CHAPTER 1

Learning and Food at the Mother's Breast

Susan Machum

Introduction

Shortly after learning I was pregnant in early 2000, I headed to the bookstore and promptly purchased *What to Expect When You are Expecting* by Murkoff, Eisenberg and Mazel (1998). This book is one among many adorning local bookshops offering advice to the soon-to-be mother. Now in its fourth edition, I owned the expanded and revised second edition published in 1998. What this book and others like it do is guide the first-time mother through the month-by-month changes their body is experiencing as their baby grows inside them. While its intention is to reassure, inform and advise the first-time mother on how to handle various situations, the book's detailed attention to what can go wrong in pregnancy was sometimes unnerving. Nevertheless, this book was constantly referenced and read throughout my entire pregnancy as I engaged in what sociologists call an **anticipatory socialization** process. Even though I was not yet a mother, I was anticipating motherhood by learning what my new role involved and preparing for life with my newborn child. In effect, as a pregnant woman, I was already preoccupied with the responsibilities of caring for a child, and this book helped me navigate both the prenatal and postnatal phases of my pregnancy.

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The truth is this book was just one among many. Before my first child was even born, I read well over a dozen books on pregnancy, breastfeeding, motherhood and parenting—and since then dozens more parenting books have been added to my bookshelves—while pretty well all of my books on the early years of childrearing have been re-gifted to first-time mothers and fathers. In fact, many of my first childcare books made their way onto my bookshelf via friends and colleagues whose children had outgrown their advice. What I have come to realize about parenting is that the learning curve is steep, and what you need to know and do is ever changing. Quite simply, the advice on how to parent, teach and guide your child is highly dependent on your child's stage within the life course.

During the prenatal phase of a baby's life, the primary agenda is to carry a healthy baby to full-term. To this end, most expectant mothers are learning to transform their lifestyles, diets and exercise habits to meet the needs of the growing baby. In effect, mothers' bodies are being 'given' over to and being 'taken' over by the unborn child. And if you opt to breastfeed—which I did—this process can last much longer than three trimesters. As Bendefy (2012, p. 25) argues 'breast-feeding is … the "fourth trimester" in terms of [a] baby's brain growth and development'.

Even if the production of breast milk is a biologically, evolutionary and ecologically sound infant feeding strategy that 'naturally' follows childbirth, for many mothers and newborns, breastfeeding involves a steep learning curve. It is a skilled activity that requires a significant amount of patience, trial and error and effort on the part of mother and child. Not all mothers and newborns take to breastfeeding easily. And while mothering books may teach pregnant women and new mothers the benefits and mechanics of breastfeeding, until you actually start breastfeeding your knowledge remains purely theoretical. It is when you start nursing your newborn that you begin to apply your abstract knowledge—some nursing mothers may experience instantaneous success, while others may experience a series of challenges, and still others may, for a number of reasons, never succeed at breastfeeding or never attempt to breastfeed. This relationship between theory and practice is referred to as **praxis**.

Praxis captures what we do, and how our everyday activities create and re-create the social world, cultural patterns and social expectations. Social policies, including health policies, are closely related to praxis in that a policy lays out a governmental plan of action (Lightman 2003). But policymakers cannot ascertain in advance to what extent a policy agenda will succeed. Likewise, during pregnancy, mothers may plan to

initiate breastfeeding, but whether or not they do, and the duration they nurse, can only be measured after the child is born and infant feeding is proceeding.

This chapter explores infant feeding, in particular the first months of life before solid foods are introduced. It does so through a sociological lens and the use of **autoethnography**. Sociologists study the relationships between an individual's life experiences and the larger social world in which our biographies unfold. Autoethnography reflects on the relationship between one's individual life and the larger social context in which it is lived. This agenda fits well with sociology, which aims to recognize that **personal troubles** and decision-making processes are embedded in larger social contexts or what C. Wright Mills (1959, 2000) called **public issues**. This is certainly the case when it comes to breastfeeding. As this chapter will illustrate, a mother's decision on how to feed her infant child is not simply a private matter; throughout the last decades, breastfeeding has become a public health issue that pits human milk against formula, breast against bottle and 'nature' against science.

The chapter begins with a brief overview of breastfeeding practices over the past century. Then it considers the range of options available to families to meet the nutritional needs of their newborn. The third section reflects on the larger socio-economic, political and cultural context within which infant feeding decisions are made—specifically it considers policy initiatives that support breastfeeding and the concurrent backlash against breastfeeding. The chapter concludes with a discussion of the role human milk plays in supporting and building a local, sustainable, food system.

Breastfeeding Practices During the Last Century

At the beginning of the twentieth century, breastfeeding was the norm with more than two-thirds of mothers' exclusively breastfeeding their infants (Wright and Schanler 2001, p. 421S). But between 1930 and 1960, breastfeeding in North America declined dramatically from one decade to the next (Fomon 2001, p. 409S), and breast milk was steadily replaced with cow's milk and infant formulas. Interestingly, this replacement of 'natural' milk with 'artificial' milk occurred during first the Depression years, then the war years, and finally as women increasingly entered the paid labor force. Even so, as Fomon (2001) documents, commercially

prepared formulas were available at the end of the nineteenth century, but the uptake was not there at that point in history.

Formula or 'artificial' feeding options fell into two categories—there were home-made formulas and commercially prepared ones. In fact, between 1880 and 1930, many corporations were making and perfecting infant formulas as alternatives to breastfeeding. They sought to create a product that was nutritionally equivalent to breast milk, but they found that formula-fed babies sometimes had poorer health and lacked nutrients when compared to breastfed babies (Fomon 2001). However, as science improved and formulas better met the needs of newborns, its adoption for infant feeding began to take off in the 1950s. At the same time, Fomon (2001, p. 412S) observes:

> considerations of convenience began to supersede considerations of cost, and the popularity of commercially prepared formulas increased dramatically … [no doubt] accelerated by the introduction in 1959 of iron-fortified formulas and the vigorous promotion of these formulas by the formula industry and by pediatricians.

It was five years later, at the height of formula and bottle-feeding, that I was born. My introduction to food was corn-syrup-laced Carnation milk, and I am convinced it is responsible for the incredible sweet tooth I harbor to this day. But as my mother says, 'I was just doing what the nurses and doctors told me to do. Everybody I knew was bottle-feeding'. According to a source in Olver's (2004) food timeline, in 1964, 'one baby in five, usually those past three or four months of age, [was getting] whole cow's milk. [While] only one in 10 [were] breastfed [even though breastfeeding was described as] still the safest, most convenient and least expensive method of nourishing an infant'.

Breastfeeding did not, however, match the ideological framework of the day, which supported the strong belief in scientific intervention and 'better living through chemistry'. It is perhaps no coincidence that this is the same historical moment that the green revolution is gaining ground and dramatically transforming food production from small-scale family-oriented farms to commercially oriented, industrial farms (Roberts 2008). Nevertheless, by the 1970s, a pendulum shift occurs and breastfeeding once again starts to gain momentum. Fomon (2001, p. 415S) reports it is hard to identify the exact impetus for this swing back toward breastfeeding but notes it is a grassroots movement rather than one led by 'health

professionals, and may have been in part associated with negative publicity directed against the formula industry'. It was during this period that North Americans and Europeans were learning of the negative impact aggressive marketing of infant formula in developing countries was having on infant mortality rates there (Fomon 2001; Brady 2012). It was also a period of Keynesian economics and the rise of the welfare state so policies were coming into play that supported breastfeeding. For example, it was in 1971 that Canadian women who had banked at least 20 weeks of insurable earnings could apply for 15 weeks of maternity leave benefits (Marshall 2003). At the same time, the World Health Organization (WHO) did, and continues to, recommend exclusive breastfeeding for at least the first six months of a child's life (Heymann et al. 2013).

The global impact of these processes was more breastfed babies; even so the WHO (2015) would still like to see more babies breastfed for longer periods of time because of the positive outcomes of breastfeeding on infant health. In Canada, there was a steady increase in the number of women initiating and exclusively breastfeeding. Health Canada (2012) reports that in 2003, 37.3 percent of new mothers exclusively breastfed for the first four months, while 17.3 percent were continuing to do so at six months of age (whereas in 2009–10, the figures were 44.2 percent at four months and 25.9 percent at six months). So clearly supplementary feedings are often being introduced after the fourth month despite recommendations to continue exclusive breastfeeding until six months of age. Personally, I remember being pressured by family and friends to introduce solids earlier than six months, and while I did not do this for my first child, I think I did in the case of my second, in part because he seemed more interested in eating solid foods.

Infant Feeding and Breast Milk Production

Feeding a newborn involves two sets of decisions based on prior learning. First, parents must decide what kind of milk the child will consume—will it be human milk or formula, or some combination of both? Second, parents must decide how that milk will be delivered—by breast or by bottle or by both breast and bottle? How these questions are answered presents a range of possibilities for feeding the newborn. At one end of the spectrum sits the newborn who is exclusively breastfed. In this case, the infant drinks human milk directly from mother's breast. On the other end of the spectrum is the newborn who is exclusively bottle-fed with formula.

In the middle, you have babies who are exclusively fed human milk by both breast and bottle. As well there are babies who are fed both human milk and formula from both breast and bottle, and still others who might be fed breast milk or formula exclusively by bottle. In short, a range of options prevails for meeting the nutritional needs of the newborn baby, but the choices made will depend on the parents' knowledge frames, their social situation, and the larger social support network in which their lives are embedded.

There is an extensive self-help literature available for expectant mothers to consult on the dynamics of successful breastfeeding. *The Nursing Mother's Companion* (Huggins 2015), *Breastfeeding Made Simple* (Mohrbacher and Kendall-Tackett 2010), *The Womanly Art of Breastfeeding* (Wiessinger et al. 2010) and *Work. Pump. Repeat.* (Shortall 2015) are just a few titles sitting on the bookstore shelves today, giving advice and information on breastfeeding from birth onwards. During my first pregnancy, I relied on Neifert's (1998) *Dr. Mom's Guide to Breastfeeding* to understand the breastfeeding process and overcome breastfeeding challenges.

Overwhelmingly, these books explain how a mother's body produces milk—that is, the relationship between giving birth, the release of hormones and the various stages of milk production. All emphasize that breastfeeding is a natural and normal part of human evolution. Humans are mammals and mammals have evolved to produce and consume mother's milk in infancy. For example, Wiessinger, West and Pitman (2010, p. 62) write, 'your body and your baby have instincts and abilities not just for birth but for breastfeeding as well'. Mohrbacher and Kendall-Tackett (2010, p. 14) argue, 'babies and mothers are hardwired to breastfeed'. Yet as noted above, many women opt not to breastfeed.

Those mothers that do decide to initiate breastfeeding are advised to do so within the first two hours of giving birth. Ideally, the baby and mother are able to make skin-to-skin contact because this promotes latching. During the first feeding, the newborn baby is greeted with **colostrum**—a 'liquid gold' that is easy to digest because it is low in fat and sugar but high in protein and full of antibodies that are 'capable of attacking harmful bacteria' (Huggins 2010, p. 41). In the first few weeks of birth, babies require frequent feedings; first because their stomachs are small and second because it is the very act of nursing that establishes the milk supply. Put simply, the more milk a baby demands, the more a mother's body produces. What is more, a mother's body quickly becomes completely in-tune with the baby's feeding patterns.

I certainly found this to be remarkably true. Most of the parenting books I read, the health care professionals teaching the prenatal classes, and lactation specialists at the hospital recommended feeding for 10–15 minutes on one breast then switching to the other. But Neifert's (1998) advice was to nurse exclusively on one breast during a feeding and then to switch to the other breast for the next feeding. She argued this pattern would maximize caloric intake by giving baby access to both foremilk and hindmilk at every feeding. As Mohrbacher and Kendall-Tackett (2010, p. 88) explain, during a feeding:

> The first milk a baby gets (sometimes called *foremilk*) is lower in fat (in some cases like the 1 percent cow's milk we might buy from the store). As baby continues to feed, the milk increases in fat (more like 2 percent milk). As the baby continues to drain the breast, the fat content increases until it is as fatty as whole milk, then half-and-half, then cream (sometimes called *hindmilk*).

What amazed me as a nursing mother was how my body produced milk according to this pattern—one breast would be full and ready to feed while the other was empty whenever my child wanted to nurse. I did feed on demand, responding to my child's indications that he was hungry, and I do remember being remarkably tired during the first six weeks of his life. In part I was sleep deprived, and even though he was gaining weight and doing well, I was obsessed with keeping a feeding log as advised by the health care professionals. It was a visit from my sister, who had successfully breastfed her daughter into toddlerhood, that finally really helped me learn to relax and gain confidence as a nursing mother. Her advice: 'You are doing fine. Stop making yourself crazy with this breastfeeding log. Just feed your son when he's hungry'. Until she spoke these words, I did not have the confidence to ignore the books and lactation experts and follow my child's lead. In the end, we were able to exclusively breastfeed until he was six months old and we continued breastfeeding until he reached three and a half years of age.

But not all mothers want, or are able, to follow this pattern of infant feeding. Infant nutrition is, in fact, very much influenced by what McMullin (2009) calls CAGEs—that is, the interconnections between a person's social class, age, gender and ethnicity. Personally in relation to breastfeeding, I am drawn to the idea of maternal CARE rather than CAGEs as class, age, the region of the globe in which women live, and their ethnicity have significant impacts on breastfeeding practices.

Nevertheless, gender remains a dimension of breastfeeding experiences. To start, fathers cannot breastfeed, but they can learn to feed their infant mother's milk from a bottle. Maher (2015, p. 195) concludes gender is an important but often neglected dynamic of breastfeeding because

> husbands and fathers are important in permitting, enjoining, or limiting breastfeeding, in determining the way in which it is done, by whom [for example, by mothers or wet nurses], and the time of weaning.

In my case, my husband supported breastfeeding, but it would seem he was unable to master the art of bottle-feeding (Bendefy 2012, p. 29) given my son refused to consume the milk I pumped and left for him. However, our family was incredibly privileged because even though I was working full-time, we live in a small city and my work offers somewhat flexible hours, so I was able to drive home between classes and meetings, nurse my child and then come back to the campus. Sometimes women are able to bring their young infants to work with them and this facilitates breastfeeding, and still others have generous paid maternity leaves. Those who do not have the capacity to stay at home, come home during the day, or take their child with them to work but want to continue feeding their child human milk can start pumping, storing and transporting their milk from work to home on a daily basis (Shortall 2015). This represents incredible dedication to both breastfeeding and the value of human milk in an infant's diet.

For some mothers, their socio-economic situation and working conditions are much more precarious, and they may not have the opportunity to work and pump, so formula feeding becomes the most practical option. The decisions that we learn to make are embedded in the larger social context we find ourselves in. Our social class position, our age, our geographic location and cultural expectations surrounding appropriate infant feeding strategies all play a role in our infant feeding practices. We need to recognize that maternal health is directly related to breastfeeding success. As Mohrbacher and Kendall-Tackett (2010, p. 220) note, ' stress can inhibit milk release, slowing milk flow'. Likewise, food insecurity and poor nutritional health for mothers can directly impact children's health and nutrition (Food Banks Canada 2015). This is especially true for breastfed babies, given their mothers are the direct producers of the milk they consume.

Breastfeeding is the ultimate form of reproductive labor in the Marxian sense of the term, in that the milk production of nursing mothers falls outside the purview of paid labor while at the same time it is directly contributing to the reproduction of the next generation of workers. Maher's (2015) discussion of the rise of milk banks and milk exchanges may provide exceptions to this case. But in general, lactation remains an unpaid and undervalued form of work. Yet advocates of breastfeeding would argue lactation and infant feeding is a critical dimension of socially necessary labor time and should be recognized as making a significant contribution to infant health. In reality, all infant care falls under the umbrella of reproductive labor.

Breastfeeding can be understood as a form of self-provisioning; but of course, mothers usually need to meet their own nutritional needs through the market. Thus, the breastfeeding mother is embedded in and consuming from a larger global food system—which may or may not be socially sustainable for her depending upon her resources and food choices—but by breastfeeding, she directly acts as a shield and mediator between her child and the global food system. Understanding the social context and the historical moment within which families learn to make infant feeding decisions is critical for understanding their choices.

Breastfeeding: A Public Issue

Over the last few decades, there has been a concerted effort on the part of health care professionals and governments to support breastfeeding initiatives. In fact in many countries, public health policies and changes in work legislation have facilitated breastfeeding, especially among working mothers. This section provides a brief overview of policy initiatives that support breastfeeding; but it also recognizes the growth of a public discourse that is undermining these very same policy efforts.

Policy Initiatives That Support Breastfeeding

The WHO (2015) notes that on a global scale, approximately 36 percent of infants aged 0–6 months are exclusively breastfed, and they report that infants who are breastfed are generally healthier than those who are not. Yet the capacity to breastfeed is greatly influenced by the CARE nursing women experience, especially given that one's region or place of origin

dictates the social, economic and health policies that govern their lives. For example, Bendefy (2012, p. 19) reports:

> Provincial Human Rights Codes in Canada protect a woman's right to breastfeed in public, as does the Charter of Rights and Freedoms. Some provinces specifically address the right to breastfeed in the workplace. These laws generally outline ways that employers should accommodate a woman who needs to pump breast milk during business hours—for example, supplying a secluded place near an electrical outlet where a woman can plug in her pump and express milk undisturbed.

Shortall (2015) reviews US legislation and state laws that support expressing breast milk while working. She indicates that only 24 states 'have laws that relate to women in the workplace. They range from amazing … to totally toothless' (Shortall 2015, pp. 60–61). She further notes (p. 62) that

> Many women who are discriminated against or denied the ability to pump at work don't pursue legal recourse, because they need the job and are scared to lose it, can't afford the legal fees, or simply don't have the energy. So they just suffer discrimination at work, move on and find a new job, or stop breastfeeding to make the problem go away.

Obviously, living in a country or region where breastfeeding is encouraged will see higher rates of uptake than ones which do not.

Kam's (2015) story of how Cambodia increased exclusive breastfeeding from 11 percent to almost 74 percent in one decade reveals how effective strong public health policies and education campaigns can be at totally transforming a nation's breastfeeding culture. According to Kam, Cambodia succeeded in changing infant feeding culture through a barrage of media campaigns and interpersonal communications with new mothers. As part of their Baby-Friendly Community Initiative, they established mother support groups and retrained health care professionals to transform cultural traditions surrounding breastfeeding practices.

Since 1991 Canada and its provinces have also been developing, implementing and monitoring Baby-Friendly Initiatives (Breast Feeding Committee for Canada 2012). A key mandate of the national initiative has been to develop policies that promote breastfeeding anywhere, anytime. Specifically, they have sought to implement

> evidence-based practices [that] create environments that support and protect breastfeeding and family-centered care which ensures that the family unit learns about healthy eating practices from birth. (Breast Feeding Committee for Canada 2012, p. 11)

And while such agendas are laudable and critical for long-term breastfeeding success, public opinion is still very much divided over the benefits and need to breastfeed.

Public Backlash Against Breastfeeding

In August 2015, BBC radio host Alex Dyke was temporarily suspended from broadcasting for saying on-air that 'breastfeeding is unnatural. It's the kind of thing that should be done in a quiet, private nursery'. He was offended that a rather 'large' woman started breastfeeding her infant toddler on a bus—witnessing a toddler being nursed in public embarrassed him and he argued the nursing mother was guilty of placing him in an awkward situation. He further added, 'I know it's natural, but it's kind of unnatural. We don't want it in public. It was OK in the Stone Age, when we knew no better' (Johnston 2015, p. 17).

Meanwhile, a month earlier, in Wiarton, Ontario (200 kilometers northwest of Toronto), a nursing mother was asked to leave a restaurant because she began breastfeeding her baby on the patio rather than in the women's bathroom. How exactly things unfolded in this situation is unclear. But that women who opt to breastfeed in public are shunned, called out, or asked to 'cover up' remains a consistent message among breastfeeding women (see CBC News 2015).

This public backlash and shaming of women who breastfeed in public is emerging at the same time that a pro-bottle-feeding movement is gaining momentum calling for the cessation of stigma associated with women who opt for formula feeding. The pro-bottle feeding activists, some feminists and some members of the scientific community have been steadfastly questioning and outright challenging the positions and benefits of breastfeeding. Situated firmly in this camp, Wolf (2011, p. xiii) posits:

> In the absence of compelling medical evidence, how have scientists, doctors, powerful interest groups, and the general public come to be persuaded that breastfeeding is one of the most important gifts a mother can give her child?

Thanks to neoliberalism, argues Wolf, science, motherhood and public health authorities have a collective interest in framing breastfeeding as the best method of infant feeding. These three institutions essentially ignore any evidence that challenges the benefits of breastfeeding by 'restrict(ing) the kinds of questions asked, or the potential risks (of breastfeeding) worthy of investigation' (Wolf 2011, p. 67). It is the position that 'breast is best' that Wolf has the greatest aversion to and her position throughout the book is the 'public health message about breastfeeding is out of sync with both the infant-feeding science and the realities of many women's lives' (Wolf 2011, p. 146). Her final conclusion (p. 148) is

> Breastfeeding [advocates reinforce] traditional notions of women, their bodies and their 'natural' orientation toward caregiving; [breastfeeding] keeps women tethered to their babies and creates risks for them in a market that demands total commitment from 'ideal workers'.

Jung's (2015a) recently published book, *Lactivism*, contributes to the public backlash against breastfeeding by arguing that breastfeeding and breast milk are oversold as infant feeding strategies. But her position is rather interesting in that she lays out just how insidious the global food system has become with corporations creating and promoting the use of an extensive range of breastfeeding paraphernalia. In effect, in the world of infant feeding, one group of corporations is pitted against the other. According to Brady (2012, p. 529), corporations selling formula have annual sales exceeding US $31 billion, while Jung (2015b) notes, 'companies that manufacture breast pumps … and … breast-feeding accessories … like clothes, pillows and nutritional supplements' also represent big business. What this means is that regardless of what side of the debate the public is on, there are corporations on each side with vested interests in influencing and promoting particular scientific research programs.

What is striking about the unfolding public debate over bottle and breast, formula and breast milk, artificial and natural infant feeding practices is how both sides are feeling shamed and stigmatized in their efforts to learn how to feed their babies. Public breastfeeding is being framed as a cultural taboo—something insidious, 'unnatural', threatening, awkward and uncomfortable to witness. Breastfeeding is framed as exhibitionism. Lactating mothers who have their nursing children in tow are expected to set up feedings at mother-baby 'feeding stations' usually located in public washrooms. Is that where you want to eat your dinner? On the other hand,

women who choose formula and bottle-feeding feel that they are being publicly branded as 'bad mothers' who do not care about the health and well-being of their young children. Paradoxically, bottle-feeding a child in a public space never meets with the same reprisal as breastfeeding—in short, bottle-feeding is a perfectly acceptable, publicly sanctioned activity.

Conclusion

Even though health, medical, socio-economic and political reasons may cause women and newborn infants to opt for bottle-feeding, it is utterly nonsensical to argue that breastfeeding is 'unnatural' or that it belongs in the Stone Age. While infant formula and bottle-feeding may offer viable alternatives to breastfeeding, it is illogical to promote formula and bottle-feeding as the best approach for meeting an infant's nutritional needs. While no significant differences in long-term health outcomes *may* be present between bottle and breastfed babies in the developed world, Brady's (2012) and the WHO's (2015) overview of the situation for children in the developing world paints a different story. Rosen-Carole (2015) contends that rather than pit bottle versus breastfeeding mothers against each other, it would be a far more useful public debate to establish what social, economic and political conditions prevent women from around the world doing what is physiologically normal—in short, what are the obstacles to breastfeeding?

This is a very critical question for educators and social scientists interested in building a sustainable global food system because the production and delivery of human milk to newborns and young children represent the very core of human existence. To live, humans need clean air, water and food. Breastfeeding represents the absolutely shortest possible food supply chain. By learning to breastfeed or pump and feed human milk to her infant child, a mother directly acts as a shield and mediator between her child and the larger global food system. As noted earlier, how well fed the baby is depends in part on how well fed the mother is. Using bottles to deliver pumped breast milk does allow a third person to be involved in infant feeding, but the mother needs to remain in close physical contact—or have stored sufficient milk—for a prolonged absence to maintain the feeding pattern. While away, she must pump regularly to sustain her milk supply.

Despite the growth in breastfeeding paraphernalia, at least in theory, breastfeeding represents the least amount of technological implements

and tools for feeding infants. Of course, to be truly implement free (i.e., void of breast pumps) nursing mothers need to be enmeshed in social and economic policies that support them staying home with their newborns. When lactating mothers and nursing children are in public, they need to be able to feed and eat without reprisal. Despite public opinion to the contrary, breastfeeding is a *natural process* that is biologically and ecologically sound. Normalizing breastfeeding is an essential step in building a sustainable food system.

The public cloaking of breastfeeding has led to the loss of tacit knowledge and the invisibility of breastfeeding mentors. Breastfeeding is not something that women can practice before birth, but once their child is born, they have multiple opportunities for learning and perfecting the feeding technique. As the WHO (2015) notes:

> While breastfeeding is a natural act, it is also a learned behaviour. An extensive body of research has demonstrated that mothers and other caregivers require active support for establishing and sustaining appropriate breastfeeding practices.

I would argue that my journey with breastfeeding was successful because I was embedded in a strong support network—both at home and in terms of labor policies and maternity leaves which gave me the opportunity to be at home with my newborn and later to navigate home and work as they grew older. Also thanks to my socio-economic position, I had access to a plentiful supply of nutritious foods. This sense of emotional and financial security meant stress and anxiety were minimized; so my milk supply was never in jeopardy. I was able to breastfeed without fear of reprisal, and I never felt that nursing my children was threatening or undermining my sense of self or career goals. I would argue that these lessons—learned while breastfeeding my children—are the parameters that any global food system needs to achieve, if it is to be sustainable.

References

Bendefy, I. (Ed.). (2012). *Baby day by day* (Canadian Edition). London: DK Publishing.

Brady, J. P. (2012). Marketing breast milk substitutes: Problems and perils throughout the world. *Archives of Disease in Childhood, 97*(6), 529–532.

Breast Feeding Committee for Canada. (2012). *The baby-friendly initiative (BFI) in Canada: BFI status report*. http://breastfeedingcanada.ca/documents/BFI_Status_report_2012_FINAL.pdf. Accessed 25 Aug 2015.

CBC News. (2015). *Breastfeeding mom asked to leave Ontario restaurant*. http://www.cbc.ca/news/trending/breastfeeding-mom-asked-to-leave-ontario-restaurant-she-claims-1.3148210. Accessed 14 July 2015.

Fomon, S. J. (2001). Infant feeding in the 20th century: Formula and beikost. *The Journal of Nutrition, 131*(2), 409S–420S.

Food Banks Canada. (2015). *Hunger count 2015*. Mississauga: Food Banks Canada.

Health Canada. (2012). *Trends in breastfeeding practices in Canada (2001 to 2009–2010)*. http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/prenatal/trends-tendances-eng.php. Accessed 25 Aug 2015.

Heymann, J., Raub, A., & Earle, A. (2013). Breastfeeding policy: A globally comparative analysis. *Bulletin of the World Health Organization, 91*(6), 398–406.

Huggins, K. (2015). *The nursing mother's companion*. Boston: Houghton Mifflin Harcourt.

Johnston, I. (2015, August 14). DJ suspended after complaining about 'unnatural' breastfeeding. *The Independent*, p. 17.

Jung, C. (2015). *Lactivism: How feminists and fundamentalists, hippies and yuppies, and physicians and politicians made breastfeeding big business and bad policy*. New York: Basic Books.

Kam, R. (2015). *How one country went from 11% to 74% exclusive breastfeeding*. www.bellybelly.com.au/breastfeeding/country-from-11-to-74-exclusive-breastfeeding/. Accessed 25 Aug 2015.

Lightman, E. (2003). *Social policy in Canada*. New York: Oxford University Press.

Maher, V. (2015). Women and children first? Gender, power, and resources, and their implications for infant Feeding. In *Ethnographies of breastfeeding: Cultural contexts and confrontations* (pp. 187–208). London: Bloomsbury Acadmic.

Marshall, K. (2003). Benefits of the job. *Perspectives on Labour and Income, 4*(5). The on-line edition. http://www.statcan.gc.ca/pub/75-001-x/00503/6515-eng.html. Accessed November 15, 2015.

McMullin, J. A. (2009). *Understanding social inequality: Intersections of class, age, gender, ethnicity, and race in Canada*. Toronto: Oxford University Press.

Mills, C. W. (1959, 2000). *The sociological imagination*. New York: Oxford University Press.

Mohrbacher, N., & Kendall-Tackett, K. (2010). *Breastfeeding made simple: Seven natural laws for nursing mothers*. Oakland: New Harbinger Publications.

Murkoff, H., Eisenberg, A., & Mazel, S. (1998). *What to expect when you're expecting*. New York: Workman Publishing.

Neifert, M. R. (1998). *Dr. Mom's guide to breastfeeding*. New York: Plume Books.

Olver, L. (2004). *The food timeline—Baby food history notes*. http://www.food-timeline.org/foodbaby.html. Accessed 25 Aug 2015.

Roberts, W. (2008). *The no-nonsense guide to world food*. Oxford: New Internationalist.

Rosen-Carole, C. (2015). Promotion without support: A reply to editorials that attack breastfeeding advocacy. *Breastfeeding Medicine*. https://bfmed.wordpress.com/2015/10/18/promotion-without-support-a-reply-to-editorials-that-attack-breastfeeding-advocacy/. Accessed 20 Nov 2015.

Shortall, J. (2015). *Work. Pump. Repeat*. New York: New York Abrams.

Wiessinger, D., West, D., & Pitman, T. (2010). *The womanly art of breastfeeding*. New York: Ballantine Books.

Wolf, J. B. (2011). *Is breast best? Taking on the breastfeeding experts and the new high stakes of motherhood*. New York: NYU Press.

World Health Organization. (2015). *Maternal, newborn, child and adolescent health: Breastfeeding*. http://www.who.int/maternal_child_adolescent/topics/child/nutrition/breastfeeding/en/. Accessed 28 Nov 2015.

Wright, A. L., & Schanler, R. J. (2001). The resurgence of breastfeeding at the end of the second millennium. *The Journal of Nutrition, 131*(2), 421S–425S.