BREASTFEEDING,
COMPLEMENTARY FEEDING
AND HEALTH

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Dynamics and interdependence relations in care and breastfeeding

Dinâmicas e relações de interdependência no cuidado e aleitamento materno

Abstract

The aim of this work is to discuss the ways of adherence, acceptance or rejection of information from healthcare professionals about breastfeeding regarding the difficulties of daily reality in the care of young children. Qualitative perspective study with interviews with 12 women mothers of children between six months and two years old, and analysis that moves among the comprehension and interpretation of the contents of the interviews in depth. The speeches of the women show that they act by articulating the culture and their position according to their needs and decide their practices based on an interdependence with other knowledge, exchanged with mothers, friends and other women, as well as health professionals. The practice undertaken by women is dedided in agreements or conflicts with laws, public policies, the different types of care, and social, cultural, economic and political issues. The needs create a fluidity among the elements, based on the decision making of these women. Reproduction as a work in society brings fragility to women's lives and is a challenge for the development of care as a policy and for the democratization of activities, ensuring the care of all as a collective activity, of each individual and the state.

Keywords: Parenting. Breast Feeding. Empathy. Public Policy

Resumo

O objetivo deste trabalho é discutir as formas de adesão, acolhimento ou rejeição das informações de profissionais de saúde sobre o aleitamento materno frente às dificuldades da realidade cotidiana no cuidado da criança pequena. Estudo de perspectiva qualitativa com entrevista a 12 mulheres mães de crianças entre seis meses e dois anos de idade, e análise que se move entre a compreensão e a interpretação dos conteúdos das entrevistas em profundidade. As falas das mulheres demonstram que elas atuam articulando a cultura e sua posição conforme as necessidades e decidem suas práticas a partir de uma interdependência com outros saberes, trocados com mães, amigas e outras mulheres, bem como com profissionais de saúde. A prática assumida pelas mulheres se faz em acordos ou conflitos com legislações, políticas públicas, os diferentes tipos de cuidado, e de questões sociais, culturais, econômicas e políticas. As necessidades criam uma fluidez entre os elementos, a partir da tomada de decisões dessas mulheres. A reprodução como trabalho na sociedade traz fragilidade para a vida das mulheres e é um desafio para o desenvolvimento do cuidado como política e para a democratização das atividades, assegurando o cuidado de todos como atividade coletiva, de cada um e do Estado.

Palavras-chave: Maternidade. Aleitamento Materno. Cuidado. Políticas Públicas

INTRODUCTION

Motherhood, care and breastfeeding are subjectively associated with women, referring to the nature and need for well-being of children, and consequently, of society as a whole. These functions reflect an understanding of both subjective and broader sociocultural issues. An implicit obligation in culture is pointed ou, which is made by a woman giving birth to a child, and the constructions on the proper way to care and breastfeed, which lend to various structures of society, in confluence of discourses that induce or repress various actions related to conception, pregnancy, childbirth, breastfeeding, feeding and child care.[1]

Social practices in many contexts are still based on the essentialist view of women, in which care is seen as their natural task, and therefore, even while working outside the home, she remains responsible for the home and children. It is a longstanding rancor of maintaining relationships and practices between men and women. Even when they deny their role as provider, women are the ones who take the responsibility left by men, given the number of poor families led by women, without denying care tasks as counterparts.[2-4]

In this context, breastfeeding is conveyed based on the mother woman's view, from who sacrifices are expected for the good of her child. For the mother, facing reality, the difficulties encountered, feelings of hopelessness and willingness to give up, or the decision not to breastfeed, are not intelligible to healthcare professionals, who talk to the mother based on the assumption of the female essence. and the naturalness of motherhood.[5,6] The information is restricted to the biological scope of interest of professionals, keeping women unable to make conscious decision. The mother has to deal with her doubts and insecurities alone, trying to match the model proposed for her.[6-8]

Mary Del Priore's analyzes[9] are very useful for understanding the historical relationship between medicine and the female body, since colonial times in Brazil, when for both the Church and physicias, the woman's body was seen as a mysterious place, inhabited by God and the Devil. The diseases were caused by the wars between these two forces, and the female body was the Devil's favorite place - so the woman was also a carrier of ills.

Medical theories about women's body and sexuality underpinned the senses of femininity and reinforced the ideals of women's place in society as a mother. Anything different from this could only fit into an opposite, immoral, inappropriate - symptoms of some female pathology.[10,11] This discourse is part of a motivation that aims to define the nature of women as fragile, homely, docile, emotional, sensitive, prudish and that seeks the comfort and stability of the home, in a category apparently less negative than its countered opposite, which she is the indiscreet,

irrational woman, slave of her body and senses, tricky and disobedient.[12] Thus, female morals and sexuality fit into a medical category, which could be disciplined and controlled from an imagined ideal. Medical knowledge thus coupled the woman's health and morality, her ideal of motherhood and childcare, as well as her social role as a mother.

It is noted that issues related to Public Health were increasingly adopting a political character. The sanitation goal of the country, led by hygienists, was to reach a civilized nation. Public Health, therefore, followed the commercial and financial interests. With such actions, medicine has gained space and credibility in society and can standardize the conduct. Likewise, the gynecologist and the obstetrician have gained importance, as they contribute to transforming sex and reproduction into a state concern.[13]

In addition to medicine's concern with marriage and reproduction, there was a growing emphasis on the necessity to protect motherhood and childhood, bringing to light childcare, the specialty that focuses on the growth and development of healthy children. Previously forgotten themes, such as breastfeeding, have gained vital importance since this time, with the thought of breed improvement. In Brazil, childcare also gained attention in the twentieth century, and medicine developed methods and propagated guidelines for good preconception, conceptional, gestational, puerperal, childhood and adolescent health. The message, therefore, is that women should take care of their children, and when assisted by doctors, the child will be born and grow up strong and healthy – that is to say, will be the wealth of the country.[13]

Thus, if care is political, as well as an instrument for observing the dynamics of social relations, and motherhood is part of a social practice impregnated with the standardization of bodies, public policies are not exempt from creating or deepening the differences between the genders[14]. Brazilian public health policies reflect the imbalance between maternal and paternal functions. They think and act towards the maintenance of sexual inequalities related to the planning and execution of health and feeding programs and strategies in the Brazilian Public Health agenda, which reaffirm the maternity model and exclude the possibility of equal participation.[4,6,7]

The ideal of motherhood conceived socially and also by biomedicine encompasses various rules, practices and logical routines and, if on the one hand, it has been observed that women continue to be part of the collective representations of motherhood, engaging and extracting pleasure in to correspond to the model, on the other hand, their experiences meet daily needs, observing other logics that cannot be predicted in the medical recommendation.[7,15] It is not a matter of disagreeing with the social valorization of medicine and its practices, but rather

reflexively conflicting, situation by situation, based on other important relationships and values in women's lives.[6]

Given this, the objective of this study is to discuss the ways of adherence, acceptance or rejection of information from healthcare professionals about breastfeeding regarding the difficulties of daily reality in the care of young children

METHODS

The study is based on a qualitative perspective methodology,[16] aiming at understanding the experience of women who become mothers in relation to the discourse institutionally conveyed by healthcare actions and recommendations, considering their social and family reality.[17] Prior to the field phase, the project was approved by the Research Ethics Committee of theUniversidade Federal do Paraná (Federal University of Paraná), under opinion 934.612.

With the consent of the Municipal Health Secretariat of a city of the coast of Paraná, all Health Units participating in the Family Health Strategy (FHS), from six different districts, were visited for the access to official information about the mothers of children between six months and two years old, cared by the FHS in the municipality in question. All community health agents (CHAs) active at the time of the research provided these data, considering the universe of mothers, which was later separated using characteristics like number of children, breastfeeding situation, work outside the home and the presence of the partner at home, and according to the proportional distribution among the randomly selected neighborhoods, accessing the coverage area of the six FHS. To understand various situations and mothering experiences, the mothers selected were housewives, formal and informal workers; primiparous and multiparous; who were still breastfeeding or had already weaned their youngest child; married, single and divorced.

To complete the field phase, data saturation criteria were obeyed, and in-depth interviews were conducted with 12 mothers. The interviews were recorded with a voice recording instrument and then transcribed. The women who assisted in the construction of the research were interviewed in their homes, in the presence of only the main researcher, and in some cases of some family member of the interviewee (mother, mother-in-law, children).

For the complete interview, one to three visits were made in each house, according to the need and specificity of the informant. In some houses, the interview occurred in the first contact. In other houses, before the interviews, some women preferred not to receive the researcher immediately and scheduled another time, that was more convenient for them.

According to the interview guide designed exclusively for the research, the interview was about the experiences of mothers with pregnancy, childbirth, breastfeeding and care of young children. The technique of content analysis was used, emerging as the category of analysis, the relationship between the perceptions and daily practices of women and the healthcare professionals recommendations. The analysis elaboration of this work moves between the comprehension and the interpretation of the contents of the in-depth interviews with the 12 women.

RESULTS AND DISCUSSION

As part of a daily theme, related to the history and culture of a place - motherhood - breastfeeding and ways of caring for a child appear in various forms and voices, as described by Fernanda: "There will always be someone who will make a comment, about the child, about the pregnancy, if the clothes are ironed, about the hair, there will always be someone to make a comment [laughs]. Always! There will always be someone! " (Fernanda, 21 years old, 01 child). The way which pregnant women and mothers receive, welcome and re-signify these comments varies in their network of interdependencies for the practice, according to their experiences.

Belonging to the social group as a mother cannot define their position in isolation, but it does mark their sociability towards professionals and other family members, especially other women. The specific advantages and constraints of being a mother are elements of her trajectories, but not the only ones; the interaction between different elements, in each specific context, characterizes the individual socially, in his trajectory and belonging, and his subjectivity.[18]

Although all women interviewed have, to a greater or lesser extent, and with varying expressions of importance, mentioned the advice of professionals on breastfeeding, other statements give them greater security, especially those from the most experienced women in the family, such as their own mothers, aunts, sisters and cousins.

> I didn't talk to anyone. More with my mother, because she understands. I guess she has seven children in all. (Suzana, 21 years old, 01 son).
> Then there is my mother-in-law, who had three children, already had a lot of grandchildren, so she helps me [...], then I have her to guide me, right, in the things I can do with him. (Joana, 25 years old, 02 children).

In addition to the affective bond with the women in their family, and the confidence in the experience, these women understand each other with their peers and can ask questions and follow their recommendations. Bruna (18, 01 daughter) tells that her mother explained things

"the way they were", and "At the Health Center, they want to explain more what they have studied." She concludes that: "Books teach a lot, but you also have to live the experience to know."

Bruna explains that the dynamics of the relationship is more important for making decisions about how to do things. It indicates that the knowledge that circulates in the structure of the Health sector and, therefore, by the professionals of the health unit, fails to transmit the knowledge to the family network and to the needs and specificities of her experience with her daughter.

In the dialogue between lay people and healthcare professionals, there are interruptions, misunderstandings and interpretations that make interaction difficult. The translation, however, does not refer to a simple exchange of words, but to a sensitivity towards the meanings that bring the medical and native categories closer together.[19] It is about understanding the relationships that permeate practices and symbolic orders of the mothers' doing, and understanding the experience mediated by these categories.

The boundary between technical and social knowledge could be recognized as complex and fluid, in which the plurality of knowledge would be intrinsic to science.[12] Separated and tiered, technical and social knowledge do not meet; instead, they often collide in a dispute of legitimation of the truth that, symbolically, has been privileging medical discourse over experience, even when the first is totally detached from practical reality.[7] But if symbolically it is considered true, when it generates a conflict with a different knowledge more suitable to reality, reflexivity turns to non-technical knowledge, and to information and help from their personal and family relations.[8,18]

Laís, for example, demonstrates that the institutionalized discourse was not appropriate for her. She could not remember what was said to her in the health unit and the hospital, demonstrating that it did not seem important to her or was not compatible with her understanding. The explanations of the mother and aunt, however, as well as the objective help with the care of the daughter, taught Lais what was necessary to feel safe.

> [My mother and my aunt] were helping me there, like, if they didn't tell me, I wouldn't understand, because I didn't know ... It was the first child. [...] If they didn't explain anything to me I would be like a fish out of water, knowing nothing, because my aunt and mother bathed her during the first month, because she was very small, this size...very little... then I was afraid, right. When she was almost two months old I started to bathe her (Lais, 25 years old, 01 daughter).

Similarly, the institutionalized recommendations did not make sense to Suzana, who does not reproduce the fixed recommendations in discourse, but offers the breast in free demand to her son, not because she learned this way from theory - although at some point she may interrelate with subjective content - but noticed in her practice the way "the breast feeds":

> When he cries I know he wants to suckle. He is hungry, right, so I think the breast feeds because he sucks and then stays quiet. Or he feels thirsty or hungry. I don't know if milk quenches thirst or quenches hunger. Then when he cries, I give him in my breast. (Suzana, 21, 1 child).

Gabriela selects what she welcomes from the medical discourse and what, in opposition, conflicts with it, and decides to follow her own experience and her mother's advice. To introduce food to her children, she chose to follow her mother's recommendation:

> So in the health center, the doctor said it was after six months. But here at my mother's house - she is from an ancient time - so she thought that at three months she could give. So she started giving at three months. She began with water, juice, baby food. So at six months he was already eating everything. At the health center they said to start giving with six months, but I started to give with three. [...] [the information of the center] some things are usable compared to others, I guess... [...] That's all I did not take seriously, but the rest I took everything seriously, the “milky”, the care, right. The vaccines that have to be all up to date (Gabriela, 30 years old, 3 children).

There may also be a convergence between medical counseling and past experience from mother to daughter. Successful experiences following medical recommendations can make them better accepted by the next generation. Suzana's mother has seven children, with a 20-year variation from the first to the last, so she has heard many recommendations from the health sector (probably even conflicting, as the recommendations and/or perceptions of the importance of practices fluctuate or change over time), and confronted them with her experience.

The latest medical recommendations, also unknown to Suzana's mother, due to the unprecedentedness of the current situation, may also seem good and judged to be correct, which will not necessarily be incorporated into practice. About this, Margarida, Suzana's mother, shared her experience with one of the children, who, being born with low weight, was hospitalized shortly after birth and received milk in the cup instead of bottle. She was advised in this regard, as the baby should make no effort to obtain food, which was considered intriguing by the mother of Suzana:

> Then I had to take and give. I used to give it in a little cup, he drank it in a little cup ... I didn't know, I have many sons and I didn't know! In the hospital, not to use the nursing

> nipple, not to give a baby bottle, we gave in the cup, they took it in the cup, just like us! I thought it was so cute, they drink it! I didn't know..."(Daisy, Suzana's mother).

Such medical advice was followed during the hospitalization period and considered appropriate. However, upon returning home, she began to offer her breast to her child, along with a bottle-fed supplement. Therefore, even considering hospital practice interesting and appropriate, her experience with the other children was more relevant when caring and breastfeeding her child at home, away from the eyes of nurses, and began to conduct more coherently with her previous experience.

It shows that not necessarily there is a disagreement with the basis of what is received as advice from medical theory. Nor is the transgression of these norms felt as disagreement. The practice, however, has one of its forms from experience, which has several strategies to combine the lived experiences with the innovations learned by theory.[6,7]

For Joana, the offer of tea for her baby, encouraged by her mother-in-law, is not inconsistent with the exclusive breastfeeding discourse. The confusion between this type of feeding and artificial feeding is resolved by her own perception, concluding that your mother-in-law's advice has yielded better results than her doctor's recommendation.

> Then she [doctor] said - Until six months, only breast milk, do not give water, do not give tea, do not give anything. - So now I'm giving because I think with milk [infant formula] he feels thirsty. So I always give something to him. [...] Then I think that now he is eating more. (Joana, 25 years old, 02 children).

On the other hand, the positive experiences with breastfeeding in the family encourage to follow the recommendation. Simone (24 years old, 02 children) accompained the care of her brother, who had exclusive breastfeeding until the sixth month and complementary until more than two years old, observing that his growth was satisfactory in her perception, because: "I saw, so, that my brother was strong, as well as very chubby, right, then, only the breast. "- then decided -" My children will be breastfed until six months alone, they will not drink water, will not drink anything."

Exchanges of experience are part of the relationships among these women, with their mothers, aunts, sisters and daughters. However, when it is necessary to confront the experience of their peers and experience alone, it is the experience lived alone, caring for other children, and breastfeeding of her own children, which is the most important.

Andrea, for example, in her sixth child, considers that her practice dispenses counseling, reporting that she didnot talk to anyone about pregnancy, childbirth and care of newborns in the last pregnancy. When asked about a possible conversation with her 17-year-old daughter, who was five months pregnant at the time of the interview, about breastfeeding and baby care, Andrea answered negatively, explaining that her daughter has already helped in the care of her siblings and in laws, so "She already knows [...], I think she's calm" - demonstrating that it is everyday experience and practice that is relevant, not advices.

Gabriela, who says that has always taken advice from her mother and that has experience taking care of her niece before her children, also relies on her practicerather than the institutionalized discourse:

> They said things about breast milk, which we had to give every three hours, the way we had to breastfeed, then put the baby to sleep sideways, these things they taught. But these things we already know, right. (Gabriela, 30 years old, 03 children).

A discrepancyfrom the medical recomendation can be noted here, but Gabriela takes it as having heard from the healthcare sector. The recommendation is breastfeeding on demand, and to put the child to sleep on his back. Conversations with her mother and other women bring other information, blurring the boundaries of what was probably heard and learned from each person.

In fact, it turns out that current or past experienceis what causes these women to confront or confirm medical discourse and establish their own ideal of breastfeeding.

> [...] but then [when I got pregnant] I didn't talk anymore. Because I already knew things, because then I already had two [daughters]. (Gabriela, 30 years old, 03 children).
> When we give bith there, they talk about breastfeeding. [...] It's a good talk, it's good, for a first-time mom, the first child, it's very good. [...] I already had a little experience, so... not for me ...that was more, really, to be there, along with them. But it was very good. (Ana Rosa, 37 years old, 04 children).
> I did not believe much, because I did not imagine that a milk could have so much. Something that is white, that has almost no color, could be rich in vitamin, could sustain. At first, I was even afraid that the milk could not sustain her, but after I saw that she was gaining weight, that she was developing, then I started to stop with the neura... that the milk was not enough. (Luana, 26 years old, 02 daughters).

Representations about milk are also part of the network of interdependencies, and may be one of the factors that influence decisions. Luana (26 years old, 02 daughters) characterizes breast milk as: "something that is white, which has almost no color". The category "weak milk" arises in other ways in the words of mothers, who consider milk "too liquid" or "not sustaining",

although they usually talk about “weak milk” to deny its existence. This is justified by the intense efforts of the healthcare sector since the 1980s, when the emergence of scientific studies on the benefits of breastfeeding, to disseminate this category as a myth and try to exclude it as a justifiable reason for weaning.

Traditional representations of breast milk have been more widespread and influential in breastfeeding and weaning decisions for both mothers and doctors.[20] In the present research, “weak milk”, or “white”, “liquid” was quoted by the mothers, but the hegemonic thinking that 'there is no weak milk' is almost unanimous in the discourse, but not in practice, when mothers wonder if their milk really sustains or would be enough for the development of the child.

Joana values the medical recommendation and reproduces it according to the norm of offering the breast exclusively until the child's six months of age, relying on the lectures she attended at the postpartum period and the knowledge acquired in the technical nursing course. In practice, however, she compared with her routine and decided to discontinue exclusive breastfeeding shortly before her son was three months old, and recognized advantage in this practice based on his observation.

> I interspersed when I started giving [infant formula]. I gave a bottle, then after three hours I gave the breast. Then I and my mother-in-law started to check. When I gave him breast milk, after one hour he wanted to breastfeed again, and [the infant formula], we gave, he took longer. [...]. So I think he is eating more now (Joana, 25 years old, 02 children).

Joana, even considering breast milk the best for a child, reflected and confronted the recommendation with her practice. Verbalized that "Breast milk is excellent," but pondered that her son "only cries.” The doctor advised her togive "until six months, only breast milk", but with the bottle he was "very quiet", cries less and sleeps more.

Because she was engaged in medical discourse, Joana went through a period of doubt to introduce the bottle, but later noted that not following the recommendation improved her daily life and seems to have been beneficial to her son:

> [...] I thought, when I started giving [infant formula], I said: “Ah, I'll give [infant formula]”, but then I kept thinking “if he gets it”, because I already knew that if he really took [infant formula] he would let go of the breast. So I knew that side, but I still wanted to give [infant formula]. I think it was the moment I thought he was going to let go of the breast. [...] I wasin doubt: “Do I give or not [infant formula]?” And I chose to give, because, look,he is very quiet here. (Joana, 25 years old, 02 children).

Likewise, Melissa, finding it difficult to manage breastfeeding, began to negotiate with herself about for how long she would breastfeed her daughter. From the consideration of at least six months, because of the importance of breastfeeding for the child, Melissa began to consider that she should breastfeed at least one month, when she began to have nipple fissures that did not heal and caused her much pain. Being helped by her sister, who advised the use of a specific healing ointment, Melissa reached the third month of breastfeeding. The conflict with the medical norm, the relativization of her subjectivity and position of reflexivity led Melissa to make decisions at all times, which fit the experiences with her daughter.

Even knowing the medical recommendation, and initially verbalizing agreement, there is a reflection based on experience, which is what happens in her family and her network of relationships. Thus, to consider the practice of breastfeeding, mothers contrast the pros and cons of concrete experience. This was also expressed by Andrea, who recognizes the individuality of each child and therefore the difference in caring for one or the other, and also that the repercussions of the same act, such as breastfeeding, are not necessarily the same for two different children.

> Oh, there are a lot of kids who haven't breastfed and are healthy [laughs]. I don't think there's much difference in bottle-feeding or breastfeeding. There are children who suckle in the bottle and are healthier than those who breastfeed [laughs]. It also depends on each child's organism too. (Andrea, 39 years old, 06 children).
> But I guess it didn't make that much difference, between the breast and thebottle because she [sister] is a healthy child. (Luana, 26 years old, 02 daughters).

Based on this child's individuality, it is also observed that this previous experience is quite influential, but not absolute for the care and breastfeeding ofthe youngest child, as one child is different from another. Joana says she *"sees the difference today"* between her two children. Unlike her first daughter, Marco Antonio wanted to breastfeed frequently, which made the recommendation on free breastfeeding, well-known by Joana, impracticable. Contrary to what she is observing from her experience, the recommendation is fixed, and Joana, even considering the importance of what she learned in the healthcare courses, continued until she considered it appropriate for herself.

> I was breastfeeding, but, as it was too much that he was breastfeeding, every 15 minutes, so I started giving [infant formula] to him. (Joana, 25 years old, 02 children).

Valentina, for example, had a personal perception of the need for children that is different from what is conveyed by medical science, and is quite convinced that her practice is best for her children, as well as facilitating their routine.

> For example, "Give water to the child only after six months," I never did that [laughs]. “Start feeding him at six months,” I never did that either. At two months I was already giving the child water, especially if it was hot. You can’t do that! [laughs] I never agreed on this matter because I never did that either, right. So there's no way I can agree on something I never did, right. [...] I think those who do these six months would have a harder time aggregating other things. I think, because women's lives are so busy today, so the easier, the better. (Valentina, 39 years old, 04 children).

In Valentina's case, her perception of what is most appropriate for a baby and herself in terms of breastfeeding and feeding is seen as a transgression of medical advice, and made her uncomfortable with her medical appointment. She reports that “pediatricians sometimes called me out” when she said that before six months he offered water, fruits, porridge and soups.

> Researcher - And how did you feel when the doctorcalled you out?
> Valentina - Ah, very sure of my position [laughs]. Very safe, it brings me no confusion what I'm sure isn't doing any bad. [...] And in the matter of the pediatrician, there was even an episode, which was an episode that was more remarkable, that the pediatrician was a mother too, and I said to her: “Look, I'm giving soup ...” , at the time it was for the [third daughter], “... already, potato, carrot ...” she was already five months old. [...] the pediatrician hit the table so when I finished talking she said I was crazy [laughs] said she would sue me, that she would take me on the guardianship council [laughs] because I was overloading the stomach of the baby. But she was in the normal weight, she was happy and joyful, you saw her there, happy and joyful. (Valentina, 39 years old, 04 children).

A medical science that starts only from the abstract and makes the mother's representations about the body and the feeding of her child invisible makes a dialogue between the two knowledge impossible. The mind/body separation made by Western medicine reduces the person to biochemical parameters, and this objective and quantifiable statistical basis hinders the communication between the two realities, women and medicine, reiterating the superiority of medical knowledge.[17,21]

In addition to previous representations, in everyday practice, based on experiences, trust can be broken, leading to the transgression of the norm. Lack of trust may not necessarily be personal; it may be related to medicine itself, when it comes to the care of children in the municipality. In addition to having only one place of care for children, which is already perceived as neglect by the interviewed mothers, the lack of problem solving in previous experiences undermines the confidence in the care and medical treatment of their children.

> I don't think there's any good doctor there. The doctor just looks at the child, comes to us and asks: “Mom, what does the child have?” If we knew, we would go straight to the pharmacy, right! [laughs] (Andrea, 39 years old, 06 children).

And distrust now encompasses other aspects of health andgrowth and development of children, including breastfeeding:

> But [breastfeeding] is good because of their health too, right. They get less sick, although these diseases are so strong these days, that not even breastfeeding is effective [laughs]. (Andrea, 39 years old, 06 children).

Violation of the medical recommendation may also be in practices that match the understanding of what the child would like to receive, caring less about the rules of healthy feeding and exclusive breastfeeding. In Suzana's case, it was the paternal grandmother who offered food for the first time, and soon began to give food that she understood as favorite for her grandson.

> Suzana - In fact, he was young, my mother-in-law, my ex-mother-in-law, started giving him chocolate, his father's mother. He already gave him chocolate, ice cream, everything. She started eating very young already.
> Researcher - Do you remember how old he was?
> Suzana - About 2 months I think, 3 months ... started givingchocolate for him. (Suzana, 21 years old, 01 son).

For Melissa, the opposite occurred. She did not agree with the diet proposed by the doctor, because she did not consider it healthy, and decided to introduce what seemed most suitable for a baby.

> I asked the doctor, right, I said it like that: “Look, Doctor, I can't afford [infant formula], what do you recommend?” [...] So then she said “give him milk with sugar”. [...] I put the [children's cereal] because I never gave them sugar in the bottle. I've always had a thought, that this encourages them to like candy a lot. That is not necessary, right, there's sugar in the milk already. For example, [infant formula] already has sugar, breast milk already has sugar. I give [child cereal] which also already has sugar. It happened not to have [children's cereal], so I gave the pure milk, but I never put sugar. [...] I thought the doctor was like that a little ... “Why give [children's cereal]? The [children's cereal] has nothing, no nutrients! ”, But you read the can label, there are a lot of vitamins, right? I gave the [children's cereal]! (Melissa, 31 years old, 03 daughter)

In some cases, the counseling and coordinating women are multiple, and the choice to put in practice is where it is most consistent and convenient for them.

Valentina says that in addition to the objective care learned from her mother at the birth of her first child, she attended prenatal and postpartum courses, did researches on the Internet, and listened to advice from “older people” as well as friends.

> So to produce milk, they would say a lot: “Oh, drink English water, eat a lot of guava candy, banana candy, which increases milk production”, this is the saying of older people. [...]

> But in the course they don't talk like that, they talk about a good diet; they talk about drinking a lot of liquids, a lot of water, regardless of the liquid, right. In the course they say: "Look, drink a lot of water, you have to drink a lot of fluid, a lot of juice", they do not speak of a specific liquid. But, however, later I found out by researching that soy juice was great, precisely because, whether we like it or not, it already has protein, because the milk comes out of us, so the more you absorb it the more you will release [laughs] . This is a fact. But these are things that in these courses I did were not passed to me; I went to research later to know. And sometimes a neighbor would tell me something, some friend would always give me some suggestion. "(Valentina, 39 years old, 04 children).

Having no contact with her birth mother, and having been adopted by an eighty-year-old lady who never had children, Luana also used the internet as a source of information and answers about pregnancy, breastfeeding and child care: "I was searching the internet". Her secondary source of information was "thelady from the healthcare center who came to givesome instructions" (Luana, 26 years old, 2 daughters).

Following medical advice, transgressing such advice, the listening to the experienced speeches of other women, their own experiences and theindividuality of the child form arrangements for breastfeeding thatgenerate a kaleidoscope of possibilities, managed according to thepossibilities, knowledge and empowerment of each woman. "The uniqueness ofthe trajectory of individuals and their creative investment in their own lives are not incontradiction with the recognition of structural constraints on their agency".[18]

These women act by articulating the culture and their position regarding the needs and strategies of knowing, but not necessarily assuming. They decide their practices from an interdependence with other knowledge, exchanged with mothers, friends, unknown mothers they meet in the healthcare unit, as well as with health care professionals.

Relationships can be conceived as the formation of a fabric by a web that is constantly changing and moving, with several interconnected poles. The abstract and symbolic representations about each situation lived position these poles and move them; with each action in one direction, the whole fabric reorganizes itself, repositioning the poles and giving rise to new decision making.[22] The poles of interdependence of this web are formed in the relationship with other women, with previous representations, with ongoing experience, with healthcare professionals, with the health structure and with other factors of daily life.

The intersection between them even presupposes reciprocity. However, it is not a reciprocity with isonomy or balance of these relations. Greater or lesser dependence on one or another web pole drives decision-making into action.[22] Thus, women who need their mothers to

care for their children tend to consider their advice more; those who are inserted as professionals in the health sector may value this information more; and those who depend on keeping their jobs for a living may consider more closely their daily schedules when deciding on feeding their children.[5,8] However, while these factors rearrange the entire web, none is crucial for final decision making, which depends on the actual situation. It is based on that situaton, lived in daily life, that the woman activates the poles that are most convenient for the moment and organizes her routine.

CONCLUSIONS

The interfaces of women's practices are made in agreements or conflicts with laws, public policies, different types of care, and social, cultural, economic and political issues. The needs create a fluidity among the elements, based on the decision making of these women. The lack of legislation to protect maternity and caregivers, and the lack of institutions to ensure reproduction as a work of society brings fragility to women's lives. These are the challenges today for the development of care as a policy and for the democratization of activities, ensuring the care of all as a collective activity, of each individual and the state.

Motherhood and childcare are in this context, where women are held responsible for various activities and judged for their actions in becoming what is a “good mother”, and breastfeeding is one of the issues to be fulfilled. Morality rests on the naturalization of motherhood, which obliges women, but not men, to fulfill these functions. The different socialization of girls and boys makes them more relational concerned with meeting the needs of others, in a cycle of misinterpretation, which makes them suitable for care, because normally they were seen as naturally suitable for care.

This cycle, contextually, did not allow the theme of care to be thought outside the private. This, however, is not a matter of the private, but a sociopolitical one, since at some point in life all people need or will need some kind of care, and at some point dispense or will dispense actions of care. Crystallized as housework, care remains feminine, undervalued, differentiating gender structures and a social relationship of inequality and power.

Care activities are undervalued, but require commitment, responsibility, time, energy, worry and money, in a relational act between caregiver and care receiver. In the care of children, it is women who undertake such activities, even when working outside the home, are overwhelmed with overwork and see their life chances limited.

Motherhood and care work are part of women's experiences, and are organized by various logics, simultaneously, in relation to their interests, needs and preferences. Autonomy is inscribed in their experience, as the facts of life are listed for the construction of a choice

REFERENCES

1. Tubert S. Mulheres sem sombra: maternidade e novas tecnologias reprodutivas. Rio de Janeiro: Rosa dos Tempos; 1996.
2. Giddens A. A transformação da intimidade: sexualidade, amor e erotismo nas sociedades modernas. São Paulo: Ed da Universidade Estadual Paulista; 1993.
3. Scavone L. Dar a vida e cuidar da vida: feminismo e ciências sociais. São Paulo: Editora UNESP; 2004. 205p.
4. Oliveira ZLC. A provisão da família: redefinição ou manutenção dos papeis? In: Araújo C, Scalon C, organizadoras. Gênero, família e trabalho no Brasil. Rio de Janeiro: FGV; 2007. p.123-147.
5. Silva TMG. "Eu pensava que filho era bom, mas filho não é bom não": articulações entre maternidade, gênero e pobreza (ou a história de Eni). In: XIII Encontro Nacional de História Oral, 2016. Anais. Porto Alegre: UFRS, 2016: 1-15.
6. Brecailo MK. Experiências de mulheres no cuidado e no aleitamento materno: Inter-relações e autonomia na maternagem. Curitiba: Universidade Federal do Paraná, 2017. Tese de doutorado em Sociologia.
7. Nogueira RP. A impotência da equidade. In: Costa AM, Merchán-Hamann E, Tajer D (orgs). Saúde, Equidade e Gênero. Brasília: Editora Universidade de Brasília; 2000.
8. Biroli F. Divisão sexual do trabalho e democracia. Rev de Ciências Sociais. 2016; 59(3): 719-754.
9. Del Priore M. Magia e Medicina na Colônia: o corpo feminino. In: _____. (org). História das mulheres no Brasil. São Paulo: Contexto; 2012.
10. Rago M. Os mistérios do corpo feminino, ou as muitas descobertas do "amor venéris". Proj. História. 2002; 25: 181-195.
11. Bordo SR. O corpo e a reprodução da feminidade: uma apropriação feminista de Foucault. In: Bordo SR,Jaggar AM. Gênero, Corpo, Conhecimento. Rio de Janeiro: Rosa dos Tempos; 1997. p. 19-41.
12. Héretier F. Masculino e Feminino – O pensamento da diferença. Lisboa: Instituto Piaget; 1996.
13. Rohden F. A arte de enganar a natureza: contracepção, aborto e infanticídio no início do século XX. Rio de Janeiro: Editora Fiocruz; 2003.

14. Tronto J. Mulheres e cuidados: o que as feministas podem aprender sobre a moralidade a partir disso? In: Bordo SR, Jaggar AM. Gênero, Corpo, Conhecimento. Rio de Janeiro: Rosa dos Tempos; 1997. p. 186-203.

15. Bonet O. Saber e sentir. Uma etnografia da aprendizagem da biomedicina. Physis:Rev de Saúde Coletiva. 1999; 9(1): 123-150.

16. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.

17. Santos BS. Semear outras soluções: os caminhos da biodiversidade e dos conhecimentos rivais. Rio de Janeiro: Civilização Brasileira; 2005.

18. Biroli F. Autonomia e desigualdades de gênero – contribuições do feminismo para a crítica democrática. Vinhedo: Editora Horizonte; 2013.

19. Good B. Semiotics and the study of medical reality. In: _____. Medicine, rationality and experience: an anthropological perspective. Cambridge: Cambridge University Press; 1994, p. 88-115.

20. Fine A. Leite envenenado, sangue perturbado. Saber médico e sabedoria popular sobre os humores femininos (séculos XIX e XX). In: Matos MIS, Soihet R. O corpo feminino em debate. São Paulo: Editora UNESP; 2003, p.57-78.

21. Costa AM, Aquino EL. Saúde da mulher na reforma sanitária brasileira. In: Costa AM, Merchán-Hamann E, Tajer D (orgs). Saúde, Equidade e Gênero. Brasília: Editora Universidade de Brasília; 2000.p. 181-202.

22. Elias N. O processo civilizador: formação do Estado e civilização. v.2. Rio de Janeiro: Jorge Zahar; 1993.

Contributors

Brecailo MK worked in Conception and design; analysis and interpretation ofdata; review and approval of the final version of the article. Vieira DG worked in thereview and approval of the final version of the article

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