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BORSTVOEDING IN NEDERLAND: THE MEANINGS AND EXPERIENCES OF BREASTFEEDING AMONG DUTCH MOTHERS

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This is dedicated to Mama, Beatrice and Eunice
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ABSTRACT

A qualitative descriptive research was conducted in the Netherlands between May and August 2004 to determine the meanings and experiences of breastfeeding among Dutch mothers. The research involved participation of 9 breastfeeding women and data was collected through interviews, focus group discussion and general observation. Interviews and informal conversation were done with professionals working in the field of breastfeeding in the Netherlands to get a broader perspective. The meanings and experiences of breastfeeding were found to be linked to individual and societal factors faced by the mothers in their everyday lives. The mother was found to be knowledgeable, organized and one whose confidence and persistence to the job of breastfeeding was challenged as she sought to understand and view her own body as an individual and as a member of the society. The meanings and experiences of breastfeeding to the Dutch mother were found to be part of the cultural beliefs and practices of her society. Although the research was not one which aimed at finding ways to promote breastfeeding per se in the Netherlands, important lessons could be learnt by analyzing the experiences of the body in relation to breastfeeding in the cultural context in which it occurs and thus understanding both the women who choose to breastfeed and those who choose not to do so.
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1. INTRODUCTION

1.1 Background Information

Contemporary medical and public health discourses represent breastfeeding as vital to infant development and the mother-infant bond. The professional accounts of medicine, nursing, midwifery, public health and public policy continually emphasize that 'breast is best' for infants, the environment and the global economy (Schmied & Lupton 2001). Regarding the economic benefits of breastfeeding, Jelliffe & Jelliffe (1979) write that human milk has an economic significance on the national level. They give an example that if breastfeeding declines on a large scale, then the need exists for a replacement - a liquid, usually cow's milk. Under these circumstances, it is necessary either to produce, process and distribute such formulae on a wide scale from resources within the country, or, alternatively, to import them from overseas. In more prosperous technically advanced countries, consideration needs to be given to the financial cost of services for the treatment of other 'cow's-milk bottle-feeding syndromes' such as infantile obesity, and cow's milk allergy.

It is claimed that breastfeeding is essential for bonding or securing the relationship between a mother and child and that it promotes the health, development and psychological well-being of the infant. Many studies have demonstrated a positive correlation between breastfeeding and subsequent health in childhood. These include studies that have shown a reduction in gastrointestinal infections, respiratory infections, ear infections, allergic diseases, and insulin dependant diabetes mellitus (Britton 2003). Although breastfeeding is promoted as an infant health issue, there is little doubt that there are health benefits for women too. Scientific studies have also shown that women with a history of breastfeeding have demonstrated a lower incidence of premenopausal breast cancer, ovarian cancer and hip fractures in older women (Britton 2003).

The WHO recommendations on breastfeeding are exclusive breastfeeding for 6 months, followed by a combination of breastfeeding and complementary feeding for up to 2 years. Although there is evidence that breastfeeding is a health-enhancing activity, the breastfeeding rates of infants at four months in Western Europe are still low.
In the Netherlands, low rates started after World War II when Dutch mothers switched in large numbers from breastfeeding to formula feeding. Greater prosperity and availability of formulae were factors involved in the switch, but the main reasons were cultural changes within Dutch society. In the last decades breastfeeding has slowly gained in popularity in the wealthier sections of the population. Nevertheless, a considerable percentage of mothers in the Netherlands do not breastfeed their babies or they breastfeed them for only a short time. A study done in 1998 showed that at birth 71% of the infants were exclusively breastfed, but after 4 months the percentage had dropped to 21% in the Netherlands (Bulk-Bunschoten 2003).

Van der Mark (1996) points out that one of the areas of healthcare that is unique to the Netherlands is the concept of home birth. Compared to other Western industrialized countries, the Netherlands has a very high percentage of home births. One-third of all babies are born at home. Along with a high regard for home delivery are the respect and status accorded to midwives, who are autonomous medical practitioners. Home birth assumes that giving birth is a natural process as opposed to the hospital setting where medical personnel are in control, and the easy availability of drugs and medical technology promote unnecessary intervention. Struhkamp & Krumeich (1998:7) use the Dutch term **vervreemden** meaning alienating, to show how gynaecologists stress a medicalized notion of accurate measurements of risk and safe care through the use of technology. The midwives and nursing staff who conduct the home births see safety and risk in relation to embodiment and social relations. This view of the midwives should also be seen as an attempt to make their profession different from the gynaecologists; however, the midwives are still medically trained.

There is a further issue for which birth location matters, namely the issue of mother-infant separation. If birth location is unmarked and unspecialized, mother and child remain together from the moment of birth. By this it is meant that through the practice of home delivery, the baby stays with the mother immediately from the time of birth. In the hospital setting, where it is more medicalized, the baby may not immediately stay with the mother as it may be taken to another room for examination, weighing and other forms of monitoring. The midwives, with the family
doctor, are therefore responsible for assessing the progress of pregnancy and only high-risk pregnancies will be sent to delivery at the hospital.

After the birth of the baby, there is also the system of well-baby clinics. Currently, 98% of the infants born in the Netherlands are brought to these clinics. Well-baby clinics were established in the Netherlands more than one hundred years ago. In the early days the main aim was to reduce the high mortality of infants. Infant mortality was particularly high when the parents lived in poverty. An important way of lowering the mortality rate was to ensure that women breastfed their infants and that they were fully instructed about good hygiene (Bulk-Bunschoten 2003).

Currently, in well-baby clinics specially trained nurses and doctors give care. The doctors in these clinics are responsible for giving socio-medical and development-related care. Screening and prevention programmes aim at early detection of problems in health and development. The training of well-baby clinic doctors has taken two forms. After their medical studies most doctors follow a short course in well-baby health care and some follow a specialized course of at least 2 years. They have to pass one of these courses successfully before the health care organizations give them permission to work in a well-baby clinic. Due to shortage of well-baby clinic doctors, doctors are sometimes allowed to work for health care organizations even if they have not followed a special training course (Bulk-Bunschoten 2003).

The Netherlands, therefore, like other Western European countries is currently facing low breastfeeding rates. Obstetric healthcare is organized through a system of home births, emphasizing birth as a ‘natural’ process. Early childhood care is done through well baby clinics where advice on child health is given.

1.2 Problem Statement

As seen in the section above, the health benefits of breastfeeding are well known, but the rates of breastfeeding in Western Europe, including the Netherlands are still low. The medical discourse views lactation as a universal phenomenon, but breastfeeding can be viewed as socially constructed and practiced. Breastfeeding does not take place as an isolated event, but is influenced by the social world of the woman. Political, economic, social and cultural influences
may shape breastfeeding decisions.

Looking at the issue of breastfeeding promotion and the role of the midwife in the Netherlands, Van der Mark (1996) shows that there is also a place for breastfeeding promotion in this system. The maternity home-care assistant or *kraamverzorgende* does this. She assists the midwife or family doctor during deliveries and looks after the mother and baby for eight days following the birth if the lying-in period is spent at home. Apart from taking care of the mother and the baby, she provides health education, contacts the midwife or family doctor if necessary, looks after other children in the family, does the housework, and may even walk the family dog. This maternity home-care assistant also gives guidance to the mother on how to establish breastfeeding.

A Dutch voluntary organization promoting breastfeeding (Borst Voeding Natuurlijk) has nevertheless criticized the fact that while these maternity assistants do a good job of stimulating breastfeeding, after eight to ten days they leave and the mother is left with no assistance if she gets problems with breastfeeding. One committee member of this organization has said: “Many women give up after the maternity care assistant has left. A mother still needs support in her efforts to breastfeed her baby after the lying-in period has finished” (Van der Mark 1966: 166).

As discussed above, the well-baby clinic is another place where the mothers can get information on breastfeeding. In these clinics, health professionals attempt to promote breastfeeding through provision of information. On this subject, Britton (2003: 297) writes:

> Traditionally, health professionals have considered health promotion to be an important aspect of encouraging more women to breastfeed. There is an assumption that imparting knowledge may change attitudes and beliefs. However, it is naïve to assume that if women are simply given more information about breastfeeding, the rates of breastfeeding might increase.... A variety of influences affect their infant feeding decisions

In Tanzania, where I come from, breastfeeding initiation is almost universal and the median duration of breastfeeding is 22 months. But even during the first months of life only half of Tanzanian children are exclusively breastfed (Shirima et al 2001). From my own experience, some mothers give water to their babies believing they are thirsty and that breast milk cannot
quench their thirst, others give *njiri* (maize or rice gruel), some soups and fruit juices believing it is nutritious even to babies who have not reached the weaning age. Improper feeding practices contribute to under nutrition, a major problem among Tanzanian children (Shirima et al. 2001). As a medical doctor, I have been trained to promote breastfeeding to mothers, as the availability of alternate safer options is limited in the Tanzanian context. This message is well received by the majority of the population and it is common and acceptable for mothers to breastfeed in public spaces like commuter buses, in parks or in the presence of most family members.

Mabilia (1996) conducted fieldwork in 1989-91 among the Wagogo, a semi-pastoral people in central Tanzania, and documented the cultural and social contexts of infant nutrition. In this setting, repeated pregnancy and lactation are natural conditions for all adult women. Breast milk is perceived as an essential source of nutrition, energy, vigour, and strength. Lactation failure does not occur much in this society. All infants nurse within a few hours of delivery and receive colostrum. The infant remains with the mother night and day, even when she is working in the fields. Breastfeeding is on demand, generally in response to crying, and lasts for 2-3 years. Any changes in the quality of breast milk are viewed as associated with maternal disease or witchcraft due to jealousy. "Bad" milk is believed to cause diarrhoea and withheld from the infant. In many cases, if milk in one breast is perceived as bad then that breast is no longer used for feeding. Sexual intercourse is prohibited during lactation, and women who become pregnant before weaning are shamed. The progressive weakening of the child associated with the cessation of breastfeeding at the time of a new pregnancy is viewed as a consequence of the breach of sexual taboos and not recognized as malnutrition.

This short description also shows that in a society different from the Dutch cultural setting, breastfeeding is also a cultural construct embedded with meanings and one where the mother gives meaning and experiences breastfeeding individually as well as socially. It seems that in Dutch society breastfeeding is more of an individual issue, which is informed and supported by the medical system as part of raising a healthy baby rather than as a social practice as in Tanzania. In the Netherlands mothers view breastfeeding as a private way to bond with the baby but in Tanzania the baby is fed in public and it can be argued that this process plays a role in its bonding/ becoming a part of wider society as well. Here there is then also a focus on its group
membership and not only on the mother-child bond.

In the Netherlands therefore, as we shall in subsequent chapters, the mothers are given information and assistance of breastfeeding from the health care system. The kraamverzorgende supports the mother after delivery and gives assistance and advice on breastfeeding and other child health issues. This information is aimed at giving the mother a chance to make an informed decision on the type of infant feeding she will provide for her child.

1.3 Breastfeeding as a bio-cultural process

If, as in the above example of Tanzania, breastfeeding is examined in different societies, there will be differences apparent in how it is performed across cultural settings. Breastfeeding is both a biological and cultural process. Decisions on whether a mother will breastfeed or how long she will breastfeed, are likely to be informed by political, economic, social and cultural influences. The reasons to breastfeed or not, are therefore multiple and complex. Breastfeeding is culturally constructed and it is an event, which occurs within a woman’s private and social world. Personal experiences regarding her life as a woman, mother, wife and wage earner need to be considered. These experiences are based on the context of the woman’s life in her society and can therefore be part of cultural beliefs and practices.

In order to look at what it means to breastfeed and the experiences that come with it, we can look at it from the perspective of the woman’s body as an individual, a member of the society and one, which is also affected by policies and regulations within her society. Schepers-Hughes & Lock (1998) describe the body as existing at three levels; the individual body, social body and body politic. The individual body is understood in the phenomenological sense of the lived experience of the body self. The social body refers to the representational uses of the body as a natural symbol with which to think about nature, society and culture and the body politic, refers to the regulation, surveillance and control of bodies. We can therefore look at how the mother gives meaning and experiences breastfeeding through these concepts of the body. At the same time we can gain a better understanding of how society perceives the act of breastfeeding gives meaning to it and impacts on it.
1.3.1 The individual body

Most research has found that almost all mothers agree that breast milk is best for their babies irrespective of what method they choose to feed their baby (Schmied & Lupton 2001). It is thus important to look at breastfeeding separate from the medical literature where a lot of information explains the importance of breastfeeding to the mother and child, and to look at what the mothers say regarding the breastfeeding experience and hence understand the whole process from their point of view. The biomedical literature emphasizes among other things, the importance of the infant-mother bond, particularly in Western countries. The mothers understand and experience this bond differently. From the mothers' point of view, breastfeeding is [was] seen as source of intimate connection or as a disrupted and disconnected experience (Schmied & Lupton 2001). These two contrasting experiences were expressed in a qualitative study done in Sydney, Australia among twenty-five first time mothers and their partners. A series of interviews were done before and after giving birth. The group who experienced breastfeeding positively was a minority and in their descriptions they used words such as harmony, intimacy, giving of self and exclusivity. One woman described herself and her baby as a ‘package’. The women viewed breastfeeding as ‘special times’ with their babies. The second group, who experienced breastfeeding negatively, described the process as demanding and very draining. They breastfed their infants but felt there was very little reward or recognition for their efforts. They felt restricted from participating in activities they had previously enjoyed and they resented this. Many women described a sense of loss of self and agency occurring as a result of breastfeeding and other demands made by the infant.

The positive experience of breastfeeding is consistent with the ideals proffered by feminists keen to celebrate the unique capacities of the female body to provide sustenance for another body. Dignam (1995), for example, believes women who are breastfeeding may use the intimacy engendered via the practice as an ‘identity tool’ through which the self can be more fully defined.

Another biomedical term used to explain the physiology of breastfeeding is the let down reflex.
Physiologically, it is a neuro-hormonal response, produced by stimulation of the nipple during breastfeeding, resulting in the flow of milk from milk-secreting cells in the breast tissue to the baby's mouth (Britton 1998). This rather complicated explanation of the let down reflex, is usually explained to mothers more simply as one that is necessary for the flow of milk from the milk-secreting cells to the baby's mouth and that it will produce a rather pleasurable feeling while breastfeeding. The sensation of the let down reflex was experienced quite differently among the women interviewed by Britton (1998:68). Some of the accounts included:

It was as if small shards of glass were being drawn through the breast, you know, an intense sort of feeling, yeah, as though a pane of glass had been cracked inside you and was being forced out.

Another said:

I don't know how to describe it. It feels like a, I don't know, like a very strong tingling sensation. Yeah! Sort of, I don't know, it's really hard to explain actually. Sort of a tingling and sometimes it hurts if your breasts are very full. And then you wonder if everything is all right.

On a brighter note one said:

It is difficult to describe it. It is almost like a tightening and a, a sort of tingling, as it occurred. Quite intense, but very gentle.

From these descriptions of how the mothers experience their individual body we see that a breastfeeding mother's way of being in the world is reflected in her everyday lived experience. Bottorff (1990: 202) writes:

By paying attention to mothers as they breastfeed in the context of their families and our present society, we may come to understand the lived meaning or significance of the experience of breastfeeding.
The individual body is therefore, the phenomenological aspect of the experience of the body. This informs us how the mother feels about her body in relation to breastfeeding. Feelings which are embodied and can explain how breastfeeding carries meanings and experiences based on the mother herself.

1.3.2 The social body

Health professionals have traditionally encouraged women to breastfeed their babies, by giving information about its benefits. However, there may be other social and cultural values, which affect the breastfeeding event, such as dominant societal and media representations of breastfeeding, and feeling able or unable to breastfeed in public. Jelliffe & Jelliffe (1979: 189) write:

Western culture of ultra cleanliness, fostered by commercially inspired anxieties over various real or imagined body odours, and general visual and actual avoidance of human secretions, including urine, tears, sweat, nasal mucus etc., can make breast milk be considered as a messy and even an unclean bodily discharge (or an ‘exuvia’ in anthropological terms), which can be ‘noisome’ to one’s clothes.

Douglas (1966) compared the concepts of ritual and secular uncleanness. Whereas the distinction between these two can be that the former is symbolic and the latter solidly based on hygiene, they may still sometimes be uncanningly close. She writes:

There are two notable differences between our contemporary European ideas of defilement and those, say, of primitive cultures. One is that dirt avoidance for us is a matter of hygiene or aesthetics and is not related to our religion. The second difference is that our idea of dirt is dominated by the knowledge of pathogenic organisms. The bacterial transmission of disease was a great nineteenth century discovery. It produced the most radical revolution in the history of medicine. So much has it transformed our lives that it is difficult to think of dirt except in the context of pathogenicity (Douglas 1966:35)

She goes on to say that if we can abstract pathogenicity and hygiene from our notion of dirt, we are left with the old definition of dirt as matter out of place. In an ordered system therefore, dirt
becomes something which contravenes this order. The ordering system involves rejecting inappropriate elements. Therefore dirt can be seen to symbolize disorder. She goes on to write about dirt as a rejected element of an ordered system:

It is a relative idea. Shoes are not dirty in themselves, but it is dirty to place them on the dining table; food is not dirty in itself, but it is dirty to leave cooking utensils in the bedroom...In short our pollution behaviour is the reaction which condemns any object or idea likely to confuse or contradicts classifications (Douglas 1966:36).

Such ideas of confusion and contradictions can be used in regard to breast milk. It is a source of nutrition for the baby, but also a bodily secretion and when it is seen in public to be leaking and causing stains it is seen as something out of place. It is seen as an anomaly, hence dirty. Breast milk becomes anomalous, out of place and potentially polluting or open to pollution.

Looking at the same example of the let down reflex, Britton (1998:73) explains that the women felt embarrassed by the unpredictability of leaking breast milk. It was a source of embarrassment when the mother experienced leaking milk in public. One woman said:

I don’t think I would have liked to walk down the street with everyone else looking at me. I had very little leakage anyway but I mean I would feel very embarrassed by it.

To avoid this ‘embarrassment’ breastfeeding women would wear special breast pads. This enabled them to maintain the appearance of a well-controlled civilized body (Britton 1998). The words used in advertising the benefits of these breast pads also show what is considered appropriate within a culture. The marketing strategies for breast pads emphasize the avoidance of being discredited in public and the soaking up of unpredictable leaking female fluids. Some of the words used include, ‘specially developed to control the problem of excess and leaking milk’ or ‘coloured white for greater discretion’ (Britton 1998:75). Breast milk is thus seen as a part of the body’s excretory fluids, as out of place in public settings and even a little shameful and disgusting.

Breast exposure while breastfeeding is also something not considered as culturally appropriate in
Western culture. Britton (2003) talks about how the societal notions of the breast and breastfeeding are embedded in a cultural context, which shapes people's opinions about the breast and attitudes towards breastfeeding activities. The sexual nature of the breast means that breastfeeding is ultimately linked with female sexuality and this might be an important factor influencing a woman's success in breastfeeding. When women breastfeed they may be seen as transgressing the boundary between motherhood and sexuality (Young 1990). British women distance themselves from immodest breastfeeding behaviour, referring to women who display their bodies as exhibitionists—"flashing your flesh", "flicking it out"..."I know it's natural but it's not very nice for other people" (Murphy 1999: 203). The media interest in breastfeeding often focuses on problems associated with breastfeeding in the social world. According to Britton (2003) the British Tourist Authority gave official advice to tourists visiting the UK that breastfeeding in public was not acceptable in this country. Britton (2003:304) gives some examples of newspaper articles debating breastfeeding in public spaces:

*Independent on Sunday* 1996- *Breast is best but not in public.*

*The Express* 1997- *SHAME* - I just wanted to breastfeed my baby, but this man threw dirty water at us.

A study done by the University of Tilburg cited in a Dutch magazine (Kraamzorg 2002: 9), showed that out of 2500 men and women interviewed above the age of 16, 65% thought breastfeeding is superior to bottle feeding but 40% of the respondents though that it was not normal to breastfeed in public (*de borst geven niet normal*). These respondents felt uncomfortable by the sight of a woman breastfeeding a child. Britton (2003) writes that women, who want to incorporate breastfeeding in their social life, will give up breastfeeding in public places and search for appropriate areas such as mother-and-baby rooms. Such rooms are away from public gaze, but the environment is not always ideal, such as being cramped, and the chairs for breastfeeding placed near nappy bins. You also find the feeding rooms often close to the toilets or in conjunction with rooms where you can change the baby's nappy. Thus breast milk expressed through breastfeeding is still symbolically associated with excreta.

Inside the domestic setting at home, although away from the public, the home itself may be
divided into private and public areas. The private place within the home where a mother may choose to breastfeed may change into a public area when guests are invited into the home for example. This domestic place has different meanings depending on who is present (Britton 2003).

Research in Euro-American context reveals how breastfeeding has been rendered pathological, the normal medicalized, and the breastfeeding body has been turned into a site of conflict and struggle (Van Esterik 2002:264). By this, Van Esterik talks about ‘bottle-feeding cultures’ where breastfeeding mothers are told they are violating public morality when they breastfeed in public, not bottle-feeding mothers. She shows that what may be seen as normal in ‘breastfeeding cultures’ has become the abnormal in this other culture. In France, cultural resistance to breastfeeding reduces women’s access to technical and emotional support for breastfeeding (Castro 2000 as cited in Van Esterik 2002). Mothers’ concern about propriety and breastfeeding in public are generally irrelevant in breastfeeding cultures (Beasley 1998). Stearns (1999) explores how mothers in Sonoma, California negotiate the act of breastfeeding in front of others - breastfeeding as a public performance. In this study, Stearns found that all the women had given significant thought about how to breastfeed in public. Women had a great deal to say about how they breastfeed in front of others, where and when breastfeeding would be inappropriate and how they perceive others do or might react to their breastfeeding. These women reported reading from the media of some incidences where women were asked to leave department stores and restaurants and being asked to use the restrooms to feed their children. Such media stories contributed to women’s anticipation of an environment hostile to breastfeeding in public. Being able to feed discretely in public was a skill highly valued by these women. Being an invisible breastfeeding mother was the goal for many women. A mother of two describes how she uses large T-shirts to be discrete:

So I found a I just buy the extra, extra large T-shirts and you know, polo shirts and they work better than nursing shirts because nursing shirts, if they are done, you’re still exposed. With a big shirt [you] pull it right over them or at least cover their face and when they’re done and you go to take them off, your shirt just automatically falls down. I mean you’re covered. (Stearns 1999:313)

Women would speak with pride about no one even knowing what they were doing when, in fact
they were breastfeeding. Embarrassment occurred if the women perceived verbal or body language of others indicated they felt the breastfeeding was inappropriate to the situation. Women tried to avoid situations that might lead to negative definitions, as many women felt the potential for public censure was always present.

Another issue to consider within the society is that with trends towards smaller family size, more working women, and increasing geographical separation of families, opportunities for exposure to breastfeeding may be decreasing. Breastfeeding is a skill, and like any other skill requires previous exposure to succeed. Hoddinott and Pill (1999) found that women’s history of their exposure to breastfeeding was strongly associated with their antenatal commitment and confidence in their ability to breastfeed and initiation to breastfeed. Crucial factors determining women’s reactions were the nature of their relationship to the breastfeeding woman, the presence of other people and their reaction, the frequency of exposure, the perceived appropriateness of the setting, and their own level of body confidence. Seeing other women breastfeed could either improve their body confidence or reinforce these negative feelings. When breastfeeding was witnessed as part of normal everyday life by the woman, her family and friends she was more confident in her ability to breastfeed and committed to her decision. If breastfeeding had been seen only infrequently and other people present made negative comments, her reaction was less positive. This was evidenced in some of the women’s stories about seeing other women breastfeed. One woman who was exclusively breastfeeding for 6 weeks said:

We’re always together anyway, so not only asking Diane [twin sister] but just seeing how she fed really helped me a lot…. [Without Diane] I would probably have relied more on midwives and even though they are really, really nice, it’s not as personal as it is between us; I mean we’re really close… I probably would have been a bit more anxious to know that she’s feeding well…. Is she getting enough? But because of Diane I know (Hoddinott & Pill 1999: 33).

Another woman, a formula feeder, said:

I saw a woman do it on a train once, which was a bit embarrassing. I was about 13 and I was sitting on the train and I was with my sister and she just started feeding the baby and I was
sort of giggling and looking at my sister because I felt really uncomfortable about it. I couldn’t look at her and that— I shouldn’t be looking.... There were all men and that on the train and it felt a bit uncomfortable. If I ever did breastfeed, I don’t think I would do it in public. I would have to get one of them pumps they have (Hoddinott & Pill 1999: 33).

The importance of involving the father in childcare is emphasized in some western cultures like the Netherlands. This is evident on the growing popularity of attendance of fathers in childbirth. In the Netherlands, as described previously, home births may mean that the father is present from the day the child is born. Hence there may also be a desire to involve the father in infant feeding. Earle (2000) did a qualitative study among 21 first-time mothers in Coventry, UK to explore women’s experience and perceptions of baby feeding and to explore the explanations offered by women who choose to either breast or bottle-feed. She found that both breast and bottle feeders possessed knowledge of the benefits of breastfeeding, but this did not seem to influence decision-making. One of the most significant factors influencing the decision to bottle-feed appears to be desire for paternal involvement. The women, who chose to bottle feed, perceived it to be a means of sharing their baby with the baby’s father. There were two reasons for sharing with the baby’s father. The first was the desire to share the ‘load’. As one mother put it, “Well, it will not only be me having to get up in the middle of the night”. Another said, “You can share the feeds easier and things like that. Share the load” (Earle 2000: 327)

The second reason was not only aimed at relieving the ‘daily grind’ but also for ensuring paternal involvement. To support this, one participant said:

I think really it’s nice to be able to share that responsibility (bottle feeding) with your partner.

Another said:

That is just one thing; at least Luke will be able to help. I think that it’s nice for him to get involved, to share everything, to see Billy grow up (Earle 2000: 328).

Describing the cultural meanings of breastfeeding, Maher (1992:9) shows that breastfeeding involves much more than relationship between individuals. The economic and social conditions of infant feeding have a fundamental effect on its chances of success. Among these conditions are
the extremely varied social and symbolic relationships which infant feeding creates and services in different cultures. Such symbolic meanings can give an idea at the different trends of breastfeeding practices across cultures. The way the mother breastfeeds will also be associated with these societal influences. Breastfeeding has other uses besides the nutritional. It is not only conditioned by cultural patterns but exerts a definite influence on them.

1.3.3 The body politic

The body politic relates to the ways in which at, for example the level of the state, breastfeeding is promoted as part of the well baby programme. Here the focus is on the healthy baby as future subject of the state and on notions of ‘healthy’ mothering. Breast milk is also increasingly separated from the mother - women can sometimes get breast milk from other women if they are unable to breastfeed themselves. Milk products try to replicate breast milk as far as possible. Thus issues surrounding breastfeeding need also be looked at from the macro level, or from a perspective that goes beyond infant feeding per se.

Breastfeeding targets set by governmental institutions and outlined in institutional policies and recommendations are not just part of a programme of health management techniques aimed at maximizing and providing health advantages for and satisfaction to the mother and her infant. They are primarily part of an overall strategy for maintaining and enhancing the quality of life of the population generally. Looking at the website of the Netherlands Nutrition Centre (www.voedingscentrum.nl) they write, “Our goal is to increase awareness of good nutrition and food safety and help consumers make informed choices”. The Netherlands Nutrition Centre also conducts public service campaigns designed to stimulate healthy and safe eating, with ‘better public health as the ultimate goal’. Infant nutrition being part of the activities of the foundation is therefore not only about the mother and child, but has a great deal to do with public health and for the general good of the population.

The medical profession is also an important force concerning infant feeding decisions. Their jurisdiction has expanded to include infant feeding in both developed and developing countries. Health professionals are involved with infant feeding decisions both at the level of doctor-patient
interaction and the international health policy. This is the process of medicalization of infant feeding that Van Esterik (1989: 112) defines as:

The expropriation by health professionals of the power of mothers and other caretakers to determine the best feeding pattern of infants for maintaining maximum health.

The argument here is that what was in the past largely the concern of mothers and women, is increasingly part of the medical domain. With the medical profession becoming more important in national and international policies, the regulation of the body is increasingly becoming an important feature of government policies.

Turner (1992 in Nettleton & Watson 1998:5) has argued that the body has come to form a central field of political and cultural activity, in that the major concerns for governments revolve around the regulation of bodies. Van Esterik (2002: 257) writes:

Breastfeeding is not a discrete behaviour but constitutes a range of practices with extraordinary temporal and spatial variation. Paradoxically, the more breastfeeding is valued the more it may be embedded in rules and patterns of interaction unconnected to infant feeding. The more we know about the desirable properties of the product breast milk, the greater is its potential to be commodified, and the more breastfeeding may become regulated or embedded in coercive practices.

Law (2000) uses a similar argument, when she says that many advocates of breastfeeding are not exactly talking about the benefits of breast milk over formula feeds but about the social, domestic, and technical arrangements conventionally associated with them.

1. Breastfeeding is said to be cheaper compared to formula feeding. This can in fact be viewed as shifting the burden squarely on the shoulders of women (formula feed is bought by income from father/parents vs. breast milk which may cause sacrifice of women’s income from participating in employment).
2. Many of the most popularly cited facts and statistics about infant feeding are not based on medical research at all.
3. Subjective assumptions - superiority of maternal child care over fathers' care, the assumption that lactation is the proper function of the breast.

4. Idealization of the family as the heterosexual male dominated household, whereas in the past 2 decades there have developed a need for different feeding arrangements for infants due to demographic and ideological shifts in the construction of the family such as growing rates of divorced/single parents, joint custody situations and gay and lesbian couples.

5. For career women who have to make the choice between mothering and participation in the labour market, this choice is not made any easier as risks of formula feeding and benefits of breastfeeding are over estimated. For example, risk factors for formula feeding are generalized based on universal inferences from situation specific dangers like poor hygiene, low level of mothers' education etc. Also it is not commonly cited that in Western countries, infant feeding is primarily related to morbidity rather than mortality. When the illnesses in question are common ones (most infants experience numerous respiratory illness and occasional diarrheal illness, regardless of feeding method), parents need to be able to think about their threshold for accepting these illnesses vis-à-vis other childcare family arrangements; when illness are serious (e.g. meningitis), they need to have clearer picture of the overall risk involved. Furthermore it must be remembered that infection has a complex relationship with immunity, and some studies suggest that early childhood infections protect against later childhood illness (Wald et al 1988).

6. The advantages of lactation to women's health can sometimes be seen as controversial. Breastfeeding is said to help protect women against breast and ovarian cancer. Jelliffe and Jelliffe (1979: 116) write 'recent international epidemiological studies have shown that the lesser frequency of mammary carcinoma occurs in communities where the reproductive pattern of early and frequent pregnancies, large families, and prolonged lactation are usual'. The same authors later say 'the high maternal morbidity or mortality seen in developing countries is the result of frequent births at too close intervals. Similarly another study (Hirose et al 1995) found lactation to be associated with a reduction of pre-
menopausal cancer rates but an increase in post-menopausal rates.

Issues surrounding breastfeeding can therefore also be looked at from a perspective beyond breastfeeding per se. By looking at the cultural beliefs and practice of a society one can see how breastfeeding as a process fits into the different rules and policies of that society and how it is impacted by it. Breastfeeding policies made by the state and international bodies can also be viewed as an overall process in which women's bodies are controlled and regulated for reasons which go beyond the woman herself, but for the general population as a whole.

1.3.4 The overlapping bodies

In the sections above, the body was divided into the individual, social and the body politic. The body is therefore not only a biological phenomenon; it is also a social creation of immense complexity. The act of breastfeeding which I have discussed as a process involving the use of a woman's body is therefore also an intricate activity and experience. It is one where there is an overlap of the 'three bodies'. Individual factors may determine how the woman gives meanings and experiences breastfeeding but these factors cannot always be viewed in isolation, but rather as governed and informed by the woman's surroundings. Hence the distinction between the three levels is not always clear and demarcations cannot be made to show where one level ends and another one begins. The experiences of the body in breastfeeding come with meanings that can be individually or culturally constructed. These meanings and experiences can further be informed by broader societal influences like the media, health sector and government policies. These all intersect in breastfeeding as a bio-cultural, embodied and political process.

In the subsequent sections, following different qualitative techniques, results will show that the experience of the body self in relation to breastfeeding among Dutch mothers is informed and influenced by cultural practices, notions, metaphors and regulations concerning the body self, the body social, as well as the body politic. Such aspects like individual infant feeding choice, institutionalization of child health and breastfeeding seem to intersect. The theoretical framework for this research will thus aim to bring to light the meanings and experiences of breastfeeding among Dutch mothers through the concepts of the body as related to breastfeeding, which will
then answer the objectives of this research.

1.3.5 Theoretical Framework

In this study an attempt will be made to examine the meaning and experience of breastfeeding among Dutch mothers. The approach to be used in this study is to find the meaning of breastfeeding among the participants within the context of their everyday lives and the experience they have of their own breastfeeding bodies from the individual level to the social and political level. Just as we differentiate between ‘illness’ as something the patient describes or feels and ‘disease’ as something the doctor defines and diagnoses from the patients’ narrative, breastfeeding will be approached as not only a biological and increasingly medicalized phenomenon, but also from the meanings given by the mothers and how they experience it in their daily lives. Cultural background has an important influence on many aspects of peoples’ lives including their beliefs, behaviour, perceptions, emotions, family structure, body image, attitudes to illness etc (Helman 2001:3). Peoples & Bailey (1997:83) write that every culture has its own ways of doing things, its own world view, its own values and so forth. Similarly, all social behaviour has a symbolic component, in the sense that participants must constantly behave in ways that others will understand. All social interaction, therefore, is symbolic and meaningful. The attempt is to understand a people’s way of life as they understand it.

Through this interpretive method one can attempt to produce ‘experience-near’ accounts of certain aspects of people’s lives (Good 1994:55). The process of breastfeeding is one that involves use of and action by the woman’s body. It can therefore be looked at from how the woman experiences and gives meaning to the use of her body, how society perceives and accepts/objects to the use of the body or how the body is controlled from a broader macro level. How Dutch women give meanings to and experience their bodies through the act of breastfeeding can inform us about the Dutch culture or it can be the reverse, whereby Dutch culture explains how the process of breastfeeding is taken up by the women. By studying the everyday experience of the breastfeeding body it is possible to uncover and capture a deeper meaning of breastfeeding.

Within this framework, the study will seek to achieve the following objectives:
General Objective:
To explore meanings and experiences of breast feeding among Dutch mothers

Specific Objectives:
- What does it mean to breastfeed among Dutch mothers?
- What are the experiences of breastfeeding among Dutch mothers?
- What features of Dutch cultural beliefs and practices are associated with the act of breastfeeding?
- What type of support is given to breastfeeding mothers?
- What is the influence of health sector, policy and the society as a whole on the issue of breastfeeding to the mother?

1.3.6 Thesis outline

Following this framework with the above objectives as the guidelines to the research, the meanings and experiences of breastfeeding among Dutch mothers will be explored. In chapter two, the methodological techniques used for the research will be outlined. In the methodology, the qualitative methods used will be explained and the value of such techniques in obtaining rich information will be explained. The third chapter consists of the findings and discussion of the research. The different themes and categories used in the discussion were obtained through coding, analysis and sorting of the data gathered. The fourth and fifth chapters will be the conclusions and recommendations made from the main findings of this research.
2. METHODOLOGY

2.1 Introduction

This research sets out to explore the meanings and experiences of breastfeeding among Dutch mothers. Breastfeeding will be studied as a process which is associated with the cultural beliefs and practices of the Dutch society. The breastfeeding body will be explored to see how meanings are given to it in terms of the body self, body social and body politic. As opposed to studies which look at breastfeeding as a purely biologic phenomenon, this study will show how the culture impacts on the act of breastfeeding. For this purpose the study is qualitative in nature and in the subsequent sections the different qualitative methods used will be explained.

2.2 Study type and design

The study was a qualitative descriptive research conducted in the Netherlands for a period of 12 weeks between May and August 2004. Of these 12 weeks, 6 were for data collection and 6 for data analysis and writing up the research. The qualitative nature of the research was useful for studying dominant cultural values through semi-structured interviews, focus group discussion and informal conversations thus discovering, understanding and explaining the feelings and opinions of the research participants. The descriptive nature of the study enabled for the systematic collection and presentation of data to give a clear picture of the meanings and experiences of breastfeeding among mothers in the Dutch context. At the same time it was possible to gain a better understanding of how society perceives the act of breastfeeding, gives meaning to it and impacts on it. Also through a descriptive study, issues surrounding breastfeeding were looked at from the macro level or from a perspective that goes beyond infant feeding per se.

2.3 Sampling Method

The mostly snowball sample was composed of participants referred to me through fellow students and teachers from the Medical Anthropology Unit. Also some participants referred me to some of their friends who were interested and willing to participate in the study. The study involved
participation of 9 breastfeeding women in order to find out their perspectives on meanings and experiences of breastfeeding. To get the broader macro-level perspective, the study also included information from a midwife, a lactation consultant, 2 paediatricians who have worked in the well-baby clinics, a research group doing work on breastfeeding, someone from the Nutritional Centre (Voedingencentrum) working on promotion of breastfeeding and a media group publishing magazines on breastfeeding for women and health professionals.

2.4 Data collection techniques

Data collected for this research was from participants in Amsterdam, Den Haag, Utrecht and Leiden. Semi-structured interviews were done with 5 breastfeeding mothers and a focus group discussion was done in the house of one of these mothers with 4 other women who were also breastfeeding. Information from other professionals was obtained through interviews, informal conversations and a working lunch to discuss the trend of breastfeeding in the Netherlands.

Semi-structured interviews allowed for a high degree of flexibility. An interview schedule (guide) was used to ensure that all issues were discussed, but at the same time, flexibility in timing and the order in which the questions were asked was allowed. Questions were open-ended hence the respondent was unrestricted in what he or she answered. The participants chose the time and place for the interviews. The interviews were conducted in the mother’s home and for the professionals they were done in their offices with the exception of two interviews which were done in their homes. The focus group discussion was done with 5 breastfeeding women with the aim of obtaining rich information. Since the discussion was done among a group, it was interactive with participants frequently building up on what another person said and it was lively thus enabling the researcher to gather the desired information. It was found that in the focus group topics which were sensitive or controversial were better handled because the participants felt more comfortable and secure about expressing certain views within the group. Similar to the semi-structured interviews a question guide was prepared by the researcher but there was flexibility in its use giving the participants opportunity to give responses that reflect their own situation. The interviews and focus group discussion were tape-recorded, fully transcribed and other field notes and observations were recorded in a diary. The tape-recorded interviews and
focus group discussion lasted between 45-90 minutes. Throughout the interviews and focus group discussion the researcher observed for such things as the surroundings and body language as an additional data collection technique.

2.5 Participants profile

The requirements for participation in the study were that the women were currently breastfeeding. In this study breastfeeding included both exclusive and non-exclusive breastfeeding and it included women who were either breastfeeding directly from their breasts or expressing milk and feeding from a bottle or a combination of these techniques. For the purposes of confidentiality and anonymity, pseudonyms have been used throughout this paper in place of the participants’ real names and also the occupation of the participants has been changed to something relatively similar to their actual occupations.

Semi-structured interviews were done with the following.

1. Anna, a 36yr old Sociologist married with two children. The eldest is a boy of 2 yrs who was breastfed for 6 months and the second one is also a boy 6 months of age currently breastfeeding. Anna is currently contemplating stopping to breastfeed. The family lives in Amsterdam.

2. Kim, a 34yr old Banker married with two children. The eldest is a boy of 3 yrs who was breastfed for 14 months and the second one is also a boy of 13 months who is currently breastfeeding. Kim thinks she will continue to breastfeed for about two more months. The family lives in Den Haag.

3. Brigit, a 34yr old Interior Designer married with one child. The child is a 3yr old boy who is still breastfeeding. Brigit is currently considering to stop breastfeeding hence she has already commenced giving fewer breastfeeds. She feels very much attached to her son and is very emotional about stopping to breastfeed. The family lives in Utrecht.

4. Anneke, a 34yr old Pharmacist married with two children. The eldest is a 4yr old girl who was breastfed for 6 months. The second is a 5-month-old boy who is currently breastfeeding and Anneke would like to breastfeed him maybe for a total of 7-8 months. The family lives in Amsterdam.
5. Yvonne, a 36yr old Social Worker married with 2 children. The eldest is a 2yr old girl who was breastfed for 9 months and the second is a 4-month-old boy who is currently breastfeeding. Yvonne feels the 9 months she breastfed her first child was good enough and so this time she may breastfeed for about 9-10 months. The family lives Amsterdam

The focus group discussion was with five women. One of them was among the women I had an interview with previously. The other four women were the following:

1. Cate, a 36yr old businesswoman. Married with 3 children currently breastfeeding her 7 month daughter.
2. Beatrix, a 34yr old doctor. She has one child, a 2-month-old boy. She is currently breastfeeding.
3. Lydia, a 35yr old writer. She is married with one child, a 5-month-old boy. She is currently breastfeeding.
4. Diana, a 32yr old designer. Living with her partner, they have one boy of 6 months. She is currently breastfeeding.

Within the background of the above-mentioned theoretical framework and through the different methodologies listed above, an account of the meanings and experiences of Dutch mothers will be discussed in the next sections. The categories and themes for the discussion were derived from the analysis and sorting of the interview transcripts.

The qualitative techniques used in this study attempt to give meanings of breastfeeding among Dutch mothers, which are rich in description, and experience-near accounts of breastfeeding. Also an overview of some of the different perspectives to breastfeeding from the health sector, policy, media and the society as a whole will be outlined.
3. BORSTVOEDING IN NEDERLAND

3.1 Introduction

The women in this study all shared a common ambition to breastfeed their children in spite of the availability of other alternatives. As seen from their ages, these women were mostly born at a time when breastfeeding rates in the Netherlands were low and hence were either breastfed for a short period themselves or not at all (Burgmeijer 1998:35). In this chapter I try to show how the cultural context under which breastfeeding occurs can bring meanings and experiences which may differ in some aspects and coincide in others when discussing breastfeeding across cultures.

The Dutch women involved in the study stressed that they had to make personal sacrifices to succeed in breastfeeding. At the same time, the support for and caretaking related to breastfeeding was viewed as the responsibility of the state and its professionals. This is in contrast to, for example Tanzania, where the above largely becomes the responsibility of the wider family. I will try to show that in Dutch society, the woman’s body is viewed as bounded (as is that of the baby). A distinction is made between the woman’s body as sexual on the one hand and as nurturing on the other. All of these issues will be discussed within the context of the woman’s everyday life and through a process of reflection comparisons will be made to what I know from my own society.

3.2 The decision to breastfeed

In societies where milk formulae are not available, not affordable or where clean water cannot be taken for granted, a woman has little alternative but to breastfeed. Mothers, therefore, must persevere in breast-feeding to ensure the infant’s survival (Raphael & Davis 1985 as cited in Bottorff 1990). In industrialized nations, mothers who breastfeed are not doing so out of necessity or because it is everyday practice, they choose to breastfeed and many continue to do so despite the fact that other alternatives are available (Bottorff 1990). Not only does a woman have to choose whether she will initially breastfeed her infant, but she may also need to consider the length of time for which she will breastfeed, how she will incorporate breastfeeding into her daily
life, where she will breastfeed, in whose company she feels comfortable breastfeeding, whether she will breastfeed during the weaning process and whose advice and opinions will guide her (Britton 2003). With all these questions on the mothers mind, the decision to breastfeed will therefore be influenced by a variety of factors. Knowledge, confidence and support together with a consideration for local beliefs and practices will be taken into account by the mother who decides to breastfeed.

3.3 The knowledgeable woman

In this study the majority of the mothers made the decision to breastfeed even before the birth of their child. These women had, and also sought, knowledge concerning the health benefits of breastfeeding. They belonged to a high-educated class of women where theoretical knowledge about the importance of breastfeeding was accessible to them. In relation to their study on decisions about infant feeding choices among women in the United Kingdom, Hoddinott and Pill (1999:33) write: “Women with higher educational qualification are more familiar with learning and making decisions on the basis of theoretical knowledge”. This was also the case of the Dutch women I interviewed- the majority of whom cited health reasons for the decision to breastfeed, as reflected in the following:

I decided to breastfeed before he was born and the reason was that I knew it was the healthiest thing for my baby. (Brigit)
The reason is that I know that it’s the best feeding for my baby.... I am sure it’s the best, that’s why I breastfeed. (Yvonne)

One woman, Lydia, was specifically concerned about the possibility of passing on her own allergy problems to her baby and she said:

I heard that if you breastfeed then the chance is less; the child will have more chance that he will not have allergies. It’s not 100% sure but at least it reduces the chance.

For Anneke it was not only about the health benefits of breastfeeding but also about her making good intuitive choices concerning her child. She said:
I’ve been thinking so hard what exactly it was that made me go into that decision. I think it was just knowledge. I’ve been told that it’s the best option and I’ve been open minded and wanted to give it a try, but it was basically how I was feeling inside.

Breastfeeding was not something women ‘learned’ through socialisation, but was based on individually searching for information about it. I would argue that the breast and its ‘product’ breast milk were seen as just one of a range of infant feeding choices individual women made as ‘consumers’. The women had access to a wide variety of information and the initiative to read about it from various sources and then made decisions about it that seemed very similar to that made by other consumers of milk formulae. Brigit, who had a 3-year-old son and was still breastfeeding, said:

Well, actually during pregnancy I did not inform myself much about breastfeeding; it was only when it was very close to the delivery. When I started I remember I had read that 6 months would be very good and when I was breastfeeding I didn’t feel like I wanted to stop at 6 months. So I started to seek more information on the Internet. There I learned that it was possible to breastfeed for years. I also read that WHO advises mothers to breastfeed for at least 2 years.

When I asked Anneke where she learnt that breastfeeding is good for her baby she replied, “In books, I’ve read a lot of books”. Kim had also bought a book about breastfeeding during her pregnancy and she says, “Two days after his birth I took the book and I have read it from the beginning to the end”.

In Tanzanian society, where literacy levels are not as high as the Netherlands, and where breastfeeding is more part of everyday practice, it would be uncommon to hear a mother talk about learning the advantages of breastfeeding through reading books. This however does not hinder mothers from knowing about the importance of breastfeeding, they learn about it through a process of socialization concerning what is appropriate or not in relation to breastfeeding. In this setting knowledge would be passed through oral narratives and regular exposure to breastfeeding in the presence of experienced mothers, older relatives and peers. Such a process prepares the
mother to view herself and her baby as initially not necessarily two individuals, but rather as a unit. She sees and learns, through her participation in the everyday life of women, many of whom have babies, that the infant is rarely separate from its mother and is fed where and when needed. In the health sector, services also view and approach mother and baby as a unit, while health promotion posters and health education sessions emphasize breastfeeding as a practice rather than highlighting the health benefits of breast milk itself. Even as a medical doctor, it is not common practice to hand out health promotion literature or to recommend books to patients about their health, but rather to teach them through examples and demonstrations.

In the Dutch setting it is very different with a lot of public instruction done through material in written form. Even when entering the houses of my participants I would always notice big shelves containing books of different types - hence you realise that a lot of information is accessible to them in written form. At the Netherlands Nutrition Centre (Voedingscentrum) in Den Haag, I was shown the organization’s website (www.voedingscentrum.nl) and informed that a lot of people log onto the site (about 3500 people per day) and give their comments and ask different questions pertaining to general nutrition and breastfeeding. The Voedingscentrum also distributes a variety of leaflets, brochures and handbooks, which can be ordered for a small fee or for free. The primary goal of the Voedingscentrum is to keep Dutch consumers informed. They provide information so that the consumers can make informed decisions. Infant feeding information is therefore about both breast milk and artificial formula. The baby is therefore seen as an individual consumer and breast milk is one of the possible ‘products’ to use to have a healthy baby with high resistance, fewer allergies etc. The majority of the mothers in this study had been able to get hold of the necessary information when they decided to breastfeed.

These Dutch women learnt, through their individual efforts and access to health information, that their breast milk ‘product’ may have particular health benefits to their children. Among the different options for infant feeding, breastfeeding was seen as the best. Breastfeeding was then weighed against cost benefit in terms of time expenditure on it, the level of difficulty and complications it causes in their lives. One mother even said that breastfeeding has the advantage of producing a child who will consume less health care.
This consumerist approach, is also seen in an example raised by Law (2000:407), who writes about a bumper sticker seen in a Chicago-area suburb saying, “Affordable healthcare begins with breastfeeding” asserting the community’s stake in the ‘economics’ of infant feeding. Similarly an officer from the Voedingscentrum in Den Hague, when talking about the campaign to promote breastfeeding said that, among other things, it is also geared at reducing health care costs for young children. One of the tenets of promoting breastfed children is that they are healthier and hence consume less health care. The type of information therefore, given to mothers about the benefits of breastfeeding from the health and policy sector may also be seen as a consumer argument.

The initiative to continue to breastfeed among these women was also based to some extent in the symbolic and emotional link they felt was established through the ‘gift’ of breast milk, which only they could give. They talked about breastfeeding as having more meaning than just being healthy food for their babies.

Researcher: And you said that you feel that breastfeeding is more than just giving food, what do you think it is then, other than food?

Brigit: For example my baby needed it to sleep. For a long time he could not sleep without breastfeeding. Also when he cries or when he is ill, I put him on the breast. So it was also about caring and giving comfort and it was also a simple way to do it. Also it was good for the bond. We are very close and this is a special moment. I didn’t know that before, this was new to me.

Anna had the following to say:

And I find it a nice way of being together because you can see the baby enjoys it a lot, so it feels a good natural way to be together with your baby. I find it a very intimate way of being together, and I think it’s a wonderful idea that he grew from this small to what he is now through me.

Anna therefore, can be seen here to imply that her baby has grown through the consumption of a product of the body of the mother. Yvonne also explained what she thought was important and
special about breastfeeding her child saying:

I feel that he has a place that is safe and where he is always okay. I think that he always has a space that has comfort. I feel that is very nice. If you have a baby who is crying and you don’t know why, at the end there is the breastfeeding. This will comfort him and you feel that you have something that will always be okay for the baby. That is a good thing to feel as a mother. So if he is crying a lot, the end of crying is when you give him the breast.

Anneke, whose second child was not able to breastfeed immediately after birth, said that she only felt close to her baby when he succeeded to breastfeed. She felt a distance between herself and her baby and the connection she had experienced immediately with her first child only came after succeeding to breastfeed. She says:

Then I started breastfeeding him and after breastfeeding I felt the connection coming and he became my boy.

Talking about her experience after the baby was able to breastfeed, Anneke also says:

So when the baby moves from one breast to another we find it funny (the baby and the mother), and we have our little laughs and the baby is smiling and is so happy. There’s all this milk around his mouth and you feel, oh, he likes his mother so much.

This could therefore be the ‘connection’ she lacked with her baby before he was able to suckle. Such a connection was also described as a sort of gift exchange by Bottorff (1990:205) as follows:

As one’s body opens outward in the spirit of the gift, an involvement which bonds mother and child together begins to grow. Instinctively, the infant eagerly, acceptingly, suckles. The contented child returns a gift that continues the exchange. The child’s eyes sparkle with delight, a smile comes to her lips. As an observer, the giver also shares in this joy and leaves feeling renewed and closer to the child. An exchange has taken place.
Within this embodied closeness or intimacy, an individual woman and her individual baby become more closely linked to each other. This can therefore be the 'connection' Anneke describes with her baby. Schmied & Lupton (2001:239) also talk about women in their study who spoke of the breastfeeding experience as producing a sense of connectedness, continuity or oneness between themselves and their baby. Apart from the health benefits, there are additional benefits the mothers saw in breastfeeding which revolved around how their bodies are giving something to the baby which is more than just food, and which cannot be given by others.

Maher (1992:155) writes that according to the adherents of the notion of 'maternal bonding', physical contact between a newborn or young baby and its mother creates a relationship between them such that the mother is seen to 'care' for her child. In an individualistic society breastfeeding is thus imbued with meaning that symbolises good care, being a good mother and having a special relationship with the baby. Yet in the process, the needs and concerns of mother and baby are not always in tandem with each other.

The mother has been seen to look at breastfeeding as an individual. She seeks and finds explanations about how to use her body for providing healthy nutrition for her baby. The decision is made based on the information she can gather, where by breast milk is seen as one of the products which can be used to feed her baby. It is here that the notion of mother and child as individuals are stressed again as seen in the next section.

3.4 The organised woman

Breastfeeding is something the women performed in conjunction with their daily activities. It was not an activity that they felt should hinder or interfere with their daily lives but should fit into the daily schedule. Scheduling daily activities is something, which I found common in my daily encounter with Dutch people in the Netherlands. From an official appointment to a social visit, all required fixed appointments prepared beforehand. Everything is well organized so as to fit into a daily schedule. I have found it very impressive how people are always planning and timing their movements. From the time you leave the train station for example, to the time you knock on someone's front door, can all be planned and timed through different means. Through timetables
at the bus, tram and train stops to internet sites you can actually get the exact time needed to move from one point to the other.

Time is a product which can be consumed or saved and needs to be managed. Such organized schedules allow for control of activities you want to perform. As one lactation consultant commented on the issue of control she said:

The other thing is control. We (Dutch) like to control everything, not the weather but all the rest we do! You know you have an agenda (diary), which says when, where and how you will do things.

The lactation consultant went on to explain that Dutch women are used to being in control, so when there is less control of their bodies they lose confidence. She says:

Now you have your breast milk. Milk just comes out, you don’t know when and you don’t know how much. You just have to trust it.

Lactation can usurp the necessity to control time as it can leak out unexpectedly and it is hard to assess how much of the ‘product’ is ‘supplied’ and ‘consumed’ within a given time. The women I interviewed were organized; they had acquired high education, had advanced in their careers and now had babies they had chosen to breastfeed. Yvonne explained to me why for some women it might be difficult to breastfeed:

They work, they have a home to take care of, children to take care of, friends to take care of, they want to be nice, they want to be supportive and they want to be and do everything. That’s not always possible and some women think that’s a fight. I don’t think it’s a fight. It’s something either that you have to do or you don’t have to do. And that’s the reason some women are not completely happy with the situation because they try to do everything. Because they are not happy with it they try it but they don’t really want it, they just do it because they have to. It’s one of the parts that they have to do to be a good wife, mother, lover, friend, whatever and I think that’s the problem. They are not settled about it, and they don’t do it because they like it nor that they think it’s the best. It’s the big fight we are in.
Brigit also explained what she thought could be the cause for low breastfeeding rates in the Netherlands as follows:

I think it can be culture. Historically I don’t know how it has become like this. I also think that life has changed a lot with more women working; they don’t like to take time for breastfeeding. They don’t have patience to just sit down; they want to continue their life like before they had children. I think in this culture if you want to breastfeed sometimes it is hard. Well for example if you want to go to a party it’s not common to go with your baby. When I wanted to visit my friends in the evenings they would say I should come on my own. That didn’t work for my baby and me so I didn’t feel comfortable.

Talking with the lactation consultant this is what she said about breastfeeding and the daily life of Dutch women:

Well, what I see is that a lot of mothers are surprised why after about 3 weeks or 6 weeks they are not able to be back to normal again. You know they expect life to continue as it was before the baby came. A lot of them are not prepared for the upheaval. I think it’s not just about breastfeeding but also has to do with having a baby. I can’t imagine it being any different than bottle feeding. Babies are babies and they want to be fed at impossible times and they always pull you back when you are just about to go out. Babies disrupt life, children disrupt life and a lot of the mothers are not prepared for that. Regardless of how you feed the kid, there will always be changes in your life. I imagine the houses where they don’t have a baby and it’s all clean and organized with beautiful paintings and artwork. When you go to such a house and the mother is pregnant you just know that all this will have to change, all this order will have to go.

The women had decided that they will breastfeed but also go on with their individual lives. Separating the baby’s needs from their own was important for them as well. In this respect breastfeeding was not seen as something that should control their life but rather something that they should control. As Kim said:

Breastfeeding is very important but there are more things that are important, like talking with friends, talking with your husband, going back to your work, reading a newspaper, that’s
important as well. It's not only breastfeeding.

She went on to say:

It is okay to give breastfeeding but it should not take like 20 hours of the 24 in a day. I don't want that, there is more in the first month than breastfeeding.

In Tanzania, mothers are commonly taught that breastfeeding is on demand, there is no fixed times or scheduling for it. The baby and the care associated with having a baby therefore becomes part of the everyday scene and activities. Supporting the view that in the Netherlands breastfeeding is done more or less following a schedule is a doctor I talked to who has worked as a paediatrician both here and in Tanzania. She said that breastfeeding failure in Tanzania was rare compared to here and from her experience she thought it was probably because of not giving feeding on demand where the baby gets frequent small feeds hence getting enough. Asked whether she has been able to encourage breastfeeding on demand in the Netherlands, she said that it is not possible here because it does not fit into the life of people in the Netherlands. She talked about a mother having to be responsible for other household, personal or work activities hence breastfeeding should be done according to her schedule. As doctor she cannot advise mothers otherwise.

Commenting on feeding schedules, the lactation consultant said that during her breastfeeding sessions with mothers, she tries to tell them that in fact it's not only babies who feed frequently, but even adults will have meals and snacks in between their main meals. She says that a common example she gives the mothers is the number of coffee or tea and snacks people take in between their meals. She therefore says that even adults need to eat more than 3 times a day. She said that mothers commonly feel that babies need to be fed too many times and that it is not according to a schedule.
The measuring of the pros and cons of breastfeeding in terms of time expenditure is less common in African settings. Latham et al (1988: 67) illustrates traditional views of breastfeeding in Kenya (a neighbouring country to Tanzania) by quoting from an East African poem by Okot p'Bitek as follows:

When the baby cries let him suck from the breast.
That is no fixed time for breastfeeding.
When the baby cries it may be he is ill.
The first medicine for a child is the breast.
Give him milk and he will stop crying.

So, with breastfeeding, the women have to accommodate it into their daily lives and let it develop its own rhythm.

In the case of the Dutch women, their education and social status afforded them jobs where breastfeeding schedule might clash with work schedules. Talking about combining breastfeeding and work, they had this to say:

**Researcher:** Do you work?

**Brigit:** Yes I work as an Interior designer, I work at home.

**Researcher:** If you were working in an office how would find combining breastfeeding and work?

**Brigit:** When my baby was about 2 months I got a job at a radio station. So I had to pump milk but I did not like it and was not very successful at it. Also my baby got sick and did not like milk from the bottle so I had to breastfeed him in the evening when I got home and also all through the night to compensate! For me it felt very unnatural so I decided to stop this job and work at home.

**Researcher:** Could you say that having a baby and having to breastfeed causes some interference or changes in your daily life?

**Brigit:** Yes I think so but of course if you are bottle feeding then maybe it is easier to find someone else to feed the baby while you do other activities, but not with breastfeeding.
Kim had the following to say, showing an organized system in breastfeeding:

I work 4 days and my husband works 4 days as well and the two boys go three times a week to the day care centre. I pump breast milk. In the beginning I did it (pumping) 2 times a day at work then after 6 months only one time a day. A month ago I stopped. Now he does not drink any breast milk from bottle but in the morning and the evening I feed him myself. And I found a good way to work with it (organize it). I have a lot of bottles, nipples, and things and every evening I sterilise everything and make it ready for the next day and it works.

Anneke said:

The other thing which we forgot to talk about, which might be an answer to your question is that we have our children at relatively late age, and we are pretty ambitious nowadays, we have to educate ourselves pretty good. We also want to have some comfort as well. I do my groceries through the internet, because I hate doing groceries, I used to have someone that cleaned my house, I had my own car so then you could say that it would be convenient if somebody could feed my child once in a while. From that point of view, it’s like we have to adjust our lives so that I can do whatever the plan is. And I think that breastfeeding interferes a little bit with that.

Researcher: So are you saying that when you become a mother, then breastfeeding becomes part of the many things that you have to do?

Anneke: Yes, breastfeeding has to be put into the schedule. So if it doesn’t fit into the schedule and you experience some trouble and it doesn’t go really smoothly as you wanted it to and your job is in one of these high knowledge environments like banks or IT environment then it is a problem. This is an entirely different culture where everybody is busy and running about. What happens if you are in a meeting and your opinion is valued and you get paid a lot of money? Then you have to say, oh! I want to pump my milk now, that’s difficult. That’s the system. Maybe we should change our culture?

The women in this study organized the breastfeeding of their children to fit into their schedules. Common features, which led to their success in this enterprise, were having a working environment that enabled them to include breastfeeding and supporting husbands or partners. Although they were able to combine breastfeeding and work, one of them reported to have had
difficulties at certain times as she said:

I've done it in places where the doors could not be locked. So you do it with one leg against the door with a sign on the door saying don't come in, don't disturb me.

Schmied & Lupton (2001:236) say:

Many women who have completed a high school or tertiary level education or hold higher status occupation possess a degree of control and autonomy over their employment options. These women are more likely to receive paid maternity leave, have option to work fewer hours and have more flexible working conditions, all of which facilitate breastfeeding.

The activity of breastfeeding is therefore performed in a similar manner to how other activities are done by the mother. It is organized, scheduled and it is controlled so that it can fit in with other activities. Combining breastfeeding and work is also arranged and scheduled with the use of breastfeeding rooms where available, planning of the pumping and storage of the milk is also done to assure that it can all be done in an organised manner.

3.5 Testing their confidence and persistence

As we have seen, these are educated women living in a literate society. For this reason they have access to and the ability to understand the health benefits of breastfeeding. With regards to childbirth in the Netherlands, there is an emphasis on the promotion of home deliveries. Home births were a common phenomenon in Europe until the mid-1950s. At that time, however, obstetricians generally believed that deliveries at home were hazardous and less safe than those in hospital, where modern technology was increasingly available to safeguard the health of both mother and infant during labour.

In the Netherlands, on the other hand, the view prevailed that birthing is essentially a physiological event and that home delivery would prevent unnecessary obstetrical interventions, which might increase the risk to mother and foetus. These home deliveries are
only for low risk pregnancies and are attended by midwives or general practitioners (GPs). The system does not allow for low risk pregnancies to be attended to by a gynaecologist unless they pay for such care themselves. It also favours midwives over GPs in areas where a midwifery practice is available. The Dutch insurance system only covers the fees of the midwife, but not of the GP (Visser 2002). This short description of the Dutch home birth system gives an impression that they view childbirth as ‘natural’ rather than as medical. It is a modern society with a lot of reliance on and belief in science and scientific evidence, but here there is almost an opposite view on birth where its ‘medicalization’ is contested in favour of a more a ‘natural’ approach.

Comparing breastfeeding to child birth, here the notion of ‘natural’ and ‘medical’ seem to collide as the women are aware of the medical benefits of breastfeeding but when it comes to the ‘natural’ aspect of breastfeeding, there is scepticism about whether their bodies can perform this ‘natural’ function. This is evidenced when further analysis of the responses of participants reveal the use of words such as I will try and I will see how it goes.

Beatrix, who is a doctor, knew about the benefits of breastfeeding but was not sure if she will manage to perform the job as she said:

And after the baby was born I thought I have to try it even once otherwise I won’t know what I would have missed. So I tried it and said that if it is very difficult I won’t continue.

Kim also talked about trying when she said:

I just try it and if it gives problems then no breastfeeding, then just a bottle with milk, but if its okay, then its okay, and I will breastfeed him.

Anna said:

With my first baby I didn’t really know how it was going to be. I just thought I’ll see how it goes and if the baby wants to drink, I’ll just take it depending how it goes.
Mothers who breastfeed, especially when it is their first child, show a lack of confidence. Unlike birth, there seems to be little that is ‘natural’ about breastfeeding. In this regard the lactation consultant said:

They have to learn about their breast and they have to learn to read the babies signs. They have to learn something new about their own bodies.

An article in a Dutch magazine *Kraamzorg* (2002:3), the chief editor writes that although Dutch women are confident people, they don’t seem to have a lot of self confidence when it comes to breastfeeding. She talks of women using terms like if I will manage or if it will work (Als het luk). There is therefore an obvious anxiety regarding their bodies and whether they can succeed to breastfeed or not. They experience their bodies in a different way from before. According to an article in *Kraamzorg* (2001:13) a study done in the Netherlands by *TNO Preventie en Gezondheid* showed that one of the main reasons why women stopped breastfeeding was concern that their bodies were not producing enough milk. The article read, “Te weining moedermelk: een hardnekkige misvatting” meaning ‘Not enough milk: A persistent misconception’. In the same magazine (2004:15) another article talked about the persistent misconception that women have about not having enough milk titled ‘Moedermilk is niet zomaar op’ translated, ‘You cannot suddenly run out of milk’. The lactation consultant also agreed that women often feel that they are not producing enough milk. Related to this, Earle (2000: 326) writes:

Breastfeeding is an activity that could be jeopardised by ‘problems’, which may prevent women from either initiating breastfeeding or from breastfeeding as long as they wish to... It has been suggested that contemporary Western society has denigrated women’s bodies, leading them to believe that their bodies are inadequately suited to breastfeeding. Consequently many women may perceive breastfeeding as something that will be difficult (or impossible) to achieve successfully.

Bottorff (1990) calls women who decide to breastfeed, even when other alternatives are available or when they experience difficulties, persistent. In his study he saw that for some women, being persistent is so much a part of their breastfeeding experience that they come to view it as a way of
life. The Dutch women I interviewed also had problems, but they still persisted in breastfeeding for periods of between 6 months to 3 years. The persistence resulted either from advice from others or out of their own initiative to make it ‘work’. Brigit gives an account of ‘being brave about it’ as follows:

Brigit: So in the first week it was difficult but I remembered what she had told me (the midwife) and I just kept trying and was brave about it!

Researcher: You said it was difficult in the first week, what kind of difficulties did you face in that week?

Brigit: The baby didn’t drink enough so I was very worried. He didn’t have enough force to drink so I had to pump for him. I didn’t like pumping. The midwife told me that you just have to pump for a few days then it will begin to come. So I had to pump and give it to him through a syringe. I didn’t have a good pump. I had one from my aunt, which was not a good one at all! It was difficult and I didn’t like it. Later he learned and was able to breastfeed from my breasts.

Diana also had difficulties at the beginning as she explains:

I didn’t think it was easy at all. I had to express milk for about five weeks before I could breastfeed her myself. I thought that if I would have had to pump for one more week I would have stopped but all of a sudden it went and now it’s very easy for me but at that time nobody told me it was so difficult.

Lydia had the following to add on to Diana’s experience:

I had a similar experience, I had sores in the beginning so I had to express milk and one boob was not doing okay and it was a hassle and I thought I was gonna quit if it doesn’t work.

The anxiety in breastfeeding can be seen as due to the fact that she has to perform a function with her body that she is not used to. Confidence can be lost when she is unsure whether her body is producing the correct quantity and quality of ‘product’. With these anxieties and uncertainties this persistence to continue can be viewed as an obligation or the work of the mother to share her body with her baby.
3.6 The woman in her social world

After looking at some of the more individual aspects around breastfeeding it is also important to examine how the process of breastfeeding is equally determined by what happens or is expected to happen within the social world of the woman. Stearns (1999: 309) talking about breastfeeding and the good maternal body writes:

Like hair or make-up, breasts are displayed as part of women’s appearance and are sometimes ‘improved’ either through implants or special garments that are typically designed to make breasts larger and more noticeable....the sexual aspects of women and the maternal aspect of women are expected to be independent of each other. Thus breastfeeding raises questions about the appropriate use of women’s body for sexual or nurturing purposes.

3.6.1 Breastfeeding in public

Breastfeeding has symbolic implications and it can tell us a great deal about apparent contradictions concerning women’s bodies. Breastfeeding, like being pregnant, is a state in which the body is in some ways of public concern and thus is open for public comment. However, unlike pregnancy and childbirth, breastfeeding is a continuous activity that requires the ongoing participation of another person. To the extent that breastfeeding occurs in the presence of others and/or symbolizes good mothering it is also a visual performance of mothering with the maternal body at centre stage. Talking about breastfeeding in public, the participants had the following to say:

Researcher: What is your experience when you are outside the house and you need to breastfeed?
Brigit: Yes I have breastfeed outside my house in the café until he was about 8 months. When he was older I felt uncomfortable because I felt people may find it strange.

Researcher: Are there any difficulties for you if you want to feed the baby out of the home setting?
Anna: Well, I feed him everywhere, I’ll cover myself up with a scarf or something so that people can’t see your breast but I will feed him everywhere....... For instance we were in
America for the past 3 months and there the people are very surprised to see a woman feeding in public...... But even in the Netherlands you see people being surprised and of course you must be kind of decent about it. Of course it's nicer to be at home but I do it in public as well.

**Researcher:** What is your experience if you want to feed the baby out of the home setting, in the public, what do you feel about such a situation?

**Kim:** I have never had a problem with that. I can breastfeed without anybody seeing anything of my body.

**Researcher:** So you cover yourself?

**Kim:** Yes, you can do it quite discrete but you have to have experience to become handy in it.

**Researcher:** I have seen you live in a very beautiful area where there is a lot of space to walk and relax outside, so if you are outside what do you do about breastfeeding?

**Anneke:** I breastfeed in public, I will not do it in the centre of everything but I do breastfeed in public. I have a baby that does the job really well; there is not a lot of hassle involved.

**Researcher:** You say that breastfeeding is easy, but what about when you are in a public setting away from your home environment?

**Yvonne:** For me it's not a problem, I don't mind at all. Of course I am not sitting there naked, I just try to cover up a little bit. Yes I try to make it less uncomfortable so they... well; I think that some people don't know where they have to look when I'm breastfeeding. So I cover it up so that they can look wherever and then I feel breastfeeding is normal. So if I am covered up I can do it wherever.

Again with these examples we find the mothers' determination in succeeding to breastfeed in an environment where there could be some difficulties and contradictions in how their bodies are viewed. The women here show that they feel like they are doing something which is right for them and their babies but still are aware that they have to behave in a way that is acceptable in the society.

Stearns (1999:310) writes:
Breastfeeding women must manage their own ideas about the appropriateness of breastfeeding as well as their perception of how others actually respond or might respond to their breastfeeding.

The participants in my study talked about being discrete, covering it up and not just doing it in the centre of everything. Because breastfeeding involves bodily secretions and is thus to some extent associated with the excretory functions of the body, it is seen as somehow ‘out of place’ in public settings and thus as shameful. While the exposure of breasts might be viewed as sexually titillating, exposing it to feed a child has a different connotation, more reminiscent of performing basic bodily functions. In this regard Scott et al (2003: 274) write:

Many women will confine themselves to their homes or restrict their movement while breastfeeding to avoid nursing in public. However, this self-imposed confinement is not feasible for extended periods, and several women reached the stage when they finally overcame their embarrassment and breastfed in a public place.

Their results showed that several women indicated that once they had got over their initial embarrassment, they were less concerned about breastfeeding in public places and considered it other people’s problem if they were offended. As seen above, the Dutch women showed that as long as they covered their breasts while breastfeeding then it was okay to breastfeed in public. They were determined to breastfeed and having breastfed for many months, some breastfeeding their second child, they were already confident and felt that they could do it with discretion.

Anneke: I see sometimes people stare, and I know sometimes people are shocked by it in Holland. That’s their problem.

Anna: Or maybe it’s my perception but I get the idea that people, not everybody feels that it’s normal. I also became kind of stubborn about it because I thought to me it’s a natural thing you know. If the whole society thinks it’s good for the baby to breastfeed, then that society should also accept that you’ll see a baby drinking.

The participants agreed that the breasts are a part of their bodies that should not be displayed in
public, particularly not when performing a bodily function of secretion. During the interviews, there were episodes where the women had to breastfeed and they would expertly do the job with no breast exposure at all by covering the breasts with a cloth or small towel and the interview would continue with the baby happily breastfeeding. Just the way the breasts were covered during this act of breastfeeding immediately showed me just how they have indeed learnt to breastfeed with discretion. They also gave their opinions why they thought it was considered not normal to breastfeed in public. Kim said:

I don’t have any problem when anyone sees any thing of my body but I think other people expect that I feed my baby very discretely. And I now notice especially when there are a few men around me and I take the baby to breastfeed all the men start looking around (away) and they are not very relaxed so that’s the culture I think in Holland.

When asked why she thought it was considered not normal to breastfeed in public Kim replied:

I don’t know exactly how it comes, but its like you’ve always had that idea that okay, I have to behave myself, I think so.

Anneke responded to this question by saying:

Well, I think and this is just my opinion, that they are seen as sexual objects and this (breastfeeding) is not what they are really meant for. I find it ridiculous.

Asked whether she thought that breasts are more or less sexualised Anna said:

I think so yes, yeah and of course I have that myself. I don’t feel comfortable with just taking out a breast in public, you know I will always try to do it discretely as possible, and like I said, cover it up, you know in a way that people don’t see my whole breast. Even I remember when I didn’t have children and I saw women who were much more open about it, who just open their shirts and do it, then I’d also think you know, why do it like that?

Given the fact that the Netherlands is known as a tolerant society, when it comes to breastfeeding
in public it seems to be less tolerated. Talking about the fact that there are many nude beaches in the Netherlands and legalized sex workers, one woman found it contradictory that when it came to breastfeeding, the breasts were seen as something that must not be exposed. She said:

I think it’s because there is not a public space where people have accepted seeing breasts exposed for breastfeeding. Maybe people find it strange, I don’t know, I just can’t imagine.

As indicated above, the nursing breast seems to have both a sexual and a more base excretory meaning and would as a result be seen as somehow out of place in public spaces. This takes us back to work of Douglas (1966) discussed earlier where dirt and pollutants were seen as elements of an ordered system which are rejected. These elements are seen to contravene this system and hence confuse or contradict the system.

I noticed a poster in the Internet section in the Openbare Bibliotheek Amsterdam, which gives the rules and regulation for the use of the computers. The list of rules each have a small photo symbolizing what the rule means, and one of them is a photo of female breasts with a cross over it and the caption next to it says no porno (geen porno). The breasts here have been used in a public library to represent pornography. The sexual aspects of women and the maternal aspects of women are expected to be independent of each other. Thus breastfeeding raises questions about the appropriate uses of women’s bodies, for sexual or nurturing purposes (Stearns 1999). By deciding to breastfeed, a woman’s body becomes a good maternal body on the one hand but on the other there is still the question of whether her breastfeeding is perceived as maternal or sexual behaviour. The joy she experiences from breastfeeding her child in the privacy of her home becomes an experience of discomfort and uncertainty when she has to do it in public.

In Tanzania one cannot deny that breasts are also sexualized in some way, but when it comes to breastfeeding there is more acceptance of it. The female body is also viewed sexually in Tanzania, but commonly the hips and thighs are the ones mostly sexualized. Wearing very short skirts or shorts by females is almost never seen apart from some areas in the major cities and in night clubs. One of the major controversies of the Miss Tanzania Beauty Pageant was allowing the contestants to cat-walk in swimming costumes. It caused major public uproar with magazines and newspapers writing that it is not appropriate for these girls to expose their hips and thighs in
public. The public demanded the resignation of the Minister for Education and Culture for allowing such a breech of cultural taboos. Currently in this beauty contest, when it comes to the swimming costume segment, the contestants have to wear something over their bikini pants but it seems the bikini tops have not been banned. Similarly one of the traditional female dresses in Tanzania is the *khanga*, a light cotton cloth wrapped around the waist and going up to just below the knees. *Khanga* is also worn over the skirt if the woman feels it is too short and does not want to risk exposing her hips and thighs.

The female body can thus at times also be seen to be under surveillance, where different cultural beliefs and practices demand that their bodies ‘behave’ in a certain way. Stearns (1999) writes that with the different hegemonic ideas surrounding women’s bodies, the act of breastfeeding, particularly prolonged breastfeeding, is a form of resistance to the sexualized image of the breast and the good maternal body.

There also comes a question of how long should a woman breastfeed her child. The WHO recommendation as stated previously in this paper recommends exclusive breastfeeding for six months followed by a period of combined breastfeeding and complimentary feeding to make a total breastfeeding period of two years. These recommendations are made based on the scientifically perceived nutritional requirements of the child. The women on the other hand mentioned that apart from health reasons and personal reasons there were also public opinions about how long a mother should breastfeed. Brigit who has been breastfeeding for 3 years talks of the public opinion of her choice to breastfeed for this length of time as follows:

*Researcher*: You said that people were saying that you were breastfeeding for too long. Why did they say it was too long? Did they give reasons why too long is not good?

*Brigit*: They said breastfeeding is for little babies. You make him too dependant on you. They said that it’s also not good for the mother to be so close to him and he becomes too dependent on me. They said I had less freedom to do other social activities. They didn’t understand me, they still don’t. Oh! And they were also saying I am spoiling him

*Researcher*: So they were saying it’s too long, that he is becoming too dependant on you and you have less freedom, what do you think about this?

*Brigit*: First I thought I was strange and different from others and then when I started finding
information about other mothers who are also breastfeeding I began reading more. I also read that WHO advises mothers to breastfeed for at least 2 years and I read about other cultures and recognized a lot. My own feelings was that he was not becoming too dependant on me. I think he felt very free and that he was more independent than other children. I felt that he was feeling secure and that he needed that. I think he is not dependant and not spoilt.

In a society where independence is highly valued, it is seen that the child reaches a stage where he/she has to be more independent by stopping to breastfeed which is seen as dependence on the mothers’ body for nourishment. Brigit was a mother who was highly motivated to breastfeed and hence did not view breastfeeding as delaying the independence of her child. This opinion of independence was also brought up by the participants in the focus group discussion.

Anna: I think that breastfeeding is like a transitional phase between the baby being in your body and being really independent.

Anna: There is a really interesting thing in our environment that people are really supportive for the first 3-6 months and then opinions change a lot. I feel if you are still breastfeeding after one year, although I did not do that, people start to question you.

Lydia: Yeah! 3-6 months is acceptable but not after that. I think people see that when the children have teeth and can have other foods they should not continue breastfeeding. I think six months is enough.

The lactation consultant also talked about breastfeeding older children as follows:

Researcher: What do you think about breastfeeding older children?

Lactation consultant: Oh, it's tricky.

Researcher: Why do you say it's tricky?

Lactation consultant: Part of it is about culture, and here it is that people think it's just a taboo, NOT DONE. Another thing that you hear from women a lot is that a two year old that walks up to his mother, rips the shirt open help themselves is just not right. It's kind of linked with an image of not setting boundaries to your child. It's like how children are taught you don't scream in the supermarket, you don't go to school with a dummy in your mouth and don't open your mothers' shirt to breastfeed.
The child is therefore being taught to be independent at an early age. He mustn’t go to school with a dummy in his mouth, but in the home he can have a dummy in his mouth, as it is away from the public view. Similarly, as opposed to suckling the breasts, which is seen as being dependent on the mother’s body, sucking a dummy is an activity the baby does independently.

Breastfeeding as explained by one mother thus can also be seen as a transitional phase. It’s a transition between being a child who is dependent and one who is independent. The child is being introduced into a new world, one where boundaries are set between what is acceptable or not and where independence is highly valued.

In interviews, different professionals talked about promoting breastfeeding for periods of up to 6 months. One paediatrician commented that the WHO guideline of breastfeeding up to 2 years is also not very applicable and at the Voedingscentrum also the campaign was to get mothers to breastfeed for 6 months. It appeared that in this society, breastfeeding for long periods is not much favoured. Looking at breastfeeding as one aspect of child rearing practices, then according to Nanda & Warm (2002:125):

Children rearing practices in all cultures are designed to produce adults who know the skills, norms, and behaviour patterns of their society - the cultural content... It involves patterning children’s attitudes, motivations, values, perceptions and beliefs so that they are in harmony with their society.

A mother who doesn’t prepare a child as such is therefore seen as spoiling the child, making him too dependent on her, breaching a taboo.

Brigit, as well as one of the breastfeeding professionals in this study, nursed their babies for more than two years. They did not share the public opinion that prolonged breastfeeding interferes with a child’s independence. They were motivated to continue because of the health benefits and the intimate bond they shared with their children. They were aware of the public disapproval they would encounter if they were to breastfeed in public.
Stearns (1999:19) found that a common belief reported (but not always shared) by those in her study in California was that breastfeeding beyond infancy or babyhood was not nutritionally necessary. Thus, the motivations for breastfeeding an older child were often questioned. Was the mother still breastfeeding because she could not ‘let go’ and did this thwart her child’s need for independence? Furthermore, children who are older can often talk and this raises problems in controlling the ‘disclosure’ of the ongoing practice of breastfeeding. In contrast to a baby who signals hunger with a cry that might mean bottle or breast, a child who can ask for its mother’s breast alerts those present that there is a breastfeeding relationship. Most of the participants in Stearns’ study viewed this as a dilemma. Some prevented public problems by creating a rule for their toddlers that breastfeeding would happen at home. Another solution was the use of code words to be used by the child to request for breastfeeding. Such words as milky or mummies, would allow the mother to talk about nursing in public without others knowing she is talking about it. The breastfeeding professional in my study breastfed for four years and she informed me that she had taught her child to ask for ‘a drink’ when they were in public. She informed me that once when they were in public, her child asked for a drink, and a man who was near by gave her a bottle of water. The mother told her child to drink the water and that he would get another ‘drink’ when they got home. She felt that it would not be appropriate for her to breastfeed a 4 year old in public according to Dutch local notions and practices. The personal desire to continue breastfeeding older children in the Netherlands may be met with disapproval. The mother who decides to continue is therefore changing the cultural definition of what is an appropriate breastfeeding relationship.

The woman’s body in relation to breastfeeding is therefore surrounded by meanings from her social environment. Breastfeeding in public is an activity which is not only defined by the mother but also by the society. A balance between a sexualized and nurturing body has to be made. Similarly, breastfeeding as a bodily function is categorized as one which cannot be performed in public. As the child grows older, public opinion change about the appropriateness of the woman to use her body to feed the child.
3.6.2 Prior exposure to breastfeeding

Breastfeeding is not an entirely instinctive behaviour but is dependent on learning. Like other practical skills, breastfeeding requires a certain degree of seeing it being done by others in order to succeed. Looking at my own society I find that women get more exposure to breastfeeding as it is more common and acceptable to see it done in public. Also, as breastfeeding is a common practice, women will see their mothers, sisters, relatives or friends breastfeeding. The extended family system in Tanzania ensures that woman will have stayed for at least some time with a breastfeeding relative. Previous exposure to breastfeeding has either a positive or negative influence on a woman’s decision and subsequent confidence in breastfeeding (Hoddinott & Pill 1999).

The majority of the women interviewed in this study had little or no prior exposure to breastfeeding. Most of them indicated that they were not breastfed themselves; they were the first in their families to breastfeed and did not have so many friends who had done breastfeeding. The women discussed the issue of prior exposure to breastfeeding as follows:

**Researcher:** So you didn’t know much about breastfeeding before this?
**Brigit:** No, not at all.

**Researcher:** Why do you think so, wasn’t it easy to get a chance to see someone else breastfeed?
**Brigit:** No (she laughs). Until perhaps when I was 20 years old I had never seen a woman breastfeed. The first time I saw it was when I went to Portugal on a short visit. My mother didn’t breastfeed my sister or me. I later saw a few of my friends’ breastfeed their babies and that’s all.

**Researcher:** So before you had your baby you did not see breastfeeding in your environment?
**Brigit:** It’s not something I could see and learn slowly from my environment; I could only learn it by reading in magazines and folders.
In another interview:

**Researcher:** Before you had a child and decided to breastfeed, did you have any experience from friends or relatives of seeing someone else breastfeed?

**Kim:** I have seen but not very much. No, my mother and my aunties they didn’t breastfeed. It was not very popular in their days. I had only for two weeks breastfeeding when I was a baby. My husband was also not breastfed and not many of my friends breastfed their own children.

**Anneke:** My sister did not do it, I have some friends who did it but it’s not the same as the family.

**Cate:** My sisters never breastfed and I never saw many friends do it. I may have seen one friend breastfeed but not very often.

Hoddinott and Pill suggest a cyclical model to the issue of breastfeeding exposure and its effect. They say:

Low levels of exposure to newborn babies result in unrealistic and unmet expectations, leading to a sense of failure and difficulty coping. Confidence as a mother declines, often resulting in a change of feeding method in an effort to regain control. Many women are reluctant to socialize and go outside the home with their newborn baby until they are feeling confident and in control. This reduces the exposure of other women in their social network to newborn babies and breastfeeding, thus completing the cycle. (Hoddinott & Pill 1999 as cited in Scott *et al* 2003)

This prior exposure may have either positive or negative influence on a decision to breastfeed as stated previously and it may also impact on a woman’s confidence to breastfeed. In a focus group discussion two out of the five participants viewed breastfeeding women negatively and as somehow shameful.

**Beatrix:** I used to think that it was a bad thing to look at other people breastfeeding. I never had breastfeeding myself. It’s ridiculous that I actually thought that it was kind of like incest.
Lydia: Well, yeah I thought it was a little bit embarrassing to see other people breastfeed, but now I don’t. I thought it was weird to see. But of course in Holland everybody lies topless on the beach, so it’s not weird to see a boob but it’s weird to see someone suck a nipple.

Researcher: Do you think it would be helpful if you see other people breastfeeding?

Lydia: I don’t think so. For me it would not help. Because if I would see her (she points to one participant) and she did it very easy, then for me because it was not very easy I would be very frustrated. I have bigger boobs and have to use a different tactic.

Lydia: (Referring to Anna) you do it very easy but I could never do it like that. I really have to pre-shape them and hold them otherwise it doesn’t work.

In contrast to the extended family network in my own society, the Dutch families are predominantly nuclear families, usually small ones. Within this type of family structure it is not common to live with distant cousins, nephews, nieces etc hence the circle of relatives who may be breastfeeding is rather small. In addition, the low breastfeeding rates mean that few woman will continue.

The lack of previous exposure leads to unrealistic expectations to some first time mothers. Listening to some of these women talking about their first experiences of nursing indicated that this was very unfamiliar to them. Some of the mothers also felt that they had a rather romanticized picture of what breastfeeding would be like. When they experienced problems with breastfeeding, they realised that it was not going as they expected.

Anneke says:

When I got my baby for the first time, they would tell me that you have to breastfeed her every three hours. Why didn’t I know this in advance? Why didn’t they tell me? Why didn’t they tell me to put him on each breast for five minutes otherwise the nipples will get sore and that it will become really hard afterwards, why didn’t somebody tell me?

Diana also felt that you never see much breastfeeding and you don’t hear mothers talking about their experiences. She felt that she also had a romanticized picture of what breastfeeding would be like. She says, “When I went back to the well baby clinic I asked them why anybody didn’t tell me that it was so difficult to breastfeed”.
At the Voedingscentrum, I was also informed that lack of previous exposure to breastfeeding accounted for the failure of some women to successfully breastfeed. They suggested that television programmes showing mothers breastfeeding may help to increase women’s exposure to breastfeeding. Similarly Hoddinott and Pill (1999:33) suggest the possible role of television or video as proxy for real life exposure. In this setting, where family structure and social networks do not allow for women to get exposure to breastfeeding, the television and other forms of media can be used as an alternative for the provision of such exposure.

3.6.3 Support for breastfeeding

Thus with limited prior exposure to breastfeeding which may have either a positive or negative influence another important factor is the support for breastfeeding. Breastfeeding, by its nature, can bring many uncertainties for a mother. The assurance that the baby is getting enough that comes with the use of graduated bottles is not available to the breastfeeding mother. In the industrialized world mothers often find themselves alone without the help of a doula, an experienced mother, grandmother or friend. The doula would be able to reassure the mother that everything is going well and guide them on what to do when things are not go so well. I discussed with the mothers about the issue of support for breastfeeding. Some of them asked me how it worked in my own society. They were interested to hear that in Tanzania what commonly happens is that a mother who has just delivered, especially when it is her first child will not go back home immediately but instead go to the house of a relative with experience in breastfeeding and child care in general. The period of having someone help you with the care of your baby may vary from a few weeks to even a few months. The mother gets assistance with childcare and also with other household activities that she cannot do on her own after going through delivery. She gets information and assistance on things like how to hold the baby when breastfeeding, how frequent to breastfeed and other childcare practices from someone she knows closely and can trust. This form of assistance unlike the type seen in the Netherlands is not professional but merely part of the obligations that women with experience in childcare have towards those with less experience.
Discussing with the women in this study, they informed me that most of the help and support they get was from professionals like midwives, lactation consultants, breastfeeding organisations and doctors. These groups of professionals had different ways of assisting, with some being more helpful than others and some found not to be very helpful at all. The need for assistance also varied depending on whether they experienced any problems or not. When asked who helped and supported them with breastfeeding they said:

**Kim:** The very important person was the *kraamverzorgende*. She helps you with the baby for 8 days after the birth. The *kraamverzorgende* I had for my second baby didn’t help me very much because I knew how it works. She helps with feeding as well. The woman who was here for my second child was very good, she liked breastfeeding, and she said it was the very best. She helped me about how to hold the baby, what is normal, what is not good. She told me everything.

**Anneke:** I got the *kraamverzorgende*. She was the most brilliant one. She was very decisive. She said this is the plan; this is how we do it, nothing else. She said don’t worry!

The women spoke highly of the *kraamverzorgende* who comes for 8 days after delivery to help the mother with the baby. She would help and advise on different issues including breastfeeding. I went on to discuss with them on the issue of support for breastfeeding, as I wanted to learn about what happens after the first 8 days when the *kraamverzorgende* no longer comes. The women all confirmed strong support from their partners or husbands who encouraged them when they had problems and they felt that this support meant a lot to them. They said that the feeling of people around them supporting their decision to breastfeed was very important to them. They talked about the lactation specialist, breastfeeding organisations and the doctors in the well-baby clinic (*consultatie bureau*).

**Researcher:** You made this very important decision to breastfeed, but what was the vision of the health workers about this. For example when you go to the *consultatie bureau*?

**Brigit:** I must say that in the *consultatie bureau* when I tell them that I am still breastfeeding, they would say, well he doesn’t need it any more (She has been breastfeeding for 3 years).
They would not tell me to stop but you can get from their hints that they don’t think I should really continue. I heard from other people that their doctors would tell them to stop but my doctor didn’t say that. Sometimes she (the doctor) would just say it’s good that you are breastfeeding, but I had the impression that she did not know how it feels to breastfeed. She didn’t say much about it. I didn’t feel like I could ask for help from the doctors. At four months they wanted me to start giving complementary food but I read that I should do it at 6 months. So I think the consultatie bureau is not so good with breastfeeding.

Researcher: Is there any area of health service that you found helpful?

Brigit: Yes, the breastfeeding organizations. When I needed help, my friends said these organizations would help.

Researcher: Which organizations were these?

Brigit: Borstvoeding Natuurlijk and La Leche League. After one year someone from Borstvoeding Natuurlijk said when she listened to me she felt I had similar ideas to La Leche League and gave me their number and whenever I have something I contact them.

Kim: Here in Holland you go to consultatie bureau every month and then later it’s less and less and now we go twice a month and I ask the doctor every time what should I do? Go on with the breastfeeding? Tell me what he needs. Should I give him meat, potatoes, tell me, tell me and I will do it? And he told me every time breastfeeding is very good; go on as long as it goes well and as long as you like it, so I did.

Researcher: Apart from the lady who was with you for 8 days after giving birth and the doctors at the consultation bureau, have you used any other people about breastfeeding?

Kim: I have called one volunteer lady one time I wanted to buy a breastfeeding pump, I asked what pump is the best and what should I buy. There are so many different pumps; some are too big you can’t take it with the bike. She helped me. But I’ve read from an organization, this is their book, this organization, La Leche League, they have magazines as well. I am not very enthusiastic about their magazines. I’ve read a few times and it gives me the idea that it’s something like a sect, do you understand, like a sect, they are very pushy? I have not a very good feeling. Its okay to give breastfeeding but it should not take like 20 hours from the 24 in a day. I don’t want that, there is more in the first month than breastfeeding.

From these two examples you see that the women seek for direction in what should be done for successful breastfeeding, and a positive advice is encouraging for them. Kim pointed out about
the breastfeeding organization (magazine) being too pushy whereas for Brigit the organization was helpful for her. Brigit though, has been breastfeeding for 3 years, which seems rather uncommon among the women I talked to, as we shall see later about their attitudes towards the appropriate duration of breastfeeding. Some other comments on the professional help were as follows:

**Researcher:** Do you think mothers get more information about breastfeeding from the doctors or the midwife?

**Yvonne:** It's more from the midwife because maybe the doctors don't know so much about it. It's also because the consultatie bureau is for the child not the mother, so that's a change. It's strange because now they don't ask how you are, but how is she or he (the baby). I think there should be more attention to the mother and more support also when it is going well. Give her support even by telling her good, nice, do you have any questions or do you want any advice on making it even better? That would be good. Then you convince the woman that she is doing the right thing and you make her feel even stronger.

In the focus group discussion they had this to say about the consultatie bureau:

**Researcher:** So do you think that when you go to the consultatie bureau, they are interested only in the baby?

**ALL:** Yeah

**Cate:** And also there is the fact that nobody looks at the mother

**Anna:** Yes it's about the baby

**Lydia:** And the consultatie bureau, they never ask how you are doing.

**Diana:** Once I had a male doctor, and he actually asked me how I was you doing. He also asked if I am still breastfeeding and when I said yes, he said that's very good of you, then he said that his wife had failed to breastfeed; that it just wasn't working so they have decided to stop breastfeeding!

**Cate:** I was asked if I was still breastfeeding and when I said yes, he said okay very good continue. That's all! (Every one laughs!)

Talking about support for breastfeeding, it is seen that the support given to Tanzanian women is different from that given to the Dutch, but both groups need support to succeed. The one in
Tanzanian is more of family support whereas the other is more of professional and institutionalized support. As discussed earlier the family and social network is different here in the Netherlands and hence more professional help has evolved to compensate for the difference. On the issue of professional versus family support for breastfeeding in the Netherlands, the lactation consultant agreed that it was difficult for mothers to get assistance and information from people other than health workers. She says there is not enough knowledge and experience in the society and that clients who come to her centre have been directed to do so by family and friends. The kraamverzorgende and the lactation consultant (Lactatiekundige) seem to act as the professional breastfeeding doula. They are the ones with the ‘knowledge’ and ‘experience’ the women can rely on to perform their job successfully. In a society where individuality and personal opinions are respected these professionals are not expected to be too pushy but rather to be a guide to the woman who wants to breastfeed. They are expected to provide advice, information and assistance to the woman so she can make her own informed decision. Speaking to a midwife about women’s decision to breastfeed she says, “Now, some women think a lot about what, how and why they do things. They try to rationalise everything”. The lactation consultant also talked about not being a breastfeeding promoter but rather a facilitator. She said that she respects the individual choice of the woman regarding what method of feeding she will give provided that she has been given the correct information. She says, “The main aim is not to promote breastfeeding or get women to start breastfeeding but to solve any problems and look at how life can be made easy for the breastfeeding mother”. She described the breastfeeding centre as one where a woman comes voluntarily to seek help in breastfeeding. Also she said the centre is not merely a place for mothers with problems but one which strives to make life easy for a mother who breastfeeds. The centre also gives support and information to mothers who want to stop breastfeeding when they feel they have done it for enough time. The lactation consultant says they give advice to anyone who has decided to stop irrespective of how long they have been breastfeeding. They say the correct time to stop is when the mother feels it is time.

Support for breastfeeding women seems to be the responsibility of the state and its professionals. This can be seen behind a background where other forms of social support like for the poor, disabled, elderly, orphans etc is taken care of by the state. Institutions are already in place to provide such assistance and citizens expect and are accustomed to their use. In Tanzania I do not
know of the existence of homes for the elderly, to the best of my knowledge there are only a few
homes for the disabled and these are for the mentally disabled, orphanages are few and may have
increased only recently with the HIV/AIDS pandemic increasing the numbers of orphans. Such
members of the society get help from the extended family. One cannot argue which of the two
systems is better but definitely they seem to be appropriate within the context in which they
exist, both with their own advantages and disadvantages.

On the issue of getting assistance from the doctors, it is only one woman who expressed a
positive experience. The majority of the women found that the doctors were not very
experienced when it came to giving advice on breastfeeding. Talking to the midwife and
lactation consultant they both agreed that the doctors do not know so much about breastfeeding.
The lactation consultant also said that the GPs or the doctors at the well-baby clinic have only a
short time for consultation, about 10-15 minutes and that in her practice it may take up to an
hour to assist and teach the mother how to breastfeed properly if she is having problems. She
also said that such a session should be followed up by other sessions. Speaking to one
paediatrician, she acknowledged that during training for GPs, there is not enough time spent on
breastfeeding during GP training. Another paediatrician also spoke of the fact the medical
doctors are trained more for secondary as opposed to primary health care where breastfeeding
falls. A study done in USA to identify clinicians’ opinions and management practices that are
associated with continuation of exclusive breastfeeding found among other things that clinicians
reported limited time during preventive visits to address breastfeeding problems as a very
important barrier to promote breastfeeding. Obstetric providers were least confident in resolving
problems with mothers not producing enough breast milk. Paediatric providers were least
confident in resolving problems with breast pain or tenderness or cracked or painful nipples
(Taveras et al 2004). Speaking to the group working on breastfeeding research at TNO
Preventie en Gezondheid, one paediatrician informed me that doctors actually see the baby quite
late after birth and that it is true there is some uncertainty by some doctors in dealing with
breastfeeding problems. During this study, I attended one session at the consultatie bureau with
one of the participants and the doctor informed that generally they have 10-15 minutes with the
client. The session was well conducted though, with the doctor attempting to use the time
effectively. The child attending the clinic was already 6 months old and when the mother said
that the baby was still breastfeeding, the doctor informed her of what food the baby should eat as complimentary feed and just emphasized the mineral contents he should be getting if he continues to get breastfeeding. At the clinic the emphasis was to see if the baby was growing well according to the charts and if they are following the entire vaccination schedule. An assessment of his neurological development was done by asking the mother what type of things the baby can do, if he can grasp certain objects with his hands and the doctor carefully observed the babies motor activities. After 15 minutes there was another baby waiting to be examined so we had to leave.

Maher (1992) writes that in the United States, new mothers have to deal with considerable muddles in obstetric and paediatric thinking and practice. She says that some of the gravest muddles derive from the fact that the medical profession conceives of mothers and babies as belonging to separate fields of research, and thus, the partners to the breastfeeding relationship are dealt with by different specialists. Such confusing and sometimes contrasting messages regarding breastfeeding have been found in the stories given by the Dutch mothers. This same medical establishment seems to provide the most vocal apologists of breastfeeding by women in developing countries. The separation of the mother/baby dyad can be seen in the well baby clinics in the Netherlands where they seem to focus more on the baby as a future citizen of the state and government policies also seem to direct its effort at positioning the baby as a future member of the society, and hence nutritional recommendations are primarily geared at producing a productive individual into the society.

Breastfeeding, as an activity the mother had to perform with little or no previous exposure to, required support to make it work. The family and social network in the Netherlands required this support to come from professionals. The main professionals in this aspect were the kraamverzorgende, lactation consultant and doctors. The kraamverzorgende was not available for a long time after delivery, the doctors were not very much informed and able to assist when it came to breastfeeding problems. The lactation consultant seemed to the most informed, therefore becoming the most efficient doula. The mothers expected and were used to getting assistance and support from professionals and institutions. This was also based on the fact that such social services were seen to the responsibility of the state.
4. CONCLUSIONS

There have been many books and articles on breastfeeding as a bio-cultural process. In this study I have tried to show that beliefs and practices concerning breastfeeding are associated with the culture, beliefs and everyday experiences of society in general. There are many ways to define culture and Van Esterik (1996) highlights that just as biologists have difficulty agreeing on a definition of life, theologians on a definition of God and doctors on a definition of health, anthropologists seldom agree on a definition of culture. Nanda & Warms (2002:71) also talk about the difficulty of defining culture by saying that:

Although culture is not easy to define precisely, practically everything humans perceive, know, think, value, feel and do-in short, almost everything that makes us human-is learned through participation in a socio-cultural system. Even the things that strike us as natural often are cultural.

The same authors go on to give a definition of culture by Sir Edward Burnet Tylor who defined it as:

The complex whole which includes knowledge, belief, art, law, morals, customs and any other capabilities acquired [learned] by man as a member of a society

(Nanda & Warms 2002:72). There is in the literature on breastfeeding clear agreement that maternal attitudes towards breast and bottle-feeding are culturally conditioned. As long as these attitudes are culturally conditioned then they are also amenable to change as culture is not a static phenomenon but a dynamic one.

By listening to mothers and other professionals talk about breastfeeding it has been possible to pick out certain cultural practices and beliefs within Dutch society which are associated with the way that the act of breastfeeding is carried out and understood. This study has shown the meanings and experiences of breastfeeding can also be viewed as a reflection of Dutch culture in general. Based on the above definitions of culture it cannot be claimed that by examining breastfeeding alone, the complete complexity of Dutch culture can be understood, although it is
relevant in certain aspects.

In an advanced Western society like the Netherlands, theoretical knowledge about the benefits of breastfeeding can be acquired by the mothers through different means because they live in a literate society. Breastfeeding has been shown to not necessarily be a process which the woman’s body will be able to perform naturally but one which is informed through books, magazines, the internet and other sources of knowledge. Following the acquisition of such knowledge and in an environment where childbirth is portrayed as being ‘natural’, women must struggle to combine the medically informed theoretical knowledge they have acquired on breastfeeding and the bodily experience of nursing.

Confidence and persistence is required to succeed and some sort of support is needed to make them continue. The support network for breastfeeding in this society is predominantly from professionals rather than family members. The evolution of such a professional network of people dealing with the support for breastfeeding can be viewed as a form of cultural adaptation to the ever changing family trends in the society and decreasing opportunities of exposure to breastfeeding. The lactation consultant has not been there for a long period of time but has gradually become one of the professional breastfeeding *doulas* in the Dutch society. This professional and institutionalized support for breastfeeding happens in a society where other forms of support, like for the elderly, orphaned, disabled and the poor is also institutionalized and is a responsibility of the state.

As part of child rearing practices, women who choose to breastfeed have to do so in accordance with the belief that a child has to be prepared for life as an independent individual. Therefore, as described by one mother, this transitional phase has to have its limit otherwise an individual who is not independent will be introduced into their society. However, some mothers may not follow this culturally prescribed appropriate breastfeeding duration, and may breastfeed for a longer time, but they will devise methods to do so without being seen by the public. Similarly the mother has to ‘behave’ when using her body to breastfeed because she should not expose her breasts but *cover it up* and be *discrete* about the act of breastfeeding. As long as the female body, especially the breasts are seen as sexual objects but also with a nurturing/maternal
function there must be a balance in its use to avoid transgressing the boundary of sexuality and motherhood.

Breastfeeding should fit into the daily schedule of the mother if it is to be done successfully for months or even years. This can be made possible depending on the social status of the mother, for example whether the type of work she does provides her with space to incorporate breastfeeding into her work or if she can afford not to work in order to feed her child.

Professionals in the field of breastfeeding will incorporate some of their cultural beliefs and practices into their professional knowledge. As long as the society respects personal opinion and individuality, authoritative regimes cannot be incorporated into the teachings on breastfeeding but rather a balance is reached to assist the mother in coming to an informed decision on her infant feeding choice. This choice must then be followed up to make it a success. Policies on infant feeding in general and breastfeeding in particular aim at producing a healthy society in general and not specifically targeting the mother-infant interaction.

Breastfeeding involves the use of the woman’s body; therefore issues around breastfeeding will be well studied if this is taken into consideration. The body is not only a biological phenomenon, but a socially constructed one too with a lot of symbols and metaphors associated with it. Everything we do we do with our bodies - when we think, speak, listen, eat, sleep, walk, relax, work and play we ‘use’ our bodies. Every aspect of our lives is therefore embodied (Nettleton & Watson 1998:1). The body is capable of carrying a wide range of ever-changing meanings, some of it parts can be divided into public or private, good or bad etc depending on the society.

Categorization of the body into the self, social and politic came out openly in the findings of this research. Breastfeeding cannot be viewed without considering embodiment and experiences from the mother. It is an act performed by the mother, and she experiences it as such. A sense of pleasure, pain, fulfilment and even a sense of encroachment of her individuality can all come out of the breastfeeding experience. Biologically explained processes that accompany the act of breastfeeding have also to be informed by such phenomenological experiences to be better understood. Generalizations are usually made about the act of breastfeeding as a physiological
process, but the experiences of the individual mothers cannot always be generalized in such a way.

The social aspects surrounding breastfeeding, give us the experience of the body self in relation to breastfeeding. Breastfeeding now becomes not just an individual activity but one which is governed by cultural beliefs and practices. Social meanings about the use of the woman’s body come into play. Through the body social, breastfeeding becomes an activity which the mother has to perform in accordance with what is culturally accepted. Her body ceases to be her own, but one which members of her society have something to say about. The body can now be seen as a good maternal body, a sexualized body or even an unclean body discharging bodily fluids which should not be exposed in public. The mother’s body is also looked at as providing something for the child, as being part of good and healthy mothering. Yet it is constrained by expectations that the child has to be independent, to become a proper member of the society, and if the mother exceeds this limit, her body spoils the child by making him too dependent on her.

Breastfeeding policies are made in such a way that the breastfeeding body is seen as a source of one of the products necessary for providing healthy nutrition to the child. The child nutrition policies are aimed at preparing the child to be a healthy and productive future individual of the state. Therefore both formula and breast milk are seen as products to produce a healthy child but breast milk is seen as superior. With such policies, then the main aim is not just about the mother-child interaction in the process of breastfeeding but rather for the general good of the population.

Synnott (1993:4) says, “the body is both an individual creation, physically and phenomenologically, and a cultural product; it is personal, and also state property”. To understand breastfeeding, the cultural context in which it is done is important too and the symbols and metaphors around the breastfeeding body together with other forms of quantitative data can prove helpful in breastfeeding research, programmes and policy.
5. RECOMMENDATIONS

The views expressed in this study were not intended to be representative of all breastfeeding mothers in the Netherlands, but the data gathered through qualitative techniques provide an insight into their perceptions and experiences. Therefore with the conclusions drawn from this study, some recommendations can also be made.

Provided it is generally agreed that breastfeeding is a bio-cultural process, then studies which focus on breastfeeding will benefit from incorporating both the biological and cultural aspects of breastfeeding. This study itself was not able to incorporate both views given the time allocation but a study with both views will yield very useful results.

In-depth qualitative analysis of the breastfeeding experience of women can provide information about what it means for them to breastfeed and the type of experiences they get. Such information can be incorporated into what women are taught about breastfeeding as opposed to providing them with factual information about the health benefits of breastfeeding alone.

The Innocenti Declaration on the protection, promotion and support of breastfeeding of 1990 adopted by WHO and UNICEF policy makers (WHO/UNICEF 1990) states the goals of the declaration may be reached by among things, the reinforcement of a ‘breastfeeding culture’. With culture being emphasized, then there should be a linkage of cultural data with other forms of data to achieve a better understanding of breastfeeding. Qualitative data which is holistic and richly contextualized may be a source of bringing a real-life picture into the different statistics used by policy makers in the area of breastfeeding.
Annex I: Data collection tools


STEP 1: Introduction
Introduce myself to the participant. Summarize the aim of my research and outline how the discussion will be. The approximate duration of the interview will be explained to the participant (30-45 minutes) and asked if it is convenient for her. Request permission to tape-record the interview and reasons why I would like to record. Explain that the contents of the interview will only be used by the researcher and that the tape may be destroyed or given to the participant upon completion of its use. If the participant is unwilling to be tape-recorded, then the tape recorder will not be used. The participant will be given the opportunity to ask any question regarding the interview process or about the research itself. Once the participant is satisfied, she will be given a consent form to sign agreeing to participate and allowing me to start the interview.

STEP 2: Background information of the participant
- Name, age, religion, marital status, level of education, address and contact details of the participant will be documented.
It will be stressed again that this information is only for the researcher’s use and the option of using a pseudonym for the research material will be given to the participant.

STEP 3: The interview
The following are guiding questions to assist the researcher during the interview. The researcher may ask additional questions on the spot to gain as much useful information as possible. The participant is unrestricted in what or how she answers the questions and will not be restricted from giving relevant information not included in this guide.

A) The meanings of breastfeeding
- When did you decide to breastfeed?
- Why did you decide to breastfeed?
- How long do you intend to breastfeed?
- How do you choose a time to stop breastfeeding?
- How do you see your relationship with your baby and how does breastfeeding impact on it?
- Do you find any difference between breastfeeding and bottle feeding?
- Do you find any difference between breast milk and formula milk?
- What do you feel is the role of breast milk for you and your baby?
- What is the reaction of people around you about breastfeeding?
- How do you see the role of your partner in infant feeding and other child care activities?
- How does breastfeeding impact on your role as a mother/woman/partner?

B) The experiences of breastfeeding
- How was your first experience of breastfeeding?
- What does it feel like to breastfeed your baby?
- Have you experienced any problems while breastfeeding?
- How have you dealt with any problems related to breastfeeding?
- Did you have the opportunity of seeing someone else breastfeed before you started to breastfeed yourself?
- What are your experiences of having to breastfeed your baby when you are outside the home or at home in the presence of other people?
- Do you feel that there is support for you to breastfeed, and if so where does it come from?

STEP 4: Closing the interview
- Summarizing key information gathered and asking the participant if it is correct
- Requesting the participant for a follow up interview at the time of her convenience
- Now the participant will be given a small diary and asked if she is willing to write about her everyday experience of breastfeeding. She will be asked to write about the events and activities surrounding the breastfeeding activity but will be given freedom on what she wants or does not want to write
- Remind the participant that the information gathered will only be used by the researcher
for the purpose of the study
-Ask the participant if she has any further questions or needs elaboration on anything regarding the research or interview that has just taken place
- Thanking the participant
Annex II: Consent Form.

UNIVERSITY OF AMSTERDAM
FACULTY OF SOCIAL AND BEHAVIOURAL SCIENCES
MEDICAL ANTHROPOLOGY UNIT

CONSENT FORM FOR PARTICIPATION IN RESEARCH

I __________________________ (name) of __________________________ (address), have agreed to participate in the research titled Breastfeeding in a Bottle-feeding culture: The meanings and experiences of breastfeeding among Dutch mothers. I have agreed to do so voluntarily and have adequate information about the research purposes and the risks and benefits involved.

Signature __________________________ Date __________________________ (participant)

Signature __________________________ Date __________________________ (researcher)
Bibliography

Beasley, A.N.

Bottorff, J.L.

Britton, C.

Britton, C.
2003 Breastfeeding: a natural phenomenon or a cultural construct.

Bulk-Bunschoten, A.M.W.
2003 Feeding practices in the Netherlands during the first four months of life: Amsterdam.

Burgmeijer, R.J.F

Dignam, D.
Douglas, M.

Earle, S.

Good, B.J

Helman, C.G


Hoddinott, P. & R. Pill
1999 Qualitative study of decisions about infant feeding among women in East of London. *British Medical Journal* 388:30-34.

Jelliffe, D.B & E.F. Jelliffe

Kraamzorg

Kraamzorg
Kraamzorg
2002 De borstgeven niet normaal. *Kraamzorg* 3(6):9

Kraamzorg
2004 Moedermilk is niet zomaar op. *Kraamzorg* 5(1):15

Latham, M.C., K.O.Agunda, T.Elliot

Law, J.

Mabilia, M.
1996 Beliefs and practices in infant feeding among the Wagogo of Chigongwe (Dodoma rural district), Tanzania. *Ecology of food and nutrition* 35(3): 195-207

Maher, V (Ed).

Murphy, E.

Nanda, S. & R.L.Warms
Nettleton, S & J. Watson (Eds)  

Netherlands Nutrition Centre Website (English version) - http://www.voedingscentrum.nl

Peoples, J. & G. Bailey  

Scheper-Hughes, N & M. Lock  
1998 *A mindful body. A prolegomenon to future works in medical anthropology.*  
In: S. Van der Geest & A. Rienks (Eds). *The art of medical anthropology.* Amsterdam: Het Spinhuis

Schmied, V & D. Lupton  


Shirima, R., M. Gebre-Medhin, T. Greiner.  

Stearns, C.A.  
1999 *Breastfeeding and the good maternal body.* *Gender & Society.* 13 (3): 308-25
Struhkamp, R., A. Krumeich

Synnott, A.

Taveras, E.M., R. Li, L. Grummer-Strawn, M. Richardson, V. H. Rego, I. Miroshnik & T.A. Lieu
2004 Opinions and practices of clinicians associated with continuation of exclusive breastfeeding. *Paediatrics* 113(4):283-290

Van der Mark, E.
1996 *Successful Home birth and midwifery. A Dutch model*. Amsterdam: Het Spinhuis

Van Esterik, P.

Van Esterik, P.

Van Esterik, P.
2002 Contemporary trends in infant feeding research. *Annual review of Anthropology* 31: 257-78

Wald, E., B. Dashefsky, C. Byers, N. Guerra, and F. Taylor
WHO/UNICEF


Young, I.M.

1989 *Throwing like a girl and other Essays in Feminist Philosophy and Sociology Theory*

Bloomington: Indiana University Press.