DOI: 10.12957/demetra.2016.22507

Breastfeeding, care, motherhood: regulations, needs and subjectivities

Amamentar, cuidar, maternar: regulações, necessidades e subjetividades

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Abstract

This article aims to analyze aspects of breastfeeding experience in relation to daily life and the institutionalized discourse on breastfeeding, as well as other speeches. It is a qualitative research with in-depth analysis of content held in 12 women interviews, mothers of 6 months to two years children. The analysis concerns to: the recommendation and the value given to the institutionalized knowledge; the incidence of medical discourse on women's practice; autonomy, interpretation and possibilities facing other women speeches; the daily organization on breastfeeding situation; and experiences with weaning. Many are the ways found by these women to address the requirements with breastfeeding in their daily lives and to accept or not the medical discourse. It is the experience, current or former, that forces them to confront or confirm this discourse, establishing their own feeding and nutrition ideal, according to what better suits to their own needs. They also consider the experience of their relatives that already are mothers, how the child reacts, and the compatibility of breastfeeding requirements with their needs and other activities. The analysis showed that are desired and necessary measures to support breastfeeding, listening to the women experiences and their needs, and equal participation in support care policies, as well as sharing of other tasks among family members as democracy of care strategy construction.

Keywords: Breast Feeding. Infant Care. Maternity. Policy. Organizations.

Resumo

O artigo objetiva analisar aspectos da experiência da mulher que amamenta na relação com o cotidiano e com o discurso veiculado institucionalmente sobre aleitamento materno, bem como com outras falas. Trata-se de pesquisa qualitativa com análise dos conteúdos das entrevistas em profundidade realizadas com 12 mulheres, mães de crianças entre seis meses e dois anos. As análises versam sobre a recomendação e o valor dado ao conhecimento institucionalizado; a incidência do discurso médico sobre as práticas das mulheres; a autonomia, interpretação e possibilidades frente a falas de outras mulheres; a organização do cotidiano em situação de amamentação; e experiências com o desmame. Muitas são as formas encontradas por essas mulheres para resolver as exigências com a amamentação no seu cotidiano e acolher ou não o discurso médico. É a própria experiência, atual ou anterior, que as faz confrontarem ou confirmarem tal discurso, estabelecendo seu próprio ideal de aleitamento e alimentação, de acordo com o que lhes pareça mais adequado à sua própria necessidade, considerando também a experiência de familiares que já são mães, o modo como a criança reage e se as exigências da amamentação são compatíveis com as necessidades da mãe e de suas outras atividades. A análise demonstrou que são desejadas e necessárias medidas de apoio à amamentação, escuta da experiência das mulheres e de suas necessidades, e equitativa participação das políticas no suporte a este cuidado, bem como compartilhamento das demais tarefas entre os membros da família como estratégia a construção da democracia do cuidar.

Palavras-chave: Amamentação. Cuidado do Lactente. Maternidade. Políticas. Organização.

Introduction

Breastfeeding imposes the need to listen to women's experiences about maternal care, some daily practice that is not always facilitated by each woman's different personal situations. It is some food for children provided by the mother's body, involving understanding subjectivities, practices, and arrangements necessary for this. It also involves its execution difficulties and the importance women attach to it when facing the challenges of doing it or when facing demands caused by work at home or other environments.

Regarding social, biomedical and normative understanding related to the importance of breastfeeding children, there are different dimensions interacting in the prioritization of providing this food as well as in the time and personal situations to do it.

The subjective, generational and cultural dimensions of mothers' experiences and tacit family arrangements to meet daily needs sometimes make decisions about breastfeeding and how to do it to be taken or excluded, based on dialogues and guidelines among generations of women who have experienced motherhood with breastfeeding or from emergencies from their own living conditions and each woman's-mother's needs in view of their work, other children, or the presence/absence of some family help.

These women's arrangements in their relationships occur outside of or in line with terms of standardizations, regulations and/or naturalizations that breasts take on in these woman's-mother's bodies as the only positively valued nutritional solution for the children. Therefore, in this day-to-day order there are maternal experience aspects that are related to their need and the construction of solutions in view of the requirement of administering breastfeeding. Therefore, the experience of breastfeeding is not an automatic consequence of being a mother nor is it associated with instinctive stimulus or response. It implies planning, knowledge and personal conditions to be able to do it.[1]

Cultural or biomedical conceptions about whether or not women are naturally capable of exercising motherhood and breastfeeding and that they instinctively want to do it, being therefore physically, sentimentally or emotionally available to breastfeed, are faced with the demanding daily routines of this practice, in their needs and the confidence that women have or not in different feeding systems.[2]

Conceiving the body as part of a milk-producing nature has implications for women's individual and collective existence and for the democratization of conceptions and the possibilities of doing so as some caring practice. Conceptions about breastfeeding and feeding practices in turn also convey images that produce stigmas and/or prejudices about non-breastfeeding women and also produce idealizations about good motherhood. Such symbolic interlacement, standardizations, perceptions, and practices constitute the experience of being a mother. Therefore, applying the norm by means of a discursive, symbolic and controlling intervention in fact is not objectively exercised and is sometimes recommended in perspectives of health actions or in laws and regulations, policies and their institutionalizations.[3]

Processes such as breastfeeding, its standardizations and practices face subjective experiences and needs, which is often overlooked. Understanding subjectivities, experiences shared among women-mothers, discourses and biopolitics on breastfeeding women's bodies, is part of thinking mothers' symbolic order and motherhood as some care bound to their body and decisions about

its concreteness. Idealizations of mothers' bodies as food suppliers disregard the way women view and circumscribe breastfeeding, family relationships, and culture about past breastfeeding practices disseminated from generation to generation. Thus, they make biomedical and/or technological interventions and discoursing about the body and will for it to take place but almost always women are not heard in their needs and they often take hybrid paths or ones different from those recommended and taught by health professionals.

We know that motherhood and breastfeeding are historically related to how relationships with child care are structured and to social and cultural recognition of being a good mother. This symbolic order is shared and often reproduced by women. Sometimes women participate in this invention of nature, in which, in addition to establishing themselves as referents of the culture that takes them as part of nature, they consider that they produce children's well-being. This reflects an understanding of both the subjective order and the wider sociocultural and political issues involved in ordering the invention of this nature.[4] It is about the processes of objectification as an expression of commitment on the part of women-mothers.

Motherhood, in its representations and perceptions shared in different contexts and in much of our social relations, appears as an unavoidable fact. Nothing from this structural position shall be taken as more unnatural than a mother who is dispossessed of her child, even though many women in our cultural and social history have freed themselves from their children born or abdicated from motherhood throughout life.

In the last 30 years in Brazil, the Ministry of Health has been waging a battle to increase the prevalence of breastfeeding. After carrying out national research on the subject, explanatory booklets, advertisements in the media, and posters spread out in Basic Health Care Units were prepared, among other actions, in order to broaden this practice, to reduce adherence to what the biomedical discourse considers "myths" and increase the period in which children are breastfed. Such policies, however, are not always established in connection with mothers' experience.[2,5,6]

Recommendations are many, aiming to guarantee the supply of breast milk exclusively until the sixth month of the child's life and complementarily for at least two years. Proposals are based on mothers' supposed physiological capacities in milk production and on their "natural" attributes for the care. Thus, the working mother is encouraged to withdraw the milk; the mother who has skin cracks is taught to heal the wounds, the mother who has other children to care for is told that the baby is a priority; among other strategies so that recommendations prescribed are accomplished.

Therefore, it is proposed that breastfeeding may be the basis for the emergence of an interface between the mothers' reality and the ideal of social life and medical-scientific discourses. In this sense, this article aims to analyze aspects of the relationship between breastfeeding women's experience and institutional discourses about breastfeeding as well as with other discourses and her own experience in daily life.

Methodology

This text results from a research linked to a Sociology doctoral degree course at Brazilian university *Universidade Federal do Paraná*. The methodology is from a qualitative perspective,[7] which is concerned with understanding the meanings of women's experience with their breastfeeding practices and breastfeeding in relation to the discourse institutionally conveyed by health actions and recommendations. To that end, a Municipal Health Department was initially contacted in a municipality on the coast of the Brazilian state of Paraná, which allowed access to health care units participating in the Brazilian government Family Health Strategy (ESF, in the Portuguese abbreviation), making it possible to access official information about mothers of children aged between six months and two years served by the ESF in the municipality in question.

In-depth interviews were conducted with 12 mothers, complying to data saturation criteria to close the field phase. The women who assisted in the construction of this research were interviewed in their homes in the presence of only a researcher and in some cases of some of their family members (mother, mother-in-law, children) about their experiences with gestation, delivery, breastfeeding and caring for toddlers. Participants were housewives, formal and informal workers; primiparous and multiparous; married, single and separated – comprising diverse mothering situations and experiences.

Interviews were recorded with the aid of a voice recording instrument and transcribed. The analysis moves between understanding and interpreting the contents of the in-depth interviews conducted with the 12 women. The research was approved by the Research Ethics Committee (REC) of the Health Sciences Sector at Brazilian university *Universidade Federal do Paraná* under legal opinion no. 934,612.

The interviewees signed an Informed Consent Form (ICF) agreeing to participate in the research. Interviewees' names were changed to preserve their anonymity.

Results and Discussion

Relationships between child nutrition, body and subjectivity have always been in the experience of mother-women, even when they were not a constituent part of morally accepted facts. Often, and for a long time, breastfeeding concerned society as some lauded or rejected act. It would be instituted in the order of compatibility as some type of feminine activity whose meaning would be positioned according to class, ethnicity, gender, discussions about femininity, motherhood and pleasure. Strategies of social and political contexts, invention of nature,[8] visions about family, projects related to ideas about modernity,[9] and individuals' instituted and instituting strategies[10]

would be included but also ways of doing science and their cultural systems.[11] Therefore, breastfeeding and caring are activities linked to diverse social constructions that permeate not only everyday life's experiences but also involve their policies and several actors.

Authors such as Joan Scott,[12] Margareth Rago,[13] Ana Paula Martins,[6] Nancy Chodorow,[14] Meina Liu & Patrice Buzzanell,[15] Alison Bartlett,[16] Louise Martell,[17] Agnes Fine[18] and Marlene Tamanini,[19,20] among many others, have discussed such aspects of motherhood imbrication with diverse contexts and complex meanings. In many cases, women are the ones who take responsibility for caring and providing for households, given the number of poor households headed by women.[21]

Specifically with regard to the history of breastfeeding, this has not always been important. Today, faced with so many campaigns and discourses and medical recommendations on this issue, mothers, when not breastfeeding according to ideals advocated, can be the target of criticism or culpableness. The relationship between breastfeeding and the question of nature and culture opens up a diverse range of theoretical, philosophical and anthropological positions, sometimes in contrast with the biomedical perspective. In the institutional and normative confrontation, it is linked to processes of coercion produced by shared customs, but above all it is a complex relationship with medicine, which has built a linear perception, with a unique proposition about children feeding and caring. This perspective defines what mothers should or should not do for their children, without considering the complex relationship between female actors who communicate and who are usually from the same family unit. In this context, breastfeeding has been proposed as the most appropriate practice, the one that "good mothers" must follow, given their excellence in caring for their children.[9,11] The notion of an imposed normality tries to dissimulate differences and demand homogenization and standardization, whereas there are obviously no equal conditions in the search for the ideal from different women who become mothers.

From the establishment of the medical ideal and the consequent imposition of practice, medical, scientific and normative knowledge has only reinforced the maternal role in the care for children, including food. Armed with scientific research conducted to prove the benefits of breastfeeding, doctors, nutritionists, nurses, psychologists and speech therapists do not shy away from explaining such benefits, in a discourse that permeates motherhood as a source of achievement for women and of "maternal love" as being natural. Sociocultural, economic, political contexts, and experiences with the various family arrangements behind these feelings taken as naturally held by women are not sought.[2]

This presupposition of medical science on women's bodies as natural data and on motherhood as instinct and mission, therefore, as a constituent part of being a woman, as well as caring for children, including breastfeeding as mothers' function, almost never takes into account the dimensions of the possibilities of choice and the personal circumstances for exercising it. Sacrifice and suffering are often triggered, constituting a moral duty to be fulfilled. This position disregards motherhood

as an experience full of meanings and social attributions, with many factors – personal, symbolic, historical, cultural – which are imbricate from the moment of fertilization and/or the project imagined by women, even before pregnancy.

In the analysis of social experiences it is necessary to know in advance that the actors are not totally blind or totally clairvoyant, although they tends to explain and justify themselves, be their behaviors automatic or traditional. It is crucial to consider the feeling of freedom manifested as an expression of their experiences, resulting from the need to manage several different logics at the same time.[22] This feeling of freedom can be present due to anguish and inability to choose, as with mothers who suffer in an attempt to follow the standards imposed, trying to manage their previous experiences and reconcile this new experience.

Women's speeches on breastfeeding

Our goal is to analyze aspects of the relationship between the experience of women breastfeeding and the discourses about breastfeeding, which are institutionally transmitted, as well as other statements about this practice in daily life. To this end, we shall consider: a) the issue of biomedical recommendations and the value given to knowledge; B) the type of medical discourse and its incidence on the mothers'-women's practices; C) its autonomy, interpretation and possibilities vis-à-vis other women; D) the organization of their own daily lives in situations of breastfeeding; and e) weaning experiments.

Biomedical recommendations and the value given to knowledge

The research field has taught us that in the relationship with health professionals, doctors, nurses and nursing techniques, breastfeeding recommendations are accepted and taken on by many women. The interviewees acknowledge their importance and said that they would like to receive information about caring and breastfeeding. This aspect often appears in agreement with the prescriptions of breastfeeding and its advantages for the health of children.

Ana Rosa says: "They talk about how you have to breastfeed, that breast milk is essential, right up to six months. You don't have to give anything else. It's good for everything, for infections..." She goes on to demonstrate her understanding as a possible practice, "[and] that we have to breastfeed until the age of two." Joana emphasizes the value of having knowledge to do this, seeing as positive the health care unit as the place for learning. "I would always go to the health care unit because there would be talks from pregnant women. Then I would always be there to see breastfeeding, how it should ideally be. I actually would feel like taking advantage of what they knew for me to learn." Laís goes beyond agreeing. She has taking on to breastfeeding in her daily

life: "[Breastfeeding] is good, right? She has nursed... She is still nursing, you know... Until the first six months it was only breast milk. Only afterwards we started giving her other things." She highlights the value of the information received in the postpartum period, "[b]ecause when I was in the hospital they lectured that up to six months it is necessary [...]. There were lots of lectures. Therefore it prevents diseases, a lot of things, it gives immunity to the child, milk, you know."

In these narratives, one notes connivance with established institutional preconceptions, recognition of the value of this knowledge that comes from the biomedical field and the reproduction of the same discourse. This dimension of the value of institutionalization is reinforced by experiences brought by the mothers themselves when they are part of the construction of these conceptions for reasons of their own profession. Melissa thus defines her learning to breastfeed: "[...] I have a technical-level nursing training [...]. I've had an internship in pediatrics area. Therefore I already knew how to take good care of babies in this sense. Not because I had experience with babies but because I had to learn it because of the course, you know."

However, when this aspect of recognition with others is confronted, tacit arrangements appear according to the mothers' needs, although this is not always a demerit to the professionals' knowledge.

The incidence of medical and professional discourses in practice

This can also be demonstrated in practice as a way of teaching what is recommended. This way of structuring knowledge is well seen by some women with whom dialogue has been held in this field. They recognize the importance of practitioners having taught in practice how to breastfeed their child, even if the recommendations provided have not been apprehended and there is no structured recall of what has been heard in the lectures and visits of the Brazilian government Community Health Care Agents at home during gestation. Suzana says: "The doctor has already taught how to breastfeed, you know, because I didn't know it either. She took him, put my nipple in his mouth and he took it immediately... He didn't want a pacifier, a bottle, nothing [...]. She placed it by my nipple and he started to nurse. He learned immediately." The issue of non-recognition in a structured way appears when she responds: "No, they haven't said anything about it." – to the researcher's question: "And has anyone told you something about breast milk, has anyone taught anything else?"

In this regard, the field has made it clear that the assimilation of specialized knowledge as well as its democratization in terms of access, does not occur in the same way for different women. It is related to the availability of the information and the way it arrives; to personal values, which change from new knowledge and from different experiences; to the possibility of unexpected consequences from actions; and to the very unstable or changeable nature of knowledge in relation

to context. The possibilities of choice of whether to follow or not the information on the part of mothers also connect with the relationships with others and their own experiences – in this case, the father, doctor, mother, sisters and other women – influence the reflexive design of the self. When there are no reflexive conditions to compare arguments, autonomy for decision making is undermined.[4,23,24]

Breastfeeding is institutionally transmitted from the mother's-woman's view, from whom sacrifices are expected for the good of her child, in order for her to be also able to be fulfilled. The decision not to breastfeed is not tolerated by health professionals, who talk to the mother from the assumption of female essence and the naturalization of motherhood. The information is restricted to the biological scope of the professionals' interest, keeping women in no state for conscious decision making. At the same time, teaching breastfeeding practices does not fit the health care unit's schedule, which prioritizes urgent and emergency care, since it does not have viable circumstances for all necessary actions. Mothers have to deal with their doubts and insecurities all by themselves, trying to match the model proposed for them. Thus, negotiations begin with themselves on the ideal and the daily life. And there is the search for support in other speeches. Which leads us to reflect on how much they can be autonomous from medicine and its standardizations in making their decisions.

Autonomy

Autonomy for decision making is marked by the women's education and effective personal circumstances and especially by the identification and appreciation of what attention and knowledge mothers can resort to for solving everyday issues. It is some power, in the sense in which Foucault[25-27] analyzes as instituting the subject but the field has shown that it is only insofar as the circumstances for their existence and for the trajectory of the desire to breastfeed can be established from women's-mothers' engagement. This female subject who breastfeeds becomes engaged with breastfeeding and establishes herself as wishing to breastfeed under certain conditions. Therefore, it is not useful only for biomedical knowledge. Women make choices according to their needs, their confidence in the knowledge, and it is not just a matter of listening to the health care unit professionals or the doctors. It is an everyday management in dialogue with multiple actors.

Although all women interviewed have, to a greater or lesser extent, and with varying expressions of importance, referred to advice from professionals about breastfeeding, other speeches give women greater security, especially those from the more experienced women in the family, such as their mothers, aunts, sisters and cousins. So says Suzana: "I haven't talked to anyone. More with my mother, because she understands it. She has seven children, I think."

Gabriela gives some notion about the relationship she has established with her mother's knowledge: "Even today my mom says: 'Breastfeed him. Breastfeed him.' She is also in favor of breastfeeding, she says: 'They have to nurse until they want to,' she says." But also because of her mother's knowledge she introduces other foods, in disagreement with medical discourses: "Only she tells us that we have to give food, we have to give food properly: lunch, dinner, afternoon coffee, breakfast, you know, one has to give."

The absence of linguistic proximity builds obstacles for these women in contact with health professionals. In addition to the affective attachment to women in their family and confidence in their experience – to the detriment of professionals' discourses or other sources, such as books –, these women have an understanding with their peers, they have a common language, guidelines are close and present in daily life, being able to answer questions and follow their recommendations such as the construction of their autonomy in view of institutionalized discourses. Thus expresses Bruna:

> *[My mother] would explain to me the way it was, you know. Everything she would explain to me. What she knew she would explain to me. What she could, she would convey to me. [...] Better than the doctor, she would guide me more. She would take care of me. I'd tell her: "You were my doctor." She is the one who helped me the most. At the health care clinic, there, they want to explain things more in their way, you know. [...] Now, the mother explains more in her way, what she has lived. [...] Sure, books teach a lot but you also have to live the experience to know it. [...] I think they should explain more in a natural way to us and not so much... as much as a book... a book ... ah, the words ... they complicate it, I think that's it. (Bruna)*

Relationships discussed here, however, are not always completely divergent. There may be some convergence between medical advice and experience conveyed from mother to daughter. Successful experiences following medical recommendations make them better accepted by the next generation. We see this in the case of Suzana: her mother has seven children, with a 20-year age difference between the first and the last ones. Therefore she has already heard many recommendations (probably even divergent, since the recommendations and/or perceptions of importance of the practices fluctuate or change over time) and she has confronted them with her experience.

However, for Suzana, hearing from her mother and being advised by the doctor to walk more to facilitate delivery has had some practical engagement effect. The agreement between the two speeches leaves no doubt for Suzana, who has incorporated such advice: "My mother wanted me to walk more. The doctor has also prescribed it, you know. Doctors would make me walk a lot for the baby to be born fast. My mother would say: 'Walk enough to exercise to get the baby to be born.', you know." Objectively, Suzana can not verify whether such a recommendation has worked for her or not but she is still convinced that it is appropriate to walk to facilitate birth.

In this regard, however, we must consider that walking to have a facilitated birth is an easier to follow recommendation than that of breastfeeding. Either because it has no fixed rules (there is no recommendation regarding time or distance, for example, pregnant women walk on how subjectively they think it is "good") as well as not having as many mishaps and difficulties as breastfeeding (tiredness, pain, fissures, breast engorgement, sucking and milk production incompatible with the needs, among others). As with childbirth, good experiences with breastfeeding in the family encourage following standardized recommendations.

> *My stepmother... she nursed my brother until 2 years, 2 years and something, he nursed. And up to 6 months she would give only breast milk, you know. Then my aunts would say that she had to bottle-feed. And I always said that my babies would be going to be breastfed until the age of 6 months, only breastfeeding. They would not drink water, they would not take anything else. And I did it. With both of them, you know. Until 6 months of age, until the day when they were 6 months old, only breast milk. Then I did it because I saw that my brother was strong, fat like that, very fat, you know. Then only breastfeeding, you see? (Simone).*

Other women say they have gotten counseling from their mother. Gabriela got advise from her mother. But this time there was some disagreement between the mother's and the doctor's speeches, since her mother had different opinions regarding exclusively breastfeeding. She demonstrates how the mother's experience and customs have influenced her decision to introduce other foods to the child's diet, even if this did not match what was advocated.

> *Then, at the health care unit the doctor would say that it should be after six months of age. But only here at my mother's house – she is, well, from the old school... Then she thought that at three months of age one could give it. Then she started to give it at three months of age. She started giving water, juice, porridge. Then at six months of age he was already eating everything. At the health care unit they said it should be at six months but I started at three. (Gabriela).*

The mother's experience is predominant for Gabriela's food-care practices. This divergence between speeches impels the adoption of strategies to deal with the issue. In the Gabriela's case, the medical recommendation transgressed is hidden to avoid annoyances.

> *Gabriela, "When I went to the doctor..." 'Ah, now you start with water, with juice.' And I had already been giving juice for some time, you know [...]."*
>
> *Researcher, "And have you told the doctor you were already giving it?"*
>
> *Gabriela, "No [laughs]! No, because she would scold me. Because once I went there... there was a lecture whenever we'd go. All the mothers going to consult would have some talk about the baby. Then she started talking about it, which was about giving food after six months, and the girl said: "Ah, I already give food to my son." He was already four months old and she fought with the girl, you know, saying that it dilates the stomach... She said a lot of things there, but it's just that... Then I would not tell her but I was giving him food.*

This apparent passivity vis-a-vis the physician and her institutionalized discourse is a way found by several women to clear their doubts and accept what seems to them to be more coherent to their own history. It is the experience, actual or previous, that makes these women confront or confirm the medical discourse and establish their own ideal of breastfeeding and feeding. Hybrid discourses are usually expressed between medical and health professional standardization and what they understand and recognize as important to do, considering their, their mothers' and their mothers-in-law's experience. Also how the children react, if they are putting on weight, if they look good, and whether the mode of operation with these breastfeeding requirements is compatible with the mothers' needs.

> *I would intercalate when I started giving [infant formula]. I would bottle-feed. Then after three hours I would breast-feed. Then I and the [mother-in-law] started to calculate. When breastfed, after an hour he'd want it again. And with [infant formula]... we'd give it and he'd take longer. [...] Hence now I think he is eating more. (Joana).*

> *I wouldn't believe it much. Because I could not imagine that milk could have so much. Something that is white, which has no right color, could be rich in so much vitamin, could sustain. Even at first I was afraid that the milk could not sustain her. But after I saw that she was getting fat, that she was developing well, then I stopped worrying about... the milk being of no use. (Luana).*

Valentina, for example, had another perception of the children's needs. And she is quite convinced that her practice is the best for her children, besides facilitating her routine.

> *For example: "Give the child water only after six months." I've never done it [laughs]. "Start giving him food from six months." I've never done it either. At two months I was already giving the child water, especially if it was hot. One can't do it! [laughs] I've never agreed on this issue because I've never done it either, you know. So there's no way I can agree to something I've never done, you know. [...]. I think anyone who does those six months would have greater difficulty to add other things. I think... because women's life today is very busy. So the easier it is, the better. (Valentina).*

Bruna claims to have followed the rule only while being "obliged" by the hospital's postpartum policy, which only authorizes the mother's discharge when it considers breastfeeding as being established. As soon as possible, she started feeding as she considered it best for her.

> *Researcher, "Then you were just breastfeeding?"*

> *Bruna, "At the hospital, you know, I would be obliged." [...] Then later [on the first day home] I would bottle-feed.*

Organizing daily life towards breastfeeding

Many of these women remain at home caring for children – their children, siblings, and nephews. Breastfeeding continuity shall be according to their routine needs, in addition to depending on the difficulties or facilities they find in the relationship between the breastfeeding process and the adequacy necessary to carry out other activities. Laís, for example, has not had difficulties to maintain breastfeeding and considers that weaning should occur when the child is old enough for this, even though this age is subjective, when she sees that "it is already possible to stop." She cited the recommendation of letting two years pass but thinks that it is good to reach one year. And finally she told about an acquaintance who considered the child old enough to wean at the age of five. Other mothers also cited age as a weaning factor ("big child," "when they are already strong") but did not consider some fixed age as the biomedical discourse wants to specify either.

For Laís, breastfeeding is actually a facilitator in her daily life because it calms the child. When she cries, the quickest and most practical solution is to offer her my breast. Otherwise, "How am I going to entertain her?" In this case, therefore, maintaining breastfeeding serves the mother, facilitating her routine. For Suzana, likewise, breastfeeding continuity seems to be a facilitator of daily life because although she has to offer her breast "all day long," she exchanges her breast for food and also calms him and puts him to sleep. Thus she expresses herself: "The breast? All day long [laughs]. Then at night to make him sleep it's only through breastfeeding [...]. That's why I breastfeed him, it's because he cries." Other forms of practicality have also been described by mothers. Andréa recounts that she breastfed for a short time, "But I liked it. You don't have to get up at dawn to prepare a bottle. I enjoyed breastfeeding, it was good." Melissa reports on maintaining breastfeeding for financial reasons:

> *Even financially, you know. Because to the others [two first daughters] I could give [infant formula]. To this one I could no longer. To this one I have to give [the breast] because to this one I can not give [infant formula]. It's an expensive milk ... So there it was... it was up to three months, at least. (Melissa).*

These narratives, with their positive elements, often base the argument used by health professionals who trigger these successful experiences to the invisibility of the diversity of this experience lived. What is recommended comes to be valued as ideal, together with some biological discourse that every woman produces milk in sufficient quantity and quality for her child. Positive experiences with breastfeeding, such as Laís', leave no room for thinking that there are other realities. Instead, they are used as confirmatory examples that breastfeeding can be successful, depending only on the mother's "willpower" and "patience."

This perspective, when also taken on by women, prevents them from making other decisions as subjects without feeling some kind of guilt or negative self-assessment. An aspect that can be perceived in Melissa's narrative: "Regarding [the first daughter], due to being the first child... perhaps I lacked some patience. At that time I had plenty of milk, I had no fissures. I had nothing in this sense that would impair breastfeeding." Ana Rosa also expresses some sense of loss for the child because she was not willing to do it in the time required: "I think that after 15 days I started giving [infant formula] because he would nurse, he would nurse my breast a lot. I think... it's not that it wouldn't nourish him. Because they say it nourishes. Only that I had to spend many hours breastfeeding, many hours, you know." The process difficulty felt by mothers is not always sufficient to reduce the sadness of not maintaining breastfeeding. Bruna expresses that, "It was painful," telling that every time she would bottle-feed her daughter, "she would cry together." Melissa reminds us that this dream of breastfeeding, for those who want to do it, has its disadvantages:

> *Willing to breastfeed is not easy, you know. You have to wake up every two hours, you're tired, it starts... you wake up every day, every day. There are days accumulating. You see some milk there that will give you six hours of sleep! Then it was like this. [...] A month and a fortnight later I said, "Oh, no more, no more." Then we started giving [infant formula] to her. But I suffered. I remember that I suffered a lot then for willing to breastfeed and not succeeding like this. (Melissa)*

Conveying some motherhood morality engages women in the sense of wishing to follow normality patterns, which includes breastfeeding for the child's sake. The connection between morality and care allows us to construct notions about egoism as an antonym of responsibility when personal satisfaction is contrary to the morality of acts considered good and responsible. The moral ideal therefore becomes giving to others without receiving anything in return. According to Carol Gilligan,[28] this notion of self-sacrifice marks women's development, contrasting the moral of goodness with the possibility of taking responsibilities and making choices for themselves. Such antagonism between selfishness and responsibility profoundly interferes with the possibility of making choices for women, since their identity is based on the pattern of relationship and care. However, in these experiences there are other senses linked to the pleasure of the mother and child relationship or the recognition of the importance of the presence of the mother, which remain among facilitating elements, in a positive meaning of motherhood in the act of breastfeeding.

Laís is not married, does not work and does not study. Her place in the family is as "mother" and "caretaker". Breastfeeding ensures that she is essential in the care of her daughter and she is the one who stays at home taking care of her daughter, niece and younger sister for her sister to work outside the home and her mother to work as a cleaning lady sporadically, which helps in the family's income. At the same time, she also finds pleasure in "exchanging affection," and this is some feeling she imagines to be shared by all women who breastfeed.

> *I think it's like bonding like this, you know. With her, you know. Sometimes I'm breastfeeding her and my dad says: "Look! Look at her face!" And she is just like that, looking at me... quite serious, looking [...]. I think [all women] feel good, which is, like, one of the best feelings they all feel, you know. (Laís)*

The theory of Sexual Difference by Rosi Braidotti,[29] in which the subject constitutes the difference by a process of reinvention of subjectivity, elucidates the forms of pleasure in motherhood. It is about making the feminine positive, with non-essentialized formative characteristics, and which gives women the capacity for action that would not be possible within the masculine symbolic system. For feminism, this would be a collective political project of "becoming a woman" that reaffirms the masculine order, representations and gender relations through some conscious reflexivity that accounts for choices and practices within a context. Such reflexivity constitutes subjectivity in relation to desire, which drives action. For the women in question in this study, there are no collective political considerations. The resignification of themselves as mothers and protagonist caretakers of the child causes that they no longer position themselves as subjects submitted. On the contrary, in their perspective they enter into the symbolic order also as agents of action.

Suzana did not show positive feelings about breastfeeding in itself but she prides herself on whether it makes her child "bond" with her or call her all the time.

> *"He cries if I don't breastfeed him, then he cries. He wants to stay on my lap. Then he goes with my sister, you know. Then he sees me, sticks to my clothes and pulls me like that. He wants to stay on my lap [laughs]. [...] He is bonded with me. I've never seen... I even think it's weird. Not even with his father he'd be so bonded." "Mom, mom, mom!" "He calls me mom and everything..." (Suzana)*

For these women who emphasize the pleasure of breastfeeding there are senses of belonging, an interdependence of love between mother and child and some network of care that they update, as some personal and symbolic position that allows them to make their motherhood to be fulfilled as something recognized by what they do in their environment or that is thought as such. These elements are considered by them as relevant. The aesthetic factors so commonly invoked in other contexts have no negative relevance in this field. Andréa's narrative is explicit about the myth of aesthetic repercussion in her breasts as well as the ability of breast milk to protect children but, on the other hand, she is suspicious of the protection from diseases that is promoted. In her practice, she liked to breastfeed and felt unique to her son.

> *"It's good. I used to enjoy breastfeeding him. There are women who do not like it because they say that the breasts sag and stuff like that [laughs]. Oh, but I enjoyed breastfeeding him, it's pleasant. I'd feel so good! It's so sweet to see him nursing... it feels good. It's bad when women choose not to breastfeed because breasts will sag, you know. Because that is a lie, you know. But it's also good because of their health, you know. They get sick less often. Although nowadays, you know, these diseases are so strong, you know, that even breastfeeding will not work [laughs]]." (Andréa)*

Weaning

Daily organization of breastfeeding begins to fail due to other life situations, women's subjectivity and other adverse circumstances, opening the path for thinking and planning weaning. Speeches about weaning practically do not follow medical discourses and are mainly based on the mothers' daily needs. Some mothers verbalize the medical rule of breastfeeding up to two years or more. But when asked about the time to stop breastfeeding, most mothers talk about their perception of breastfeeding as supplying nutrients ("health," "immunity") for young children and other children's characteristics, demonstrating that their personal and subjective perceptions of how they view their children are more important than some rule set for all children based on their age alone.

Andréa, for example, reproduces the talk about the need to breastfeed a child until the age of two because "up to two years the child is a little weak." She considers, however, each child's individuality, each requiring a different way of caring. Based on her experience, she said that "It does not make much difference to bottle-feed or to breastfeed," because "There are children who nurse from bottles and are healthier than those who nurse on the breast."

Subjective age as a weaning factor is the mother's perception and she also uses her goals when she wants to stop it. Thus, Joana states: "I think it's up to when they want it. But I also find it weird when big kids ask to be breastfed. I think it's weird but I think the ideal... I think it's up to one year. It's already fine, the ideal." For Simone, the need is limited to the child's age, how much they ingest. And what it produces in terms of feelings and sensations in the mother.

> *"It's anguishing. The child is already big, the breast is sensitive, the nipple is sensitive, I feel uncomfortable with that huge child there nursing. [...] I like to breastfeed only to a size, an age. When I see that they no longer need it so much, that they are nursing by... The child has eaten some plate of food, now... Soon she comes to my breast. There is no need for it [...]. I think even to a certain age it is good ... Two years or older, I am against 2 years or older." (Simone).*

Another justifiable reason for weaning is the mother working outside the home, which makes the breastfeeding routine much more difficult. Weaning then becomes necessary. Andréa, who would consider breastfeeding a facilitator because she would not have to "get up at dawn to prepare a bottle," when she went back to work she saw her life made difficult by breastfeeding because she left the baby with her sister and had to go back and forth from work on her bicycle to breastfeed, traveling six kilometers in total.

> *"In the first days I started working, it was difficult. I had to come running from my job. I had to go to my sister's house because he would stay with my sister so I could work. I would leave here at six o'clock in the morning, walk with him, [go] there in [the other neighborhood], go back to work. She would lend me her bike so I could go to work. Then at lunch I had to come to her house, there in [another neighborhood], to breastfeed." (Andréa).*

This arrangement is compatible with medical discourses but obviously it is a routine with sacrifices, which Andrea did not abandon before only because he "would not take the bottle at all, no milk." Women can stop breastfeeding to return to work or start this process when returning to work. Simone decided to stop when: "the [son]... It was because I had to work, you know." Fernanda, by fatigue and impossibility of reconciling breastfeeding, sleep and work:

> *"He would eat [infant formula] during the day and [...] I would stay the whole night breastfeeding him and that lasted about two months. Then I started to feel unwell. I could not sleep. I'd work badly, you know, because... tired, tired. I would spend the whole night awake and I had to work the following day. Then one day I left the job late and my mother-in-law gave him milk. Hence he never wanted to nurse again. I never wanted it anymore." (Fernanda).*

Weaning also occurs because breastfeeding hinders other domestic activities which are also under their responsibility. Obligations with the house and with the children are understood as being women's responsibility, although admittedly it is much work for only one person. Breastfeeding time is an overload work. Ana Rosa says: "There are children who nurse for half an hour and it is enough. Not him. He'd want to nurse one, two, three hours straight, you know. Then I would get tired. It would tire me." In addition to breastfeeding a child, others also needed care. This reflexivity leads her to make decisions about weaning. "And there was my other girl that I had to take care of. I had to make lunch. So I'd give a little bit [of infant formula] to nourish him a little bit." Luana reports the need for some peace of mind:

> *"Some peace, that's what I need. A bit of quiet. One day, one day, one day of tranquility. Just that. For me, just that, just that. One day when I could say, 'Wow, I can clean the whole house because my husband will help me, or someone will help me.' [...] Because I can't... I can barely wash my clothes, which is just throwing it in the machine and hanging, you know. I can't." (Luana).*

Other justifications, from their own experience, also appear and are related to the mother's interaction with the child. Weaning becomes the only viable alternative for the mother and the child in many cases when their concrete experience is contrasted with generic recommendations, even when considered "correct" and "important." Andréa says: "I've nursed him until ten months. Then I stopped it because he began to bite my nipple and it'd hurt. And I did not want to breastfeed anymore, I was afraid [laughs]." Melissa considers that it is not possible to wake up so often: "So, you see ... she would wake up two, three times during the night to nurse. Then when I gave [the infant formula]... I would give it at midnight. She would nurse only at six o'clock in the morning."

Conclusions

These women's narratives are certainly not the only ones because care and caring are topics that are not only personal and private but also socio-political. At some point in life all people need or will need some kind of care, as analyzed by Joan Tronto[30]. And at some point they waive or will waive acts of care.

It is necessary to point out, from the same author's perspective, that a feminine ethics of care understands women's role as a social actor involved in care. However, this can be used to justify women's confinement in private spheres and lead to the reinforcement of stereotypes, which, by the way, have already placed care in a marginalized place, of identification with female figures and with validity only within private spheres.

As for the feminist ethics of care, it encompasses the domains of sociology and politics, in some thinking social organization in order to reduce inequalities. In this way, one can think of the concept of care and its relationship with institutions, leaving the relationship between care and feeling and detaching women from some natural aptitude for care.

Considering these meanings, the issue of caring (and breastfeeding) is a political issue, of women's autonomy, which encounter many challenges in their daily lives and labor orders when they keep caring and breastfeeding. According to Tom Cockburn,[31] recognizing people who need care as a legitimate social group can make visible that caring is a job. Recognizing care as work would allow greater sensitivity to consider differences and to recognize the importance of gender analysis in child care activities.

The issue of differences within the moral theory is one of the aspects discussed by the feminist theory in order to discard conceptions about the universality of care in relation to specific needs of others as being women's task. For the women interviewed, motherhood brings a situation that, if on the one hand they would be subordinated to the home, on the other, motherhood would be the expression of their power, an autonomy in view of deprivation. Such statement contains aspects of great ambiguity, since if, on the one hand, they find their ways of organizing caring and breastfeeding as they face everyday life problems and find support in other women, on the other they reinforce the feminization of caring. This occurs when they struggle to take care of all their children and perform household activities while finding alternatives that make sense to them but do not go beyond the barriers of gender inequalities and the devaluation of care.

In this study, social practices of care, as in many other contexts, are still based on an essentialist view of women. In it, mothering and caring are seen as their natural task, and therefore, even when working outside the home, mothers remain in the role of being responsible for the house and the children. These relations are long-standing, we know, and the maintenance of unequal

relationships and practices between men and women is also reproduced in biomedical knowledge and its normative formulations, as observed in this field.

Given the processes ambiguities, mothers have also made personal arrangements or in their networks of mothers, friends, sisters, capable of giving them some means of sharing the tasks of care and sometimes deriving pleasure from this mothering. It should be considered, however, that, like all reflexivity, it is not forged from emancipatory principles and often deals with arrangements made under some symbolic order that is based on the fixity of maternal obligations.

Thus, although these arrangements liberate women by sharing their tasks with other women, they continue to be barriers to the construction of democracy because they resolve issues of specific needs but weaken emancipatory achievements already achieved such as the right to decisions and discussions on capabilities, right, intimacy and autonomy to do it.

It is necessary, from a structural point of view, to overcome the separation of the productive and reproductive orders, considering that men's and women's work must be of the same species and that the spheres of family and society can not remain separated. Such issues have already been advocated in the 1970s by different feminist texts, for which it was necessary to articulate production, consumption, child rearing and economic decision-making as constituting a single social sphere.

Karen Sacks,[32] a partisan of this position, has also argued that in order to achieve social equality, individuals' autonomy would need to be inserted in multiple and non-congruent registers. From this perspective, women's experience and decisions shall be affected by what is inscribed in their life in simultaneous factors such as age, parity, previous experience of gestation and delivery, previous experience of health services, presence or absence of paid work, presence or absence of help in caring for children, listening to their mothers', sisters' and friends' experiences, among others.

The aspects narrated in the previous points of this article have brought elements of the relationship between the experience of the woman who breastfeeds, the institutional discourse about breastfeeding, as well as with other discourses and her own experience in daily life. They are questions loaded with meanings about feelings of joy, pain, pleasure and the maternal obligation of daily administration of a series of needs of the children and mothers. Care, from essentializing motherhood, has as main challenge the need to problematize motherhood contexts and ensure the politicization of the content of care from denaturalization and deconstruction of the symbolic order of care, which shall allow encompassing diversity in the act of breastfeeding.

Support measures are needed based on reproductive processes, which involve effective social policies in the areas of paid work outside the home, as well as in home care work, with a division of tasks not based on an unequal gendering of activities. Inequalities have contributed to women's

poverty and the lack of health and education services fitting the new needs of women who are mothers, in view of the creation of a network of protections by the State.

It is in this sense that Garrau & Le Goff[33] analyze care, which should be thought of as encompassing the wider community, based on its vulnerabilities and needs. Breastfeeding enters this aspect as a major challenge to democratization, as it involves policies, conceptions, the mother's privacy and the need for work, income and survival. It demands, therefore, a complex view from the health system and its professionals on institutionalized knowledge and on breastfeeding, which considers the mothers'-women's practices and possibilities, in their autonomy and subjectivities, as well as the situations that are presented for continued breastfeeding or for weaning.

Thinking about care as socio-political, it is necessary to consider the fair participation of support, sharing care tasks in the family and public strategies for building a democracy of care, far beyond the private sphere.

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Received: April 15, 2016
Reviewed: July 28, 2016
Accepted: August 2, 2016