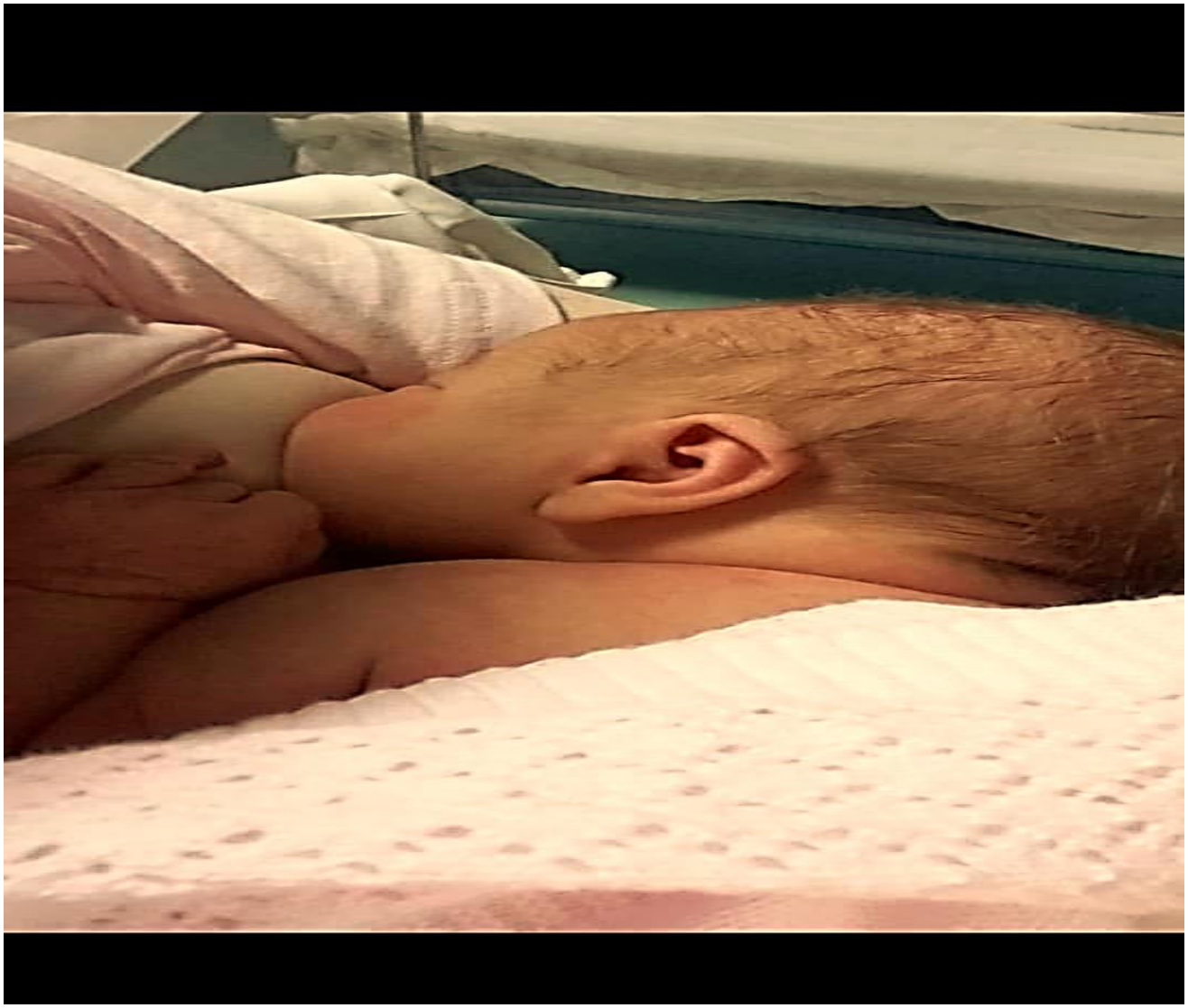
An Exploratory Study of Women's Experiences of Breastfeeding.

Can social and cultural understandings of gender be considered as a contributing factor for low exclusive breastfeeding rates in Ireland?



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Abstract

This project set out to explore the possible reasons behind low exclusive breastfeeding rates in Ireland which are amongst the lowest in the European Union. The literature reviewed for this project demonstrated that there are several factors which can influence women's infant feeding decisions. These included socio-economic factors such as age, social class and spatial location, and social and cultural norms and expectations relating to gender and gender roles. Taking a qualitative and feminist methodological approach, the data gathered through semi-structured interviews with eight women, revealed that there are complex and often interconnecting factors that can influence the relationship between women and infant feeding in contemporary society. While there has been much change in terms of access to information and support for women who want to breastfeed, this study found that societal and cultural understandings and expectations associated with gender plays a noteworthy role in terms of creating the conditions to achieve higher rates of exclusive breastfeeding.

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Chapter One: Introduction.

In contemporary society, increased focus has been given by public health officials in relation to increasing exclusive breastfeeding rates. Ireland is said to have one of the lowest exclusive breastfeeding rates in the EU. The Health Service Executive says that, "breastfeeding initiation rates in Ireland are currently among the lowest in the world, compared to initiation rates of 90 per cent in Australia, 81 per cent in the UK and 79 percent in the USA" (2016: 6).

In the context of a global public health drive to increase breastfeeding rates, breastfeeding advocates have presented breastfeeding as a mechanism by which a mother can provide her child with the best possible start in life (HSE 2106). Breastfeeding advocates have represented breastfeeding as a practice by which women can empower themselves, challenge gender stereotypes and take back control from the medical and business model of mothering and infant feeding (Van Esterik n.d.).

However, Goodwin and Huppatz argue that, "despite decades of feminist critique" (2010:1) around the representation of mothers and motherhood, "public policy, the media and popular culture" (2010: 1) continue to represent women in a way that powerfully shapes women's lives. Within the context of 'intensive' and 'good mothering' ideology, Carter et al say that in Western societies today, mothers are often pressured to breastfeed, a practice which is "widely publicised as the gold standard of infant feeding" (2018: 677).

Breastfeeding is understood here through the lens of gender and society, as a social practice and a form of personal and social identification as well as form of gendered performance. Focusing on literature on breastfeeding as a public health issue and as a social practice, this project will endeavour to explore the factors that contribute to the decision to breastfeed, but also the factors that influence the experience of breastfeeding in contemporary society.

Breastfeeding is a uniquely gendered practice and as such, this project will explore how social and cultural understandings of gender can influence women's experiences of breastfeeding. Taking a feminist, qualitative approach, this project will carry out eight semi-structured interviews to explore mother's experiences of breastfeeding in contemporary society. Reflecting on the ideas discussed above, this project is concerned with understanding the possible reasons behind breastfeeding rates in Ireland being amongst the lowest in the European Union.

Chapter Two: Literature review.

Introduction:

This chapter begins with a discussion around the social construction of gender, along with an explanation of Risman's (2004) theoretical framework for understanding gender. Following on from this, I draw on varying accounts of breastfeeding from a feminist perspective and then I reflect upon work that looks at infant feeding trends and studies around the incidence of breastfeeding from a historical and contemporary context. Some of this work includes analysis of whom is most likely to breastfeed and what factors can shape or influence breastfeeding durations.

This is followed by sociological literature on ideologies associated with social and cultural expectations around the performance of motherhood. Following on from this, a review of literature around cultural and social expectations and norms around the realities of breastfeeding. For example, literature relating to breastfeeding in public along with analysis of mothering and working whilst breastfeeding will be reflected upon and discussed.

The Social Construction of Gender:

Sex refers to the biological differences between men and women, whereas gender refers to the "social, behavioural and cultural attributes that are associated with being a man or a woman" (Warwick-Booth 2019: 55). From a sociological perspective, this means that gender is a socially constructed concept (Connell 1987). It is argued that social and cultural norms, values, beliefs and expectations influence the construction of gender, gender identity, gender roles and gender stereotypes. It is argued that cultural norms and expectations influence gendered behaviours in terms of what is seen to be normal and acceptable and what is not (Giddens 2001).

Through the process of socialisation, the social construction of gender and gender related norms and expectations continues (Giddens & Sutton 2017). For example, girls are socialised to be caring, nurturing and dependent and boys are encouraged to be tough, hardworking and self-reliant. Children also learn about expected gender roles through play. As we move through the life stages, the socially constructed expectations around gender roles and norms are reinforced in social institutions (Giddens 2001). For example, the behaviours and values we are taught through social institutions outside the family, such as the State, in schools, and through mass media play a dominant role in how we perform our gender roles.

Theoretical Perspective:

From a sociological perspective, social and cultural understandings and expectations of gender related norms is a contributing factor which can lead to gender inequality. Gender inequality is defined by Lorber (1994) as the devaluation of one sex over another or the social domination of one sex over another. It is said that gender inequality is produced and reproduced through the socially constructed norms, beliefs and expectations around gender behaviours and is reinforced by, and within, social structures in society.

Risman's (2004) ideas were chosen because this theoretical framework provides a way to understand the interconnections between gender and women's participation in the social world. Risman (2004) sees gender as a social structure. It is argued that just like other social structures, gender is responsive to individual action, which then responds to other existing structures "in ways that either reinforce or challenge" gendered expectations or norms (in Scarborough and Risman 2017: 2). It is argued that conceptualising gender as a structure, allows us to explore the relationships between gendered phenomena at an individual, interactional and/or an institutional dimension (ibid 2004: 446).

At an individual dimension, our identity is shaped by the process of socialisation, including the expectations and norms around the presentation of our physical body. At an interactional dimension, our interactions and experiences are often guided by the socially constructed gender stereotypes and norms around gendered behaviour. Dominant culture and ideology, reinforced by powerful social institutions such as mass media, play a significant role in reinforcing gender stereotypes, norms and expectations around gendered behaviour. At an institutional dimension, the dominant social and cultural ideals, norms and expectations around gender and gender roles can impact on the opportunity to participate in the public sphere.

Taking into consideration "the material and cultural processes that operate" at an individual, interactional and institutional dimension, it is argued that our "physical bodies, laws, or geographical locations" are reflective of the material processes which can impact our social lives. The cultural processes refer to the "ideological or socially constructed ideas" that influence or shape peoples' "perspectives or world views" (in Scarborough and Risman 2017: 2).

In applying Risman's ideas to motherhood and associated practices such as breastfeeding, it could be suggested that this theory of gender provides a useful framework for analysing how women's lives and experiences of infant feeding are influenced by social and cultural understandings and expectations around gender. For example, at an individual level, women's identities are shaped and influenced by norms and expectations associated with how we are socialised. At an interactional level, societal and cultural expectations and norms around gender roles and gender behaviour might influence how a person's identity or social role is performed. The opportunities for women in terms of participating in the economic sphere may also be influenced by societal and cultural understandings of gender. At an institutional dimension, societal and cultural expectations and norms in relation to gender can seep into organisational practices which can constrain some women's ability to do both mother work and paid work.

Feminist Standpoint on Breastfeeding:

Feminism is a long-standing social movement that has worked towards raising awareness of the social and political issues that can have an impact on women's lives (Connelly and O'Toole 2005). Bell Hooks says, 'simply put, feminism is a movement to end sexism, sexist exploitation, and oppression' (2010:1). Feminism and feminist theory focus on issues relating to discrimination, oppression and exclusion based on gender and sex, race and ethnicity, structural and economic inequality, power and oppression and the stereotypical gender roles placed on women in society (Inglis and Thorpe 2019). The literature discussed here was chosen because breastfeeding is a highly gendered practice which can influence the experiences and choices made by women.

For some feminists and breastfeeding advocacy groups, such as the World Alliance for Breastfeeding Action (2020), it is argued that breastfeeding allows women to use their productive and reproductive abilities to assert the value of the subsistence work that women carry out. For Van Esterik (n.d.), breastfeeding is a source of empowerment and reflects a woman's capacity to assert control over her own body. Breastfeeding is also perceived as a practice which challenges the "male dominated medical model and business interests that promote bottle feeding" (Van Esterik n.d.).

For example, it is suggested that infant formula manufacturers rely on women not to breastfeed for profits to be achieved. Van Esterik (n.d) states "the constant efforts of infant formula manufacturers to expand their markets for these products fuels advertising campaigns directed to women as consumers". Van Esterik contends that choosing to breastfeed allows women to challenge and reject the "media model of women as consumers". It is also argued that breastfeeding can reduce a mother's dependence on medical professionals. For example, in the context of increased medicalisation of childbirth, Van Esterik argues that when women choose to breastfeed, they "discourage the medicalisation of infant feeding".

However, not all feminist and women's groups agree with this perspective. For example, Robyn Lee (2012), highlights concern around how breastfeeding is presented as a choice that mothers can make, yet it is often influenced by powerful social forces which can constrain women's agency. Lee argues that in the context of contemporary infant feeding discourse, "the female subject is displaced by an emphasis on the health and well-being of the infant, resulting in an expanding list of self-regulatory behaviour for women to abide by" (2012: 94). For example, it is argued that expert and public health discourse "strips mothers of their roles as experts through the medicalization of childbirth and childrearing" (ibid 2012: 94-95).

Furthermore, Lee suggests that the current approach taken by public health officials reinforces gender stereotypes and expected gendered behaviours. For example, presenting breastfeeding as a natural practice, reinforces the idea that caring comes natural to women and because breastfeeding is part of women's "nature", mothers are expected to want to breastfeed and find it easy (Lee 2012: 95). It is argued that this presents a false description because breastfeeding can be challenging. This can lead to some women feeling like they have 'failed' at being a good mum (Lee 2012).

Hausman (2012) writes about 'Feminism and Breastfeeding: Rhetoric, Ideology and Material Realities of Women's Lives' in '*Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities*' (in Labbok et al. 2012). Hausman (2012) proposes that healthcare professionals and public health policy makers promote the idea that "breast is best" based on what scientific evidence tells them. It is suggested that because value continues to be placed on the health benefits of breastfeeding, women's "material difficulties and social circumstances" are often neglected to be taken into consideration. Hausman states, "in other words, women's experiences are treated as beside the point" (2012; p. 16).

Studies of Breastfeeding in Ireland

A Historical Context:

I chose to review Dr Michael Curtin's (1954) analysis because it provides an insight into infant feeding trends before infant formula became readily available in Ireland. Dr. Michael Curtin carried out a study to investigate the feeding history of 1007 babies in Ireland. It is one of the earliest studies of its kind in Ireland. The study reported that babies born in hospital were more likely to be breastfed than those born at home. Curtin also found that a higher proportion of mums from working class backgrounds succeeded in establishing breastfeeding but "by the end of the third month the incidence of breast feeding was much the same in all groups" (1954: 451).

It was observed that babies born into larger families were less likely to be breastfed with "eighty-two percent of babies, with three or more siblings, being artificially fed by the end of the third month" (1954: 450). Curtin recounted some of the reason's participants gave when breastfeed did not occur for longer periods. They included, "I don't believe in breastfeeding", "I don't feel up to breastfeeding", "I am too busy to breastfeed" and "I had not got enough breast milk" (1954: 454).

While Curtin wanted to promote a positive social attitude towards breastfeeding, he saw that mothers with several children could not invest all their energy in feeding one child. This indicates that the caring responsibilities a mother has can influence the infant feeding choices she makes. Curtin's (1954) analysis also identified that mothers who gave birth at home were less likely to breastfeed their children. This suggests that the type of support a mother has access to after childbirth is another factor that can influence infant feeding choices.

Contemporary Context:

Layte and McCrory (2014), explored maternal behaviours as part of the National Longitudinal Study, Growing Up in Ireland. According to their report, half the mothers in Ireland breastfeed their child on discharge from hospital and forty-seven per cent of babies are exclusively breastfed. Furthermore, they say that women from other EU countries who gave birth in Ireland, were "at least six times more likely to breastfeed than women from Ireland" (2014: 6).

Layte and McCrory (2014) say that a mother's socio-economic status was an influential factor in relation to maternal behaviours. It is reported that "women of higher income, education and social class were much more likely to breastfeed and tended to breastfeed for longer" (2014: 6-7). The study also showed that older women were more likely to breastfeed. Layte and McCrory (2014) found mothers who work full-time were one hundred and thirteen per cent more likely to stop breastfeeding compared to mums who did not return to work.

This indicates that participation in the economic sphere is a factor that contributes to infant feeding patterns and breastfeeding durations. The data here provides insight into the incidence of breastfeeding and the factors which influence infant feeding practices. Socio-economic factors such as age, social class, educational attainment, and employment status are factors that can contribute to the choices that mothers make in relation to infant feeding in contemporary society.

One of the changing trends seen over time relates to the socio-economic background of mothers and who were likely to breastfeed. For example, Curtin (1954) found that working class mothers were more likely to initiate breastfeeding, whereas, Layte and McCrory (2014) found that women from higher social class/professional backgrounds were more likely to choose to breastfeed. This indicates a shift in the patterns in relation to who is more likely to breastfeed.

Changing Trends: From Breast to Bottle to Breast.

Up until the mid-twentieth century, breastfeeding was perceived as the norm in Ireland. Most women did not have access to alternatives such as cow's milk. However, the invention of infant formula started to change this trend. Infant formula became available in Ireland during the 1950s (Tarrant and Kearney 2008), and it was from this point that women had the opportunity to choose between breastfeeding or formula feeding. As formula became less expensive, making it more accessible to all women, the incidence of breastfeeding started to decline, and the culture of breastfeeding started to become less the norm. Since its introduction into Irish society, the infant formula industry is one which has created great wealth for the Irish economy. It is estimated that the infant formula industry in Ireland is worth billions of euro yearly. According to the CSO (2017), 1.3 billion euro of infant formula was exported from Ireland in 2017.

Lubold says that since the 1970s, "aggressive manufacturing and marketing by infant formula companies, combined with cultural shifts, facilitated a move away from breastfeeding and towards formula feeding, leading to public health organisations to address the decline of breastfeeding" (2019: 1). Foss and Southwell (2006) suggest that increased advertisements by infant formula companies, in parent's magazines or on social media platforms, serves as a common thread regarding the changeable trends in relation to infant feeding practices.

However, despite the powerful presence of the infant formula industry in contemporary society, the incidence of any breastfeeding, which refers to the use of both breast and formula milk, has increased over the last several decades. Purdy and Cotter (2017) say that the number of babies who were receiving any breast milk on discharge from hospital increased from forty-nine percent in 2006 to fifty-eight percent in 2015. It is suggested that breastfeeding rates have increased because of the increased focus on breastfeeding by public health officials. Factors such as increased access to information and knowledge which allows women to make informed

decisions, along with factors such as migration are also said to contribute to increased breastfeeding rates.

Factors behind increasing breastfeeding rates:

It could be suggested that the increase in any breastfeeding rates is linked to increased awareness around the health benefits for both mum and baby. For example, the World Health Organisation (WHO) (2020) contend that breastfeeding reduces the risk of many common childhood illnesses and it can reduce the risk of childhood obesity. It is claimed also that through breastfeeding, a woman can "reduce the risk of breast and ovarian cancers" (WHO 2020).

Presenting breastfeeding as a mechanism by which women can improve their health is an example of a 'gendered public health claim. Woodward (2009) argues that "governments have long targeted the body as a means of creating 'good citizens' as expressed in the 'healthy mind healthy body' cliché" (2009; p. 143). Experts' direct breastfeeding information towards women to encourage them to behave in certain ways. Women are told that by doing what 'experts' claim is best infant feeding practice; they can improve not only their baby's health but also their own.

Migration as factor that has contributed to increased rates of breastfeeding:

Research suggests that migration into Ireland should also be considered when accounting for increasing breastfeeding rates (Gallagher et al. 2015). It is suggested that from 2004 (15.5 %) to 2008 (22.5 %), there was a seven per cent increase in the number of babies born to non-Irish born women (Gallagher et al. 2015). In 2018, 22.8 percent of mothers who gave birth were of a nationality other than Irish (CSO 2019).

Nolan and Layte (2014) say that changing patterns of "breastfeeding behaviour in Ireland may exhibit a healthy immigrant effect" (ibid 2014: 626). The 'healthy immigrant effect' refers to

the idea that the cultural practices and health behaviours of migrants can encourage positive change (ibid 2014). However, Nolan and Layte also note that as the length of time since migration increases, non-Irish women are inclined to "converge to native levels" (2014: 626). This may indicate that social and cultural norms and expectations around breastfeeding in Ireland have a strong influence over mothering practices such as breastfeeding.

Motherhood Ideology and Contemporary Breastfeeding Discourse:

I chose the literature discussed in this section because it is argued that ideology around motherhood, working alongside 'expert' discourse around infant feeding can shape and influence how women perform roles such as mothering. Arendell argues that "motherhood ideology reaches deeply into the lives of individuals and family processes; it shapes women's very identities and activities" (1999: 3).

Good Mothering' is a term used to describe the socially constructed ideas around the cultural norms and expectations in relation to acting out the role of mother. It is argued that intensive mothering, as a "paradigm of modern mothering" is guided by powerful cultural logic whereby, to be a 'good mother', you are required to invest intensively into the role (Prikhidko and Swank 2018: 278; Faircloth 2013).

Hays (1996) proposes that mothers strive for perfection by engaging with expert knowledge in child-rearing and that dedication to the good mothering ideology is demonstrated by staying home and caring for your child full time, and also by doing what 'experts' say is best practice. Marshall et al., reiterates this point, claiming that the "health professionals, social networks and the wider social and structural context" in which we live can influence and shape how women perform the role as mother (2007: 2147).

Knaak, in a multidimensional analysis of the construction of 'good mothering' and infant feeding discourse, claims that expert discourse around breastfeeding in contemporary society

is “an ideologically infused, moral discourse about what it means to be a good mother” (2010: 345). Knaak argues that “mothers in contemporary society are seen as having a moral and social responsibility to be risk conscious” (2010: 345).

Risk consciousness refers to how individuals in society are increasingly aware of and understand the risks associated with everyday life and as a result adopt behaviours that have the objective of managing, minimising or eliminating risk (Beck 1992). Knaak contends that, “within such a framework, mothers’ risk consciousness vis-a-vis infant feeding is activated primarily as an issue of identity of ‘good mothering’ as defined by the dominant, expert-guided, scientific-medical discourse” (2010: 345).

Wall argues that breastfeeding is portrayed in literature as “not only natural, but also as convenient, simple and enjoyable” (2001: 598). It is suggested that this presents a picture of breastfeeding as a “relatively easy process that any ‘motivated mother’ should be able to succeed at and find rewarding” (Wall 2001: 598). Wall says that “the moral constructions of motherhood” which work alongside “the neo-liberal preoccupation with individual responsibility” (2001: 595) situates breastfeeding as a maternal moral obligation and that this can impede upon a mother’s sense of self.

For example, Leeming et al. says that the way infant feeding is framed in breastfeeding literature can position mothers in a moral dilemma around “feeling potentially judged and obliged to account for themselves to others” (2017: 2). In their study on the impact of breastfeeding advocacy on a mother's sense of self, Taylor and Wallace use the term ‘maternal guilt’ to describe a mother’s negative self-assessment of themselves as a result of failing “to achieve an idealised notion of good motherhood” (2012: 76).

The analysis discussed here suggests that infant feeding practices are mediated by the social and cultural construction of gender, motherhood and femininity. It shows how social and

cultural ideology can shape expectations around social roles and can influence how these roles should be performed by women.

Breastfeeding in Public:

The articles discussed in this section were chosen because it is argued that breastfeeding is a "uniquely embodied part of parenting" (Stearns 2013: 359), that must be negotiated by mothers who breastfeed in public. It is suggested that the sexualisation of the feminine body in Western societies has led to the breast becoming a symbol of feminine sexuality, and this has influenced the acceptance of breastfeeding in public domains (Schmied and Lupton 2001).

Matthews in '*Reconfiguring the Breastfeeding Body in Urban Public Spaces*' (2019) says that "the breastfeeding body challenges normative understandings of gender, motherhood and sexuality in its participation and presence in public spaces" (2019:1266). Matthews contends that "the breastfeeding body is subject to overt and subversive forms of regulation and control in contemporary society" (2019: 1266). For example, to contend with the tensions between cultural and social expectations around feminine modesty and the laws around preventing a woman from feeding her child in public, the development of designated parenting or nursing rooms in public spaces has continued to increase. The development of designated spaces in public may be seen to reinforce the stigma associated with breastfeeding and sends a message to nursing mothers that they need to cover up or be discrete in order to negotiate this.

In her research around the representation of breastfeeding in media and public health campaigns, Giles (2018) says that representations of breastfeeding mothers and their children on many media platforms has increased over the past decade. Giles maintains that "familiarity with the health benefits of breastfeeding over formula, as well as social support and comfort with breastfeeding in social settings is a predictor of exclusive breastfeeding" (2018: 4). However, Giles found that, despite the 'Brelfie' era, which is the practice of taking selfies while

breastfeeding and sharing the images with online audiences, "most contemporary images of breastfeeding mothers and their children remain situated in the private domestic sphere, isolated and distanced from the everyday" (2018: 3).

It is argued that when images continue to represent breastfeeding as a practice which is best suited in a domestic setting, achieving familiarity can be challenging (Giles 2018). It is suggested that breastfeeding portraiture which represents breastfeeding as a practice "held at a reverential distance from everyday social interaction with others" can reinforce the idea that breastfeeding belongs in a space of seclusion (Giles 2018). It could be suggested that by continuing to portray breastfeeding in this way makes it harder to challenge social and cultural norms and expectations around the feminine body. It may also detract from the efforts to normalise breastfeeding in public spaces.

Combining Paid Work and Mother Work:

Structural Barriers:

In 1911, Charlotte Gilman argued that for progress to be achieved in terms of gender equality in the labour market, we needed a society that allowed women to be both mothers and workers. In reflection of the time at which Gilman was speaking, there has been much progress. Women's opportunity to participate in the labour market has improved over the last several decades. However, it is argued that despite much progress, women still experience considerable levels of inequality in terms of access to and participation in the economic sphere.

It is said that there are several structural barriers that can impact upon women's participation in the economic sphere when they become a mum, particularly so if they wish to continue breastfeeding (Brown 2017). For example, it is suggested that the length of time a mother breastfeeds for can depend on factors such as access to maternity benefits.

In Ireland, a woman is legally entitled to take twenty-six weeks paid maternity leave (Citizens Information 2020). Fathers can take up to two weeks paid maternity leave. An additional sixteen weeks maternity leave can be taken by both parents, but this is unpaid leave. However, Barry argues that the nature of parental leave in Ireland "reinforce the traditional roles of women as carers and continue to place women at a significant disadvantage in relation to paid employment and to income" (2015: 21). For example, Barry found that "women make up the majority of part-time workers in Ireland" (2015: 13). Barry argues that part-time work is becoming increasingly casual and benefits such as maternity benefits and even pensions can be impacted upon by this.

Research tells us that it is women who parent alone, or women from lower socio-economic backgrounds who are most likely to work in low paid precarious employment where maternity benefits and access to other social supports are often scarce or even non-existent (Barry 2015). Barry's (2015) analysis may provide an explanation for Layte and Mc Crory's (2014) findings in relation to women from lower-socioeconomic backgrounds being less likely to breastfeed. The literature discussed here indicates that socio-economic status can be a contributing factor that influences infant feeding choices. In the context of increasing levels of mothers who parent alone (CSO 2016) or the high levels of women who participate in the labour market on a casual basis, this may be a possible explanation for breastfeeding duration trends.

Cultural Barriers:

Working alongside barriers at an institutional and organisational level, women's infant feeding choices can be influenced also by social and cultural norms and expectations associated with gender and the feminine body. In their research on combining breastfeeding and paid work, Turner and Norwood say that, "the embodied experience of navigating both working and mothering is particularly salient for working women who breastfeed" (2013; 397). It is argued

that “the breastfeeding working mother has three strikes against her” (ibid 2013: 400). These are being a woman, being a mother and being a nursing mother. It is argued that women must “manage their maternal, lactating bodies within professional space and time” (Turner and Norwood 2013: 397) and this creates a tension for women who need to return to work but who also want to continue to breastfeed.

Matthews (2019) argues that women’s bodies are perceived as both natural and sexual and this creates a conflict for women who are managing the identity of both ‘ideal worker’ and ‘good mother’. Matthews (2019) contends that working nursing mothers must negotiate and manage her body in a certain way to abide by expectations and norms within society. This shows that social and cultural understandings associated with the feminine body can influence the performance of the role as mother while participating in the workforce.

Johnson argues that the “simultaneous demands for women’s workforce participation”, working alongside intensive mothering ideology, “place women in a double bind” (2019: 885). Johnson states that for nursing mothers who return to work, women must answer to two competing institutions. These are, “work, which values a disembodied, unencumbered worker; and breastfeeding, which values an embodied, continuous, maternal presence” (2019: 885).

It is suggested that a nursing mother’s participation in the workplace breaches the expectations surrounding the ‘ideal worker’. To be seen as an ‘ideal worker’, it is widely held that an individual is not only committed to the job, but that they also put in extra hours, remain on call and are willing to sacrifice their personal life for the good of the organisation (Ridgeway and Correll 2004). It could be suggested that being an ‘ideal worker’ is not compatible with societal and cultural expectations associated with gender and with being a ‘good mother’. In this context it could be argued that women’s opportunities to participate in the economic sphere are

constrained due to gender stereotypes and expectations. Under these circumstances, some mothers may have limited choice in terms of choosing between mother work and paid work.

Conclusion:

This project is interested in understanding the experience of being a woman and a mother, and the factors which might influence infant feeding decisions. The literature discussed here indicates that choosing which way to feed an infant is complex and involves several factors which can interconnect and influence the choices that mothers make along with the experiences associated with those choices. The ideas discussed throughout this chapter may provide useful insight in terms of understanding and explaining the data collected for this study.

Chapter Three: Methodology.

Research Problem.

Recently, concerns have been raised around the low rates of exclusive breastfeeding worldwide. Ireland has one of the lowest rates of exclusive breastfeeding in the EU. For example, the Health Service Executive says that "Ireland's rates of breastfeeding are amongst the worst in the world" (2016: 6). However, a criticism of the public health drive towards increasing rates of breastfeeding relates to contemporary infant feeding discourse which is perceived by some as moralising infant feeding. In this context, contemporary motherhood ideology and expert infant feeding discourse places a moral obligation on women to breastfeed. Not all women have access to the resources needed to breastfeed. Not all women who become mothers can or want to breastfeed. Some argue that women's material and cultural circumstances are neglected in expert discourse around breastfeeding (Hausman 2012).

Research Purpose and Design:

In the context of contemporary breastfeeding discourse, this project has the purpose of exploring the experience of breastfeeding in Irish society. The objective is to explore the factors that influence the decision around choosing to breastfeed and the factors that can shape breastfeeding durations. I wanted to explore the experience of breastfeeding from not only a contemporary perspective but also from a generational perspective.

My approach to answering this research question is taken from a feminist perspective. Letherby (2015) says that the recognition of "gender as a significant variable" (2015:77) within social research, has led to the development of feminist research approaches which are concerned with giving "continuous and reflexive attention to the significance of gender as an aspect of all social life and within research" (2015:78).

Letherby argues that "gender sensitivity within research is essential, as gender is a difference that makes a difference, even if it is not the only difference, or even the defining feature of a person's life" (2015:81). I believe that how gender is socially constructed contributes to how feminine practices like breastfeeding are both understood and experienced.

Throughout this study I have endeavoured to keep in mind that gender is an important variable in terms of explaining the experiences and accounts provided by the women who participated in this study. While I understand that my research is not generalisable to all women, I believe the data collected here is sociologically significant because it provides knowledge around the reality of women's experiences.

Research Type:

I believe that the most appropriate method in answering this type of question is a qualitative research method. McDonald says that "qualitative research aims to study people in their natural social setting" (2009: 46-47). Researchers who undertake qualitative studies aim to understand the meaning that people attach to their experiences within the social world (Bell 2005).

Research methods used in qualitative inquiries include, participant observation, case study, focus groups and interviews (Bell and Waters 2014). Weiss says that the use of interviews in a qualitative study "can shed light on events that would otherwise remain unknown because they happened in the past or out of public sight" (2004: 44).

Sampling Approach:

Sampling refers to the approach taken in relation to selecting from a population, the group, event or phenomena from which you want to collect data (Chambliss and Schutt 2016). The approach which will be taken for this project is non-probability sampling. Nonprobability sampling refers to "sampling techniques for which a person's, event's or researcher's focus's likelihood of being selected for membership in the sample is unknown" (Chambliss and Schutt 2016).

Types of nonprobability sampling includes, but are not limited to' purposive, snowball, quota or convenience sampling. The type of nonprobability sampling utilised for this project was snowball sampling. Snowball sampling refers to the process of participants being nominated or referred by another participant. Denscombe says that for small scale projects, "snowball sampling is an effective technique for building up a reasonable sized sample" (2014; p. 42).

Conducting the Research:

When discussing my project with a family member, I was put into contact with a Breastfeeding Lactation Consultant. This participant put me in contact with a colleague who also worked as a Breastfeeding Lactation Consultant. The remaining participants were recruited through a friend who had breastfed recently. To avoid the possibility of skewing my data, I chose not to interview my close friend. As she knew my standpoint on breastfeeding, and I did not want to create a situation where my own opinion would influence the response this individual might

give. However, she did put me in contact with women of her acquaintance who were willing to participate in the study. This is how the remaining participants were recruited.

All participants of this study were selected based on being women. All participants had either expertise in the area of infant feeding or had experience of breastfeeding or were able to talk about the perception of breastfeeding when they became a mother. Participants were aged between sixty-nine and thirty-one years of age

Name	**Age**	**Civil Status**	**Employment Status**	**Breastfeeding duration per child**
A: Carol	69	Separated	BF Consultant F/T	N/A
B: Michelle	43	Married	BF Consultant F/T	1 year
C: Maureen	60	Married	Retired	1 week 6 weeks 6 weeks
D: Marie	59	Married	Retired	N/A
E: Grace	36	Cohabitating	Employed F/T	3 months
F: Rachel	40	Married	Stay at home	6 weeks 6 months +
G: Emma	35	Married	Household Duties	6 weeks 6 months +
H: Chloe	31	Married	Employed P/T	Formula 6 weeks 6 months +

Ethical Considerations:

Due to the personal nature of the research topic, several ethical issues were considered.

Because the research topic involved intimate aspects of a person's lived experience, I wanted the participants to feel as comfortable as possible to avoid any embarrassment or unease about discussing their experiences. To achieve this, interviewees were asked to read and sign the consent form and if they were happy to take part in the study, we could then arrange to meet in a place most suitable and comfortable to them. I believe this was the best choice because during the interviews, participants appeared to speak openly about their experience.

Before interviews commenced, participants were informed that they did not have to answer questions they were uncomfortable with. They were under no obligation to take part and could withdraw at any time. Furthermore, participants were made aware that their identity would be anonymised. Their personal information and accounts of their experiences would be kept confidential. I asked participants for their permission to record interviews on my laptop which would be secured using a lock code and password. Participants were assured that all interview data would be permanently deleted once the data was transcribed.

Limitations:

I was aware that the personal nature of the topic had the potential to be perceived as sensitive. I devised my questions to ensure that questions did not come across as overly personal.

Subject Position:

As a White working-class woman, I have a certain set of value judgements around social class and gender. I also have my own experience of mothering and breastfeeding. However, I always endeavoured to remain unbiased in the collection and analysis of the data gathered for this study.

Conclusion:

This chapter has outlined the methodological approach taken to conduct this study. This project will be a qualitative study, and the method of collecting data for this project will be the 'standardised open-ended interview. A snowball sampling approach was undertaken. The data collected in this project was analysed from a feminist qualitative perspective, the limitations of this study and ethical considerations were also reflected upon.

Chapter Four: Analysis and Findings.

Introduction:

The data collected here had the purpose of exploring the experiences that participants had in relation to breastfeeding. The analysis is structured into different sections reflecting the themes drawn from the analysis of literature. The first section looks at the data collected from Carol and Michelle who both work as Breastfeeding Lactation Consultants. The following section reflects upon data collected from participants associated with cultural understandings of gender and the influence of social and cultural norms and expectations on mothering and infant feeding practices.

Then the socio-economic factors such as age and social class, which were identified by Layte and McCrory (2014) as being factors which can influence breastfeeding initiation and duration patterns, which came through in participants' experiences are reflected upon and discussed. The concluding section reflects upon the social and cultural understanding and expectations associated with gender that influenced participants' experiences of breastfeeding in public, but also how they shaped participants' opportunities to do both mother work and paid work.

Professional perspectives on the influence of breastfeeding promotion:

Carol and Michelle are both professionals in the area of infant feeding. They have many years' experience working in maternity hospitals in Ireland. Michelle also has experience of working in hospitals in other European maternity hospitals. The questions posed to Carol and Michelle

have the objective of exploring how professionals in the area of infant and maternal care view breastfeeding in contemporary society.

Carol says that she believes that increasing breastfeeding rates in Ireland can be attributed to the improvement of access to information and support within maternity hospitals over the last decade. Carol suggests that there are much more practical supports in hospitals now than there were when she started working over thirty years ago. She states; Carol: "*Women are invited to breastfeeding classes before her baby is born, more information is provided around breastfeeding at your first ante-natal appointment, and all mothers who have indicated that they intend to breastfeed can request to see a breastfeeding consultant before they leave the hospital*". Michelle also believes that mums in society today have more access than women had in previous generations. Stating that "*Mums today have much more support that their mums or nans had*".

Hausman (2012) argues that by focusing on the health benefits associated with breastfeeding, women's material and social circumstances continue to be neglected. To explore if breastfeeding promotion has influenced the approach taken by Carol, she was asked if there were any cases where a mothers infant feeding choice would be questioned.

Interviewer: In your role, if you were to meet a mum who wanted to breastfeed, but was finding it very difficult and it was impacting on her well-being, would you influence alternative infant feeding methods such as formula? Carol; "*no not really, my job is to encourage women to breastfeed and help them to do that. The issue is when they leave the hospital to go home, that link is gone. So, unless they have a support structure in place at home, these are the women who are more likely to turn to formula*".

The approach described here suggests that breastfeeding promotion can influence how healthcare staff work with women. It could be argued that the push to increase breastfeeding

rates has made mother's infant feeding choices more limited. This is an example of Hausman's ideas around how in the context of breastfeeding promotion and increased focus on the health benefit of breastfeeding, a mothers' experience becomes 'beside the point' (2012: 16).

Furthermore, while support networks are an important factor in terms of supporting women to recover from the experience of childbirth, it may be suggested that the belief that a mother needs support in order to succeed at breastfeeding is a reflection of gender stereotypes which are reinforced through the process of socialisation. Women have long been represented as dependent, this kind of attitude may be seen to reinforce that idea.

Gender Stereotypes, Breastfeeding Promotion and Mothering Ideology.

The literature discussed in chapter two indicated that breastfeeding is a practice which is mediated by the social and cultural construction of gender. It is argued that societal and cultural expectations around intensive mothering, situated alongside contemporary infant feeding discourse which promotes breastfeeding, presents to women, a powerful ideological and morally infused discourse around what is best practice in terms of mothering and infant feeding (Faircloth 2013; Wall 2001).

The "moralizing" of infant feeding was apparent in the accounts expressed by some participants in this study from both a generational and contemporary context. For example, Maureen is an older woman who has three adult children. She is married and lives in an affluent part of Dublin where she also grew up. Maureen says that when she had her first baby in the last 1970s, it was taken for granted that she would breastfeed and how she felt like it was something she should be able to do as a mother. Maureen describes feeling '*fraught disappointment*' when she found that breastfeeding was not as natural or easy to do as she was led to believe.

Maureen's experience is suggestive of an environment where expectations around mothering were guided by social and cultural understandings and expectations of gender. As a woman

who is perceived as naturally nurturing, and because Maureen had the biological capacity to breastfeed, Maureen was automatically expected to know how to breastfeed. When she experienced challenges, this impacted upon her sense of self and made her question her ability to provide her infant with the nutrition he/she required. This is indicative of Turner and Norwood's (2012) ideas around how women are made to feel guilty by the pressure placed on them to achieve an idealised version of motherhood.

Maureen describes how after eight days in hospital, she had to pretend to be ok at breastfeeding her newborn so that the 'sister' (a nun) would allow her to go home. Maureen: "*It was very hard; I was in a lot of pain. It wasn't just me, loads of us were in tears. I was in so much pain because my breasts were so sore from trying to feed **** (baby). When I asked the sister (nun) to help, she just painted this orange stuff on my nipples and told me to keep at it. I was kept in hospital for eight days and forced to stick at it. One of the Sisters told me I was staying there till I got it, but I wasn't shown how. I was completely drained, emotionally and physically.*

The way in which women were treated by members of powerful institutions in society, who had the ability to perpetuate and even reinforce gender stereotypes, may have contributed to the treatment Maureen experienced. For example, it is argued that "ideologically, powerful texts such as the Bible and the Irish Constitution situate women as objects in society" (Warwick-Booth 2019: 70). The lack of empathy shown towards Maureen, along with the way Maureen's experience seemed irrelevant to the 'sister', reflects this type of ideology.

However, Maureen describes how she managed to pull away from this control by turning to the commodified version of infant feeding. While the corporate version of infant feeding provided Maureen with an alternative to breastfeeding, it could be argued that both the health system and the business model of infant feeding both had influence over the way Maureen fed her child.

Rachel describes how she felt like breastfeeding was the only option she had in terms of feeding her infant. Rachel is a mum of two. She is in her late thirties and married. Rachel no longer works and is a stay at home mum. Rachel said that she had always intended to breastfeed. She was asked if there was anything that influenced her decision to breastfeed.

Rachel: "I felt very pressured that breastfeeding was the only option and it would be a major failure if I didn't do it".

Rachel's first baby was born in the late 2000s. It could have been that the information Rachel was receiving is reflective of the increasing awareness of and promotion to increase breastfeeding rates in Ireland at that time. However, Rachels statement indicates that there is a pressure placed on mums today to choose breastfeeding. From a sociological perspective, this is an example of how expert and dominant social and cultural ideology can shape and influence the choices that are made by some mothers.

Cultural Understandings of Gender: The influence of cultural norms and expectations:

Cultural and social factors that influence infant feeding practices include cultural understandings of gender, the expectations and norms around the feminine body and the dominant culture shared within a society. For example, research suggests that the likelihood of breastfeeding increases when a woman has lived in an environment where breastfeeding is embedded in culture and is seen as a normal practice (Pain et al. 2001). Peer relationships are also said to influence behaviour in relation to infant feeding choices (Gallagher et al. 2015).

An example of how cultural norms and expectations can influence infant feeding choices is drawn from Marie's account of her experience of becoming a mum. Marie describes growing up in a working-class community in a rural village. She had her first of five children in the 1980s. Marie met her husband when she worked as a cleaner in a hospital in Dublin and they married just before her first child was born.

Marie describes living in a community where breastfeeding was not the norm. For example, Marie states; "*everybody just gave their baby a bottle, it was just how it was back then".* Interviewer: Did you know anyone who breastfed? Marie: *"anyone I knew with babies gave formula; I didn't know anyone who breastfed*". Marie's infant feeding choices may have been a result of the cultural norms in her community. Marie also describes how the people around her also bottle-fed. This indicates that Marie's social networks may have also influenced the choices she made in relation to infant feeding.

Marie was asked if there was any reason that she thought could explain why nobody she knew breastfed. Marie*:* "*Back then you wouldn't even say the word breast to your own mother let alone a stranger. When I had my first baby it [breastfeeding] wasn't talked about the way it is today. You weren't allowed breastfeed in restaurants or anywhere, not the way you are today"*. Marie's statement around the language used in front of her mum indicates that there was a stigma around women's bodies in her family environment. This shows how gender related norms and stereotypes can impact on the way in which women perform social roles such as motherhood.

Furthermore, Marie says that breastfeeding was not allowed in public places such as restaurants. This indicates that breastfeeding was perceived as a breach of the norms in her society. It reflects how cultural norms and expectations around gendered bodies can result in women's behaviour being regulated and controlled in society. To explore if Marie believes there to be a change in relation to the acceptance of breastfeeding in contemporary society, she was asked the following question; Interviewer: do you think more women breastfeed today? Marie: *Definitely, you see more women out in restaurants, shopping centres, all 'them' places where you weren't allowed to do it in my day*. This indicates that there was a strong level of stigma around breastfeeding in Marie's community. It may have been that at this time there

was a strong connotation of sexuality associated with women's bodies played a crucial role in this.

Research tells us that when a woman's mother has breastfed, this increases the likelihood of multi-generational breastfeeding patterns (Pain et al. 2001). Marie stated that she did not know if her own mum had breastfed any of her twelve children. However, considering the data provided by Dr Curtin's (1954) study, it could be suggested that because Marie's mum had so many children, it is unlikely that she breastfed. However, Marie goes on to explain how her daughter did breastfeed but, described how her daughter is not comfortable breastfeeding outside the home. Marie states that she is not sure how she can help her daughter to feel more comfortable to breastfeed.

Reflecting on Marie's statement, it could be suggested that how Marie was socialised has limited her ability to help her own daughter to navigate the challenges associated with breastfeeding. It could also be argued here that Marie's conceptualisation of gender and gender related norms has resulted in a cross-generational transmission of shame around the feminine body between Marie and her daughter which has shaped Marie's daughter's experience of breastfeeding. This is an example of how cultural understanding of gender and gender related norms and values can influence and reinforce expectations and norms around the performance of gender and social roles across generations.

Socio-economic factors that Influence Breastfeeding Initiation and Duration.

Research tells us that socio-economic factors such as age, social status and spatial location can also influence infant feeding choices. Like Marie's daughter, Rachel, Emma. Grace and Chloe came from a familial background where breastfeeding was not the norm but also chose to breastfeed at least one or more of their children. However, in the accounts of the experiences they had in relation to making infant feeding decisions, participants demonstrated how age,

spatial location and social class were contributing factors in relation to the experiences they had.

Spatial Location:

Grace is a mum of one, she lives in a rural area of Ireland and she is aged in her mid-thirties. Grace returned to education after her child was born to upskill. At the time her baby was born, Grace was working as a photographer and was living with her partner. Grace indicated that she had always intended to breastfeed. Grace was asked if there was anything which influenced her decision to breastfeed.

Grace: "*Back when I had my son (in 2007), there wasn't too much information available to me. I had done my own research. There was information on the internet and in books but I would have liked to go to a class or something to hear how other mums did it and get some tips but there wasn't any where I lived*".

Through technology, Grace was able to do her own research which helped her to make an informed decision around infant feeding, but the access Grace had to social support in her community was limited. Research suggests that access to resources that provide peer support is an influential factor in terms of breastfeeding durations (Gallagher et al. 2015). Grace says that 'classes' in her community were limited or non-existent.

It could have been that Grace didn't know how to find out where the 'classes' were taking place. However, it could also indicate that a person's spatial location can determine access to resources such as support from peer groups. Limited access to social support may be a result of cultural and social norms also. If breastfeeding is not seen as the norm in society, or if there is stigma around the feminine body, less focus may be placed on developing social support for women who do want to breastfeed in that community. Here you can see how a person's spatial

location and gender are factors which interconnect and can influence access to resources and social supports but may also shape the performance of gendered roles such as motherhood.

Age:

It is reported in studies of the incidence of breastfeeding (Layte and McCrory 2014; Gallagher et al. 2015) that a mother's age is one of the indicators of breastfeeding initiation. Grace was asked if she could describe the societal attitude or expectation that was attached to infant feeding when she became a mum. Grace: "*Aside from my sisters who were supportive, I got a lot of, 'oh you're breastfeeding' and how long will you do that for, and why don't you just give a bottle. Even in the hospital, I was met with a shocking response that a 24-year-old would 'want' to breastfeed their child without being made to".*

Grace indicates here that hospital staff were surprised that a young mum would choose to breastfeed. This may be down to previous trends in relation to who is more likely to breastfeed. As discussed, Layte and McCrory (2014) and Gallagher et al. (2015) found that younger mums are least likely to breastfeed. It may have surprised hospital staff that a younger mum would want to breastfeed. However, in the context encouraging more mums to feel comfortable with making the decision to breastfeed, if younger mums are met with such a response, it could be argued that this is a contributing factor in relation to age and infant feeding trends.

Carol suggested in her interview that supports made available through breastfeeding promotion, such as prenatal breastfeeding classes, have been developed to help some mums to be more prepared for breastfeeding before they give birth. To note, this contradicts the notion that breastfeeding is a natural practice that all mothers should find easy and suggests that it is a practice which can be learned and takes time or experience to master.

Not all participants experienced the benefit of these classes. Emma is a mum of two children aged between two and seven. Emma is in her mid-thirties and she is married. Emma said that

she gave up her role as a schoolteacher after she had her second child and had always intended to breastfeed. Emma was asked if she could describe her experience of becoming a mum.

Emma: "*The whole experience was nerve racking. I wanted to breastfeed because the nurses were telling me it was better for the baby and you see it everywhere*". *Being a young mum, I didn't think about going to classes".* Emma indicates that her age was a factor which shaped the access she had to some maternal supports. This indicates that potentially she was not offered the opportunity to attend a class. This may stem from research which describes young mums as being the unlikeliest to initiate breastfeeding. It could also be the case that Emma did not feel comfortable going to breastfeeding classes.

Reflecting on Emma's experience, it could be suggested that targeting supports towards the needs of young mums, may help in changing the trends in relation to age and breastfeeding patterns. This may also help with breastfeeding rates from a generational perspective. If more young mums are encouraged to breastfeed, the stigma around breastfeeding and women's bodies may be reduced for the next generation.

Social Class:

Emma was asked what had influenced her decision to breastfeed. Emma: "*Like it was my first baby so I was looking at mam's pages on the internet and that, or I looked at magazines, and everyone I met were all saying you should breastfeed because it's better for your baby*". This suggests an element of societal or peer pressure attached to infant feeding practices. Stemming from middle class ideologies and practices (Faircloth 2013), it is suggested that contemporary mothering and infant feeding discourse can create a sense of societal/peer pressure on mum's today to breastfeed. Emma is a schoolteacher. This suggests that she has a high educational attainment level which then also indicates that she may be from a middle-class background.

If Emma's social circle was one whereby breastfeeding was perceived as a practice that determined the status as 'good mother', it could be suggested that her decision to breastfeed may have been influenced by both her social class and contemporary discourse around 'intensive mothering' and infant feeding. Emma's case is an example of social and cultural norms and expectations around gender and gender roles, along with a person's social class are interconnected and can influence how motherhood and practices associated with mothering is performed.

Factors that Influence the Performance of Gender and Social Roles.

Public perception:

Research tells us that one of the cited reasons why women tend not to breastfeed is because they fear being judged or embarrassed about doing so in public (Layte and McCrory 2014). Participants were asked to describe the experience they had in relation to breastfeeding in public.

Rachel was asked if her experience/feelings associated with breastfeeding differed at home compared to feeding her baby in public? Rachel: "*Yes, definitely. I was always very discreet when feeding but still got dirty looks from people, mainly older women. One friend was asked in a café to take her baby into the toilet to feed, which she refused*". Interviewer: why do you think people still judge women who breastfeed in public? Rachel: "*Some people can't separate the sexual connotation of breasts from the functional purpose and seem to think it's in some way dirty or rude. That's just my opinion*".

Rachel's experience demonstrates the ways in which societal and cultural gender norms and expectations can lead to a breastfeeding mother's behaviour being frowned upon, regulated and controlled. Rachel's account here suggests that there is still a stigma associated with

breastfeeding in public and it is still as prevalent in contemporary society as it was in Marie's account.

Chloe's experience has been more recent and describes a different experience of breastfeeding in public. Chloe has three children; she is married and has worked part time since her first child was born thirteen years ago. Her second and third children were born in 2013 and 2019. Chloe said that she did not breastfeed her first baby but did on her second and third babies. Chloe describes breastfeeding her third child in public to be a lot easier than the experience she had when she first breastfed her second child seven years ago. Chloe says that she felt it was much easier to feed **** [youngest baby] because there were more places to breastfeed when you are out and that she has also "*learned techniques to cover up*" to make the experience less daunting.

There are many factors which may have contributed to Chloe's improved experience of breastfeeding in public. There is a six-year gap between Chloe's second and third child, it could be that the increased focus on increasing breastfeeding rates has contributed to more acceptance of breastfeeding where she lives. It could be that her maternal experience has developed overtime, and this could have helped Chloe to feel more confident about breastfeeding in public. It could also be due to her age, as she has become older, she may not have paid as much attention to what people think as she did when she was younger.

However, both Rachel and Chloe both describe how they were either discrete or learned ways to cover up when breastfeeding in public. This suggests that women still feel that they must negotiate the practice of breastfeeding in public. It could be suggested then that due to societal and cultural norms and expectations associated with gender, nursing mothers must learn ways to manage breastfeeding in public in order not to breach these norms. Despite increased representation of breastfeeding in society today, this shows that the feminine body, and the

social and cultural understanding associated with the feminine body, is a factor which reproduces gender norms and expectations and influences how motherhood and associated practices such as breastfeeding are performed.

Combining Mother work and Paid work.

Where gender is a factor that leads to unequal opportunities, unequal access to resources or other constraints based on one's biological traits, this can lead to gender-based inequity in relation to political, economic and social status (Connell 1987). It is argued that when a woman becomes a mother, gender inequality in terms of participating in the economic sphere becomes even more prevalent (Smith 2013).

Maureen describes being lucky enough to be able to be a stay at home mom and Rachel says that after her first baby, her job was made redundant, so she did not have to worry about going back to work after her second child. Grace describes how she had trained as a professional photographer and because she had worked full time for three years, she also had access to maternity benefits that allowed her to take extended time away from work. All three participants describe having supportive partners who worked to support the family while they remained home to care for their child/children. In a contemporary context, while more men are taking up more responsibility in the domestic sphere, responsibility for primary care giving and household duties continues to be placed on women in the household. The accounts described here may suggest that it is still much more likely for women to remain in the home in lieu of returning to employment after having a baby.

Chloe also had a supportive husband who works full time. She describes how she had to start weaning her baby after five months so that she could return to her part-time job when her maternity leave ended. Chloe stated that the family relied on both her own and her husband's wage to "*be able to afford the bills*". This statement illustrates how some women must negotiate

both mothering whilst also contending with the 'neoliberal preoccupation with individual responsibility' which requires women's participation in the labour market (Wall 2001).

Chloe was asked if she had thought about continuing to breastfeed whilst she worked. Chloe: "*No, I planned to wean for when I returned to work, so it all went smoothly and according to my plan. My plan would have been different if I knew there were options to continue to breastfeed while working like a room to pump or an extra break*".

Chloe's statement here indicates that 'her plan' to return to her part time job was not only influenced by the financial situation of her family, but it was also influenced by a lack of facilities that would allow her to do both mother work and paid work. It could be suggested then that the place that Chloe works is centred around the needs of the 'ideal worker' or the male model worker.

At an institutional level, some women are not supported to continue breastfeeding whilst also working. For example, employers in Ireland are not legally obligated to provide women with the facilities or extra breaks needed to express breastmilk or to breastfeed (Citizens Information 2020). If women do not have the resources available to them to do both mother work and paid work, and if paid work is not an option to give up, then this may be a reason why exclusive breastfeeding rates are so low. Chloe's experience then is an example of how a person's socio-economic status, of how organisational structures that centre around the needs of the ideal worker, and how institutional practices can interconnect and constrain some women's lives.

Smith (2013) says that a failure to "provide the support the female body needs to fully participate in the social world" (2013: 373) is a failure to recognise the value of and unique ability of women, and this creates obstacles that constrain women's lives. When structural barriers constrain the choices or opportunities for mothers to do both mother work and paid

work, then this is a system that reinforces gender inequality based on norms and expectations around gender roles and gender stereotypes.

Conclusion:

The analysis here shows that participants' experiences of infant feeding is influenced and shaped by many factors. It can be shaped by mother's experiences, by the generation they are born into and by social class. Age is also a factor as is a person's spatial location. In terms of access to social support and information that may help women's experiences of breastfeeding but that may also encourage younger mums to feel able and ready to breastfeed also.

In the context of gender stereotypes and constructions of femininity, women's experiences of breastfeeding are often guided by dominant social and cultural norms associated with expectations around gender role and behaviour. Social and cultural understandings of gender can also create structural barriers in terms of performing motherhood but also in terms of participating in the economic sphere. Despite progress in terms of improving gender equality, women, especially when women become mothers, and even more so when they choose to breastfeed, can be constrained in performing dual roles of both mother and paid worker.

Chloe's trajectory shows us how all the things I have discussed so far can interact over the life course and can shape the performance of not only motherhood but also the ability to perform the additional role as paid worker. Chloe's described how with each new experience of becoming a mum, she grew into her role as mother, she became more confident, and she learned how to negotiate infant feeding practices. Over time you can see how Chloe came to understand the value of breastfeeding. However, Chloe had to choose between continuing to breastfeed or returning to work. Chloe's case also exemplifies how gender norms and expectations, along with social and cultural expectations around motherhood and infant feeding interact and sit in tension with her need to work.

My research also suggests that there are factors that make breastfeeding feel individual to women and this makes women feel responsible for the outcomes of their children. However, the literature reviewed for this project, along with the data gathered here, demonstrates that there are broad complex factors that influence infant feeding patterns, factors that at an individual level can be challenging to overcome. My interviewees showed how societal and cultural perceptions can impact women's breastfeeding practices. It appears to me that health promotion programmes do not address the complex social and individual factors that shape a mother's decision about how to feed her infant(s). The slogan 'Breast Is Best' offers no actual support for mums to breastfeed. Some of the messaging and supports are not nuanced enough or agile enough to compensate for either material or resource deficits for some women.

Chapter Five: Discussion and Conclusion.

This project set out to explore the possible reasons for low exclusive breastfeeding rates in Ireland. In the context of increased awareness and promotion of breastfeeding, this project was concerned with understanding the factors that influenced infant feeding choices and experiences related to breastfeeding in contemporary society. To do so, this project reviewed literature in relation to breastfeeding in contemporary society. Historical and contemporary studies in relation to the incidence of breastfeeding in Ireland were analysed. Following on from this, eight women agreed to be interviewed. Participants were selected on the basis that they were women with some sort of experience in relation to either breastfeeding or an awareness of the norms and expectations around breastfeeding in their social world. Based on my analysis of interview data, I argue that there are a range of broad complex factors that guide and influence the relationship between motherhood and infant feeding patterns.

In the context of changing trends and norms in relation to who is more likely to breastfeed, it could be suggested that some participants have begun challenging the norms illustrated in

previous research. For example, Rachel, Emma, Grace and Chloe came from familial backgrounds where breastfeeding was not the norm. They made the decision to breastfeed at least one of their children. Grace and Emma were young mums when they had their first babies, and this suggests that a mother's age in terms of the likelihood of breastfeeding may also be changing. Contemporary infant feeding discourse may be playing a role in this. It could be that Grace and Emma's decision to breastfeed was influenced by their social class and the ideological expectations around 'intensive mothering'. Their decision to breastfeed may also have been influenced by increased focus on breastfeeding by public health institutions also.

In the context of the social and cultural conceptions of gender and the norms and expectations around the feminine body, attitudes towards mothering and breastfeeding have improved compared to the generational perspectives provided by Maureen and Marie. This indicates that there has been some change overtime. For example, factors such as institutional control over the relationships between women and their children have improved. Laws, regulations and standards have contributed to this. Drawing from Maureen's experience, the way she was treated by members of the clergy when she had her baby is no longer the norm, nor would it be accepted in Ireland.

However, in terms of social and cultural understandings of the norms and expectations around gender and the feminine body, there still seems to be an element of stigma around practices such as breastfeeding in public. Today it is illegal to ask a woman to leave an establishment for breastfeeding, yet the stigma associated with breastfeeding in public does not seem to have subsided. It is evident in Rachel and Chloe's experiences that breastfeeding has yet to be fully accepted in society. The way in which society continues to maintain social control over those who are seen to breach social and cultural norms relating to gender may be drawn from the development of designated breastfeeding areas. It could be argued that these spaces in the public arena are just less authoritative forms of regulating nursing mum's behaviour. This was

evident in Rachel's account where she explained how her friend was asked to feed her baby in a bathroom when they had been dining out.

In the context of breastfeeding promotion, women today have more access to information and social support in relation to breastfeeding than women in previous generations had. However, in the context of increasing pressure from public health institutions in relation to increasing breastfeeding rates, I feel that some of the discourse presented to all women is not well suited to address the needs of all women. Considering both social and individual factors that can shape women's decision making around infant feeding, I argue that the promotion of breastfeeding by public health officials is not compatible with all women's lives.

My research suggests that Irish women have both different levels of access to social support and unequal access to resources which can contribute to the infant feeding decisions they make. Some women may not have support from family or peers in terms of being prepared for the challenges associated with breastfeeding. Other women may not have access to maternity benefits or support from their employer which might allow them to breastfeed for the recommended six months or more. Other mothers may live in a section of society where breastfeeding is not the norm. Some public health messages presented through breastfeeding advocacy discourse are not nuanced enough to compensate for complex factors that can influence women's breastfeeding practices and experiences.

In the context of 'intensive mothering', it could be argued that women from higher social classes are under increased pressure to breastfeeding in contemporary society (Faircloth 2013). This is evident in some participants' accounts. For example, Emma felt that breastfeeding was the only option for her, she was encouraged to breastfeed by her peers and by those she interacted with online. However, when Emma did breastfeed, she still had to contend with societal and cultural expectations around gender behaviour.

This suggests that there is a tension between this version of motherhood and breastfeeding practices that must be negotiated by all women but can also be shaped or influenced by a mother's social status. Regardless of social class, women are beset with pressure to do motherhood well and 'right'. Contemporary motherhood ideology, that is the practice of committing to caring intensively for your child in accordance with expert discourse (Knaak 2010), situated alongside public health pressures to breastfeed, contributes to the pressure on women to perform this social role a certain way.

Looking at infant feeding expectations in contemporary society give you a sense of how neo-liberal society creates a situation whereby women are expected to make themselves available to do both mother work and paid work. For women who need to work to survive, this can be challenging. An example can be drawn from Chloe's experience.

Chloe chose to breastfeed and was encouraged to do so by healthcare professionals. Chloe also needed to return to work after her paid maternity leave period had elapsed. However, in her place of employment, there was little recognition of Chloe's role as mother in terms of providing the facilities she needed to continue to breastfeed. In reflection of Chloe's experience, it could be suggested that workers are assumed to be free of any constraints which might impede the 'ideal' worker model. It may be that supporting 'mother work' is not seen as a valuable investment as it is the unencumbered worker which is most effective in terms of generating capital.

In this context, you can see how neo liberal ideology, the infant formula industry and the labour market interconnect. For example, for nursing mothers who must return to work to support their family, but where there are no facilities to continue breastfeeding, the infant formula industry provides an alternative. It might be suggested that the labour market rely on the infant feeding industry to provide workers with alternatives to embodied mothering practices such as

breastfeeding in order to create unconstrained workers who are free to focus on their role in the workplace.

In the context of the gendered division of labour and the opportunity to participate in the economic sphere, feminists and women's rights advocates have fought hard to change attitudes towards expectations and norms around gender roles. The increasing number of men who are taking responsibility for domestic work is evidence of changing trends in relation to who has primary responsibility for care and domestic work in the home. Partnership negotiation plays a role in women's opportunities to breastfeed for the recommended six months.

However, even where participant's partners were supportive, many participants did not breastfeed for the recommended six months or more. The participants who did breastfeed longer term, expressed returning to work as the reason they weaned their baby from the breast before returning to work. This indicates that wider social support is a major contributing factor in relation to Ireland having one of the lowest exclusive breastfeeding rates in Europe.

The embodied act of breastfeeding is not something a partner or husband can do unless they want to buy into the commodification of breastfeeding. This can be expensive and not accessible by all families. Be it the celebrity endorsed expensive breast milk pumps or other gadgets which 'make breastfeeding easier', the consumer industry has managed to commodify breastfeeding. This has made breastfeeding a practice which is no longer as cost free as presented by breastfeeding advocates.

In conclusion:

Breastfeeding is an exclusive feminine practice that in the biological sense, only women can do. This makes breastfeeding a predominantly gendered practice. Any discourse around breastfeeding, be it from 'experts' or otherwise, needs to consider the material and cultural constraints that can influence the performance of gender roles. Reflecting on the experiences

described by participants, I feel that contemporary breastfeeding discourse may be challenging this. I argue that while breastfeeding promotion has improved access to resources such as information and social support, this is available to some mothers more than others.

I find Smith's (2013) argument to fit quite well here. Smith states that, "seeing breastfeeding as a cause of negative effects ignores the role of structural inequalities. Rather than focus on breastfeeding bodies as a constraint, research should instead focus on socially created norms and institutions, often constructed upon a framework of biological differences, which sustain gender inequities" (2013: 372). Going forward, I believe that we need to continue challenging the social and cultural understanding of gender and the feminine body.

We need to ensure that the unique role played by mother's in society is valued by those with the most power to create change. We also need to ensure that all mother's material and cultural circumstances are taken into consideration. Unless we can achieve this, I do not feel that breastfeeding promotion will make meaningful progress in creating the conditions where high rates of exclusive breastfeeding can be achieved. I believe that pushing the breastfeeding movement without taking due consideration to all women's needs, may reinforce and perpetuate differential outcomes among and between genders.

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Appendices One: Special Topics Consent Form 2020.

Thank you for agreeing to take part in my assignment for my Special Topics module in the department of Sociology at Maynooth University, NUIM. My research is designed to explore how women experience and navigate expectations around motherhood and infant feeding. I am particularly interested in experiences associated with breastfeeding.

This interview will take up 30 minutes and with your permission I would like to tape record the conversation. A copy of the interview tape will be made available to you afterwards if you wish to hear it.

All the interview information will be kept confidential. I will store the tapes/notes of our conversation safely i.e. promptly removed from mobile devices and kept in a secure manner. Your identity will be kept confidential and I will use a code number/pseudonym to identify your interview data. Neither your name nor private information will appear in the final research project.

Your participation is voluntary. You are free to refuse to take part, and you may refuse to answer any questions or may stop at any time. You may also withdraw at any time up until the work is completed.

If you have any questions about the research, you may contact me at:

gillian.mcginley.2018@mumail.ie or alternatively 0851298562.

"I have read the description above and consent to participate."

Signed_____

Date _____

If during your participation in this study you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact my supervisor at Pauline.Cullen.mu.ie Please be assured that your concerns will be dealt with in a sensitive manner.

Appendices Two: Interview Questions.

1. Can you tell me a little bit about yourself, your family and your experience of becoming a mum?
2. Can you describe your expectations around becoming a parent?
3. Did anyone give you advice around what to expect and if so, can you give some examples?
4. What support network did you have in place before and after you gave birth? Can you give some examples of how they supported you?
5. Can you remember and give a brief explanation of what information was provided to you in hospital around infant feeding before and after having your baby?
6. On a personal level, can you describe to me your own experience of breastfeeding.
7. How would you describe the representation of breastfeeding in the media or in brochures from the hospital or clinic or other literature you might have read?
8. Do you feel that it accurately represented the reality of breastfeeding?
9. Can you explain the societal attitude or expectation that was attached to infant feeding when you first became a mum?
10. In your opinion, has the perception of breastfeeding changed overtime and if it has can you explain how?
11. At a societal level, did you face any challenges in relation to breastfeeding? And if so, can you explain what they were?
12. Did your experience of breastfeeding differ at home compared to if your baby needed to be fed in public?
13. Did you attend any support groups like community groups for mums or maybe La Leche league?
14. Research tells us that some women choose not to breastfeed because they feel embarrassed to do so in public or they do not feel comfortable doing so in front of other people. Why do you think someone might feel embarrassed to breastfeed in a public place?
15. Some women have said that they express milk into a bottle if they are going to be out in public with their baby. Have you and if so why?

16. How do you think breastfeeding has or might impact on your work life?
17. Were there provisions made in your workplace where you could have continued to breastfeed?
18. Are there any personal challenges you faced in relation to returning to work after you had your baby?

Appendices Three: Interview Transcript.

Maureen:

Interviewer: Did you think about which way you were going to feed your baby before you gave birth? Maureen: "*when I had my first baby in hospital, it was taken for granted that I was going to breastfeed. I was a new mum and hadn't a notion about what I was supposed to be doing. I felt I was just supposed to be able to do this, but I really wasn't".*

Interviewer: Can you describe how you managed feeding in the first few days? Maureen: "*It was very hard; I was in a lot of pain. It wasn't just me, loads of us were in tears. I was in so much pain because my breasts were so sore from trying to feed (baby). When I asked the sister (nun) to help, she just painted this orange stuff on my nipples and told me to keep at it. I was kept in hospital for eight days and forced to stick at it. One of the Sisters told me I was staying there till I got it, but I wasn't shown how. I was completely drained, emotionally and physically.*

Interviewer: That must have been hard, if you can recall, do you mind describing how that made you feel? "*I was fraught with disappointment, I felt I was letting my baby down and I just wanted to go home. We decided the only thing to do was pretend I was ok at feeding my baby so that they would let me leave. On the way home Myself and my husband made the decision to stop at the chemist and get the stuff we needed to feed (baby).*

Chloe:

Interviewer: Can you tell me a little bit about yourself, your family and your experience of becoming a mum? *Chloe: I am thirty-one and recently married. I have 3 children with an. 8-year gap between them. I have worked part-time since my first baby was born and my husband works full-time. We recently moved into our forever home.*

Interviewer: What expectations did you have around becoming a parent? Chloe*: As I can imagine with most new parents, I aimed to be the best parent possible for all my children, and as with most things our expectations and the reality are often quite different than imagined.*

Interviewer: Did anyone give you advice around what to expect and if so, can you give some examples? Chloe: *I think there can be general advice with friends and family and their experiences that's passed on*

Interviewer: What support network did you have in place before and after you gave birth? Can you give some examples of how they supported you? *Chloe: I'm lucky in the sense that I have 2 older sisters and 2 younger, and moved back home to my mom's house after I had my first child, so I had plenty of help and support in every type of way, be it advice on how to wind or feed my baby, or nappy rash creams and also hands on help if I needed a babysitter.*

Interviewer: Can you remember and give a brief explanation of what information was provided to you in hospital around infant feeding before and after having your baby? *Chloe: On my first pregnancy (2007) I was asked at my first antenatal appointment how I would like to feed, I answered bottle and that was it until I was in the labour ward where I was asked the same question again, I answered bottle again and that was that.*

On my second pregnancy (2012) I answered saying I wanted to try breastfeed this time around, again in labour I was asked and I said breast feed, later in the day when my baby was born I was given a bottle to settle him. i gave him this but continued breast feeding when I went home

On my third pregnancy (2019) again I was asked at first appointment, I was also advised of any classes that were happening in the maternity hospital, I was diagnosed with gestational diabetes and I was encouraged to breastfeed and to start harvesting colostrum antenatally and went to a class to support this. After giving birth my baby was experiencing some effects due to being born to a mother with gestational diabetes and formula was needed to help this.

Interviewer: On a personal level, can you describe to me your own experience of breastfeeding. Chloe: *I am lucky to have had a good experience with both my breast-fed children, we managed to breastfeed successfully with no major issues, both babies thrived and gained weight and it just worked for me and my family.*

Interviewer: How would you describe the representation of breastfeeding in the media or in brochures from the hospital or clinic or other literature you might have read? Chloe: *I think it has come on leaps and bounds as the years have gone on. It is very encouraging to see.*

Interviewer: Do you feel that it accurately represented the reality of breastfeeding? *Chloe: In my experience it has, but I can imagine if someone is experiencing difficulties it might not be such a pleasant experience as it is often portrayed in the media and brochures*

Interviewer: Can you explain the societal attitude or expectation that was attached to infant feeding when you first became a mum? Chloe: *In 2007 it was so normal to just give a bottle, very little advice was given about breastfeeding and no encouragement, the only people who seemed to have breastfed in the hospital were foreign women, who I think contributed to breastfeeding becoming more normal in Ireland today. But I feel the societal attitude has changed a huge amount from when i gave birth to my first child in 2007 to when i gave birth to my 3rd in 2019, and i hope that this continues to improve as the years go on.*

Interviewer: In your opinion, has the perception of breastfeeding changed overtime and if it has can you explain how? Chloe: *The information, especially the medical advice has come on leaps and bounds, the encouragement and support nowadays and then just witnessing babies being breastfed publicly. I hope to see this continue and support breastfeeding becoming the natural choice for new mothers now on.*

Interviewer: At a societal level, did you face any challenges in relation to breastfeeding? And if so, can you explain what they were? Chloe: *It can still be quite daunting to feed in public as*

a lot of people would still have quite old-fashioned views when it comes to breastfeeding in public, fortunately this has improved as the years have gone on.

Interviewer: Did your experience of breastfeeding differ at home compared to if your baby needed to be fed in public? Chloe: *Yes definitely, I would still be shy at feeding outside the home but with experience I learnt to feed my baby in a way that no one would notice.*

Interviewer: Did you attend any support groups like community groups for mums or maybe La Leche league? Chloe: *No, fortunately for me I didn't need to, everything was plain sailing.*

Interviewer: Research tells us that some women choose not to breastfeed because they feel embarrassed to do so in public or they do not feel comfortable doing so in front of other people. Why do you think someone might feel embarrassed to breastfeed in a public place? *Chloe: I can understand this feeling, it's not in our culture to expose our breasts and it's not something I would have seen growing up, but hopefully it will become the new normal for our children to witness babies being breastfed and it becomes the natural choice in years to come.*

Interviewer: Some women have said that they express milk into a bottle if they are going to be out in public with their baby. Have you and if so why? *Chloe: I have done this as, again it comes back to being embarrassed to feed in public, I feel like by doing it we are leaving ourselves open to negative comments from strangers that may not approve.*

***Working and Breastfeeding**:*

Interviewer: How do you think breastfeeding has or might impact on your work life? *Chloe: It does have an impact on work life. I returned to work when my baby was 6 months, unfortunately that was the start of the end of our breastfeeding journey, but the bills need to be paid.*

Interviewer: Were there provisions made in your workplace where you could have continued to breastfeed? *Chloe: None at all unfortunately, I didn't ask, and none were offered. I didn't*

want to ask as 1) I was embarrassed and 2) I didn't want to come across as needing special privileges just because I am a mother.

Interviewer: Are there any personal challenges you faced in relation to returning to work after you had your baby? *Chloe: No, I was lucky in the sense that it was my 3rd child and second to breastfeed, also I was able to return part time so I had a plan to wean from the time I returned to work, so it all went smoothly and according to my plan. My plan would have been different if I knew there were options to help support a mother to continue to breastfeed while working i.e. a room to pump or an extra break.*

At the end of the interview's participants were asked what they felt were the main barriers for women in relation to breastfeeding, responses included;

Chloe: *"The more women who breastfeed in front of their daughters, the easier it will be for them if they have children. Making breastfeeding the normal thing to do will break down the barriers that women say stop them from breastfeeding"*.

Emma: "*we need to challenge the perceptions and portrayal of women's bodies. Women have been educated that their breasts are sexual objects and as such this has created a sense of deviancy when breastfeeding in public*".

Michelle: "*There is a certain level of pressure placed on women to mother their child a certain way. Parenting and the way it's portrayed-on television or on social media, or by women with money to pay for stuff a lot of us don't have access to creates this unrealistic version of motherhood that women feel they need to live up to*".

Carol: "*Stop telling women breastfeeding is natural and easy. It's not. It takes effort and perseverance. Women need to know that having sore breasts and being exhausted is normal. Having a crying baby that won't latch on is normal. Making out ii is not normal makes women feel like it is them that is doing something wrong*".

Grace: "*Advertisements, companies who make money from formula do not want more women breastfeeding and certainly not for long periods. There should be tougher regulations on these companies*".

Reflecting on your own experience of becoming a mum and the choices you had to make in relation to infant feeding, what in your opinion can we, as women do, to create an environment where more women feel comfortable to breastfeed and do so for longer?

Michelle: "*We need to normalise breastfeeding, if we have more signs in public places saying 'breastfeeding friendly' it will help make it normal and it would make mams more comfortable to go out and breastfeed when they need to*".

Rachel: "*We need to stop pitting mums against each other. Vilifying women who breastfeed in public, or shaming women who feed their baby formula creates a sense of them and us. One a baby is looked after and loved who cares what way they are fed. We need to make sure that women feel ok because if they aren't ok then they won't be able to care for their baby at all*".

Carol: "*Mums today don't seem to understand that their bodies need to recover. Pregnancy is not just for 9 months. Mammies need to be minded, most give up breastfeeding because "I'm too tired, he's always feeding", they forget that all babies make you tired regardless how they feed. Mammies need to be minded too*". *Support in the home is key to this, whether it is a partner or mum or mother in law, mams need to feel that they are supported".*

Grace: "This malarkey of celebrities looking fresh and brand-new right after giving birth is not the reality. People are obsessed with putting on this performance, look at me, only had a baby and I look and feel great. Women need to look after themselves and then they will be a 'good mum'. Just because your one on the telly looks great and makes breastfeeding look so easy, it doesn't mean that this is true". They are making money looking that way, us average joe soaps don't need to pretend".