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BREASTFEEDING AS AN IDEOLOGICAL PRACTICE: CHINESE IMMIGRANT MOTHERS' POSTPARTUM LEARNING IN CANADA

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Abstract

This paper problematizes Canadian breastfeeding policies and programs. It criticizes Canadian federal and provincial government policies and programs, which focus on a global goal of enabling all women to practise exclusive breastfeeding and do not pay enough attention to immigrant mothers' breastfeeding experience. Based on an analysis of government policies and in-depth qualitative interviews with two Chinese immigrant mothers in Canada, I argue that breastfeeding is an ideological practice associated with neo-liberalized restructuring that shapes the organization of current breastfeeding policies, educational and medical programs, and migrant mothers' everyday practice.

Résumé

Cet article problématise les politiques et les programmes d'allaitement au Canada. Il critique les politiques et les programmes fédéraux et provinciaux, dont l'objectif global est de permettre à toutes les femmes d'allaiter exclusivement et qui tiennent insuffisamment compte des expériences d'allaitement des mères immigrantes. Selon une analyse de politiques gouvernementales et d'entretiens qualitatifs approfondis auprès de deux mères immigrantes chinoises au Canada, je soutiens que l'allaitementconstitue une pratique idéologique associée à une restructuration néolibérale qui façonne les politiques d'allaitement et les programmes éducatifs et médicaux actuels, ainsi que la pratique quotidienne des mères migrantes.

Introduction

In 1989, due to a decrease in the breastfeeding rate globally, the World Health Organization (WHO) and UNICEF announced a joint statement for "supporting the initiation and continuation of breastfeeding" with a suggestion of "ten steps to successful breastfeeding" (Canadian Paediatric Society, 2012, p. 1). In 1990, over 40 countries produced the Innocenti Declaration, which called on governments to "undertake programs to protect, promote and

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support breastfeeding" (Canadian Paediatric Society, 2012, p. 1). The declaration concluded that "as a global goal for optimal maternal and child health and nutrition, all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breast milk from birth to four to six months of age" (p. 1). In Canada, about 90% of new mothers start breastfeeding when their children are born, but by the time their babies are three months old, only half are still exclusively breastfeeding, while about two-thirds combine breast- and bottle-feeding (Weeks, 2012).

Based on the global goal for breastfeeding, the multiple levels of Canadian government launched a variety of breastfeeding education programs and services to help increase the national breastfeeding rate. A report from the Ministry of Health in British Columbia communicated three main strategies for national breastfeeding practice and programs. First, it indicated that the key strategy for improving service and support for breastfeeding women is to build strong policies "in support of the WHO's Baby-Friendly Initiative (BFI)" (British Columbia Ministry of Health, 2012, p. i). Second, it stated that breastfeeding is "a major population health issue that requires a focused public awareness campaign to inform the public about benefits and importance and encourage attitudinal shifts in support of breastfeeding" (p. i). Finally, the report highlighted the Best Practice Guideline (BPG) for breastfeeding, which includes "provincial leadership and coordination for implementing the BFI," "increased training for public health care providers," "prenatal education including education for mothers, fathers and family members," and "special initiatives to support rural women and women from diverse cultures" (p. i).

An examination of the practice at the provincial level reveals that the provinces launched breastfeeding education in local clinics based on the national and international idea of BFI and BPG. For example, a survey from the Ontario Ministry of Health Promotion (2009) about breastfeeding support and service in Ontario indicated that "six percent (2) of all 36 health units [in Ontario] reported receiving a BFI designation, 64% (23) reported working towards designation, 19% (7) reported considering BFI and 11% (4) reported no plan for BFI designation" (p. 7). The survey further found that "nineteen (53%) of all 36 health units have implemented BPG, eleven (30%) are planning to implement them, one (3%) has no plan" (p. 8). It also found that there were barriers in supporting breastfeeding in Ontario. For example, many breastfeeding programs were facing a lack of resources—financial as well as staffing. The hospitals in the community have "been down-sized or completely stopped their breastfeeding clinics and services, but no replacement" (p. 10).

Such studies and statistics show how breastfeeding service in Canada has been organized and developed under the global and national guidelines. However, researchers and program organizers have largely ignored how breastfeeding as an ideological practice interacts with globalized neo-liberal restructuring at the local level. In this study, I address the tension between globalized neo-liberal restructuring and local practice in current breastfeeding programs in Canada.

In addition, previous studies on breastfeeding education have focused on how to train nurses or educators to improve their attitude and knowledge concerning breastfeeding (Boyd & Spatz, 2015; Tajeu, 1983) and how to best support new mothers to practise breastfeeding (Smale, Renfrew, Marshall, & Spiby, 2006; Lin, Chien, Tai, & Lee, 2008). However, there is scant discussion of how breastfeeding as an ideological practice shapes the organizing of current breastfeeding educational programs in Canada and interacts with the everyday lives of new immigrant mothers. Recent studies have devoted little attention to new

Chinese immigrant mothers' transnational and cross-cultural breastfeeding experiences in Canada. Therefore, it is necessary to examine the power relations and interactions between Canadian breastfeeding policies and programs, the global community, and immigrant mothers' participation.

As a new Chinese immigrant mother and a patient, I participated in a hospital-based breastfeeding educational program in Ontario. Taking my experience in this breastfeeding program as an example, I realized that there was a gap between my cultural understanding of breastfeeding and the terms or concepts in the program's texts, such as the policies and teaching materials about breastfeeding. The notion of breastfeeding is socially constructed, and the experiences, knowledge, and feelings of new immigrant mothers are largely excluded from the policies and practices. Therefore, I use a textual analysis of government policy and two interviews with Chinese immigrant mothers to examine how breastfeeding became an ideological practice and how policies and practices affect new immigrants' everyday lives in Canada.

This paper is divided into six sections. In the first section, I provide a literature review on breastfeeding. I particularly discuss how knowledge of breastfeeding has been conceptualized and manipulated in educational programs and how breastfeeding as an ideology shapes the way programs and policies are organized. In the second and third sections, I introduce textual analysis and interviews as the research methodology and provide the research background for this study. In the fourth section, I provide a textual analysis of the provincial breastfeeding strategy. In the fifth section, I investigate how Chinese immigrant mothers learn breastfeeding in Canadian breastfeeding educational programs. I take two Chinese immigrant mothers' stories as a standpoint and question how the knowledge of breastfeeding has been constructed in relation to race, gender, and class inequalities. In the last section, I conclude that the development of current breastfeeding policies and programs in Canada need to pay more attention to new immigrant mothers' cross-cultural experiences and to the race, gender, and class relations behind new immigrant mothers' learning practice.

Breastfeeding as an Ideological Practice

Breastfeeding as an ideology has to be understood as "a class-specific, culturally based resurgence" that requires all mothers to practise breastfeeding exclusively (Blum, 1999). Nathoo and Ostry (2009) examined how breastfeeding became an ideology in Canada from the 19th century to the present. After a solid investigation of federal breastfeeding policy and practice over the past 150 years, they argued that breastfeeding practices are "more than a matter of individual choice" (p. xiii). They found that breastfeeding policies have repeatedly failed to "understand, acknowledge, and invest in changing the determinants of women's infant feeding decisions" (p. xiii). Blum (1999) pointed out that motherhood and breastfeeding "have been and continue to be public matters" (p. 2). While the public has paid attention to the "biological realities and actual concerns with health," women's bodies and the breast have been constructed within a patriarchal, androcentric, racial, and capitalist framework (p. 2). She particularly discussed how working-class women negotiate the ownership of their bodies and breasts with husbands or boyfriends even within the "private" sphere of the home. In addition, Blum (1999) proposed a notion of "exclusive motherhood" that has its origins "in the idealized female domesticity of the eighteenth-century European

middle classes" (p. 9). According to Blum, exclusive motherhood echoes with the neo-liberal "good mother/bad mother binary" (p. 9), which serves as an ideology to "control, police and sanction the action and activities of mothers who are expected to meet or conform to dominant standards of motherhood" (Crawford, 2011, p. 11). Gustafson (2005) criticized that the binary as a limited analytic tool is reductionist, which ignores mothers' experiences, feelings, and everyday lives. "Good mothers" are constructed as "loving self-sacrificing nurturers, who put their children's needs before their own" (Crawford, 2011, p. 11). The "bad mother," on the other hand, is a mother "who is an inept nurturer, lacking in demonstrative love and who is not readily available to meet her child's emotional and physical needs" (Crawford, 2011, p. 12). Mothers who have failed to breastfeed are usually constructed as bad mothers that need to be educated.

The term *ideological practice* is conceptualized by Dorothy E. Smith. According to Smith (2005), an ideological practice is an epistemology that dominates the world of thoughts through the process of abstraction, separates relations with material worlds, and has power relations within capital and the division of labour. Here, I use *ideological practice* as a framework for understanding how bourgeois society and its state use ideology to sustain unequal social and power relations. Ideology was first introduced by Marx and Engels to examine how people perceive the world. It has been used to "overcome the dualism of materialism and idealism" (Rehmann, 2007, p. 211), and it provides a framework to bridge people's subjective perceptions and ideas to their actual practice, different ways of knowing, and material conditions of everyday organizing. Smith (2011) re-examined ideology theory and developed it as a feminist method of inquiry to understand society. She pointed out that ideology, as a practice of "reasoning about society and history" (Smith, 2011, p. 26), involves interactions between ideas and reality. I take Smith's idea of the problematic of the conceptual separation between consciousness and life as a theoretical framework to study the abstraction process of differentiating ideas, concepts, and consciousness from material activities (Smith, 2011, p. 25). I believe that examining immigrant mothers' experiences could challenge the notion of exclusive motherhood and the ideology of breastfeeding and help to return inquiry to mothers' everyday world.

The learning of breastfeeding as part of a lifelong learning project has been associated with globalized neo-liberal restructuring and knowledge-based economy. In alignment with global neo-liberal restructuring, the meaning of the discourse of lifelong learning has changed from a focus on the development of the citizen or civil society to an emphasis on "human capital formation to serve a competitive global market" (Lauzon, 2013, p. 4). The focus has shifted toward a neo-liberal ideology that emphasizes the need for individuals to support themselves and quickly adjust to the globalized market. Ng and Shan (2010) demonstrated that the discourse of lifelong learning greatly affects people's understanding of reality, social organizing for social services, and the problematics of immigrants' everyday world. Breastfeeding as an ideology requires new mothers, particularly immigrant mothers, to demonstrate best-practice breastfeeding skills and support themselves to become "good mothers." Through an exploration of immigrant mothers' experiences as a standpoint, the study finds that mothers' individual abilities and responsibilities to learn breastfeeding skills are strengthened in association with the neo-liberal good-mother myth. There is less support for mothers to overcome stress and frustration after delivering their babies.

This study takes Chinese immigrant mothers' experiences as a standpoint to challenge the ideological practice of breastfeeding. Hartsock (1998, 2002) proposed a "feminist

standpoint" to develop the ground for "specifically feminist historical materialism" and to challenge systemic oppression and ruling relations (Hartsock, 2002, p. 350). She particularly pointed out that the lives of women contain possibilities for "developing critiques of domination and visions of alternative social arrangement" (Hartsock, 2002, p. 351). She argued that a feminist standpoint could be developed to deepen the critique "available from the standpoint of the proletariat and allow for a critique of patriarchal ideology and social relations that would provide a more complete account of the domination of women than Marx's critique of capitalism" (Hartsock, 2002, p. 351). Through an examination of immigrant mothers' experiences in learning breastfeeding, this study posits that the ideological practice associated with neo-liberal restructuring and the globalized economy should be challenged by taking the standpoint of the everyday practice and experience of marginalized women, especially immigrant women.

Methodology

This empirical study adopts Dorothy Smith's approach of textual analysis and interviews under the framework of institutional ethnography, which is understood as a method of inquiry to question everyday practice and means of organizing within institutions. Smith (2005) believed that the actualities of our everyday world are socially organized. She developed this method of inquiry to challenge people's held beliefs about social organizations from a bottom-up perspective. She observed how the foundation of institutional relations is textual and that texts coordinate "institutional courses of action" (p. 180). Ng (2006) explored the globalized regime of ruling from the standpoint of immigrant women and elaborated on the use of "standpoint" to understand globalized restructuring. For her, "standpoint" entailed a starting point outside the institutions from which one can challenge conventional scientific approaches and previous "logic of discovery" within the institution (p. 179).

This paper harnesses the framework of institutional ethnography in an analysis of government guidelines for breastfeeding strategies and in-depth interviews with two Chinese immigrant mothers. It explores the tensions among the ideology of breastfeeding, the institutional practice of breastfeeding, and new Chinese immigrant mothers' experiences.

The Study

In 2012 after giving birth to my son, I participated in the Mother-Baby Program (pseudonym), a hospital-based breastfeeding clinic in Toronto that provides a teaching and learning program for new mothers who give birth in this hospital. One of the main purposes of this program is to assist new mothers with breastfeeding their babies. They offer nurses to teach mothers knowledge and strategies for breastfeeding. In my experience, there was a gap between my goal of breastfeeding my baby, the government objective, and the clinic practice for assisting new mothers to breastfeed.

The data were collected from 2012 to 2014. During that time, I conducted in-depth interviews with two Chinese immigrant mothers participating in the breastfeeding program in Toronto. Each interview lasted for three hours. Both of the Chinese immigrant mothers faced cross-cultural barriers in their postpartum learning.

In the following section, I first analyze a text from provincial government guidelines for breastfeeding strategies. I then take two Chinese immigrant mothers' stories as narratives to

examine Chinese immigrant mothers' experiences and how they understand breastfeeding practice based on their transnational and cross-cultural experiences.

A Textual Analysis of the Provincial Breastfeeding Strategy

Smith (2005) observed that the foundation of institutional relations is textualized. This paper conducts a textual analysis of a document called *Recommendations for a Provincial Breastfeeding Strategy for Ontario* (2009), which was developed through a collaboration of stakeholders in Ontario. The stakeholders included all kinds of breastfeeding-related institutions, such as INFACT Canada, Newman Breastfeeding Clinic and Institute, and the Ontario Breastfeeding Committee. This document shows the data of breastfeeding duration and exclusivity rates in Ontario and suggests four key components of a provincial breastfeeding strategy, including "leadership and policy development," "service delivery," "surveillance, research and evaluation," and "capacity building" (pp. 3–7). The document first gives a definition of breastfeeding:

> Breastfeeding is the norm for infant and young-child feeding and the foundation for a healthy life.…The international, national and provincial standard for feeding of infants and young children is exclusive breastfeeding for the first six months, the addition of iron-rich complementary foods at about six months, with continued breastfeeding to two years and beyond, as recommended by the WHO/UNICEF Global Strategy for Infant and Young Child Feeding. (p. 3)

Table 1 summarizes the four key components proposed in the *Recommendations for a Provincial Breastfeeding Strategy for Ontario* (2009) to increase the breastfeeding rates within the province.

I analyze the text in Table 1 on two levels. The purpose of the first level is to understand the conceptualization of breastfeeding from the standpoint of an immigrant mother. The text above, which is produced by all kinds of "authentic persons," introduces breastfeeding as "a norm for infant and young-child feeding and the foundation for a healthy life" (*Recommendations for a Provincial Breastfeeding Strategy for Ontario*, 2009, p. 6). The knowledge of breastfeeding is based entirely on medical conceptions that are far alienated from my understanding of breastfeeding from my everyday experience as a new Chinese immigrant mother. Here, breastfeeding is constructed as a path to a healthy life, a construction that leads to a promotion of breastfeeding from international, national, and local levels. Breastfeeding is ideological, and some beliefs that "breastfeeding is good for infants' health" become "common sense" that has been recognized not only by doctors, but also by ordinary people without any challenges (Gramsci, 1971; Ng, 1993). The concept of common sense was highlighted by Gramsci (1971) and has been understood through an exploration of the relationship between ideology, concepts of the world, and philosophies (pp. 323–324). Gramsci (1971) defined the notions of *ideology* and *hegemony*. He investigated "the origin of ideas" and believed that the origin of ideas passed from meaning science of ideas to meaning specific systems of ideas (p. 376). In his works, he also examined how Western power has been experienced not just through the political state, but everywhere.

Table 1: Key Components of the Provincial Breastfeeding Strategy for Ontario

Strategy	Suggestions
1. Leadership and policy development	• **Provincial Breastfeeding Policy**—The policy will provide leadership for the protection, promotion and support of breastfeeding, improve the health status of mothers and babies by increasing breastfeeding initiation & duration in Ontario and support the implementation of the Baby-Friendly Initiative. • **Provincial Coordinator**—Designate a coordinator at the provincial level to develop and co-ordinate the strategy through the establishment of a provincial committee with participation from key stakeholders. • **Baby-Friendly Initiative**—Determine the process to ensure the implementation of the WHO/UNICEF Baby-Friendly Initiative (BFI) in Ontario. Set requirements for hospitals, public health units, and other community health services to begin the process towards Baby-Friendly designation. (p. 6)
2. Service delivery	• Recommend and support strategies, in collaboration with key stakeholders, that ensure that all Ontario maternity services implement the *Ten Steps to Protect, Promote and Support Breastfeeding* and that all Ontario community health services implement the *Seven Step Plan for the Protection, Promotion and Support of Breastfeeding in Community Health,* so that all new parents have access to skilled, evidence informed counseling and support for breastfeeding. (p. 6)

Strategy	Suggestions
3. Surveillance, research and evaluation	• Establish target rates for increased breastfeeding initiation, duration and exclusivity. • Collect breastfeeding initiation, exclusivity and duration rates using the Breastfeeding Committee for Canada's standardized definitions and timelines. • Develop and implement systematic evaluation of programs and policies to ensure progress towards established targets. (p. 7)
4. Capacity building	• Advocate for universities, community and vocational colleges to offer future health care professionals and social service providers adequate attitudinal, theoretical and practical education and training regarding breastfeeding best practices and approaches inclusive of the principles of the Baby-Friendly Initiative (BFI) and The Code. • Encourage and support the training of all health care professionals, social service providers and volunteers who are currently working with families according to their role and scope of practice. (p. 7)

Note. Strategies and suggestions quoted from *Recommendations for a Provincial Breastfeeding Strategy for Ontario* (2009, pp. 6–7).

In the social and cultural construction of breastfeeding, different actors—policy makers, clinic nurses and doctors, and patients, including new immigrant mothers—co-construct breastfeeding as a common-sense practice that is a path not only to a healthy life but also to being a good mother. However, breastfeeding ideology does not acknowledge differences in new mothers' breastfeeding choices and practices. I suggest that it is necessary to deconstruct the notion of breastfeeding and to be mindful that this notion is associated with race, gender, and class inequalities.

The purpose of the second level of textual analysis was to understand breastfeeding from global to local. My analysis of the text about strategies to support breastfeeding reveals that breastfeeding as an ideology involves social and cultural imperialism under the trends of globalization. Pyle and Ward (2003) pointed out that globalization involves several trends in which "capitalist process and ideologies spread throughout the world" (p. 463). These major trends include international financial institutions and most nations promoting the market determination of economic outcomes (p. 463), the use of "liberalization" and "free

market" as the language for global restructuring (p. 464), and the involvement of institutions and organizations empowering sustainable human development (p. 464). Under the trends of globalization, international organizations such as WHO and UNICEF provide "global strategies" for breastfeeding, such as the BFI and BPG, which significantly affect the process of policy making and the practice of breastfeeding at national and local levels. The standards and global strategies for breastfeeding were developed by these international organizations containing messages of imperialism. Many new Chinese immigrant women have a transnational experience of breastfeeding. When they gave birth in Canada, these mothers as learners have to relearn the knowledge of breastfeeding based on the Western medical philosophy and the "logic" of the local breastfeeding educational programs.

In addition, federal policy and the local practice of breastfeeding have shifted in emphasis from nation building to economic development. When policy makers developed strategies for breastfeeding by using the global goals, they cooperated with local social and medical organizations to develop the (inter)national strategies of increasing the breastfeeding rate. Breastfeeding as an ideology has been used for the purpose of strengthening Canada's competition in the global market. When Canada reaches the target rate of breastfeeding based on the Innocenti Declaration, it will be recognized as a "developed" country, earn a good global reputation, and become more competitive in the global society. However, local breastfeeding educational programs have faced a lack of resources, funding, space, and staffing while attempting to meet the (inter)national goal.

As a new immigrant mother in a local program, I found that my identity, transnational experience, knowledge, and practice were largely excluded from the organization of breastfeeding educational programs. The local program focused only on me reaching the goal of breastfeeding my baby for at least six months. There was a gap between the ideology of breastfeeding and my knowledge and practice of breastfeeding. Therefore, taking immigrant mothers' experiences as a standpoint is urgent and necessary for problematizing the institutions of medical care and social services.

Learning Breastfeeding: Chinese Immigrant Mothers' Experience

In this section, I explore two new Chinese immigrant mothers' narratives to understand their identity construction and learning practices as they participated in Canadian breastfeeding educational programs. Narrative is "the ways humans experience the world" (Clandinin & Connelly, 2000, p. 2). Taber (2010) brought narrative and institutional ethnography (IE) together in arguing that "autoethnography is appropriate for use in IE, as 'autoethnography is defined as a form of self-narrative that places the self within a social context', and IE explores the social from the point of view of the self's every day.…The narrative must be explored in relation to institutional practices" (p. 15).

Anna's Story: The Abstraction of Breastfeeding

Anna is a 30-year-old Chinese immigrant mother in Toronto. She gave birth to her son in 2012. She immigrated to Toronto in 2009 as a skilled immigrant worker. After giving birth, she participated in the breastfeeding program in one of the clinics in Toronto. She described her learning experience as follows:

> I am a new mom and a Chinese immigrant with a two-month-old baby. Two months ago, when I finished the painful birth process, I was sent

> to the breastfeeding clinic right away. It was a miserable experience while I was taught to breastfeed my baby. The breastfeeding expert in that program did not allow me to use any kinds of formula or bottle. She believed that breastfeeding is the best and only way for feeding my baby. It makes me even more nervous for thinking about myself as my baby's only food. In addition, she did not allow me to sleep over two hours because the breastfeeding needs to be done by every two hours and each feeding needs to last for one hour. A lack of good rest increased my blood pressure and caused some health problems at that time.

Anna further described the learning environment in the clinic. She said,

> The environment is great. There are many posters about breastfeeding on the wall, which visually taught me the correct position of breastfeeding. I still remember one of the posters said, "baby's best food" and "every mother should nurse her baby." But, at the beginning, I failed several times. I felt that I was not a good mother. I was so frustrated that I could not do breastfeeding well.

When I asked why she felt that she was not a good mother, she said,

> When I first visit them [the clinic], I tried very hard to breastfeed my baby, but it seems that my baby did not "latch onto the breast properly." As a new mother, I felt so worried for my breastfeeding as if I were not a "good mother" and did not try hard. However, the nurses, also seen as teachers, only taught me the right position and strategies without any consideration of me, as a woman and human being, suffering with the pain from my uterus, the tiredness, the depression, destination, worry, ambivalence, exhaustion, and all kinds of emotions that affect my breastfeeding practice. But what I have heard from the nurses is only one sentence: "breastfeeding is the best."

From Anna's experience, we can see that breastfeeding has been abstracted as a good mothering skill. A dialectical approach to understanding breastfeeding would suggest that mothers' concrete and actual breastfeeding practices, including their emotions and feelings, are greatly ignored. In the abstraction process, women's breasts are treated as containers. Mothers who breastfeed their babies are considered good mothers. The breast milk has been constructed as a product that contains nutrition and is good for baby's health. These imaginations of mothers' breasts and immigrant mothers' breastfeeding practice ignore mothers as human beings and individuals who have diverse cultural backgrounds, socio-economic statuses, body conditions, emotions, feelings, breastfeeding experiences, and knowledge.

In addition, there is a good-mother myth behind the breastfeeding ideology. The slogans "baby's best food" and "every mother should nurse her baby" involve logics such as "only good mothers breastfeed their baby" or "if you don't breastfeed your baby, you are a bad mother." These logics become a common sense that forces every mother to try her best to breastfeed her baby without any thinking of her own needs and embodied conditions.

A lack of social support for immigrant mothers is a major problem. Most of the support considers the baby's needs first rather than the mother's. Not enough funding goes to taking

care of immigrant mothers' needs, emotional care, and social support. Anna mentioned that the most challenging part is a lack of family support in Canada. She said,

> One of the most difficult parts for me is that I did not get any support. Since my grandmother was very sick at that time, my parents had to stay in China and take care of her. I am the only child in my family. Except for my parents, I don't have any other support here. Even though my husband took care of me and the baby at that time, we still did not have enough energy in the first three months. I needed a break. Even though I had to breastfeed my baby, and I knew that breastfeeding is good for my baby, I just couldn't do it. I didn't have any breaks through the days and nights. I did not sleep at night for the first month. There were no social supports for me. At least I didn't know any support I could get. I was so frustrated and cried every day. No one could help me.

In the interview, Anna believed that she could not breastfeed her baby any longer after the first month of practice. The reasons are diverse, including her emotional reaction and postpartum depression, a lack of support from her transnational family, the cross-cultural barriers, and her grandmother passing away in China. All of that forced her to decide to stop breastfeeding after the first month. She described her feeling after making this hard decision:

> It was very difficult to make this decision. I felt very guilty. I tried so hard but still failed. I believe I was not a good mother…at least not good enough. But I have no choice. Living in Canada, everything is expensive. I don't have money to hire a babysitter, don't have family support, and don't have energy. I felt so sad and disappointed in myself.

While the state achieves the global goal of increasing breastfeeding rates, it has to consider the social problems, social differences, and social justice issues in distributing state welfare and support. Immigrant mothers' practices of breastfeeding, settlement conditions, family support, and emotional challenges all need to be considered. Furthermore, an immigrant mother's decision regarding whether she wants to breastfeed should be respected. The decision may be due to a series of physical, emotional or social conditions.

Emily's Story: The Institutional Relations of Learning Breastfeeding

Emily is a Chinese immigrant mother from Shanghai. She immigrated to Toronto in 2011 and gave birth to her daughter in 2013. Emily said,

> At first I was very nervous because my English isn't very good. After I went to the clinic, the nurse was very friendly. She taught me the correct body gesture for breastfeeding. However, she wanted me to practise it for hours. She even required me to go there and practise it every week. You know, I was very tired after giving birth to my baby. As a Chinese, we have to "Zuo Yuezi" [known as "sitting in the month," a traditional Chinese culture of postpartum care that women cannot walk or travel around after giving birth for a month] and stay at home. I think I need more time to rest.

Emily particularly mentioned how she uses the Chinese traditional way of postpartum care. She said,

> Before I went to the program, I had some difficulties in producing my breast milk. My mom found me a breastfeeding specialist in traditional Chinese medicine. I received acupuncture and other training from the specialist. It was really helpful for my breastfeeding process. After that, I went to the clinic. The nurses there thought my skills are wrong. They corrected my position, and they thought I should visit them first and receive the correct training.

Emily talked about her family and mentioned that her father was a Chinese doctor. After she had finished the breastfeeding training, she came back home. She felt that her left breast was very painful and swollen. Her father soon found out that she had a breast mass. He used a traditional Chinese way of doing massage. He used a towel with warm water to heat the breast and sent her to the hospital. However, at the hospital, the nurses questioned what her father did and said that using the warm water in the towel could hurt the baby. Emily said,

> Well, I agreed with the nurse that using the warm towel may hurt the baby, but it didn't happen. We took our baby very carefully. But I felt that there was discrimination in that they believed my father's way is very unprofessional and even wrong. But you know, my dad worked in a Chinese hospital for more than 30 years. He is a very experienced doctor.

During my interviews, I discovered that many Chinese immigrant mothers had experienced cross-cultural struggles in their breastfeeding. In Emily's case, she and her family insisted on using the Chinese traditional postpartum care. For instance, she followed the Chinese indigenous rules to take one month of rest in bed, which is known as "sitting in the month." During that month, she did not wash her hair and body, drink cold water, or walk around. However, when she went to the clinic, the nurse told her that the Chinese style of breastfeeding and postpartum care was wrong. Both the use of Chinese acupuncture and the practice of staying in bed were considered uncivilized or wrong. The Chinese breastfeeding tradition and postpartum care comprising Chinese ways of organizing people's lives are excluded from the local medical care and social service system. In addition, Emily's father's indigenous way of heating the breast was questioned. In comparison with Western-style breastfeeding, which was treated as an advanced, scientific, and healthy practice, Emily's father's traditional Chinese breastfeeding practice was constructed as unprofessional, unscientific, unhealthy and even wrong.

When Emily returned to the breastfeeding clinic, she was told that she had to attend the clinic every week. She said, "The nurse told me that my breast is bad, and my breastfeeding skills are very poor. They booked many appointments for me. But I didn't want to go there since I think I may need to stay at home for taking my 'month.'"

There are strong institutional relations behind the learning activities in breastfeeding clinics. The program encouraged these women to participate almost every week and pointed out that their positions for breastfeeding were wrong. Requiring them to return to the clinic on a frequent basis is a strategy for fulfilling the funding criterion of recruiting more participants. With this purpose, immigrant mothers have to follow the clinics' rules and practice as much as possible for the clinics to reach the national goal of increasing

breastfeeding rates. It is the hospitals and clinics that benefit, because they can receive further funding and report increased breastfeeding rates. However, immigrant mothers' decisions, practices, and experiences are greatly ignored and excluded in the process of learning to breastfeed.

As a researcher and a Chinese immigrant mother, I suggest to develop a transformative learning for immigrant mothers as a way of improving government policy and program planning in breastfeeding to include greater cultural sensitivity. Taking Chinese immigrant mothers' experiences as a standpoint, one will find that breastfeeding programs lack consideration of immigrant mothers' previous culture, their barriers in living in Western culture and society, and their dynamic everyday mothering experiences and hybrid identities. As an educator, I believe the government and breastfeeding programs need to include the voice of all immigrant mothers, raise consciousness on race, gender, and class inequalities, and be aware of the social and cultural differences behind immigrant mothers' learning experiences for the purpose of social transformation and social change.

Conclusion: Taking Immigrant Mothers' Standpoint

This paper problematizes Canadian breastfeeding policies and programs. Canadian federal and provincial government policies and programs focus on a global goal of enabling all women to practise exclusive breastfeeding. They do not pay enough attention to immigrant mothers' breastfeeding experience. Using a textual analysis of government policies and two Chinese immigrant mothers' narratives in Canada, I argue that breastfeeding is an ideological practice associated with a changing discourse of lifelong learning that shapes the organization of current breastfeeding policies, educational and medical programs, and migrant mothers' everyday practices in Canada.

The narratives from two Chinese new mothers not only help us to understand their experiences, identities, and struggles in breastfeeding, but also enable us to reflect on the relationships between individuals and institutions. In taking Chinese new immigrant mothers' standpoint, I find that the discursive experience of learning from immigrant mothers could help to defamiliarize the ordinary and routine that is seldom challenged. Chinese new immigrant mothers' standpoint can be a tool for problematizing the unequal institutional relations behind breastfeeding ideology in Canadian clinics. Hartsock (2002) proposed a feminist standpoint to develop the ground for "specifically feminist historical materialism" and to challenge systemic oppression and ruling relations (p. 350). Based on this understanding, I believe taking Chinese new immigrant mothers' lived experiences as a standpoint is significant for not only understanding the social relations of women's lives and practice, but also challenging the ruling power of government policy, national goals, and local organizational practice of breastfeeding.

Last but not least, I suggest to develop a transformative learning program for immigrant mothers' postpartum learning. The breastfeeding program needs to focus on not only the teaching and learning of breastfeeding skills, but also other social elements that interact with new immigrants' learning practice, such as their previous culture and experience, barriers in settling in the new country (e.g., language barriers, cultural barriers, family support), physical and mental health, and relationships with the community. Moreover, I suggest policy makers and program planners on breastfeeding need to raise their consciousness of

the unequal power relations such as race, gender, and class inequalities behind immigrant women's postpartum learning experience.

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