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Abstract
Improving the rates of breastfeeding has been a prime interest of Public Health Nurses focusing on health promotional strategies as outlined by the World Health Organization. However, evidence of the perceptions held by perinatal families regarding the encouragement to breastfeed is lacking. With the goal of uncovering existing research, an integrative review was conducted, retrieving nine studies. Themes included: variables of delivery (beliefs and ambiguity), outcomes of receivers (expectations, emotions, empowerment versus pressure), and contextual factors (social, cultural, and political forces). Notable differences between the experiences of parents in differing social locations were found. The results demonstrate a need for professionals and policymakers to consider the nuanced ways in which individuals experience breastfeeding health promotional messaging. Unintended impacts of this strategy potentially widen breastfeeding inequities between the groups most and least advantaged in society. The diversity of Canadians was found to be vastly underrepresented in the literature.

Key Words Breastfeeding, Health Education, Health Promotion, Public Health

Contextualizing the Health Promotion of Breastfeeding: An integrative Review of Parent and Provider experiences in Canada

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Background

Breastfeeding is a protective factor in the health of breastfeeding parents and their infants (1). However, the rates of breastfeeding tend to be particularly low in high income countries (2). The World Health Organization (WHO) recommends exclusive breastfeeding until 6 months of age, with continued breastfeeding until 2 years and beyond (3). Despite the variation of policy documents among the health authorities in Canada, the general health information regarding breastfeeding promotion is based upon the recommendations from WHO and Health Canada. The Canadian Community Health Survey in 2011-2012 found variations in breastfeeding rates across the country, with the province of British Columbia (BC) having the highest rate of exclusive breastfeeding for 6 months or more (41%), and the province of Quebec having the lowest incidence (19%) (4). This large discrepancy suggests a need to better understand the unique needs of different groups of parents in Canada preventing the ideal rates of exclusive breastfeeding from being achieved. In 2018, the Government of Canada announced an investment of $1.3 billion into promoting breastfeeding by increasing the application of the Baby-Friendly Initiative (BFI) across the country (5). The BFI is a set of guidelines initiated by the WHO and United Nations International Children's Emergency Fund (UNICEF) aimed towards increasing the rates of breastfeeding (5). Still, responses are mixed.

Despite data quantifying the rates of breastfeeding throughout the implementation of these guidelines around the world, we lack data exploring the qualitative experiences of how this health messaging is being delivered

and received. Providers of this health messaging range from nurses and physicians to dieticians and lay professionals providing support to perinatal individuals, and their modes of deliveries may differ among themselves and impact how such messaging is received by the parent. There is also a large range of knowledge levels of care providers that provide infant feeding support and education. Formal education programs for care providers of breastfeeding support with standardized, approved curricula are available, however to a limited degree (6). The International Board of Lactation Consultant Examiners (IBLCE) has a certification process that provides specialized knowledge for care providers (7). However, a large variety of care providers provide breastfeeding support as a small portion of their overall scope, and therefore do not receive specialized training unless they seek it out (6). Moreover, we need nuanced understandings of the effects of social, cultural, and political structures intersecting with the promotion of breastfeeding. With overall breastfeeding rates far below WHO standards, there is opportunity to not only improve rates, but also quality of care through improved understanding of the reception of messaging. Additionally, the ways in which these rates are measured is also worth re-considering (8). Measurements of health promotion interventions need to include an evaluation of the effects of this intervention on different groups and the potential inequalities embedded throughout these effects (9). Without an evaluation of how different populations experience a health promotional strategy and their various contexts, the health equity gap between the individuals most and least advantaged in society may widen (9).

A review provides an opportunity for further exploration leading to recommendations and potential interventions that may bring nuance to breastfeeding promotion guidelines and provide further insight into the barriers preventing ideal breastfeeding rates from being achieved. Through this review, we seek to gain a deeper understanding whether the current approach serves some populations more than others, thus creating inequities in breastfeeding outcomes, and inadvertently disadvantaging parents who might for various reasons not be able to breastfeed. The main purpose of this integrative review is twofold: to explore existing evidence on the experiences and perceptions of the parents receiving this health messaging, and, in addition, to examine the perspectives of the care providers delivering this messaging in accordance with the dominant breastfeeding guidelines outlined above.

The terms used in this review include 'breastfeeding parent', 'parent', 'perinatal individual', and 'care provider'. The term 'breastfeeding parent' refers to a parent who is breastfeeding either partially or exclusively. The term 'parent' is used to be inclusive of parents regardless of breastfeeding status. The term 'perinatal individual' includes parents and expected-parents within the spectrum of the perinatal stage. The term 'care provider' refers to various healthcare professionals and lay professionals such as nurses, physicians, dieticians, and lactation consultants.

In qualitative studies conducted in Scotland and England exploring experiences of breastfeeding parents, themes identified included: mixed and missed messaging, clashes between idealism and realism in terms of expectations, emotional costs, pressure and judgment for feeding choices, and the identity formation of a 'good mother' (10-13). One study found that breastfeeding parents in the United Kingdom (UK) expressed the need to improve the health promotion messaging by moving away from the 'breast is best' phrase, as such language was perceived to frame breastfeeding as a high, unachievable standard for all individuals (14). In contrast, parents preferred the promotion to focus on the normalcy of breastfeeding (14). Calls have been made for research into the relational aspects of breastfeeding interventions, specifically the ways in which health messaging and language are perceived (15). Other themes that emerged among parents in the UK in a 2016 qualitative study included: shifting the focus of education away from health impacts, encouraging the importance of each feed rather than just the need to exclusively breastfeed, being honest about the challenges, and extend education to other members of society as well (14).

Other concerns were raised with breastfeeding being socially constructed as a moral obligation of mothers, thus, being defined as a pivotal aspect of maternal identity formation (16). In Northern Ireland, researchers found a higher risk of alienation among parents who had accepted the moral imperative of 'breast is best' messaging but were unable to meet the goals of exclusive breastfeeding (17). Alienation was found to be a risk factor for postnatal depression (17), leading to negative behavioural health effects for both children and parents (e.g., depression, reduced quality of functioning, coping abilities and enjoyment of parenting) (18,19). Failure to meet the moral standard of exclusive breastfeeding may be internalized as failing at parenthood, which can be further unpacked through the concept of shame (20). Negative emotions, such as feelings of shame arising from breastfeeding challenges, can further hinder the ability to breastfeed due to the distress faced by a parent unsuccessfully attempting to latch their baby to the breast (21).

Experiences of Canadian parents are not well documented. Developing critical research from other countries conveys the need for a critical review of the health messaging of

breastfeeding in Canada, particularly, how social, cultural, and political structures may affect different populations. Therefore, the scope of this integrative review is the examination of existing studies exploring the ways in which health promotion of breastfeeding is perceived by different populations within Canada, inclusive of both the receivers of the messaging and those delivering the messaging.

Methodology

The selected method of review for this topic is an integrative literature review. Torraco (22) differentiates this type of review from others by focusing on the creative process of synthesizing information from different perspectives and introducing a framework that has not been comprehensively used in studying the topic. The goal is to integrate existing notions with different ideas to construct a perspective that will influence future directions of research and policymaking (22).

We have used a feminist intersectionality framework. Bowleg (23,p.1) describes "Intersectionality [as] a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)." Hankivsky and Christoffersen (24) argue that intersectionality is necessary to complicate analyses of Canadian health determinants to better understand how existing inequities among social groups lead to further inequities in health. While much literature exists regarding the concept of breastfeeding through the lens of feminism, we instead situate our review upon the works of Crenshaw (25) and hooks (26) acknowledging the problematic historical privileging of white women in gendered issues when utilizing a single-axis feminist lens. Therefore, the intersectional feminist lens used throughout this review aims to disrupt the singular gendered view of infant feeding.

The search strategy used to obtain relevant studies involved three databases: the American Psychological Association (APA) PsychInfo, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and the PubMed database. These databases were selected with the goal of garnering perspectives from the disciplines of nursing, psychology, and the medical community. The truncated term "breastfeed" was used with Boolean operators of AND in conjunction with OR to include the terms of "promotion" OR "education" AND "Canada" OR "Canadian". These terms were selected due to the interchangeability between promotion or education when referring to breastfeeding promotional guidelines. The results were further narrowed down through the limiters of full text or peer reviewed journals only, with the time frame set to the last decade, and English as the language of publication. The latter decision was made due to the authors' limited capacity in other languages. The decision to limit the range of years to ten was made to capture the experiences based on current social and political trends.

Initial search results were reviewed by the first author in May 2021 through careful reading of article titles and abstracts to determine which articles could be excluded from the review. The inclusion criteria included: studies exploring the experiences of either providers of or parents receiving messaging in relation to breastfeeding, studies conducted in Canada, published within the last ten years (2011/01/01-2021/05/01), and in the English language. Ultimately, sixteen (n=16) articles were retrieved from these initial results. These articles were reviewed by reading through the full text to determine if inclusion criteria (Table 1) were met, resulting in exclusion of another seven articles, leaving a total number of nine selected articles (28-36). The seven excluded articles focused either on solely measuring rates of breastfeeding, reasons for early cessation of breastfeeding, or the barriers and facilitators of implementing breastfeeding guidelines on units from a leadership perspective, but did not include inquiry into the ways health promotion of breastfeeding was perceived or experienced.

The selected studies differentiate between locations across Canada, study designs, theoretical frameworks, and the populations being studied. Three out of the nine studies focused on experiences of providers, mostly Public Health Nurses (PHNs). Five focused on perinatal individuals with varying socio-economic positionality, and one study included PHNs and mothers. The study designs include qualitative methods (n=7) and mixed methods (n=2).

Results

The results of the review have been categorized into the following themes: variables of delivery, outcomes of receivers, and contextual factors (Figure 1). This approach aligned with the integrative review process described by Whittemore and Knafl (27) of holistically representing a problem in healthcare through the extraction of variables and themes, and the subsequent displaying of such themes in a visual map of emerging concepts. We did this by reviewing the themes presented in the individual studies, and then comparing these themes across all the included studies to create links as shown in Figure 1. Variables of delivery are derived from the data gathered from the healthcare providers delivering the health promotion of breastfeeding; outcomes of receivers result from

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Qualitative, quantitative, or mixed methods • Studies exploring the experiences of either providers of or perinatal individuals receiving messaging in relation to breastfeeding • Studies conducted in Canada • Published within the last 10 years (2011/01/01-2021/05/01) • Published in the English language	• Studies conducted outside of Canada • Studies solely measuring rates of breastfeeding • Published more than 10 years ago • Systematic reviews

data gathered from perinatal individuals who have received health promotion messaging related to breastfeeding; and contextual factors include the overarching cultural, social, and political forces that came to light throughout both accounts. These concepts are visually presented as rotating gears (Figure 1) that may appear to be separate components at first glance but are all interconnected. Movement or changes in one component result in changes in the others and vice-versa. The size of each gear is representative of the weighting of each component. We determined these sizes based upon the number of times these themes were seen throughout our review.

Our analysis reviewed the following themes: variables of delivery, outcomes of receivers, and contextual factors with additional sub-themes identified among the studies in this review (Figure 1).

Variables of Delivery - Ambiguity and Beliefs

In the four studies exploring the experiences of providers (28-31) two key phenomena were observed. Firstly, ambiguity, both about the role of the provider and about their understanding of breastfeeding promotion. Secondly, studies noted the beliefs the providers carried with them from their personal and practical experiences with breastfeeding. In these four studies (28-31), the perceptions and views of the care providers demonstrate the ways in which current dominating practices fall short in representing the diversity of the perinatal individuals receiving their care, further evidenced by three studies (32-34) qualifying such recipients of care. The goal of uncovering these shortfalls is not to place blame on individual providers, but instead to critically shed light on the potential gaps in guidance for such providers to decrease the various interpretations and beliefs currently preventing a unified practice.

The participants in the studies representing care providers included Public Health Nurses (PHNs) (28,31), perinatal nurses (29), and other professional and peer providers (30). The studies were conducted in different Canadian provinces, focusing on different components of breastfeeding promotion. The key similarity among these four studies was how participants held differing beliefs about the concepts under exploration, resulting in differing practices. These components included practical applications of culturally competent care (28), health literacy (30), the Baby-Friendly Hospital Initiative (BFHI) (29), and breastfeeding care specific to late preterm infants (LPI) (31).

Nurses in two of the studies (29,31) highlighted the challenges they faced due to the inconsistent, and at times, conflicting information perinatal individuals received from care providers regarding breastfeeding. In a study conducted in Quebec for example, a province where the rate of exclusive breastfeeding at six months of age is low (4), perinatal nurses noted a lack of consistency amongst healthcare providers along the continuum of perinatal care regarding breastfeeding education (29). They expressed a lack of effectiveness in in-hospital advice provision due to conflicting information being provided prior to admission (29). This finding adds to the overall theme of ambiguity in the provision of breastfeeding education among care providers. To address the variations in messaging received by parents, Dosani and colleagues (31) concluded additional training is needed for providers regarding breastfeeding challenges, in addition to the adoption of a more coordinated approach within the healthcare team, inclusive of acute and community providers. This recommendation arose from the responses of PHNs reporting that the initiation of breastfeeding was both complex and crucial for successful breastfeeding (31). Due to this complexity, they felt a coordinated response from the healthcare team was also needed (31). The PHNs expressed further challenges in providing education to parents due to the unique complexity associated with LPIs (31). The researchers suggest PHNs provide education to parents to include the LPI's developmental stages and brain development related to breastfeeding to explain the challenges and thus providing reasoning behind the difficulties (31).

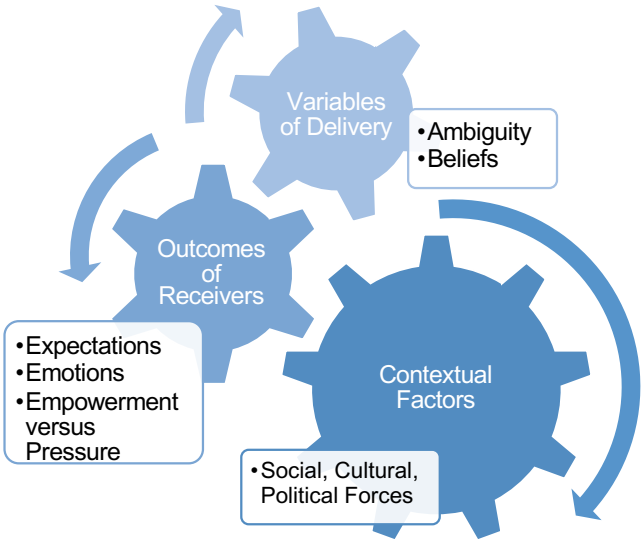

Figure 1. Concept Map of Results.

Chabot and Lacombe (29) explored the potentially positive impact of the Baby-Friendly Hospital Initiative (BFHI). One hundred and fifty-nine (n=159) perinatal nurses responded to a survey using convenience sampling, with the theory of planned behaviour (TPB) serving as the theoretical basis for the study (29). The TPB helped to understand the perceived controllability and perceived difficulty of implementing the intervention (29). The BFHI requires strict adherence to a set of steps (29). The nurses who believed they could overcome the difficulties associated with meeting all these standards were more likely to adopt the intervention (29). On the receiving end, participants in studies exploring the experiences of perinatal individuals confirmed receiving messages that varied depending on the individual care provider (32-34). Of note, Crenshaw (25,p.49) argues the need to "develop language which is critical of the dominant view and which provides some basis for unifying activity".

In the studies focusing on parents (32,33), care providers' beliefs appeared to affect the care being received. In the NICU environment, some parents experienced breastfeeding support differently depending on whether it was delivered by the nurses on the unit or the lactation consultants (32). The nurses were described as reassuring, knowledgeable, and supportive in the relationships they built with the mothers (32). Interestingly, the lactation consultants were described by some parents as pressuring and overly enthusiastic (32). The parents felt their needs were secondary to lactation consultants' goals of meeting breastfeeding targets and outcomes, thus perceiving their role in a negative light (32). In another study (33) featuring participants from a community-based program, lactation consultants in this context were perceived to be empathetic and encouraging, with supportive factors being home visits and providers' attitudes. However, participants did report negative experiences due to conflicting information and opinions received from other care providers and support persons (33). The high prevalence of conflicting information was also noted by parents in another study (34), with one participant stating "Prenatal classes say something, the nurse at the hospital said something, the [community clinic] nurse said something else... I had three different health professionals, three different messages… at a point you start wondering what is happening." (34,p.4) Researchers (34) found this report to be more common amongst parents who attended sites with low implementation of BFI.

In rural Nova Scotia, Gillis and colleagues (30) examined the engagement of health literacy within health promotion practices around breastfeeding from the perspectives of care providers along the continuum of perinatal health. They noted lower rates of breastfeeding and literacy levels in rural areas of Atlantic Canada, as compared to averages among the rest of the country (30). The participants included a range of professional and peer providers (30). Part of the challenge in implementing health literacy in health education is the lack of a clear conceptual definition (30). For this study, the researchers (30) defined health literacy as described by Zarcadoolas and colleagues, which encompasses the domains of fundamental, scientific, cultural, and civic literacy. The participants of this case study demonstrated varying beliefs within the concept of health literacy and how it applied to breastfeeding promotion (30). Fundamentally, a key belief arising in the study was health literacy often being perceived by participants as a deficit preventing those with lower rates from adequately accessing health information. Within the scientific domain, contrasting beliefs presented among practitioners: while some practitioners valued the scientific component of breastfeeding and the need to provide this scientific basis to clients,

others believed the use of medical terminology hindered understanding of breastfeeding information (30). In the instances of practitioners utilizing the medical terminology, there was a lack of intervention noted for situations of clients not being familiar with these terms. Ambiguity was also quite evident in this study, specifically through the lack of consensus among participants regarding the understanding of health literacy. Different components of health literacy were being applied by different practitioners, with the domains of cultural and civic literacy being the least engaged with (30). Discussion of the two latter components is included in the contextual factors section below.

McFadden and Erikson (28) explored breastfeeding health promotion through a critical lens, with the aim of uncovering processes of racialization present in the care provided by PHNs in a western Canadian health authority. Study participants included PHNs with varying ethnocultural diversity (28). A quarter of these participants identified that English was not their first language, and a third of them reported as having migrated to Canada (28). Although data about race was not gathered, "many participants disclosed their personal identifiers including terms such as 'white,' 'Caucasian,' 'European,' 'Chinese,' and 'Filipino.'" (28,p.E15). PHNs' age spanned between mid-20s to late-50s. All participants expressed their belief in the benefits of breastfeeding (28). Additionally, most PHNs conveyed their application of breastfeeding support differed from one mother to the next, but they did not feel the differences were due to breastfeeding inequities or resulting in a lower quality of care; rather their belief was rooted in their intention to provide culturally competent care (28). Close to half of the participants held stereotypes about clients' culture and race through clients' documented last name, despite not having had any interaction with the clients at that point in time (28). These stereotypes were linked to preconceived notions of the client's race and that race's (presumed) breastfeeding practices; for example Chinese mothers and their assumed breastfeeding decisions. One nurse believed the phrase 'no milk syndrome' was a common belief held by Asian women (28). This 'syndrome' refers to the misconception that Asian women cannot produce enough breastmilk due to having smaller breasts than white women (28). This nurse did not believe this 'syndrome' to be biologically true but did view it as the shared cultural perspective of all Asian women, and therefore altered the care she provided believing she was providing culturally sensitive care (28). Furthermore, this stereotype ties into the assumption held by some nurses that Asian mothers would choose to either mix feed or exclusively formula feed, but not exclusively breastfeed. The beliefs held by individual nurses affected the infant feeding support they provided to individual parents.

Ambiguity is evident in the study conducted by McFadden and Erikson (28) in the conflicting forces affecting nursing practice. On the one hand, the WHO guidelines are based on the premise that all women are equal with regards to breastfeeding. In contrast, the widely taught notion of cultural competence instills the idea of cultures being different and the need to respect such differences. This ambiguity leads to unclear direction for the nurses providing care to women outside the dominant culture, and it inappropriately serves the women being cared for. The racialization evident in this ethnography (28) manifested in the ways the nurses believed they provided culturally competent care, including by using stereotypes to guide the support provided. At times, nurses would provide information regarding formula feeding to Chinese mothers without first assessing these mothers' feeding plan, which differed from their care of non-Chinese mothers (28). Nurse participants in this study did not see their differential treatment of Asian mothers as a form of breastfeeding inequity, but instead viewed themselves as providing care in line with their knowledge of Chinese culture (28). PHNs may not be aware that they are racializing the care they provide, but the unconscious beliefs underlying their care need to be addressed to lessen the impact of stereotypes held against some cultures and to improve the quality of care being provided to all individuals. This ethnography (28) exemplifies the intersection between infant feeding and race.

Exploring Receivers' Perspectives - Expectations, Empowerment versus Pressure, and Emotions

Experiences of the perinatal individuals receiving the health promotion messaging regarding breastfeeding have also been studied. Key themes identified in these studies (n=6) are expectations, empowerment versus pressure, and emotions (31-36). The expectations arise from the messages received by the perinatal individuals from various sources, including their environments, individual care providers, and broader society. In turn, these expectations may be interpreted as empowering to navigate and overcome the challenges associated with breastfeeding or they may be internalized as pressure to provide breastmilk to their infant despite other barriers. This interpretation provokes strong positive or negative emotions depending on whether empowerment is experienced or pressure is felt, respectively. As represented by the gears in Figure 1, changes in the variables of delivery affect the outcomes of receivers.

The theme of expectation is evident in four of the studies (31-34) included in this review. Brockway and colleagues (32) explored the 'maternal' experience in Alberta NICUs in relation to feeding preterm infants, through interviews with 14 parents identifying as 'mothers', with breastfeeding self-

efficacy (BSE) theory guiding their research. A key theme was the institutional forces of the NICU affecting the parents (32). They perceived an unstated expectation that the needs of the infant eclipsed the health needs of the parent in the NICU, both mentally and physically (32). This expectation resulted from the policies in place to support the medical goals of weight gain among the infants (32). The parents felt the NICU environment reinforced the belief that their importance was merely reduced to their ability to produce breastmilk (32). The NICU environment was described as celebrating the production of breastmilk, rather than parents' efforts to meet these production standards (32). The term 'getting enough' was commonly used by the parents when referencing the success of their feeding attempts, specifically through measurable indicators of infant weight gain or the amount of breastmilk ingested by the infant (32). Parents who had left the NICU with a pumping plan experienced a large disconnect between their expectations and reality (32). The plans did not account for the overwhelming nature of managing care to an infant while pumping and breastfeeding (32).

Francis and colleagues (33) utilized focus groups and individual interviews to explore experiences of perinatal individuals participating in a community-based lactation support program located in Toronto, Ontario. This program includes breastfeeding support and education provided by lactation consultants, PHNs, and dieticians, as well as referrals to community resources, childcare support, access to a food bank, and vouchers for public transportation and grocery stores (33). Seventy-five percent (75%) of the study participants were below the Canadian low-income threshold and 85% were born outside of Canada (33). The researchers explored participants' experiences with breastfeeding in relation to the support they received (33). The key themes involved parents' feeling unprepared for the physical and practical challenges of breastfeeding, such as discomfort resulting from painful or cracked nipples, engorgement, mastitis, milk supply concerns, or a poor latch, and medical reasons for formula supplementation such as slow weight gain or jaundice (33). Practical challenges focused on the ways in which breastfeeding did not align with parents' life context, revealing a disconnect between previous expectations and the reality of the overall breastfeeding experience (33). The time commitment required to breastfeed was noted as another challenge, often in competition with the time needed for parents' other commitments (33).

Other researchers (31) explored the experiences of 11 parents with LPIs and triangulated the data using interviews conducted with 10 PHNs. Dosani and colleagues (31) utilized an exploratory mixed methods design, including quantitative data from 74 parents, inclusive of the 11 parents interviewed (31). The quantitative results indicate that only 10 parents were exclusively breastfeeding at 6-8 weeks postpartum, and 51 parents were partially breastfeeding (31). The number of parents breastfeeding at 6-8 weeks postpartum, whether exclusively or partially, represented 82% of the sample, with the vast majority not meeting the WHO recommendation of exclusive breastfeeding until six months of age (31). In the qualitative data, substantial challenges with breastfeeding emerged among parents leading to increased parental stress (31). Challenges were related to the initiation and continuation of breastfeeding with the LPI. The PHNs in the study confirmed observing these challenges (31). The gap between prior knowledge and the reality of breastfeeding a LPI rather than a term infant was highlighted by the parents. Limited psychomotor development of the LPI made a difference (31). In the breastfeeding support provided by PHNs, researchers noted missed teaching opportunities. For example, some of the PHNs' education and interventions addressed latch issues and the difficulty in coordinating sucking and swallowing, common among LPIs, but without explaining the rationale. These challenges related to feeding had a compounding effect on parents' stress (31).

Groleau and colleagues (34) conducted a qualitative case study in Quebec exploring parental experiences with breastfeeding health promotion and support, how these experiences connected to their social and embodied breastfeeding experiences, and whether variations were found among sites with different levels of BFI implementation. Of note, the sample in this case study consisted primarily of middle-class women holding university degrees (79%), with a relatively high family income, with forty-five percent (45%) reporting annual family incomes of $80,000 or more (34). Parents were interviewed at 4-12 months postpartum, with 48% of them exclusively breastfeeding at the time of the interview (34). When discussing prenatal breastfeeding classes, parents expressed they were not adequately prepared for the reality of the challenges that may present during breastfeeding; rather, they felt the class relied too heavily on presenting the health benefits associated with breastfeeding (34). Parents in the groups with higher implementation of BFI took on a more flexible approach to breastfeeding and felt more prepared to handle technical challenges due to the preparation in prenatal classes (34). Parents in the lower implementation group reported feeling unprepared to address the social barriers of breastfeeding such as family members being unsupportive of breastfeeding, with more parents ceasing breastfeeding and

more often feeling guilty or being judged as incompetent (34). In contrast, parents in the higher implementation group felt better equipped to deal with social barriers and better prepared to address technical challenges associated with breastfeeding (34). A protective factor identified by this group of parents was the belief that partners, and support networks, needed to be notified of the plan to breastfeed and its potential impact on the usual domestic tasks expected of the parents (34). Partners willing to take on a greater share of household duties provided a more supportive environment for the breastfeeding parent (34). However, many of the parents reported feeling as though they needed to negotiate breastfeeding with their support networks (34).

The theme of empowerment versus pressure was clear in two of the studies (32,34). In the study exploring BSE in the NICU environment, some researchers found that the participants held conflicting views regarding the strict routines imposed on them (32). Some parents expressed feelings of reassurance, while others felt as though their feeding experiences were being interfered with (32). Despite having lactation consultants available to support mothers with their infant feeding, participants preferred feeding support from nurses on the unit (32). The 'breast is best' messaging was prevalent in this study, with some parents perceiving this message as being tied to the unit culture, resulting in pressure being placed on them to produce breastmilk. Participants held polarizing views of this 'breast is best' culture. On one end, those who successfully met their breastfeeding goals reported the pressure to breastfeed as encouraging, whereas others reported this pressure as a negative force affecting their parenting experience (32). In the other study (34), Bourdieu's concept of habitus was used by the researchers to review the social aspect of embodiment, defining the concept as "a mental disposition expressed in the body, a way of being and using the body that feels natural for the person and close ones". (34,p.2). Groleau and colleagues (34) determined habitus was not commonplace in the province at the time of the study, but achievable by empowering parents through the promotion of breastfeeding. The path to habitus requires building of social and cultural capital of the breastfeeding parent to bring about embodied change within themselves and the space they inhabit (34).

Emotions were evident in five of the studies, with the vast majority focusing on negative emotions such as guilt (31,33-34,36), and two studies (32,35) noting both positive and negative emotions. All the participants in the study focusing on the NICU environment reported full dedication to producing breastmilk, with their entire schedules revolving around pumping and producing breastmilk (32). Many of the participants reported being dependent on the breast pump even after being discharged from the NICU (32). Some parents highlighted positive emotions of feeling rewarded and happy that they successfully provided breastmilk to their infant (32). Conversely, some of the participants described reaching an emotional and psychological breaking point after returning home, resulting in the decision to quit the pump (32). These parents reported feeling disappointment and a sense of failure and grief regarding their feeding experience (32). Expressions of disappointment and regret were noted among parents that ceased breastfeeding earlier than expected (32). Guilt and failure were also noted by participants that received support through low-BFI implementation facilities, specifically due to feelings of being labelled as an 'incompetent mother' for not breastfeeding (34). Similarly, challenges with self-efficacy arose as a theme in the study set in a community-based program (33). Researchers found "many [parents] perceived that feelings of guilt, stress, anxiety, depression, loneliness, and pressure affected their ability to feed their infant and their emotional health in the prenatal and postnatal period" (33,p.6). Opinions expressed by care providers and support persons contributed to these negative emotions (33). In the study focusing on parents of LPIs, feelings of frustration and anxiety were emerged due to the additional time needed for feeding while already being exhausted, and at times, due to inadequate support provided by healthcare providers through conflicting information, a lack of anticipatory guidance, and a lack of control over their choices (31). In one example, a breastfeeding parent described a situation of neonatal jaundice requiring formula supplementation. The formula was medically indicated, however with breastfeeding often framed as a "choice", distress was felt when this choice was taken away (31).

Greene and colleagues (36) utilized narrative methods to explore the experiences of mothers in Ontario diagnosed with HIV in relation to their inhabiting a culture that dictates that 'breast is best' but not for those who are HIV-positive. A diagnosis of HIV is considered a contra-indication to breastfeeding within Canadian clinical guidelines (36). Participants were interviewed in their third trimester of pregnancy, and again at three months postpartum. Participants' ethno-cultural backgrounds included Black or African (53%), White (33%), and Aboriginal (10%), the remaining 4% identifying as 'other' (36). Other key traits included place of birth, with 48% of participants born in Canada and 45% originating from Africa, and relationship status, with 35% of participants indicating they were not in a relationship (36). When discussing participants' 'maternal' identities, a central theme was the inability to breastfeed due to HIV: "Concerns about the impact of not breastfeeding on their role and identity as a mother; feelings of loss and guilt; the surveillance of their infant feeding practices; concerns about HIV-related stigma and disclosure; and the need to develop a

plan for how to confront the surveillance of their infant feeding practices as a response to concerns about stigma and disclosure" (36,p.890). Parents revealed the emotional costs of internalizing their lack of choice to breastfeed as a failure to provide the 'best' (as alleged by health messaging) for their infants, thus failing at parenthood (36). The myriad negative health consequences listed in public health messaging when attempting to encourage women to choose to breastfeed resulted in feelings of loss and guilt among women who did not have the choice. Participants also shared coping with this pressure to breastfeed by taking on a pragmatic view of bottle feeding and focusing on the associated benefits, including the involvement of support persons to feed the baby and health outcomes of formula-fed babies to include strong and healthy children (36).

Leurer and Misskey (35) utilized a mixed methods survey to explore infant feeding experiences of parents in Western Canada. The survey yielded a response rate of 35%, with participants primarily being from higher income and education levels. These parents found breastfeeding to be an emotional and personal life event (35). Overall, most participants reported a positive experience with breastfeeding, describing it as easy and challenge free. Some parents noted mixed feelings, as they experienced some difficulties, however they were able to overcome these and continued to breastfeed (35). Parents felt a sense of pride about their parenting abilities as a result of providing optimal nutrition to their infants as recommended by healthcare professionals (35). These participants felt a deepened emotional connection through breastfeeding. The relatively fewer negative experiences recounted by parents related to physical challenges, discomfort or pain, time commitment, and a sense of embarrassment when breastfeeding in front of others including healthcare providers.35 Some parents who encountered feeding challenges and thus discontinued breastfeeding sooner than they had hoped, described feelings of regret, sadness, and guilt.35 Negative emotions and a sense of disappointment or failure was a prominent theme in all of the studies exploring receivers' perspectives, highlighting the importance to think critically about the impact of breastfeeding health promotion messaging.

Synthesis of Contextual Factors – Social, Cultural, Political Forces

A key thread in the nine studies selected for this review were the social, cultural, and political contextual factors affecting all the populations' experiences regarding breastfeeding promotion. These factors affected the entire continuum of care and the ways in which the breastfeeding was experienced by each individual parent. Throughout this section, we refer to various contexts affecting the social, cultural, and political factors at play, ranging from the larger biomedical views of Western society to the micro levels of specific hospital units or communities.

In McFadden and Erikson's ethnography (28), social, cultural, and political forces were evident in the racialized care provided to parents, despite participants not always recognizing them. This study highlighted how PHNs unknowingly stereotyped their clients and the care provided through the silent racialized curriculum prevalent in Western biomedical practices. The researchers (28,p.E21) noted that "although most PHNs resisted the idea that they provide differential treatment to their clients which they understood to mean providing suboptimal care—some nurses provided examples of how their practices changed when they provided services to Chinese mothers." For example, while a standard information package is given to postpartum parents, the PHNs at this health unit used a separate 'Chinese package', which differed from the standard package by including additional information on how to use formula (28). The PHNs simply stated that this decision was made as a team to better utilize their time since they believed Chinese parents were more likely to use formula. Rather than ask parents whether they planned to provide formula, they made the assumption it would be the preferred choice and provided relevant information as standard practice. The researchers (28,p.E21) note "this example [as providing] a nuanced understanding of how a seemingly appropriate "culturally competent" practice of providing language-specific information can deviate when coupled to an essentialized, racialized assessment". There was an overall lack of holistic understanding of the structures affecting the breastfeeding experiences of the mothers receiving support from the PHNs (28).

A barrier identified by Chabot and Lacombe (29) regarding nurses' willingness to adopt a BFHI approach revolved around the perinatal individuals' social support networks. Nurses in that study identified the negative comments from support persons about BFHI as a large obstacle. Both subjective norms and moral norms presented as statistically significant among the nurses. Survey results revealed the strong influence that parents' perceptions have on nursing practice, with a higher proportion of nurses willing to undertake a BFHI approach if it were socially accepted by the parent they cared for (29). Personal values of the individual nurses also mattered, including whether the BFHI aligned with their values or whether these values conflicted with the opinions expressed by the parents being care for (29).

Gillis et al.'s case study (30) reviewing the application of health literacy within care providers' promotion of breastfeeding spoke to the contextual factors specific to the cultural and civic aspects of health literacy. Socio-cultural aspects of breastfeeding were recognized in the results of the study, with participants stating the need for a broader social response in an environment supportive of breastfeeding. The researchers (30) suggested greater practitioner involvement in improving policy and organizational practices could be achieved through an increased focus in the application of the civic domain of health literacy.

The cultural norms of the NICU identified by parents in Brockway and colleagues' study (32) revealed a 'breast is best' message being received by the parents and further perpetuated by staff. The biopower exerted over the parents in this setting was evident through the positioning of parents' needs as secondary to the needs of the infant and valuing the importance of producing breastmilk above all else. Ultimately, the pressure to breastfeed while failing to meet 'ideals' resulted in feelings of guilt, failure, disappointment, and grief for some parents (32).

In Francis et al.'s study (33), parents noted the social determinants of health and the potential impacts on breastfeeding outcomes. They suggested more awareness and focus on these determinants within breastfeeding support (33). Examples included: lower income combined with food insecurity resulting in a decreased access to healthy foods needed for adequate milk production, and the potential for social isolation and language barriers related to being immigrants in Canada (33). These researchers suggested further exploration of the social structures that influence breastfeeding, while attending to the disconnect between the promotional messaging of 'breast is best' and the realities of breastfeeding (33).

Groleau and colleagues' case study revealed cultural barriers preventing some parents from seeking breastfeeding support due to the discomfort of revealing their breasts to care providers (34). The concept of empowerment was noted when addressing cultural norms and attitudes that were unsupportive of breastfeeding. Parents receiving care from areas with higher implementation of BFI reported feeling more empowered to confront these barriers (34). The researchers argue the need to increase cultural and social capital of breastfeeding through the empowerment of parents to act as change agents within their own spaces. The promotion of breastfeeding often involves describing breastfeeding as a choice with measurable outcomes, however the more appropriate description would be that breastfeeding constitutes a social, cultural, and embodied act, with a key aim of empowerment (34).

Interestingly, the two studies in this review that recruited primarily higher income-earning, educated parents also yielded more positive results in terms of both experiences and rates of exclusive breastfeeding (34,35). The findings from these studies differed widely from the breastfeeding experiences expressed by lower income-earning parents in another study (33). The majority of the accounts of higher income-earning parents from one study related to personal journeys, with primarily individual-level challenges such as a painful latch (34). This finding contrasted with Francis et al.'s study (33) with primarily lower income-earning parents, with references to a lack of time due to obligations in other aspects of their lives, including caring for others, and the difficulty of fitting breastfeeding into the context of their lives. These parents also raised the challenges of breastfeeding in relation to the social determinants of health (33). The case study (34) involving higher income-earning parents raised concerns with social norms and the need to empower women to challenge these norms through being change agents within their communities. However, it is important to note the differences between parents of higher socio-economic standing aiming to achieve greater social capital versus vulnerable populations having a lower social capital to begin with. All three of these studies (33-35) raised concerns with the technical challenges of breastfeeding experienced by parents, and the resulting emotions of guilt and failure for those who were unable to meet their breastfeeding goals. Upon review of the quantifiable outcomes of breastfeeding, 48% of the higher income-earning participants in one study (34) conducted in the province of Quebec were exclusively breastfeeding, however according to Statistics Canada (4), the percentage of overall parents reaching this standard was only 19%. The parents from higher income levels in this study had positive experiences with breastfeeding, and many of the parents expressed a sense of pride upon overcoming technical challenges (35). In contrast, the study (33) involving lower income-earning parents found that almost all the participants reported planning and attempting to breastfeed, however ultimately reaching the standard of exclusive breastfeeding at six months was not common amongst these parents. Considering feelings of failure and guilt associated with unmet goals of exclusive breastfeeding, this discrepancy in breastfeeding outcomes between higher income-earning versus lower income-earning parents in these studies suggest vulnerable parents are at higher risk of facing detrimental mental health outcomes due to their social positioning.

Greene et al.'s study raised the intersectionality of HIV-related stigma with the pressures to breastfeed as related to Canadian public health recommendations (36). The intense social and

cultural pressures to breastfeed have resulted in surveillance between parents regarding their feeding choice, and subsequently, parents who do not breastfeed are challenged to disclose their reasons for this 'choice' (36). The parents in this study revealed instances of lying or preparing excuses for their infant feeding choices, with the intent of concealing their HIV diagnosis and the stigma that may ensue. The encouragement of breastfeeding in public health messaging may not have considered the effects of framing breastfeeding as a choice that results in better health outcomes in comparison to formula feeding in situations where breastfeeding is contra-indicated, however the inadvertent consequences on vulnerable populations remain and need to be addressed from a policy standpoint.

Limitations

We reviewed studies involving some populations within Canada, however our systematic search did not yield results representative of all care providers, perinatal individuals, and parents in Canada. Our decision to limit our search to English-only publications excluded studies published in French. As a result, all studies reporting research conducted in the province of Quebec were not captured. Further research is also needed to uncover the experiences of individuals who may face inequities in the breastfeeding care they receive, including but not limited to the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Two-Spirit (LGBTQ2S+) population, Indigenous individuals, and non-English speaking individuals. Additionally, our review did not include a population of parents who do make the informed choice to use an alternative infant feeding method rather than breastfeeding. The experiences of these parents are not captured within our results, however they are relevant.

Conclusion

An integrative review of the literature was conducted to determine the state of available evidence in the experiences of perinatal individuals and care providers in relation to breastfeeding health promotional messaging in Canada. There were nine studies identified that explored this phenomenon, and the populations represented in the research was vasty under representative of the diversity in Canada. The limited experiences explored raised concerns of a 'breast is best' culture, noted the unintended outcomes of guilt, shame, failure at parenthood, and highlighted how the needs of all parents were not adequately met. The emotional impacts of not meeting expected breastfeeding outcomes were noted across the studies, with parents of lower socio-economic positioning being at higher risk of 'failing' at breastfeeding. Policymakers involved in setting standards should consider the experiences of parents, care providers, and the intersection of social, cultural, and political structures to improve not only the rates of breastfeeding, but the quality of care being received by different groups of individuals. Quality improvement of clinical and public health guidelines should be undertaken to address the ambiguity faced by the care providers referring to such guidelines, and challenge care providers to critically reflect upon their own beliefs that may be affecting the breastfeeding care they provide

References

1.Dowling J. Key Concepts of Lactation as Health Promotion. In: Campbell SH editor. Lactation: A Foundational Strategy for Health Promotion: A Foundational Strategy for Health Promotion. Jones & Bartlett Learning; 202. p. 19-36.

2.Victora CGP, Bahl RMD, Barros AJDP, França GVAP, Horton SP, Krasevec JM, et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. The Lancet (British edition). 2016;387(10017):475-90. https://doi.org/10.1016/S0140-6736(15)01024-7

3.World Health Organization. Breastfeeding. N/A. Available from URL: https://www.who.int/health-topics/breastfeeding#tab=tab_2. Accessed 25 August 2022.

4.Statistics Canada. Breastfeeding trends in Canada. 2016. Available from URL: https://www150.statcan.gc.ca/n1/pub/82-624-x/2013001/article/11879/c-g/c-g-03-eng.htm. Accessed 25 August 2022.

5.Government of Canada. Government of Canada investing in maternal and child health. 2018. Available from URL: https://www.canada.ca/en/public-health/news/2018/10/government-of-canada-investing-in-maternal-and-child-health.html. Accessed 25 August 2022.

6.Brooks EC. Coleman J. Mannel R. The International Board Certified Lactation

Consultant® (IBCLC®) and the Healthcare Team. In: Wambach K, Spencer B, editors. Breastfeeding and human lactation. 6th ed. Burlington, MA: Jones & Bartlett Learning; 2021. p. 3-20.

7.International Board of Lactation Consultant Examiners. Clinical Competencies for the Practice of International Board Certified Lactation Consultants® (IBCLCs®). 2018. Available from URL: https://iblce.org/wp-content/uploads/2018/12/clinical-competencies-2018.pdf. Accessed 15 February 2023.

8.Niquette, M. La promotion du soutien aux femmes qui désirent allaiter : pour en finir avec la culpabilité. In. Dans Bayard C, Chouinard C. (eds), La promotion de l'allaitement au Québec. Montréal: les éditions remue-ménage, 2014, 89-113.

9.Rice W. Health Promotion through an Equity Lens. Wellesley Institute, 2011.

10.Hoddinott P, Craig LCA, Britten J, McInnes RM. A serial qualitative interview study of infant feeding experiences: idealism meets realism. BMJ open. 2012;2(2):e000504-e000504. https://doi.org/10.1136/bmjopen-2011-000504

11.Hunt L, Thomson G. Pressure and judgement within a dichotomous landscape of infant feeding: a grounded theory study to explore why breastfeeding women do not access peer support provision. Maternal and child nutrition. 2017;13(2):n/a-n/a. https://doi.org/10.1111/mcn.12279

12.Lagan BM, Symon A, Dalzell J, Whitford H. 'The midwives aren't allowed to tell you': Perceived infant feeding policy restrictions in a formula feeding culture – The Feeding Your Baby Study. Midwifery. 2014;30(3):e49-e55. https://doi.org/10.1016/j.midw.2013.10.017

13.Redshaw M, Henderson J. Learning the Hard Way: Expectations and Experiences of Infant Feeding Support. Birth (Berkeley, Calif). 2012;39(1):21-9. https://doi.org/10.1111/j.1523-536X.2011.00509.x

14.Brown A. What Do Women Really Want? Lessons for Breastfeeding Promotion and Education. Breastfeeding medicine. 2016;11(3):12-110. https://doi.org/10.1089/bfm.2015.0175

15.Leeming D, Marshall J, Locke A. Understanding process and context in breastfeeding support interventions: The potential of qualitative research. Maternal and child nutrition. 2017;13(4):n/a-n/a. https://doi.org/10.1111/mcn.12407

16.Lee E. Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. Sociology of health & illness. 2007;29(7):1075-90. https://doi.org/10.1111/j.1467-9566.2007.01020.x

17.Smyth L. Social roles and alienation: Breastfeeding promotion and early motherhood. Current sociology. 2020;68(6):814-31. https://doi.org/10.1177/0011392118807512

18.Goodman SH, Gotlib IH. Risk for Psychopathology in the Children of Depressed Mothers: A Developmental Model for Understanding Mechanisms of Transmission. Psychological review. 1999;106(3):458-90. https://doi.org/10.1037/0033-295X.106.3.458

19.Wisner KL, Chambers C, Sit DKY. Postpartum Depression: A Major Public Health Problem. JAMA : the journal of the American Medical Association. 2006;296(21):2616-8. https://doi.org/10.1001/jama.296.21.2616

20.Taylor EN, Wallace LE. Feminist breastfeeding promotion and the problem of guilt. In: Smith PH, Hausman BL, Labbok MH, editors. Beyond Health, Beyond Choice. New Brunswick, New Jersey: Rutgers University Press; 2012. p. 193-202.

21.Hanell L. The Failing Body: Narratives of Breastfeeding Troubles and Shame. Journal of linguistic anthropology. 2017;27(2):232-51. https://doi.org/10.1111/jola.12158

22.Torraco RJ. Writing integrative literature reviews: Using the past and present to explore the future. Human resource development review. 2016;15(4):404-28. https://doi.org/10.1177/1534484316671606

23.Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. American journal of public health. 2012;102(7):1267-73. https://doi.org/10.2105/AJPH.2012.300750

24.Hankivsky O, Christoffersen A. Intersectionality and the determinants of health: a Canadian perspective. Critical Public Health. 2008;18(3):271-83. https://doi.org/10.1080/09581590802294296

25.Crenshaw K. Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics. In: Jagger AM, editor. Living with Contradictions. Routledge; 1994. p. 39-52.

26.hooks b. Third World Diva Girls: Politics of Feminist Solidarity. In: Yearning Race, Gender, and Cultural Politics. 2nd ed. New York: Routledge; 2014. p. 89-102.

27.Whittemore R, Knafl K. The integrative review: updated methodology. Journal of advanced nursing. 2005;52(5):546-53.

28.McFadden A, Erikson SL. How Nurses Come to Race: Racialization in Public Health Breastfeeding Promotion. Advances in nursing science. 2020;43(1):E11-E24. https://doi.org/10.1097/ANS.0000000000000288

29.Chabot G, Lacombe M. Factors Influencing the Intention of Perinatal Nurses to Adopt the Baby-Friendly Hospital Initiative in Southeastern Quebec, Canada: Implications for Practice. Nursing Research and Practice. 2014;2014(2014):603964-8. https://doi.org/10.1155/2014/603964

30.Gillis DE, Gray NJ, Murphy E. Multiple domains of health literacy as reflected in breastfeeding promotion practice: A Canadian case study. Journal of health psychology. 2013;18(8):1023-35. https://doi.org/10.1177/1359105312454041

31.Dosani A, Hemraj J, Premji SS, Currie G, Reilly SM, Lodha AK, et al. Breastfeeding the late preterm infant: experiences of

mothers and perceptions of public health nurses. International breastfeeding journal. 2016;12(1):23. https://doi.org/10.1186/s13006-017-0114-0

32.Brockway M, Benzies KM, Carr E, Aziz K. Does breastfeeding self-efficacy theory apply to mothers of moderate and late preterm infants? A qualitative exploration. Journal of clinical nursing. 2020;29(15-16):2872-85. https://doi.org/10.1111/jocn.15304

33.Francis J, Mildon A, Stewart S, Underhill B, Tarasuk V, Di Ruggiero E, et al. Vulnerable mothers' experiences breastfeeding with an enhanced community lactation support program. Maternal and child nutrition. 2020;16(3):e12957-n/a. https://doi.org/10.1111/mcn.12957

34.Groleau D, Pizarro KW, Molino L, Gray-Donald K, Semenic S. Empowering women to breastfeed: Does the Baby Friendly Initiative make a difference? Maternal and child nutrition. 2017;13(4):n/a-n/a. https://doi.org/10.1111/mcn.12370

35.Leurer D M, Misskey E. The Psychosocial and Emotional Experience of Breastfeeding: Reflections of Mothers. Global qualitative nursing research. 2015;2: 1-9. https://doi.org/10.1177/2333393615611654

36.Greene S, Ion A, Elston D, Kwaramba G, Smith S, Carvalhal A, et al. "Why Aren't You Breastfeeding?": How Mothers Living With HIV Talk About Infant Feeding in a "Breast Is Best" World. Health care for women international. 2015;36(8):883-901. colorectal cancer screening: Perspectives of community advisory board members. West J Nurs Res. 2021;43(10):930–8. Doi: 10.1177/0193945921993174

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