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Review article

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Towards an Anthropology of Care: Breastfeeding as a Care Work

This paper discusses different aspects of anthropological research on breastfeeding, corporeality and ethics of care. The main focus is on the problem of relating care studies to the breastfeeding phenomenon and the conceptualisation of woman's body, sexuality and motherhood. The paper suggests the need for a critical approach to the problems of caregiver domination and care receiver vulnerability in the "chain-of-care", as well as the need for an anthropological contextualisation of relationships between care professionals' and women's experience.

Key words: breastfeeding, body, feminism, motherhood, care work, care studies.

Ка антропологији неге: случај дојења

Овај рад има за циљ да укаже на могућности повезивања антрополошких истраживања и *Care* студија (студија неге) у анализи феномена материнства. У сврху успостављања корелације између ових дисциплина, ауторка проблематизује праксе дојења и представе о женском телу у дискурсу хијерархије унутар „ланца неге".

Кључне речи: дојење, тело, феминизам, материнство, нега, студије неге.

Introduction

The perspectives and research I will present in this paper deal with breastfeeding, embodied experiences and corporeality which I will try to relate to the care studies. Breastfeeding itself has remained a relatively rare and understudied topic until recently in social and humanistic sciences, despite the great interest being shown in reproduction, motherhood and the female body. On the other hand, this phenomenon has become a key public health issue in many societies over the past few decades. In much of medical literature, reproduction is treated as a subject of "natural laws" rather than of human choices and cultural factors. Accordingly, Nature is also seen as a source of authority in the discourse of breastfeeding. Seen in this light, some anthropologists, like Vanessa Maher (Maher 1992, 31), assert that even the decline in breastfeeding is interpreted nowadays as an instance of women's

alienation from their "natural" biological roles.[1] We can see that breastfeeding is, like many sociocultural imperatives associated with gender roles, often considered as *natural*, despite the fact that - like pregnancy and childbirth - it is one of the events in women's life most profoundly influenced by social custom.

Even though the reproductive role of women and the biological functions of the female body are marked and recognised in most cultures, many contemporary authors dealing with these subjects advocate that we should consider breastfeeding as a cultural practice instead of seeing it as a natural behaviour. In any case, "breastfeeding is, like female sexuality and biological reproduction, the subject of considerable cultural elaboration in most societies" (Maher 1992, 9).

Breastfeeding as a performance of motherhood

As the anthropologist, Penny Van Esterik (Van Esterik 1995, 86) suggests, breastfeeding theoretically requires negotiating socially constructed dualisms that dominate Western thinking, such as nature/culture, mind/body, private/public, maternal/sexual and others. Generally speaking, breastfeeding is often considered not only as innate and *natural*, but also as an immanently somatic, in-the-body practice, which is taken-for-granted and consequently seen as a visual performance of mothering (Shaw 2004, 100-112). At the same time, in Western culture, breasts are viewed primarily as sexual objects - although ethnographic data gathered from different parts of the world show that the sexual breast is not universal historically nor cross-culturally. However, the maternal body is not commonly believed to be simultaneously sexual, as sexual and maternal aspects of womanhood are expected to be independent of one another. Thus, we can see that breastfeeding represents an embodied experience which provokes apparent contradictions concerning women's breasts (and bodies) and raises questions about their appropriate uses (Stearns 1999, 309). Van Esterik also pointed out that "Breastfeeding heightens awareness of body as self and body boundaries; but meanings assigned to bodies and boundaries are neither universally shared nor un-changing" (Van Esterik 2002, 263). In this context, breasts may be viewed as ambiguous, liminal body parts and a liminal zone between motherhood and sexuality.

There are many factors to consider in the conceptualisation of the phenomenon of breastfeeding and its organisation in everyday life. In most Western societies, breastfeeding is considered to be a private activity, while people often attach shame to all those activities which imply physical and emotional intimacy (like menstruation, sexuality, labor and delivery, personal/body hygiene and others). Additionally, the "management" of "private" embodied activities, therefore breastfeed-

[1] Attempts to authorize the idea of "human nature" and "autonomous naturalized realm of universals" that can be valued as independent of culture, may eventually lead to different forms of essentialism (Kleinman 1998, 373). However, in contemporary anthropological thought, *a human being* is most commonly seen as constructed within social and cultural practices, and through the complex interactions between personal experience and cultural patterns - between subjectivity and collective processes which exist in a given society.

ing practice, may be considered necessary in order to define the person in conformity with social and cultural requirements.

We should not forget that breastfeeding also represents a bodily technique[2] which was for a long time associated with "traditional knowledge" and was transmitted through generations from woman to woman. With technological progress, industrialisation and evolution of medical science, biological reproduction - as a matter of great social concern - has become highly medicalised. Being a part of it, breastfeeding shared the same destiny. Breastfeeding under the supervision of medicine enforced a separation between scientific and traditional "handed down" knowledge. Persistent interference of health professionals in the relationship between mother and infant tend to depersonalize them both, by placing them in to separate fields of research and practice (obstetric and paediatrics). Moreover, recommendations of health professionals on infant feeding have become a source of authority, and sometimes they even tend to influence the mother's private decisions about how to feed her child.[3] Simultaneously, "formula", or bottle-feeding marketing, has become entangled with the provision of health care to the extent that infant feeding itself has become the domain of the health-care system.[4]

Understanding of breastfeeding practices is also bound up with changing cultural understanding of children's needs and maternal responsibilities, but also with tendencies within various schools of feminist thought. Traditionally, breastfeeding, as well as any form of nurturant and caring attitudes, is considered to be the characteristic of woman/mother, and it is *she* who must assure safety, well-being and a loving environment for an infant. In this context, breastfeeding is perceived not only as a question of the child's survival but of its emotional development (Maher 1992, 22). At the same time, the question of breastfeeding is also bound up with the social and cultural organisation of space, time and relationships.

Breastfeeding as a care work

In most cultures women are obligated to find ways to integrate infant care and feeding into their daily activities. As Van Esterik points out, this problem is deeply affected by dominant gender ideologies and by the fact that the work is an activity which varies across different social contexts and throughout a woman's life. However, many studies from different perspectives indicate that women *do* syn-

[2] In a Maussian sense breastfeeding is a learned activity for both mother and child.

[3] In everyday life, new mothers have to cope with different requirements and medical advices on infant feeding. Some professionals insist on early weaning because "the mother's milk is not nutritional enough" and then impose a formula and a strict feeding schedule, while the others insist on exclusive breastfeeding without considering each woman's personal circumstances. However, it is interesting that women who opt for a long-term breastfeeding feel the same social pressure as mothers who choose bottle-feeding. (Srdic Srebro 2015, 47)

[4] Since the 1950's baby bottles figure as the iconographic representation for infant feeding (Hausman 2007, 480)

chronize their workloads with child care in many ways. Consequently, "breastfeeding and women's work cannot be examined independently of the economic and political context of maternity entitlements, health insurance, wages, and child-care arrangements" (Van Esterik 2002, 266).

Judith Butler (Butler 2009, 33) argues that the body is a social phenomenon, which exposed to others, is vulnerable by definition. Hence, its very persistence depends upon social conditions and institutions. Undoubtedly, all previously evoked issues lead to the conclusion that the maternal, breastfeeding body is a highly vulnerable category. As outlined earlier, many women, particularly new mothers, try to define and redefine their breasts, thus their bodies and breastfeeding itself. Experiences of their personal histories reflect upon this process. At the same time women's gender roles shape according to the particular sociocultural context. The question of breastfeeding is, as a result, entangled with many other factors such as economical aspects, reproductive policies, social care system, religion etc. (Srdic Srebro 2014, 45). In that sense, the sociologist Ronda Shaw (Shaw 2004, 102) argues that breastfeeding itself often represents an important part of a process through which maternal identity is constituted. The core research question that emerges from the above is how to think about the vulnerability of the breastfeeding body and breastfeeding women in the discourse of the Care studies?

During the last two decades, *care* has become an important issue of research in several disciplinary fields. Anthropology and sociology, as well as gender studies, tend to analyse the ways in which socio-cultural and politico-economic factors shape people's experiences of care practices, both within particular societies and on the global level. Drotbohm and Alber (Drotbohm et al. 2015) argue that multiple dimensions of care should be examined in the context of three concepts: work, kinship and the life-course. The reason for this lies in the fact that care has an impact both on one's position within the sphere of work and on one's sense of relatedness and belonging, but also in the fact that normative expectations of care practices change during the different phases of one's life. In this sense, breastfeeding represents a complex subject of anthropological care studies and should be analysed considering ethical implications of different cultural meanings, not only of breastfeeding but also of the notion of care.

The ethics of care directs our attention to the need for responsiveness to others (Gilligan 1982) so it is very important to hear women's voices which are largely missing in the study of breastfeeding. In public discourse the ideal mother is often represented with an image of the breastfeeding mother but this is not always in accordance with the mother's wishes or choices. Many women cannot breastfeed or choose not to do it.[5] For some, breastfeeding is a natural use of their bodies while others fear how their breastfeeding bodies could be interpreted. For many women, being an invisible breastfeeding mother is a goal (Stearns 1999, 313) and for others,

[5] "By participating in the medicalisation of their bodies and in the view of breast-feeding as desirable almost exclusively for nutritional reasons women lose touch with their own desire (or reluctance) to breast-feed their babies." (Maher 1992, 32).

breastfeeding is *just one of* the infant feeding methods and "a natural part of life". In any case, breastfeeding remains an activity which oscillate constantly between the notions of "private" and "public".

Besides, the ethics of care theory suggests that we are always interdependent beings. So, when we speak of *care*, we should always bear in mind the relationship of asymmetry of someone who is in need and someone who is helping him (Brugère 2011, Tronto 2013). According to psychologist and ethicist Carol Gilligan (Gilligan 1982), woman's - and therefore the mother's - experience of the self is inseparable from the context of caring and relationships. Additionally, Maher (Maher 1992b, 171) underlines that "what women do for the household is rarely called work, but rather 'looking after the children' 'keeping house', a natural extension of their conjugal and reproductive role". However, some feminist scholars tend to observe breastfeeding as a form of labor - *the work of mothering*, while the breastfeeding body is valued as a *laboring body* (Hausman 2007, 492, Shaw 2004, Stearns 1999). What I want to suggest in addition to this, is the following: breastfeeding can be viewed as a *care work* in which the woman's body simultaneously plays two roles: the role of caregiver and the role of care receiver. First of all, in the mother-child dyad, it is the mother who provides care while the child is in a situation of absolute dependency. This represents an example of *actual work of caring*, of a particular kind of maternal practice that affects "all maternal practices because it requires proximity, flexibility with regard to time, intersubjective give-and-take, and a loss of personal boundaries" (Hausman 2007, 492). The woman-mother must constantly negotiate and *manage* the act of breastfeeding, and thus her care work, in every sector of society – in the public as well as in the private (Stearns 1999, 332). In this light, Muers asserts that "the body of the breast-feeding mother is neither complete nor total; it is, in fact, because of the non-negotiable demands being placed on it throughout the day every day, particularly vulnerable to threats or disturbances within the mother's environment" (Muers 2010, 21).

Subsequently, during the breastfeeding period, the vulnerability of the woman is considerably emphasized and she gets into a position of a care receiver as well. As I mentioned earlier, the breastfeeding body and the breastfeeding woman require a special form of care. First of all, a woman who decides to breastfeed is obliged to learn how to do it. As a result, she finds herself in the position of dependence on health or care professionals (doctors, midwives, nurses, lactation consultants and others) or the other women who are supposed to initiate her in breastfeeding techniques. In the last decade the cultural imperative to breastfeed has become so strong that it admits no alternative; though, the mothers are faced with a double social message: the widespread injunction to breastfeed on the one hand, and the opposite advice or orders from the health professionals on the other (Balsamo et al. 1992, 63).[6] Shaw (Shaw 2004, 101) points out that "it is very easy to perform breastfeeding 'wrong' or 'incorrectly' and to be reprimanded for doing so, which is why women think long and hard about the pros and cons of breastfeeding; not only

[6] We should have in mind that people frequently rely on the medical authorities' advices.

for their infants, but also for themselves". Hence, decisions not to breastfeed may be considered as a "symptom of unconscious resistance to medical invasion" of the body and of the self (Maher 1992, 32).

It is often said that to discuss *care* is to raise a question about *power* (Brugère 2011, Tronto 2013), so I propose that in the discourse of breastfeeding we examine the question of the "chain-of-care"[7] and the problem of caregiver domination and responsibility. Balsamo (Balsamo et al. 1992, 68) suggests that the control of infant feeding, and therefore breastfeeding, is often right from the start entrusted to the impersonal eye of the medical staff and separated from the main actors in the breastfeeding process – the mother and the child. By taking up the place of the mothers in making decisions on feeding, the specialists in the newborn are becoming the centre of power inside the chain of care. This may lead the mothers to feel like being treated as machines or incapable of achieving the socially constructed ideal of the *good mother*.[8]

Concluding remarks

In light of preceding remarks, I would like to emphasize the necessity of studying the relationship between care givers and care receivers: between medical/care professionals, and women/mothers (and their babies). In his context, the role of women's families and their social environment should not be overlooked. Raising these issues could make a significant contribution in redefining and eventual reducing of hierarchy related to the chain of care. Additionally, the specific position of professional care providers could likewise be interpreted as vulnerability. In everyday practice, there is often no time to do what professional caregivers have been trained to do to provide quality care: to solicit the person who is the care receiver, and to engage the emotional, family, work, cultural, religious, and other issues that together constitute one person's life. All the problems considered imply that the ethics of care should be related to the breastfeeding issues and the conceptualisation of women's body, and that the status and objectives of medical/professional care should be perpetually questioned and rethought. This also en-

[7] The term "chain of care" refers to all care providers, all care receivers and their interpersonal relationships.

[8] Balsamo (Balsamo 1992, 68-69) well illustrates this problem through the example of the hospital postnatal care of the mother and newborn: "And since the baby does not always grow at the same rate and his needs vary as time passes, the doctor often decides that the mother's milk is not enough for him. In hospital the result is that vicious supplementary feeding circle that even specialist in the newborn are familiar with. Often, when little or no help is given by the staff, the baby is not properly attached to the breast or, in the brief space of time for which he is left to the mother, he doesn't suck 'enough' (according to the standard grow trends). Then he may be given a supplementary bottle-feeding and minimise breast-feeding. […] In the meantime the mother's breast may become engorged by the milk she is unable to give her child. The staff do not give any real help beyond resorting to the breast pump which many women dislike, considering it as a further insult to their bodies, which are being treated as machines, as imperfect machines at that, since they are unable to adept to the industrial rhythms of the hospital".

tails rethinking the women's presence in public and private sphere, and the dominant discourses of motherhood as well.[9] As a result, anthropological research on breastfeeding and ethics of care might be used to develop eventual strategies for improving the *independence* for women as mothers – not only in sense of working conditions or public performance, but in the sense that women could be allowed to make their own choices about breastfeeding and decide what to do with their own bodies.

I have presented only a few possible aspects of research on breastfeeding, corporeality and ethics of care. Furthermore, I would like to underline that these questions deserve, not only attention of care studies and feminist theory, but also the attention of various academic disciplines. It seems to me that the future research on this subject from different perspectives could also help us in establishing its broad relevance to anthropological studies.

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[9] Van Esterik proposes that we observe breastfeeding as a "single-issue social movement" which has broad implications for understanding issues of women's reproductive rights (Van Esterik 2002, 272).

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