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Available online: 21 Jun 2010

To cite this article: Joan Dodgson & Roxanne Struthers (2003): TRADITIONAL BREASTFEEDING PRACTICES OF THE OJIBWE OF NORTHERN MINNESOTA, Health Care for Women International, 24:1, 49-61

To link to this article: http://dx.doi.org/10.1080/07399330390170033

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TRADITIONAL BREASTFEEDING PRACTICES OF
THE OJIBWE OF NORTHERN MINNESOTA

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The Ojibwe have transitioned over the past 100 years from a woodland people moving with the seasons, to forced confinement on rural reservations, to inner-city poverty. Traditionally, Ojibwe women’s knowledge has been passed through the generations orally. Using ethnographic methods, data were gathered on traditional infant feeding practices from Ojibwe women (N = 44). Few of these traditions have been documented previously. Some traditions are similar to other indigenous cultures while others are culturally specific. Understanding traditional breastfeeding practices can provide valuable information for those working with indigenous people in a variety of settings, so that they create services that are consistent with traditional values.

Worldwide, indigenous cultures often have been forced by colonial powers and national governments to change in ways that are not congruent with their traditions. For the Ojibwe (also known as the Chippewa or Anishinabe) of the Great Lakes region of the United States and Canada the past centuries have brought profound change. In the United States the Ojibwe have transitioned from woodland people who moved with the seasons, to forced confinement on rural government controlled reservations, to inner-city poverty. As a result, some of the Ojibwe people are very connected to their traditional ways; others have never known their traditions.

Received April 2000; accepted December 2001.
This study was funded by The National Institute of Nursing Research (1F31-NR 07211-01), Sigma Theta Tau International Research Grant, and Zeta Chapter, Sigma Theta Tau International.

The authors acknowledge the contributions of Dr. Laura Duckett and Dr. Sonia Patten (University of Minnesota) during the development of this research as well as their insightful suggestions during the analysis of the data.

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Historically oral transmission of cultural traditions and values through storytelling passed important information from generation to generation, and many indigenous peoples still use this mode of transmitting essential information today (Benton-Banai, 1988). Knowledge was verbally passed through the generations by the Ojibwe elders, whose role within this society was to educate, role model, and counsel. History is a part of everyday life for many Ojibwe people; it frames who they are and how they think about their life (Cornell, 1988; Deloria, 1989). History is alive and coexists with the present. This orientation is different than the mainstream perspective (see Table 1) and must be taken into consideration when providing health care and services to these communities (Jacobson, 1994).

Ojibwe people originally inhabited the eastern seacoast of North America, extending into what is now Nova Scotia. Pushed by the Iroquois Wars and European settlement over a period of several hundred years, they migrated around the Great Lakes, eventually settling in the Lake Superior area currently part of both the United States and Canada, including most of the northern and central portions of Wisconsin and Minnesota (Pfaff, 1993). Before contact with Europeans, the Ojibwe were hunter-gathers, moving with the seasons. As Pfaff noted, “Oral traditions and spiritual practices reinforced and promoted those behaviors that maintained good relations with the spirits of the plants and animals upon which the Ojibwe depended for their survival” (1993, p. 17). They were peaceful people, even after contact with the European Americans; they preferred negotiation to using violence (Pfaff, 1993).

Ojibwe were active in the fur trade of the eighteenth and nineteenth centuries, first with the French and British then the Americans (Pfaff, 1993). As the fur trade dwindled, land for the ever-expanding westward settlement and for natural resources became the driving force behind the U.S. government’s policies toward indigenous peoples (Cornell, 1988). By the mid-nineteenth century the Ojibwe were forced to live on reservations with few civil or legal rights. Traditional customs, religion, and language were first discouraged and then forbidden as the U.S. government

<table>
<thead>
<tr>
<th>Present orientation</th>
<th>Future orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group/tribal empowerment</td>
<td>Individualism</td>
</tr>
<tr>
<td>Cooperation</td>
<td>Competition</td>
</tr>
<tr>
<td>Interdependence</td>
<td>Independence</td>
</tr>
<tr>
<td>Nonverbal communication prized</td>
<td>Verbal skills highly prized</td>
</tr>
<tr>
<td>Avoidance of eye contact</td>
<td>Eye contact important</td>
</tr>
<tr>
<td>Less acknowledgment of others’ conversation while listening</td>
<td>Much verbal encouragement part of listening (e.g., nodding, agreeing)</td>
</tr>
<tr>
<td>Harmony with nature</td>
<td>Power over nature</td>
</tr>
<tr>
<td>Participates only when certain of abilities</td>
<td>Trial and error</td>
</tr>
<tr>
<td>Privacy and noninterference; harmony</td>
<td>More invasive and interjecting; direct criticism</td>
</tr>
<tr>
<td>Allow others to go first/less assertive, interject less</td>
<td>Aggressive/ assertive, interrupts frequently</td>
</tr>
<tr>
<td>Values sharing/keep only enough for present needs</td>
<td>Materialism, accumulation of material goods and wealth</td>
</tr>
</tbody>
</table>

Table 1. A comparison of Ojibwe and Anglo-American worldviews

*aAdapted from Sanders (1987), Struthers (unpublished, 1996), and Vogt (1994).*
attempted to force assimilation of native peoples into their European-based cultural model (Cornell, 1988).

While a moderate amount has been written about traditional Ojibwe life and practices, mostly by non-Ojibwe scholars and interested others, little has been documented concerning infant feeding traditions. In the eighteenth and nineteenth centuries, many historians and social scientists who studied the Ojibwe culture did not write about women’s lives. Only one of the three female anthropologists who studied the Ojibwe culture in the early part of the twentieth century wrote about infant feeding practices (Densmore, 1929), while another wrote several paragraphs (Hilger, 1951). Until the late 1990s, this was the only written record of Ojibwe infant feeding practices.

More recently a few researchers have studied contemporary Ojibwe infant feeding practices in North Dakota (Blue, 1997), Minnesota (Gold, 1992), Alberta (Martens & Young, 1997), and Wisconsin (Stoddard, 1997); however, cultural and historic traditions have not been their focus. Blue (1997) used Ajzen and Fishbein’s theory of planned behavior (TPB) to determine the attitudes and beliefs of 60 Ojibwe community college women concerning breastfeeding and found most participants had positive views. Martens and Young (1997) also used the TPB model to construct a decision-making model for factors influencing Canadian Ojibwe women’s breastfeeding. Gold (1992) surveyed 32 urban indigenous women to determine the factors influencing these women’s decisions concerning infant feeding. Most participants knew the value of breastfeeding their children, but they thought breastfeeding was too difficult because of work and other commitments. Using culturally sensitive education techniques, Stoddard (1997) developed a breastfeeding promotion program in Northern Wisconsin that had very positive outcomes.

The loss of infant feeding traditions is one factor within the larger cultural context, in which formula feeding has become the norm for Ojibwe women. Change has occurred over the past century also in infant feeding practices for all women in the United States. However, the change away from breastfeeding as the norm came later to the Ojibwe in Minnesota than to members of the mainstream society living around them. Ojibwe mothers living on reservations during the 1950s and 1960s were breastfeeding (archived materials, Red Lake Reservation), when most women in the rest of the country were formula feeding (Riordan & Auerbach, 1999). Another contributing factor was that by the mid-1970s federal nutrition supplementation and formula distribution by the Women, Infants and Children (WIC) program were available to most women in the United States; however, this program did not reach some of the reservations in Minnesota until the mid-1980s (MN WIC Breastfeeding Coordinator, personal communication, February 20, 1998).

Today, although breastfeeding rates vary considerably from one reservation to another, and from urban to rural areas, breastfeeding rates for Ojibwe women (20%–55%) are much lower (Johnson, 2000) than rates of the general population (78.2%) in Minnesota (Ross Products Division, 2000). To better understand the sociocultural influences contributing to this disparity, an ethnographic investigation was undertaken within an Ojibwe community. Many study participants referred to historical events and cultural traditions throughout their interviews. In this article we report the results specifically related to traditional infant feeding practices within a historical context from the findings of the larger investigation aimed at understanding the current breastfeeding and weaning patterns of Ojibwe women living in an urban neighborhood within Minneapolis, Minnesota (Dodgson, 1999). The aim of
this article is to describe traditional Ojibwe infant feeding practices and historical influences as reported by contemporary Ojibwe sources, which have affected current infant feeding practices.

**METHODOLOGY**

We used a focused ethnographic approach (Muecke, 1994) to fulfill the aim of this study. Focused ethnography aims describe a specific issue within a defined cultural subgroup. This research approach seeks to increase understanding of “emic” or cultural insider’s view of the phenomena studied, in this case the historical and traditional infant feeding practices of the Ojibwe in Northern Minnesota.

**Setting**

Currently, the Minneapolis area has one of the largest per capita urban Native American populations in the United States (Russell, 1993). Since the government-sponsored urban migration of the 1950s, the Minneapolis neighborhood studied in this research has been the urban center of indigenous cultural and political life in Minnesota. In addition to this urban neighborhood, participants from three rural northern Minnesota Ojibwe reservations were included. Many Ojibwe who live in the city spend part of the year on their reservation, and travel back and forth is common. Further, some traditional healers and elders who are knowledgeable about Ojibwe traditions live only on these reservations. All of these sites were necessary to obtain as detailed and in-depth information as possible.

**Sampling**

We used purposeful sampling to recruit Ojibwe women (N = 44) into this study. The goal was to interview as many Ojibwe women living under as different circumstances as possible in order to obtain a broad range of experiences and perceptions. To obtain as much diversity in participants’ perspectives and experience as possible participants were recruited from varying socioeconomic backgrounds. The sample included middle-aged professional women as well as young mothers on public assistance. Women who fulfilled various functional roles (e.g., teachers, healers, and elders) within their communities were also recruited. Tribal elders actively were recruited as well. In Table 2 we describe the demographic characteristics of the sample, and in Table 3 we list the functional roles of the participants.

It is important to understand that many of the Ojibwe interviewed are of mixed heritage and have varying degrees of experience and affiliation with their own cultural traditions. Most of the information about Ojibwe infant feeding traditions, historical changes affecting the Ojibwe, and cultural background information were obtained from in-person interviews with elders and women who taught Ojibwe traditions. Only two younger participants of childbearing age who were breastfeeding did not know much about their cultural traditions related to infant feeding.

**Data Collection**

Ethical approval to conduct this study was obtained prior to data collection and all procedures were in accordance with the ethical standards of the Institutional Review Board.
Table 2. Age and educational level of participants (N = 44)

<table>
<thead>
<tr>
<th>Age</th>
<th>Participants n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 20 years</td>
<td>3 (6.8)</td>
</tr>
<tr>
<td>21–30 years</td>
<td>12 (27.3)</td>
</tr>
<tr>
<td>31–40 years</td>
<td>16 (36.4)</td>
</tr>
<tr>
<td>41–50 years</td>
<td>4 (9.1)</td>
</tr>
<tr>
<td>51–60 years</td>
<td>4 (9.1)</td>
</tr>
<tr>
<td>61–70 years</td>
<td>3 (6.8)</td>
</tr>
<tr>
<td>&gt; 70 years</td>
<td>2 (4.5)</td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
</tr>
<tr>
<td>&lt; High school</td>
<td>5 (11.4)</td>
</tr>
<tr>
<td>High school</td>
<td>11 (25.0)</td>
</tr>
<tr>
<td>Some college</td>
<td>12 (27.3)</td>
</tr>
<tr>
<td>Baccalaureate or higher</td>
<td>12 (27.3)</td>
</tr>
<tr>
<td>Unknown</td>
<td>4 (9.0)</td>
</tr>
</tbody>
</table>

Table 3. Participants grouped according to their primary and secondary roles (N = 44)

<table>
<thead>
<tr>
<th>Roles</th>
<th>Primary&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Secondary&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfed &lt; 2 months (early weaning)</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Breastfed ≥ 2 months</td>
<td>8</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>Breastfed &gt; 1 year</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Did not breastfeed</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Breastfeeding experience unknown</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Function within the community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Social Service provider</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Elder</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Traditional healer</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Teacher&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Student</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Community leader (not elders or healers)</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

<sup>a</sup>Primary role was the role in which each participant was placed for coding. It was the main reason the participant was selected for inclusion in the study.

<sup>b</sup>The secondary roles were the other roles that participants fulfilled. Groups are not mutually exclusive; a participant may be in more than one secondary group.

<sup>c</sup>The role of teacher is a major portion of the participant’s livelihood. This group does not include elders, who do a lot of teaching, unless they had additional employment as a teacher within the community.
Board of the University of Minnesota. Each participant received written information about the research and signed a consent form prior to the interview.

The researcher conducted all the unstructured in-person interviews. Participants were asked to describe their personal or professional experiences with breastfeeding. They were prompted to include descriptive information on traditional practices and historical influences. Participants were generally comfortable discussing these issues and eager to share their perspectives, often requiring little prompting from the researcher. Interviews generally were between one and two hours in length. Audiotaped interviews were transcribed, and accuracy of the transcription process was verified.

Additional qualitative data (unpublished archived interviews, personal journals, newspaper clippings, and photographs) were gathered from reservation archives and the Minnesota Historical Society’s Research Center. These data were used to formulate interview questions and to provide added cultural and historical depth to the findings (Morse & Field, 1995).

Data Analysis

An ethnographic approach was used to analyze the transcribed interview data. Atlas.ti, a qualitative software program, was used to facilitate data coding, develop categories, and then identify patterns within these categories. One of the major patterns emerging from the categories formulated within the larger study was the importance of traditional Ojibwe infant feeding practices; these results are the focus of this article.

A number of steps were taken during the data collection (e.g., audit trail, process recordings) and analysis (triangulation, verification) to address issues of methodological rigor (Morse & Field, 1995; Muecke, 1994). Two Native women who were knowledgeable about their traditions, language usage, and this research method reviewed transcripts independently and verified the accuracy of the coding. Their findings were then compared with the researchers’ for accuracy in understanding the meanings and information given during interviews and for coding consistency. To further address the aim of this study and to ensure trustworthiness (confirmability) of the findings, the analyses of categories related to cultural and historical influences on infant feeding were triangulated with the historical sources (Morse & Field, 1995). Credibility (truth value) of the findings was verified by two or more sources (multiple participants or a participant and historical sources, or a participant and existing data-based literature) for all findings presented in this paper (Morse & Field, 1995).

FINDINGS

Findings are presented in an ethnographic format, which recognizes that all cultures exist within a specific period of time and an ecological context. A description of this context is essential for understanding Ojibwe traditional breastfeeding practices. The findings are presented in the three categories that emerged from the larger study related to this topic: historical influences, Ojibwe culture, and traditional breastfeeding practices. Issues raised by these findings are discussed within each of the relevant subheadings.
Historical and Social Changes Affecting Infant Feeding Practices

The change away from traditional infant feeding practices toward manufactured formulas was the result of historical and social events unique to Native American women, as well as the tremendous pressure caused by the manufacturing sector and medical establishment as they pushed artificial infant feeding for all women. Historical and social changes that have affected present-day Ojibwe women’s infant feeding practices include the delivery of health care services by non-Native Americans, forced assimilation, and urbanization.

Added to the medicalization of childbirth experienced by women in this country during the early part of this century, Ojibwe women also had additional cultural barriers. Birthing moved away from traditional midwife practices into Indian Health Service facilities run by non-Native physicians and nursing staff who knew little about traditional Ojibwe birthing practices (participants: Ojibwe elders, public health nurses). Birthing became a medical event, as it did for all women in the United States, with the additional layer of disconnection from centuries-old cultural and spiritual practices. According to participants, traditional practices were discouraged by health care providers as “unclean” or “wrong.”

The deliberate U.S. government policy of forced assimilation of indigenous people, prevalent throughout the middle of the nineteenth century, played a major role in the breakdown of tribal customs and the loss of traditional practices in other ways as well (Cornell, 1988). Ojibwe children were taken from their homes and placed in boarding schools. For several generations this practice effectively alienated many Ojibwe young women from their traditional childbearing and infant feeding practices and beliefs. Participants spoke often about how their mothers or grandmothers could no longer learn about childbearing and rearing from their families or elders. One 50-year-old study participant reported that she had been counseled by her mother, who had spent many years in a government boarding school, to avoid breastfeeding because “it wasn’t the right thing to do.” Most boarding schools were run by Christian organizations that may have been well intentioned but were specifically aimed at indoctrinating indigenous children into an ethnocentric worldview that did not recognize the cultural values of their people. Another young woman spoke of repeatedly asking her grandmother, a boarding school graduate, about traditional child rearing and infant feeding ways of her people. Her grandmother always answered, “There is no use in any of those things in this world.” Other participants also spoke of the disconnection their mothers and grandmothers, who spent their early years in boarding schools, had from traditional ways. Removing Native children from their families continued into the 1930s and 1940s (Pfaff, 1993), when breast milk was being replaced by manufactured formulas for many women in the United States. The role that boarding schools may have played in reducing breastfeeding is implied by participants, but requires further study to validate.

Again in the 1950s and 1960s, to increase assimilation and decrease governmental responsibilities on poverty-ridden mismanaged reservations, the Bureau of Indian Affairs (BIA) enacted policies that promised jobs and resources to Native Americans who would relocate to major urban areas (Cornell, 1988). The rewards were short lived, leaving most urban Native Americans in poor, crime-ridden inner cities without adequate employment (Cornell, 1988). As a result of these BIA policies, many
Ojibwe men and women moved to the Minneapolis area. Most study participants were the first or second generation in their families to live in the city. Many older participants reported breastfeeding their children while they lived on the reservation and then changing to formula when they moved to the city. When asked why they switched from breast to bottle, participants often reported that their physicians told them it was the “best way.” This is consistent with general medical advice of the time and is well documented. Other researchers have identified also the detrimental effect that urbanization has had on traditional infant feeding practices (Jelliffe & Jelliffe, 1979; Stuart-Macadam & Dettwyler, 1995).

A few study participants discussed issues of class distinctions related to their feeding choices. They associated breastfeeding with poverty; it was not a choice but an economic necessity. One 65-year-old grandmother, who switched to formula feeding after moving to the city, summarized, “Breastfeeding was what poor people did” and she wanted to leave the poverty associated with reservation life behind. Researchers have raised questions regarding the role of poverty and the desire to disassociate from it by adopting infant feeding behaviors thought to be practiced by the higher classes. When artificial formulas became safe enough for infant survival and were endorsed by the medical profession, upper-class women were the first to adopt it. Middle-class women soon followed. During the 1950s and 1960s, poor women in the United States still breastfed (including those living on poverty-ridden reservations) because they did not have the economic resources to do otherwise (Fildes, 1988; Golden, 1996). Unfortunately, the WIC program gave low-income women other options. Although the role of perceived class association with a particular infant feeding practice is suggested by the findings, a further exploration of the impact of this issue on Ojibwe women’s choices is needed.

Ojibwe Cultural Traditions

The Ojibwe’s deep spiritual traditions, which have been nurtured and passed on despite the cultural destruction of the somewhat-recent past, were frequently spoken about during interviews with elders and healers. They emphasized that the indigenous worldview is quite different than the European-based mainstream American worldview (see Table 1). Holism, balance, and harmony are three central traditional Ojibwe values (Benton-Banai, 1988). In the Ojibwe view the individual is a whole, and no separation between mind, body, and spirit exists. Respect for others is central to maintaining balance and was implicitly discussed by all participants. Elders explained that humans have responsibilities to family, community, other living creatures, and nature, so the Ojibwe’s traditional focus, unlike Western society’s focus, is collectively based rather than individually driven.

Women’s Roles in Traditional Ojibwe Culture

Women held the family together: They organized the seasonal moves, gardened and gathered food, and maintained the home according to the older participants. Gender roles existed but were not rigid. Women often hunted and took on other traditional male activities (Landes, 1938). It was common for both men and women to have several consecutive monogamous marriages over the course of their lives. When marriages dissolved, children usually stayed with the mother, so a family might consist of children by several different fathers, a practice that is still evident in the studied community.
According to elders, women are considered particularly powerful during their menstrual cycle. During this time, they used special eating utensils and ate apart from others. Lactating women avoided contact with menstruating women to protect their milk supply. Elders discussed how women were thought to come into their real power during the postmenopausal period. Thus, grandmothers were considered wise and powerful. They often were consulted and had a significant role in community and family decisions. Many study participants reported that it is still common for young women to seek advice concerning parenting, including infant feeding, from their grandmothers or women of this generation.

Networks of extended family, and relationships within the family, have traditionally played a central role in the lives of Ojibwe women (Stoddard, 1997). An Ojibwe traditional teacher explained that when a woman became pregnant, the elders would teach her how to care for her infant and herself during pregnancy and postpartum. Most participants expressed that each child was considered a gift to be respected and cherished. Elders related that the birth of a child was a joyous event, regardless of the social situation of his or her birth. The extended family had responsibility toward the well-being of this child, and child care was often shared. According to many participants this continues to be a common practice.

**Health Beliefs and Practices**

Balance is essential for health; illness often results from a lack of balance, explained an elder and a healer participant. Harmony with others and with the environment is needed for balance and health (Day, 1992, p. 16). Participants frequently mentioned that family members were and still usually are consulted and advise members on health-related problems. The Ojibwe have a long history of traditional healers, who may be either male or female and who have specific areas of expertise (e.g., herbalists, seers, spiritual helpers). Elders explained that traditional healers often were consulted if the health concern was not resolved. Traditional healers discussed how they address the whole person in their healing. Western medicine was spoken of as only treating the body, and it is still common for Ojibwe women to seek traditional, as well as Western, medical treatment.

**Traditional Breastfeeding Practices**

Early ethnographic writings and the elders interviewed clearly explained that the precontact Ojibwe had a sophisticated understanding of the role of lactation in prevention of postpartum hemorrhage, child spacing, and infant health (Densmore, 1929; Hilger, 1951). According to those who taught others about the Ojibwe traditions, in the past the Ojibwe gave special status to breastfeeding women. Their important contribution to the well-being of the future generation was recognized.

**The Cultural Value of Breast Milk**

Van Esterik (1995) proposed that one can tell a great deal about the values of a cultural group by the value they place upon breast milk. Unlike the view common in industrialized societies that breast milk is a commodity (Golden, 1996), the Ojibwe view of breast milk was summarized by a traditional educator: “Breast milk is a gift and a medicine a mother gives her child.” Knowledge of the anti-infective qualities of breast milk was evident in the common Ojibwe practice of using it to treat eye and ear infections in the newborn (unpublished interviews, Red Lake Nation archives, and participant reports). This is a practice that has been reported in many cultures.
as far back as ancient Egypt (Baumslag & Michels, 1995, p. 64). Elders suggested that characteristics, strengths, and a sense of respect were thought to be passed to infants through mothers’ milk. Wright and associates (1993) found similar beliefs in the Navajo.

**Feeding Patterns**

A number of elders and traditional teachers provided insights into infant feeding patterns:

1. Babies were put to the breast immediately after birth and nursed as often as they wanted.
2. Children were nursed on demand. This suggests the Ojibwe understood the importance of colostrum in promoting infant health in the early postpartum. Unlike the Ojibwe, many cultures worldwide avoid feeding colostrum and offer prelacteal foods to newborns (Baumslag & Michels, 1995).
3. Almost immediately after birth babies were securely wrapped and put into a cradleboard that had been especially made by a close family member: “My mother would always say to wrap up the babies tightly, and they are calmer. It helps to keep their spirit in; when they are not wrapped their spirits go this way and that.” The cradleboards were placed so babies could be a part of daily activities and were stood up so babies could view their surroundings. Babies often remained in the cradleboard during the day and at night slept with their mothers. As the baby grew, hammocks were also used for sleeping in the home and hung on trees while mothers worked outside. These practices facilitated the mother’s ability to feed her infant according to the infant’s schedule. Therefore, infants were fed frequently and the natural child spacing effect associated with frequent lactation occurred.
4. Although additional foods were given to the growing child, breastfeeding prolonged into the infant’s second year or more was the norm. This is consistent with other traditional cultures (Baumslag & Michels, 1995). Foods given during the first year included soups and soft foods, and jerky when teething.
5. Ojibwe babies were weaned when the child determined it was the right time. The Ojibwe recognized that different children have different needs. However, elders agreed that weaning was required if the mother became pregnant while nursing. It was believed that to continue to breastfeed might hurt the pregnancy.
6. Unlike some indigenous cultures, participants knew of no taboos regarding sexual intercourse during lactation.

**Maternal Diet**

According to elders the importance of the maternal diet while lactating was recognized. Women were encouraged to eat foods that would promote their milk supply and replace nutrients their bodies lost while lactating. There was a general consensus between participants and historical data sources about which foods were best for these women. Soups (i.e., wild rice, fish, oatmeal), grains, and meat were encouraged. Raw foods, or anything “hard and crunchy, was not eaten.”

**Herbal Medicines**

The herbal knowledge of the Ojibwe healers was extensive and well documented in the literature (Densmore, 1929). One participant remembered her mother making a salve from tree bark for sore nipples. Many participants spoke of using herbal teas,
recommended by their elders, to maintain their health while lactating. Healers related that traditional medicines were given to strengthen the new mother, to increase or decrease her milk supply, and to treat infections. Early anthropologists reported similar findings, such as herbal medicines used to treat insufficient milk (Hilger, 1951), an overabundance of milk, and breast infections (Densmore, 1929). Herbal medicines are still widely used, and traditional herbalists remain active members of this community.

**Wet Nursing**

Throughout history, wet nursing has been a practical and life-saving alternative for mothers unable to nurse their babies. There are reports of the early European colonists in America relying on indigenous women as wet nurses; some were paid and others did it as a humanitarian act (Fildes, 1988). Wet nursing was common in Ojibwe culture, embodying the traditional values of living in harmony and with a personal responsibility to the community, particularly to the children. Many participants had heard stories from elders or their mothers about wet nursing in times of need. Participants also told stories about sisters who acted as wet nurses for their nieces and nephews when necessary.

The existence of kinship ties between the woman nursing a child other than her own (milk mother) and the child whom she breastfed was more difficult to determine. Two elders did address this issue. They provided a description consistent with other indigenous cultures (Wright, Bauer, Clark, Morgan, & Begishe, 1993). The Ojibwe elders spoke of a special bond between the child and the wet nurse that was lifelong: “It was like adopting that child as part of your family.” Nursing another woman’s child gave one additional responsibilities toward that child. The child also had a special tie with the woman, similar to that with a close aunt.

One wet-nursing story shared by 86-year-old Ojibwe elder stands out as reflecting many Ojibwe cultural values related to breastfeeding. In her living room, on the wall above where she sat, were five photographs of women—five generations of her family. She pointed to the photo on the far end of this group and said, “This is my great-grandmother; I will tell you a story about her.” Her husband needed to go hunting to get some meat for the family. As he was tracking a deer, he came across a very young bear cub. Knowing that the mother bear was nearby and would be upset by his intrusion, he moved quickly to leave. The mother bear attacked him and he was not able to get away without killing her. He knew the bear cub was too small to be accepted by another female bear and would die if left in the woods. He felt responsible for the little bear’s life, so he took it home to his wife who was nursing one of their children. “Great-grandmother nursed the small bear until it was old enough to be introduced into a group of bears and feed on its own,” she said.

**CONCLUSIONS**

The Ojibwe have rich and complex traditions surrounding infant feeding. However, little has been recorded previously about traditional infant feeding practices. Perhaps this is due to the nature of oral societies, which transmit cultural knowledge through storytelling, or because women’s infant feeding practices have not been seen as important by those who described other traditional aspects of this indigenous culture. Women’s knowledge surrounding childrearing, particularly infant feeding, too often has been a neglected aspect of sociocultural and historical studies.
In this study we have described traditional practices of infant feeding based on the cultural understandings of Ojibwe women who have tried to preserve and teach these traditions to their people. However, this study is only a beginning. There is much more to be learned and recorded so that future generations can experience a deeper understanding of this culture. Of course none of this knowledge could be recorded without the participants’ gracious willingness to share. Participants repeatedly mentioned having to consider very carefully if it was appropriate for them to share this information with a non-Native woman, knowing that it would be disseminated to others. They participated because they felt that a better understanding among people helps us all.

If we understand the historical context of infant feeding for the Ojibwe in Minnesota, we may be able to apply it to promote breastfeeding and support interventions and community-based health programs aimed at facilitating breastfeeding for Ojibwe women. Many Ojibwe are returning to their traditional ways; this presents an excellent opportunity for promotion of breastfeeding, as it is congruent with traditional values and practices. Although some of the infant feeding practices described are unique to the Ojibwe, many of the values and ways of operating in the world are similar to other indigenous populations. The importance of the collective or community orientation in determining an individual’s course of action has a number of implications for any service or educational program in indigenous communities. Decision making will most likely include consultation with family and respected elders in the community. Therefore, community-based approaches that include grandmothers and elders in the planning, implementation, and evaluation of services may be accepted more readily and therefore be more effective. Also, using culturally relevant teaching strategies, such as incorporating oral traditions of storytelling, may be more effective than conventional methods.

Optimistically, those who work with other indigenous peoples will use the approach presented in this article to encounter, connect, and learn about the traditions of the indigenous people they serve, thereby grounding their actions in culturally appropriate life ways. For nonindigenous people to be able to work effectively and collaboratively with indigenous peoples, it is essential to understand and respect their cultural heritage and traditions.

REFERENCES


Ojibwe Breastfeeding Traditions


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