rather, we posit that it is their low levels of education and corresponding lack of access to power that limits their capacity to negotiate and resist the barriers to breastfeeding that are present in the western *social spaces* they engage in.

Our results suggest that low educational levels limit access to the discursive power necessary to negotiate the hypersexualization of the breast in Western societies. Low levels of education may also make women more reliant on the experiential knowledge of family and friends, in which formula feeding is stressed as a healthy option for both baby and mother. Having a low-income and the corresponding limited sources of power also make these mothers more dependant of the "good mother" criterion determined by the experiential knowledge of their kin. Together, poor levels of education and low income diminish women's access to the knowledge and power necessary to negotiate and challenge the pervasive and reductionist views of women's bodies and femininity that prevail in Western societies where formula-feeding is the *habitus* expected to be seen in social and public spaces.

Breastfeeding promotion and support activities need to take into account the social and symbolic meaning of breastfeeding and corresponding spatial predicaments it imposes on Western born women living in poverty. Public health cannot ignore the role played by *social spaces* in the promotion and support activities. While UNICEF/WHO based policies and programs have successfully addressed the *social spaces* of hospitals and community clinics with the Baby Friendly Initiatives, our results strongly support the need to address more toughly and strategically the other *social spaces* women—in particular poor women—engage in, such as within intimate relationship and with their family, but also

with the larger social and public spaces. Our study points to the urgent need of reintroducing the nutritional role of the breast into various social and public spaces including the medias. Reintroducing the normality of breastfeeding in visible public spaces through images and pictures of women of all ages, body types and styles would be a positive step toward making breastfeeding an infant-feeding *habitus*—thus morally acceptable—in Western countries as opposed to a sexually provocative practice.

The inclusion of kin and friends also appear to be paramount during breastfeeding promotional activities and should contribute to diminishing the mother's exposure to conflicting or stigmatizing discourse linked to infant-feeding choice. This inclusion strategy could also enhance the capacity of close-ones to help mothers resolve potential breastfeeding problems if and when they arise, and access professional support when needed. In this context, tailored prenatal promotion activities should be developed for women with low levels of education as well as for their kin, in order to help them become more aware of how Western hypersexualization creates a reductionist view of women's bodies and their breasts. As Bourdieu points out “determinisms operate to their full only by the help of unconsciousness (1992: 136).” Such activities could also provide low-income mothers with discursive and embodied ways to resist the sexualizing gaze of others during breastfeeding while allowing them to feel entitled to breastfeed whenever and wherever they are. This critical awareness and empowerment on the part of mothers, their kin and close-ones, would better support poor women who wish to initiate and sustain breastfeeding.

Understanding the social process that contribute to shape poor women's infant-feeding decisions is important if health policies and public health programs wish to address their spatially grounded needs and predicaments. While we cannot directly enhance the *symbolic capital* of women living in poverty, we can work towards changing their *social spaces* in a way that empowers them to negotiate aspects of our western culture that can engender health inequalities.

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