



Feeding babies and the problems of policy

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Summary

Background

The expansion of policy making that seeks to promote breastfeeding has in recent years provoked scholars from the social sciences and humanities to research the question of feeding babies, and the tensions within breastfeeding promotion strategies.

In Britain, as in many other countries, a growing number of Government-supported initiatives have been implemented to increase the rate and duration of breastfeeding. Such schemes represent breastfeeding as unquestionably superior to any other way of feeding a baby. This official emphasis on the importance of breastfeeding is based on the claim that all the available evidence points to the need for this approach.

Policy makers appear guided by the certainty that breastfeeding promotion will make things better for mothers, families and society. Our reading of the research suggests a much less cut-and-dried picture. In particular it draws attention to important tensions between policy presumptions and mothers' actual experience of feeding their babies, and indicates that the current approach to breastfeeding promotion now has deep roots in Britain's National Health Service (NHS). We hope, however, that this briefing can help to encourage serious discussion that takes into account the findings of intelligent, well-designed research and commentary.

Key messages

1. Infant feeding needs to be depoliticised

Policy in this area should aim to support individual mothers to feed their babies in the way that makes most sense for them and their families. It should cease to connect mothers' infant feeding practices with solving wider social and health problems. Doing so, evidence suggests, has failed to do much to increase breastfeeding rates; has generated a distorted picture of the causes of health and social problems; and has encouraged a situation where many mothers experience being placed under pressure to feed their baby according to priorities laid down by others.

2. Policy makers should treat infant feeding as an issue in its own terms

Active efforts need to be made to separate infant feeding from morally-charged ideas and rhetoric about motherhood. The moralisation of infant feeding is detrimental for mothers - however they feed their babies - and damaging for wider society. Policy needs to be disentangled from the promotion of a particular orientation towards motherhood and family life.

3. Policy makers should aim to promote an ethos and practice whereby choice really means choice

Mothers feed their babies in a range of ways, yet as things stand, lip-service is paid to choice in infant feeding: alternatives to breastfeeding are routinely portrayed as inferior. As a result, tensions exist between mothers and health service staff. Policy makers need to work to change this situation. Mothers should be provided with properly balanced information about all feeding methods as a matter of course. Policy should seek to encourage maternal confidence and a sense of mutual trust between mothers and those who are there to offer advice and support. They should seek to engage fully with the real experience mothers have of feeding babies, and develop the approach of the health service accordingly.

Introduction

In Britain, as in many other countries, a growing number of Government-supported initiatives and interventions have developed to increase breastfeeding rates. Based in maternity wards in hospitals and in community-based health and social services, such schemes represent breastfeeding as unquestionably superior to any other way of feeding a baby. The context in which British women make decisions about infant feeding is therefore one in which policy makers seek to encourage more women to breastfeed their babies, and to do so for longer periods of time.

This unequivocal official emphasis on the importance of breastfeeding, and on changing maternal behaviour to increase the prevalence of the practice, is based on the claim that all the available evidence points to the need for this approach. Policy strongly associates breastfeeding with strategies to address health, as well as social problems:

- Breastfeeding is promoted as a route to better physical health in mothers and future generations (cancers, coronary heart disease, and childhood obesity are highlighted particularly in British policy documents, but a very wide range of health problems are presented as directly connected to infant feeding practices);
- The mental/emotional health of mothers and babies is also deemed to be maximised by breastfeeding; some policy statements suggest a connection between 'good parenting' and breastfeeding, often through reference to the relation between breastfeeding and mother-infant attachment, or 'bonding';
- 'Inequality' in society has been strongly associated by policymakers with differential breastfeeding rates by social class for many years; it is therefore argued that social inequality will decrease if more women breastfeed;
- Claims are made that it is important to discourage formula feeding on environmental grounds;
- It is suggested that policy reflects what mothers themselves want: the goal of increasing breastfeeding rates is represented as empowering for women, as this objective is allegedly in harmony with the aspirations of most women when it comes to how they want to feed their own babies.

In recent years scholars working in a range of social science and humanities disciplines have published research contextualised by this policy agenda and expansion of programmes seeking to promote breastfeeding. This research tells an important story about recent experience, and it paints a much less cut-and-dried picture of what the evidence suggests.

Overall, the research draws attention to the dangers of posing infant feeding practices as a cause of, and solution to, varied and complicated social problems in this way. Issues of concern detected by this research include:

- *Important tensions between policy presumptions about the experience of feeding a baby and mothers' actual experiences, including their experience of initiatives to increase breastfeeding rates*
- *Misrepresentation of the causes of social and health problems, with far too much emphasis placed on the significance of infant feeding practices*
- *Confusion about the legitimate purposes and aims of policy*

The purpose of this CPCS briefing is to summarise findings of this research. In the following sections we highlight three main themes:

- The politicisation of infant feeding
- The moralisation of infant feeding and women's identity work
- Scientisation and changing meanings of 'choice'

(1) The politicisation of infant feeding

Continuity and change in policy agendas about infant feeding is an established topic of academic interest. Contributions that have analysed the history of policy in this area detect continuity, in that there is a long-standing tendency to represent *individual* maternal behaviour as an important cause of major health and social problems. Changing the way mothers feed their babies has thus been perceived, in the past as well as the present, as a way of addressing and ameliorating these problems. In this way, infant feeding stands as a paradigmatic example of the wider tendency of modern society to individualise social problems, and seek solutions through interventions that influence people at an individual level.

Yet although significant continuity has been identified in this way, attention has also been drawn to notable changes in the way that attempts to influence behaviour have been justified and enacted. Some research has explored political concern in Britain in the late 19th and early 20th centuries with how babies were fed, and compared this with more recent developments.

In the earlier period, as political concern grew about infant mortality and morbidity, the education of 'ignorant' mothers who did not breastfeed but used wet nurses was represented as a route to improving the health of the nation and halting perceived 'national decline' (Carter 1995, Murphy 2004). Whilst 'politically expedient', this rendered 'other sources of infant morbidity and mortality less visible', explains Murphy (2004: 205). Studies of other Western countries have drawn attention to similar developments, whereby the propensity of women to breastfeed and 'the state of the nation' were connected in the political imagination. Maternal attitudes and traits including vanity, ignorance and selfishness were the subject of concern and educational initiatives (Kukla 2005, Wolf 2011).

Taking into account very obvious differences between the past and the present (including huge declines in infant mortality and malnutrition, and the emergence of infant feeding with formula milk as the main alternative to breastfeeding) the following observations have been made about later policy measures.

Analysis has shown how breastfeeding rates featured in the rise of 'health inequality' as a policy concern in the 1980s (Carter 1995). The framing of the problem by this time as one of 'inequality' is an important development. However, if at this point the language used about women who do not breastfeed was no longer explicitly negative, the relatively worse health among poorer sections of society continued to be blamed on the behaviour of poorer mothers, as indicated by their relative failure to breastfeed. Carter therefore notes that while 'non breast-feeders' were not explicitly labelled 'ignorant', their 'habits and attitudes' were the main focus for policy makers, rather than the 'structural and material factors' that impact on health (1995: 61).

The use of increasingly non-judgmental language, combined with a continued, determined focus on changing 'attitudes' and 'habits' in relation to breastfeeding (rather than on addressing wider structural and material factors), has been emphasised. More recent efforts to increase breastfeeding rates, in Britain at least, thus make reference to increasing 'awareness', and providing 'information' and 'support', rather than crusading against 'ignorance' and 'carelessness' (Murphy 2004). It has been argued that these contemporary approaches remain fundamentally consistent with the past, however, in that they leave material and structural conditions unaffected. This means that breastfeeding promotion remains rooted in an explanation for health and social problems firmly focused on individual behaviour. Initiatives in the US that have utilised overt risk-based messaging have attracted detailed consideration, by merit of their extremely individualised approach to breastfeeding promotion. The language and imagery of these campaigns, which explicitly connect formula feeding and placing babies' health and welfare at risk, have been analysed in detail, and are considered very clear examples of the way breastfeeding promotion problematically individualises social problems (Wolf 2007, 2011; Kukla 2006).

Breastfeeding promotion has thus been criticised because of the connection it makes between addressing health and social 'inequalities', and changing the way women feed their babies. Scholars have drawn attention to the way breastfeeding promotion can generate a view of society that effaces the reality and effects of inequality, by failing to be honest about what is required if women are to breastfeed exclusively for many weeks (Carter 1995). 'Such support [provided by breastfeeding promotion programmes] is generally just verbal encouragement and advice', states Murphy (2004: 207). Set against this, she contends, a mother's ability to meet the demands of exclusive breastfeeding 'is inextricably linked to the availability of human and material resources', which include someone else taking on running the home, looking after other children, and giving the mother time to rest. This point is made particularly strongly in studies of risk-based campaigns referred to above, and the way they (mis)represent the lives and experiences of low-income women in the US. These critiques of some

breastfeeding promotion initiatives make powerful points about the way they represent poor mothers, who have very limited material and social resources, as personally responsible for their children's health and other problems, because they do not breastfeed enough (Wolf 2007, 2011; Kukla 2006).

The direction of policy has thus been questioned on the grounds that it is unlikely to work (these analyses suggest that breastfeeding rates are likely to be relatively unaffected by behaviour-change initiatives), and questions have also been raised about the objective relation between infant feeding practices and large health and social problems. It is suggested that these problems have other, far more influential causes than the way babies are fed.

The individualising nature of policy initiatives has also been considered important because it generates other significant, detrimental outcomes. These concern the social and cultural perception of mothers, and the effacing of their autonomy. An interesting contribution about policy at an international level, which explains how 'individual behaviour rather than structural problems' is central to policy-making, explores this point (Jansson 2009). Drawing on the work of the US sociologist Linda Blum (1999), this commentary draws attention to the way that the language of support, protection, and empowerment of women and children is especially notable in breastfeeding promotion policies developed by the World Health Organisation and other international agencies.

One important point made in this analysis is that within this framework, women's *willingness* to breastfeed 'is assumed', with their failure to do so considered entirely a product of the negative influence of 'a bottle feeding culture' which they are victims of. In this approach, women are considered empowered through schemes that combat a 'bottle feeding culture' (See also Lee and Bristow 2010). Hence their breastfeeding behaviour is 'constructed as a means to an end'. The idea 'of mothers as a means for someone else's wellbeing', and 'as tools' for the implementation of policy seeking to address social problems (including *global* inequality), are 'made fully legitimate' through their iteration in international policy (Jansson 2009: 245).

The issues of autonomy and choice and how these imperatives are configured in breastfeeding promotion, are the subject of further discussion in Section 3.

(2) The moralisation of infant feeding and women's identity work

As noted above, policy today eschews the use of categories that could be accused of stigmatising mothers or overtly moralising about their behaviour. Mothers who do not breastfeed are, for example, usually represented as currently insufficiently 'supported' rather than selfish or ignorant, as they were in the past (Lee and Bristow 2009). Infant feeding has, nonetheless, been conceptualised as a moralised enterprise. Murphy argues that the force of official advice that defines how best to feed babies is not in 'compelling women to conform'. (Indeed, all the effort that has gone into changing infant feeding behaviour has not had dramatic effects on feeding practices; the majority of women still formula feed well before official advice suggests they should). Murphy explains that, rather, the main power of breastfeeding promotion is, 'in the way it sets the moral context within which women negotiate their identities as mothers' (2004: 209).

The idea that there is a 'moral context' for infant feeding is upheld by virtually all studies about maternal experience. Miller et al (2007) thus suggest that a dominant theme that emerges from the qualitative literature is that infant feeding is often experienced by mothers as a moral problem. Infant feeding attitudes and practices are experienced as a measure of motherhood: 'The literature suggests that perceived societal and peer pressure, the expectations of health professionals, and feelings of guilt and concern over the need to be a "good" mother profoundly shape not only the decisions and practices of women but also the accounts they offer of these' (2007: 216). Research has detected, notably, that infant feeding is frequently experienced this way, regardless of the *actual* feeding strategies mothers adopt. Pain et al (2001) note that the mothers in their study – some of whom formula fed and some of whom breastfed – 'felt under pressure to live up to certain ideas about good mothering. Frequently they felt judged by others, including health professionals, friends, family members and strangers' (2001: 265).

'Identity work' is associated with the widespread sense that 'good motherhood' is linked with infant feeding practices and decisions (Murphy 1999). Mothers' emotionally demanding 'struggles' as they work to maintain their identity as good mothers have been documented in some detail. The evidence thus 'points to the struggles that women engage in to maintain their status as "good mothers" which lead them to produce accounts of infant feeding aimed at protecting the moral defensibility of their decisions and practices, regardless of what these are' (Miller et al 2007: 224).

Some work focused on women's decision-making around formula feeding has shown, for example, that starting to formula feed is often experienced as an extremely powerful challenge to a mothers' positive sense of their mothering practices (Murphy 1999; Lee 2007a, 2008; Stapleton et al 2008). It has therefore been argued that the normality of formula feeding offers relatively little protection against the power of professional and policy-based presumptions that deem this feeding method inferior and even risky to child health (Murphy 2003).

At the other end of the spectrum, research has shown that the official validation of breastfeeding, and the relentless stream of initiatives to promote it and change behaviour, do not, in fact, make the experience of women who breastfeed unproblematic. On the contrary, the small percentage of women who do breastfeed according to policy recommendations (exclusively for six months, and up to two years or beyond, in conjunction with other foods) sit at a juncture between affirmation and marginalisation, highlighting a significant dissonance between statistical, ideological and cultural norms. For example, women who breastfeed toddlers and older children report feeling stigmatised and isolated (Dowling 2009, Faircloth 2010b). Related literature considers the identity work women do to justify breastfeeding in familial or community contexts where bottle feeding is considered normal and less troublesome than breastfeeding; where mothers breastfeed for longer than a few months; and where breastfeeding is not going to plan, meaning that babies are not gaining weight very fast (Bailey et al 2004; Murphy 2004; Marshall et al 2007; Faircloth 2010a, 2010b).

A point to emerge from this literature is the observation that the need to perform identity work to uphold moral status pertains regardless of how women actually feed their baby. One interpretation of this finding is that as long as heightened concerns regarding the effects of feeding practices for child welfare are so strongly validated, including through policy, women will find it difficult to gain acceptance of their choices and decisions from others. Those who breastfeed for a relatively lengthy period are susceptible in the same way as those who formula feed from birth to accusations that they are harming their child, albeit on different grounds. However, the literature suggests that common features that shape the experience of mothers are rarely articulated; rather, the moralisation of infant feeding practices (and

parenting more generally) appears to have proceeded in a way that amplifies tensions between various 'tribes' of mothers (Faircloth 2010a, 2010b).

One strikingly honest contribution illustrating this point comes from Crossley (2009). She uses her own experience to draw attention to how internalised cultural expectations regarding breastfeeding can work themselves out. She describes the ordeal of accepting her 'failure' as a mother by formula feeding, in the face of her baby consistently failing to gain enough weight over a period of 12 weeks' exclusive breastfeeding. Her account includes important insights about how this 'failure' made her feel. She draws the conclusion that breastfeeding has become for some women an activity, 'fraught with tension', a 'normalised moral imperative'. Crossley also identifies how infant feeding decisions and practices can detrimentally impact on relations between mothers. 'It is not surprising that I felt that the other women in my [National Childbirth Trust] group would think of me as a failure. After all this is how I had privately judged others who had failed in their attempt to breastfeed', she recounts (2009: 82). Others have also noted how mothers covertly (and sometimes overtly) make judgements about each other based on how they feed their babies (Lee 2007a, 2007b; Knaak 2005, 2010).

Variations in maternal experience associated with formula feeding have been noted, however. Mothers do not simply consider themselves 'bad mothers' when they fail to comply with the advice to breastfeed exclusively. Feelings of guilt have been found to be most apparent among first-time mothers, especially those who held a strong antenatal expectation that they would breastfeed (Lee 2007a, 2007b). It has also been suggested that it is women from middle-class circles who most clearly experience formula feeding as a moral problem, as it contradicts peer-group expectations (Pain et al 2001). Other mothers, however, respond with anger, rather than guilt, to the suggestion they are second-rate mothers because they use formula milk, and some treat those who criticise them with contempt and hostility (Lee 2007a 2007b, 2008).

One important outcome presently associated with breastfeeding promotion, the literature suggests, is that some mothers have come to consider feeding babies as not only a task but as a project closely bound up with the development of their 'identity work' as a certain sort of 'good' mother (Avishai 2007; Knaak 2010; Kukla 2008). Some have internalised the idea that how babies are fed is a legitimate measure of motherhood, and they consciously or unconsciously judge other mothers accordingly. Thus departing in feeding practice from what is 'best' – breastfeeding – is not experienced as acceptable and uncontroversial on pragmatic grounds, but as somehow symptomatic of an individual woman's failure as a mother.

(3) Scientisation and changing meanings of 'choice'

The claim made most strongly and frequently in policy documents is that breastfeeding makes for better health. An apparently straightforward logic is put forward: since evidence shows that formula feeding is harmful to health relative to breastfeeding, the promotion of breastfeeding by policy is self-evidently necessary and right. Socio-cultural research has told a different story, however.

Hausman states that some writings from this perspective 'refute scientific claims to the health benefits of breastfeeding, at least in the developed world, so as to argue that breastfeeding promotion is largely political having most to do with certain kinds of mothering' (2003: 197). US scholar Joan Wolf has recently developed sociological work in an important way by bringing together commentary on the methodology, findings and arguments of studies about health and infant feeding, with socio-cultural analysis of risk society in general and motherhood in particular. She argues that in contrast to the certainty with which many associate formula feeding with a large range of health problems, in many areas (for example obesity, IQ and psychological development) the evidence is varied and highly inconclusive (Wolf 2007, 2011. See also Balint 2009). Instead, her argument is that an account needs to be provided as to why breastfeeding promotion is so forceful and widely accepted, given that science is in fact far less clear than is usually suggested by policy makers. 'In the absence of compelling medical evidence, how have scientists, doctors, powerful interest groups and the general public come to be persuaded that breastfeeding is one of the most important gifts a mother can give to her child?' (Wolf 2011: xiii).

One answer explored in the literature is that the dominance of 'scientific evidence' as the legitimated arbiter of the appropriateness of infant feeding methods is itself a cultural product (Lee 2008, Jansson 2009, Faircloth 2010b). The rise of breastfeeding promotion based on 'the science' can be understood less as a result of 'science' and its findings, than as the outcome of a cultural process in which the authority of science and medicine is borrowed by lobbyists and campaigners, and also expands to influence areas of life where its purchase has been previously less powerful. In turn, other forms of authority are diminished (most notably that of the parent, especially the mother).

Some have argued that the de-authorisation of the parent when it comes to infant feeding is one aspect of a wider cultural development. Providing parents with 'expert', 'scientific' guidance about how to look after their children has become central to modern 'parenting'. Dominant messages about how best to feed babies in this way strongly typify the wider development of parenting culture. Change and continuity is again a theme in the relevant research, with some noting historical continuity (Pain et al 2001). The scientisation of infant feeding is 'just one aspect of the growing involvement of professional experts in all aspects of child-rearing and family life throughout the twentieth century', contends Murphy (2004: 207). Some also emphasise that the rules governing parenting have become more extensive in recent years, and policy in particular has sought to play a far larger role in shaping parental behaviour (Furedi 2008; Gillies 2005).

The concepts of 'intensive' or 'total' motherhood have also been used in the literature (Wall 2001, Lee and Bristow 2009, Wolf 2007, 2011). These terms describe a culture that requires the parent – the mother especially – to take individual responsibility for maximising her child's physical and mental health, by avoiding any risk to health, however small, at all costs. It demands that serious attention be paid to scientific and expert guidance about 'parenting' and the reduction of risks to child health and welfare. 'Total motherhood', writes Wolf, 'is a moral code in which mothers are exhorted to optimize every aspect of children's lives, beginning with the womb' (2011: xv). Contemporary culture is thus one that requires parents to agree – even if they do so ambiguously – that they will always put the child (and 'unborn child') first, but also that they do not 'know best' about what makes children thrive (Furedi 2008).

The wider culture is in this way viewed as critical in facilitating an increasingly vigorous prioritisation of breastfeeding promotion, in a form that relies on one-sided claims about risk, and which presents evidence about infant feeding to mothers in a misleading way. Some have drawn attention to the meaning of 'evidence' in this context, exploring in particular the way what counts as evidence is defined. This has included exploration of the provision of information to women about infant feeding, and the related concept of 'informed choice'.

Policies regarding 'informed choice' should mean that women are provided with a fair and honest account of alternatives, to assist the individual to come to a decision about a course of action (Wray 2005). According to Knaak, however, 'choice' in infant feeding methods is no longer defined as

something that is 'actual', meaning individual mothers might legitimately decide between two alternatives each with benefits. There is, rather, a context of 'constrained choice' because the alternative to breastfeeding is predominantly represented in very negative ways (Knaak 2005. See also Knaak 2006, 2010). 'Informed choice' in infant feeding, it has been argued, has acquired a different meaning to the past, as it is now defined as a choice made only when women fully appreciate that breastfeeding brings with it numerous scientifically-verified benefits for mothers and babies, and formula milk carries risks (Knaak 2006; Lee and Bristow 2009). As noted above, the emphasis on the risks of formula-feeding in North American breastfeeding promotion programmes has been the subject of important critiques (Kukla 2006; Wolf 2007). Risk-based promotion of breastfeeding is less overt in Britain, but is nonetheless increasingly embedded in policy and practice (Murphy 2004; Lee 2007b).

Information provided to women to enable them to make an 'informed choice' about feeding babies thus expresses certainty about the unambiguous evidence in favour of breastfeeding. Yet while this approach is deemed 'evidence-based' it has been argued that it is at best one-sided, and at worst reflects a growing gap between what is represented as 'scientific fact' and the lived reality of feeding babies for mothers. 'In general there is a failure to appropriately contextualise risk and benefit', explains Knaak (2006: 413).

A message of studies that have examined information provided about infant feeding, and educational efforts seeking to increase breastfeeding rates, is that women are provided with often exaggerated accounts of the drawbacks of formula feeding, with almost no consideration given to the health and mothering considerations that impact on the decisions many mothers actually need to make (Knaak 2005, 2006; Wolf 2007). Knaak suggests, on the basis of her analysis of Canadian breastfeeding education efforts, that breastfeeding advocacy is perhaps more accurately understood as a form of advertising, than of education (2006: 413).

Studies of women's infant feeding experiences have illuminated the 'health and mothering considerations' referred to by Knaak. Attention is drawn in this way to important evidence that appears to be insufficiently recognised by current policy.

Mothers being unsettled by their actual experience of what breastfeeding demands is highlighted in the literature, noting a gap between expectation and reality, which is highly disorienting (Lee 2007a; Miller et al 2007). Pain, discomfort and tiredness feature prominently in accounts of breastfeeding for some mothers and explain the decision made by many to formula feed (Murphy 1999; Murphy et al 1999; Bailey and Pain 2001; Lee 2007a, 2007b; Miller et al 2007; Stapleton et al 2008). A more or less overt conflict between the imperative to breastfeed and other cultural norms valued by many mothers is another theme in the literature. Formula feeding is discussed by many mothers in a way simply not recognised in official information provided to women: it is described by mothers as a means of 'getting back to normal' and 'having freedom' from the baby, re-establishing their identity as 'non-mothers', as an 'convenient' and 'easy' (Earle 2002; Lee 2007b). 'Normality' can involve going back to work quite soon after birth. Doing so quite soon has been described as a 'necessity' for some working-class mothers, making formula feeding from a fairly early point after birth appear to be an inevitability (Pain et al 2001). Some studies also report a positive identification with work on the part of mothers, and formula feeding is considered a valued means to an end, facilitating the transition back to work, and the restoration of an important part of 'normality' for some mothers (Lee 2007b). Male partners' involvement in feeding babies also shapes feeding decisions and experiences. Paternal involvement through formula feeding is identified as positive, both to enable the work to be shared, and also as a pleasurable and so valuable aspect of maternal experience (Earle 2000; Pain et al 2001; Lee 2008; Schmidt 2008).

Experience of the regime of 'informed choice' also forms an important area for research. It has been suggested that 'informed choice' is paradoxically associated with mothers becoming less likely to know how best to formula feed babies (Wall 2001; Cairney et al 2006; Cairney and Barbour 2007). 'Inadequate information and support for mothers who decide to bottle-feed may put the health of their babies at risk', argue Lakshman et al (2009). Others have highlighted the difficulties the current regime of 'informed choice' presents for health professionals. According to Miller et al (2007), healthcare professionals, midwives especially, face a dilemma when charged with responsibility for increasing breastfeeding rates but confronted with the reality of maternal experience (see also Lomax 2009). 'Contemporary midwives are in a difficult position with regard to advising childbearing women', note Stapleton et al, since they must encourage breastfeeding, but also 'strive to be "with" women (and the "bad" choices they make)' (2008: 110. See also Furber and Thomson 2005, and Cloherty et al 2004).

Perhaps the most thought-provoking contributions on this subject have focused on the way that the meaning of 'choice' (and so the concept of autonomy) is modified by policies that promote 'informed choice'. Jansson addresses this, and her analysis of the approach taken by the *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* and the WHO Baby-Friendly [hospital] Initiative (BFI) is worth quoting at length:

...breastfeeding is framed as a (mother's) choice and as a question of information, as stated in the Baby Friendly Hospital Initiative; 'To enable mothers to make an informed decision about how to feed their newborns'. However, the *Declaration*...holds a normative view of what is the 'right choice'. To hold a strong normative view on the one hand, and to stress the value of informed choice on the other, the assumption of some form of misconception, manipulation, or 'false consciousness' is necessary. In the *Innocenti Declaration*, this is construed as the abstraction of the 'bottle feeding culture' that entices mothers to make uninformed decisions. The implicit message is that mothers will come to the right decision once properly informed about the benefits of breastfeeding. (Jansson 2009: 244)

In the context of the growing significance of the BFI for maternity services in Britain, it may be argued that the approach to 'choice' described here is now institutionalised in the British NHS (and in health care systems elsewhere). One of the most important areas for further research and analysis is the effects of this way of defining 'choice' for mothers' decision-making processes and experience.

Conclusions

The research discussed in this briefing suggests there are important tensions between policy imperatives and the everyday experience of mothers. Some key concerns to emerge are that:

- One-sided accounts of the benefits of breastfeeding create unnecessary anxiety, impacting markedly when mothers decide to formula feed;
- A policy discourse that attaches benefits to breastfeeding and risk to formula feeding demeans the importance of informed choice, properly defined;
- Informal solidarity between mothers appears to be impacted upon negatively by the current approach;
- Relations between mothers and healthcare professionals also appear to be negatively influenced.

The relevant research also indicates that the problems of policy in this area have a long history and that the current approach to breastfeeding promotion has deep roots in the NHS. As a consequence it will take more than a review of a set of academic papers to bring about a different approach. We hope, however, that this briefing can at least help to provoke serious discussion that takes into account the findings of intelligent, well-designed research from the humanities and social sciences. Our reading of the research concludes that the following might usefully form the starting point for such a discussion:

1. Infant feeding needs to be depoliticised

Policy in this area should aim to support individual mothers to feed their babies in the way that makes most sense for them and their families. It should cease to connect mothers' infant feeding practices with solving wider social and health problems. Doing so, evidence suggests, has failed to do much to increase breastfeeding rates; has generated a distorted picture of the causes of health and social problems; and has encouraged a situation where many mothers experience being placed under pressure to feed their baby according to priorities laid down by others.

2. Policy makers should treat infant feeding as an issue in its own terms

Active efforts need to be made to separate infant feeding from morally-charged ideas and rhetoric about motherhood. The moralisation of infant feeding is detrimental for mothers - however they feed their babies - and damaging for wider society. Policy needs to be disentangled from the promotion of a particular orientation towards motherhood and family life.

3. Policy makers should aim to promote an ethos and practice whereby choice really means choice

Mothers feed their babies in a range of ways, yet as things stand, lip-service is paid to choice in infant feeding: alternatives to breastfeeding are routinely portrayed as inferior. As a result, tensions exist between mothers and health service staff. Policy makers need to work to change this situation. Mothers should be provided with properly balanced information about all feeding methods as a matter of course. Policy should seek to encourage maternal confidence and a sense of mutual trust between mothers and those who are there to offer advice and support. They should seek to engage fully with the real experience mothers have of feeding babies, and develop the approach of the health service accordingly.

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