Infant Feeding in Newfoundland and Labrador, Canada: Perceptions and Experiences of Maternal Grandmothers

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ABSTRACT

The purpose of this study was to examine the primary factors that influenced grandmothers' choices of infant feeding and to explore the role that grandmothers feel they played in their daughters' choices about infant feeding. Twenty-two maternal grandmothers who bottle fed their children and whose daughters also bottle fed their babies were recruited to participate in 4 focus groups and/or 2 interviews. Using the constant comparative method of data analysis, 3 themes emerged that described how grandmothers felt about their infant feeding experiences: "powerlessness," "modesty," and "ambivalence." These themes and their implications are discussed in this article.

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INTRODUCTION

Newfoundland and Labrador (NL), a province in Eastern Canada, has historically experienced low breastfeeding initiation and duration rates. A review of records from the 1950s and 1960s showed that breastfeeding rates may have dropped as low as 3%–4%, at least among women on the Avalon Peninsula part of the province (Child Welfare Association [CWA] Annual Reports, 1961). Currently in NL, 70% of mothers initiate breastfeeding (Perinatal

Program Newfoundland and Labrador, 2014). This rate compares to a Canadian breastfeeding initiation rate of 89% (Gionet, 2013).

It is in this context that the Breastfeeding Research Working Group (BRWG) was formed under the auspices of the Baby-Friendly Council of NL to gain a better understanding of the reasons for the low breastfeeding rates in this province. The BRWG is a multidisciplinary group of researchers who are committed to protecting and supporting

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As part of a larger program of research, the BRWG undertook a study in the spring of 2010 to explore the experiences of mothers who had chosen to feed breastmilk substitute. The “You’re Not Going at That!” study consisted of focus groups conducted in three locations across the province. One of the major findings was that new mothers looked to their own mothers as a significant source of advice and support on feeding practices (Bonia et al., 2013; Ludlow et al., 2012). Based on the findings of this 2010 study and recognizing the role of grandmothers played in daughter’s current feeding choice, further research on the attitudes and experiences of grandmothers toward infant feeding was warranted.

Much of the current research explores perspectives of grandmothers who have breastfed, as opposed to the perspectives of grandmothers who bottle fed. Thus, the BRWG set out to explore the experiences and perceptions of grandmothers who bottle fed their children and whose daughters also chose to bottle feed.

Background

Research has shown that a mother plays an important role in her daughter’s decisions about infant feeding, and if a woman was breastfed herself, she is much more likely to breastfeed her own baby (Bentley et al., 1999; Ekström, Widström, & Nissen, 2003; Meyerink & Marquis, 2002). Other studies have found that the opinion of the grandmother is a major contributing factor to a new mother’s

decision to breastfeed (Bentley et al., 1999; Duong, Binns, & Lee, 2004). In recent years, a newer body of research is confirming that grandmothers play a key role in the infant feeding decision-making process and should therefore be included in educational efforts aimed at promoting breastfeeding (Agunbiade & Ogunleye, 2012; Bezner Kerr, Dakishoni, Shumba, Msachi, & Chirwa, 2008; Grassley & Eschiti, 2007, 2011). Grassley and Eschiti (2007, 2008, 2011) suggest that the infant feeding experience of the grandmother needs to be acknowledged and that their knowledge can be enhanced along with their support for breastfeeding. Reid, Schmied, and Beale (2010) argue that in planning interventions to improve breastfeeding, it would be useful to engage grandmothers to facilitate breastfeeding. Grandmothers should be included in pre- and postnatal programs that promote current infant feeding practices as they are a significant source of support and advice for the new mother (Aubel, 2012; Ekström et al., 2003; Kaunonen, Hannula, & Tarkka, 2012; Masvie, 2006).

METHOD

Once ethics approval was granted, participants were recruited through Family Resource Centers (FRCs) throughout the province of NL. Eligible participants included maternal grandmothers who had bottle fed their babies and had a grandchild born in the last 5 years who had been or was currently being bottle fed. For some participants, this meant that either they or their daughters had initiated breastfeeding but had stopped shortly after birth. Participants had to be available for a focus group at a local FRC. In the case of two communities, the FRCs were unable to recruit sufficient numbers for a focus group; thus, a one-on-one interview was conducted with an interested woman from each of these towns. The data collected from these interviews was given equal weight to the data that emerged from the focus groups.

The decision was made to focus on maternal grandmothers and not paternal grandmothers as previous research suggests that it is the maternal grandmother, at least in North American and European countries, that has the greater influence on infant feeding decisions (Arora, McJunkin, Wehrer, & Kuhn, 2000; de Medeiros Gross, Van Der Sand, Girardon-Perlini, & Cabral, 2011; Susin, Giugliani, & Kummer, 2005).

Each focus group and interview lasted approximately 60 minutes and was audiotaped with the consent of the participants. The focus groups were

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facilitated by a qualitative investigator experienced in focus group research, and a second investigator was used to record important comments in three of the four focus groups. At the end of each session, although not part of the recruitment process, each participant received a \$20 gift card as a thank you gift for their participation. The audiotapes were then professionally transcribed.

Analysis

Transcripts were analyzed using the constant comparative method of qualitative analysis (Merriam, 2009) starting from the time that the first transcript was available. The constant comparison method of analyzing qualitative data involves numerous rounds of reading and coding the data and comparing the codes between transcripts. Coding was done by the first author and reviewed by the other authors. The 13 initial key codes were highlighted and grouped into three main categories: “Beliefs and Attitudes,” “Choice,” and “Body Consciousness.” These categories were then further broken down. For example, all quotes that were, in the initial round of coding, under the keyword “Public Breastfeeding” were, in second round of coding, grouped under the heading “Body Consciousness.” In subsequent rounds of coding, the quotes from this group were further analyzed until the researchers realized that almost all quotes in the “Body Consciousness” section were related to the idea that breastfeeding in front of others is wrong and that modesty should prevail. The theme of “Modesty” was chosen to represent the quotes related to this feeling and could be further broken down to show the various ways that grandmothers felt that modesty was important. Using this process, the other themes of “Powerlessness” and “Ambivalence” also emerged from the data. As this study was part of a dissertation for a master’s degree, the supervisory committee met regularly to review the data and assess the findings. The committee members included an expert in qualitative analysis who assessed the steps taken during the data analysis and advised on the plausibility of the findings.

The saturation point was reached at the end of the third focus group. The fourth and final focus group provided no new key points or emerging themes.

Findings

Recruitment resulted in four focus groups and two individual face-to-face interviews that included 22 participants. The women ranged in age from

TABLE 1
Participant Characteristic

Characteristic	<i>n</i>	%
Number of children		
1–3	16	73.0
4–6	5	22.0
7–9	1	4.5
Education level completed ^a		
Less than secondary	8	38.1
Secondary	6	28.6
College	6	28.6
Some university	1	4.8
Location of residence		
Rural	5	22.7
Small population center	12	54.5
Large population center	5	22.7
Annual income ^a		
Below 10,000	6	28.6
10,000–30,000	11	52.4
30,000 and up	4	19.0

^aThese figures are calculated for a sample size of 21 as one response was left blank.

43 to 81 years, with the mean age being 59.9 years. Table 1 presents the characteristics of the study sample. Although ethnicity was not asked, it is likely that the participants were of North American or European origin as more than 95% of Newfoundlanders identify themselves as either of Canadian, English, or Irish origin (Statistics Canada, 2006).

The interviews and focus groups provided rich data about the infant feeding experiences and perceptions of grandmothers. Three themes emerged from the data analysis that describe how grandmothers felt about their past infant feeding decisions and practices and how they currently felt in relation to their daughter’s infant feeding: powerlessness, modesty, and ambivalence. Pseudonyms are used throughout this section to ensure the privacy of the participants.

Powerlessness. The women in this study expressed a sense of powerlessness when it came to talking about their own infant feeding decisions. The perceived power and authority of medical professionals was a recurring theme. Many of the women felt powerless to stand up to or question medical advice even if they felt it was unnecessary or unfair. Sarah echoed this common complaint, “They didn’t ask me in the hospital what I wanted to do. I mean she was born [during] the night and the next morning they came in with the baby and the bottle.”

Many participants also described a feeling of powerlessness when it came to their own mothers. Over and over again, the participants noted that they had simply followed what their own mother had done, feeling that they could not go against her advice. For example, Janet stated, “I was the first out of the few of my friends to get married and have children and I had no one really to go by only mom and she couldn’t stand it and I had no desire to honestly.”

However, many participants felt that their daughters were better educated than they were and, as a result, had a chance to make more informed decisions regarding infant feeding. Some women felt that this could be attributed to the Healthy Baby Clubs, a government-funded prenatal nutrition and support program, which are widespread throughout the province and are staffed by resource mothers who offer advice and guidance to new mothers.

Although some grandmothers were pleased that their daughter had more choice than they themselves had, others showed some discontent that their daughters were not always following their example as they themselves had done. Mary bitterly expressed her opinion, “But what cracks me up today, like we did what our mothers did, what our mothers told us. But today, they don’t listen to their mother, a lot of them don’t.” Many of the grandmothers felt that they had no influence on the choices their daughter made. Paula, for example, felt that her daughter, living away on the mainland, was unaffected by her mother’s feelings on the subject, “They’re just smart today. They got all the education, they go to school, university and that, they just—I know I had no influence on my daughter.”

Modesty. In addition to their feelings of powerlessness, the participants in this study felt strongly about the importance of modesty in relation to their own and other women’s bodies. The prevailing sense of modesty that these women felt meant that considering breastfeeding as an infant feeding option was almost unfathomable.

Of all the topics discussed in the focus groups and interviews, the idea of breastfeeding in front of others caused the most emotional reaction. There was a mix of opinion on the issue; some women were vehemently against nursing outside of the privacy of one’s own home, whereas others were okay with it as long as the mother kept herself and the baby covered. For many, the taboo of nursing in front of others seemed to be a major factor in their decision to

bottle feed. Many grandmothers remembered having been advised that if they breastfed, then their social lives would be severely restricted. In describing the secrecy surrounding her aunt who had breastfed her children, Paula shed light on the extent to which nursing in front of others was considered wrong, “Yeah, it was always done, like, in cloaked—like, she was in the living room, and it was, like, a big cloak thing, you know. It was almost, like, forbidden, taboo. . . . It felt, you know, she’s weird.”

Similarly, other women reported being “shocked” at seeing a woman breastfeeding in public. Some wondered why breastfeeding could not simply be done behind closed doors. As Sherry wondered, “. . . I’d be like, ‘oh my God, can you go to the washroom or something?’”

Some felt that this sense of outrage or disgust at the thought of breastfeeding in front of others was a result of their own mother’s warnings about what was and was not acceptable. As Josephine explained, those warnings were hard to ignore, “Yeah, Mom used to say you can’t go nowhere. You’ve got to stay in the house in the bedroom or no one could come when it was feeding time and that kind of discouraged me . . .”

A sense of modesty about the female body was also evident in Louisa’s comments about feeling a need to hide her pregnancies from others when in public. “If you were pregnant and anyone came in, you sat behind the table, so no one would see that you’re pregnant, right. It was sort of a hidden thing, right.” Others described how they would hide their pregnancies by wearing something too big for them or even wearing men’s clothing.

Although modesty was an important factor in the lives of these grandmothers, there was a real sense that values have changed. For some, this provided an obvious sense of relief and pride that their daughters would not have to endure the same strict moral code, but for many others, there was a clear sense of loss and anger that modesty was not held in high regard anymore.

Ambivalence. It became clear that many of the grandmothers felt a great sense of ambivalence or an internal struggle when it came to their role in supporting infant feeding practices. Those grandmothers whose daughters initially attempted breastfeeding struggled to offer support, despite what they were told about the benefits of breastfeeding. Some saw breastfeeding as a bit of a meaningless fad with no

real health benefits. Many grandmothers expressed concerns about hunger and infant growth in the newborn, and they did not feel these concerns were addressed properly by their daughters or the medical professionals. They felt at a loss as to how they should deal with it. Finally, each grandmother genuinely wanted to be a “good grandmother” but struggled with how to provide support to her daughter.

Although every participant knew that breastfeeding is promoted as the best way to feed a baby, there were several who did not agree. For example, Martha stated, “From my view . . . I don’t consider that a breastfed baby is any better off than a bottle fed baby.” Janice stated, “So I don’t see it, if you want to do it—do it. Some people like to do it so, but I don’t see any difference in it. They’re no healthier.”

Concern over the amount of food their grandchild was receiving was another major area of concern for the grandmothers. This was particularly hard for the grandmothers who felt that the new guidelines on starting solid food at 6 months were too drastically different from what they followed when feeding their own babies. Several participants spoke about starting solid food as early as 3 months.

For some grandmothers, the issue of weight gain and hunger was so important that they stepped in to fix the problem themselves, even without their daughter’s approval. This was particularly easy and tempting for the grandmothers who lived in the same house as their grandchildren. Sherry described how she would often feed her grandchild cereal or other solid food even though her daughter did not agree. As she said, “That’s like me, I mean, you know, what the eyes don’t see, the heart don’t feel. . . . She’d probably say something to me after the fact, but it’s too late now, he got it ate, right.”

There is much discourse about the concept of trying to be a “good mother” (Ludlow et al., 2012), but there is not much reference to the concept of a “good grandmother.” Nonetheless, the participants in this study seemed to feel a great deal of pressure to do what is “good” in their view. This sparked a conflict in many of the women as they struggled with deciding what is “good.” For example, Paula’s ambivalence was obvious when she described her experience with supporting her daughter’s attempt to breastfeed: “I encouraged her all the way for the 2 or 3 weeks she was on it and prayed every night she’d give up the foolishness.” Bertha felt that the right thing to do in her case was to not put pressure on her daughter either way: “My daughter, she had

such a hard time, and I said to her, she didn’t want to breastfeed, I said, ‘My dear it’s up to you, you can breastfeed or you can bottle feed.’”

For many of the grandmothers, being a “good grandmother” meant providing healthy food for their grandchild. Many women went to great lengths to describe the healthy food they provide for their grandchildren while caring for them. For example, Jeanette said, “No junk. He’s not getting no junk food [at my house].”

DISCUSSION

The interviews and focus group with grandmothers provided rich data from which the three themes of powerlessness, shame, and ambivalence emerged. These themes reflect the grandmothers’ perceptions and experiences regarding their own and their daughter’s choice of infant feeding method. The grandmothers in this study voiced that they had little control over choosing an infant feeding method. Grassley and Eschiti (2011) also found that some of the grandmothers in their focus groups recalled a sense of lack of choice, especially in the face of pressure from medical professionals. In this same study, the authors reported that they also heard stories from grandmothers whose doctors had “convinced them to formula feed when they or their infants developed complications such as developing toxemia or having cesarean surgery” (Grassley & Eschiti, 2011, p. 137).

The concept of family influence being so strong as to render a new mother powerless over what her new baby eats was echoed in a 2011 study of Brazilian women (de Medeiros et al., 2011). The researchers in that study found that “the lack of independence, whether it is financial or emotional, often forces young mothers to live with the infant’s grandmothers, and subordinate their desires and beliefs in relation to their infants’ care” (de Medeiros et al., 2011, p. 537). This was very similar to the accounts of the grandmothers in this study which found that they often blindly went along with what their own mother had done. Also, the grandmothers in this study who lived with their grandchildren were often able to manipulate things to go their way by feeding the baby in secret or by doing what they thought was best, knowing that their daughter needed their support.

As the second theme showed, the participants in this study very clearly expressed that they felt society expected them to be modest. Modesty was

a big deterrent for some participants as they felt that their family, friends, and community would not accept them if they breastfeed in front of others. In fact, breastfeeding was viewed as such a taboo form of infant feeding that many grandmothers could not see it as a viable option for themselves or their daughters. In many cases, this sense of modesty was passed down to the grandmothers by their own mothers. Similarly, Grassley and Eschiti (2011) found that grandmothers recalled being taught that breastfeeding was embarrassing or “trashy” (p. 136). A participant in that study recounted how she once told a young child about breastfeeding when he noticed her feeding her baby. She remembers being worried that the child’s mother might be mad at her for telling him about it. Such accounts demonstrate the idea that breastfeeding is something women are taught to be modest and private about. McFadden, Atkin, and Renfrew (2013) also found that new mothers reported being taught by their own mothers that breastfeeding was something to be embarrassed about.

Many of the grandmothers’ beliefs and attitudes about infant feeding were related to weight gain and hunger. Some participants had very strong opinions about these issues and admitted to behaviors that went against their daughters’ wishes, for example, feeding their grandchildren behind closed doors or openly disputing the advice of medical professionals. In many cases, they were not sure how to reconcile the advice given today with what they had been told years ago. This finding has also been reflected in the work of Reid et al. (2010), who found that grandmothers were sometimes not supportive of the later introduction of solids that is presently recommended. These authors noted that, at times, the advice given by grandmothers seemed to be based more on “the grandmothers own parenting experience rather than an understanding of what might be important for the baby and the continuation of breastfeeding” (Reid et al., 2010, p. 78). Bezner Kerr et al. (2008) also found that grandmothers can be reluctant to adopt infant feeding practices that are different from those that they have known throughout their own lives. For instance, the grandmothers who were interviewed felt that “women often have insufficient milk when breastfeeding and babies may need water, dawale or porridge to supplement breastmilk” (Bezner Kerr et al., 2008, p. 1099). This was a difficult belief to change because it was long held and widespread in the community.

Findings suggest that the grandmothers also felt ambivalent about their role within the family. Some, for example, believed that their role was to encourage their daughter to breastfeed or to introduce solids before 6 months of age, whereas for others it meant stepping back and letting their daughter find her own way. Still, others felt that it meant going out of their way to provide healthy foods for their grandchild to eat. Those grandmothers who lived with their daughters and grandchildren seemed to have a particularly hard time with this because they were highly involved in the grandchild’s care and thus had to carefully negotiate their role as a grandmother.

Reid et al. (2010) also found that grandmothers were sometimes unsure of their position within the family: “Grandmothers in this study were aware that stating their own views carried a risk in terms of potentially jeopardizing their relationship with the new family” (p. 78).

The idea of being unsure about their position in the family was also evident in the work of McFadden et al. (2013) who noted that grandmothers who were immigrants reported a struggle with their role once they had grandchildren born in the United Kingdom. They knew that in their country of origin, the grandmother would have been a respected source of advice, but in their new country, they felt that they were not afforded the same respect. This caused the grandmothers distress over their role. When asked how she would feel if the advice she gave to the new mother was not accepted, one participant said, “If they don’t [accept it], it does make you feel small and unworthy” (McFadden et al., 2013, p. 6).

Part of the struggle felt by the grandmothers in this study was evident through the various ways that grandmothers chose to approach the question of infant feeding with their daughters. They seemed to take one of two routes: They either told their daughter they would support whatever feeding method she chose but that they themselves could not help with breastfeeding as they had no experience with it, or they simply ignored the issue altogether. Although many of the women who employed the latter strategy felt they had little or no impact on the infant feeding decisions of their daughters, this is inconsistent with other studies that have looked specifically at the perspective of the daughter. For example, the “You’re Not Going at That!” study conducted by the BRWG (as cited in Newfoundland and Labrador Centre for Health Information, 2010) found one participant who said, “My mother wouldn’t even think about

sitting down and talking about that [breastfeeding]. If I . . . told her I was going to breastfeed, she'd look at me like I had 10 heads" (Newfoundland and Labrador Center for Health Information, 2010, p. 6).

As well, Grassley and Eschiti (2011) found that grandmothers who struggled with breastfeeding when they were young mothers had mixed feelings about supporting their daughters in breastfeeding. One of their participants talked about the "pressure" she felt as a new mother and wanting to relieve her daughter of that same pressure. These feelings were very similar to those felt by the participants in this study who expressed memories of feeling pressured to choose one type of infant feeding method over another and not wanting their daughters to feel the same way.

In some cases, this ambivalence about their role led the grandmothers to act in ways that they kept secret from their daughters. Some admitted to secretly hoping that their daughters' plans to breastfeed would be sabotaged, whereas others fed their grandbabies solids without their daughters' permission. This finding is also reflected in the work of Reid et al. (2010) who found that grandmothers admitted to not always following the instructions left by the new mother. Similarly, Grassley and Eschiti (2007) reported that some grandmothers found that supporting their daughters in making choices different than their own was especially hard. As one of the participants in their study stated, "I think you have to learn when to back off and how to give them space and to support their choices, even if they aren't the same as ours. That's a really hard one" (Grassley & Eschiti, 2007, p. 24).

Implications for Practice

Based on the findings of this study and an analysis of previous interventions that have included grandmothers in the pre- and postnatal education process, the following recommendations are offered:

1. Any intervention involving grandmothers should be respectful of the local culture, language, and traditions. In the context of NL, an intervention could include humor as the grandmothers in these focus groups almost universally had a strong sense of humor and showed a readiness to laugh even when dealing with difficult subject matter. It would also be important to respect the strong sense of modesty that the women in this study expressed.
2. Interventions should be designed to include both new mothers and grandmothers as a unit. Perhaps by accompanying their daughter to a

session on breastfeeding that was geared toward engaging grandmothers would give them the chance to start a conversation about infant feeding that they might not otherwise have initiated.

3. Grandmothers need to be given some room to share their own stories of pregnancy, childbirth, and infant feeding. Although these are almost universal experiences, they are not always ones that are discussed among family and friends. The recognition that many of the feelings they possess, particularly those that are linked to the experience of being powerless, are universal and could be a significant motivator for grandmothers to change their views on infant feeding. Ideally, the grandmothers would share these feelings and experiences with their daughters because it will help them to understand why their mothers act and feel the way they do.

Grandmothers may need some support in defining the role they play should their daughter choose to breastfeed. The grandmothers in this study and in others expressed a strong desire to want to be a "good" grandmother and to provide superior care to their grandchild. Interventions could include specific things that a grandmother might do to encourage their daughter to breastfeed such as helping with other household duties, helping to ensure a good latch by accessing professional help, and supplying healthy meals for the family. In cultures and societies where modesty is a considerable obstacle to breastfeeding, grandmothers should be encouraged to advocate for the new mother when she needs to breastfeed in an awkward social situation.

Grandmothers appear to be open to learning new things, and as such, should be given current information and recommendations on infant feeding practices, especially breastfeeding. Other studies have found that grandmothers want to learn more about the latest research on infant feeding (Aubel, Touré, & Diagne, 2004; Grassley & Eschiti, 2007), and when they do, it helps them to support their daughter to breastfeed successfully (Aubel et al., 2004; Banks, 2003). When developing interventions, care and respect should be directed toward grandmothers as well as providing an understanding and appreciation of their past experiences. This will engage grandmothers in conversations around infant feeding myths as well as to provide a nonthreatening atmosphere where grandmothers can ask questions about breastfeeding.

Engaging and providing grandmothers with up-to-date information on infant feeding practices, related health benefits, and advice on how to best assist a new mother will help grandmothers become actively involved in promoting and supporting breastfeeding.

CONCLUSION

Grandmothers play an important role in the family, and their support or lack thereof can directly or indirectly influence whether a new mother decides to initiate breastfeeding. It is imperative that grandmothers are included in pre- and postnatal programming. Engaging and providing grandmothers with up-to-date information on infant feeding practices, related health benefits, and advice on how to best assist a new mother will help grandmothers become actively involved in promoting and supporting breastfeeding.

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