

WOMEN'S SOCIAL SPACE AND THE REFERENCE FOR BREASTFEEDING PRACTICE

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This study aimed to identify agents or institutions taken as reference by women when breastfeeding. A qualitative study was carried out on 20 primiparous who were assisted, for reasons not related to breastfeeding, in the five health services selected by this study. Data were collected by semi-structured interviews carried out in the participants' households and were analyzed by content analysis in the thematic mode. We identified that health professionals play a standardize role of breastfeeding based on scientific knowledge. In the daily breastfeeding routine, the family is the first reference for women, transmitting beliefs, habits and behaviors. We believe in the valorization of the family context by the health professional, in which actions and interactions in the breastfeeding issue are developed in order to constitute the foundations for a new care model in breastfeeding. This model should, therefore, consider the practice diversity, adapting actions to the multiple roles of being mother/fortress/wife/worker in the social context.

DESCRIPTORS: breast feeding; women's health; maternal-child nursing

EL ESPACIO SOCIAL DE MUJERES Y SU REFERENCIA PARA EL CUIDADO EN LA PRÁCTICA DE LA LACTANCIA

Este estudio tuvo como objetivo identificar los agentes o instituciones consideradas como referencia por las madres lactantes en la práctica de amamantación. Investigación cualitativa con 20 puérperas quienes buscaron por razones ajenas a la lactancia una de las 5 unidades básicas de salud seleccionadas en este estudio. Los datos fueron recolectados a través de entrevistas semi-estructuradas realizadas en su domicilio; su análisis se apoyó en el análisis de contenido, modalidad temática. Fue identificado que el profesional de salud asume un rol normativo en este proceso, apoyándose en conocimientos científicos. Dentro del proceso de amamantar, la familia ocupa el primer lugar de referencia para las mujeres, transmitiendo creencias, hábitos y conductas. Se cree que la valorización del contexto familiar por el profesional de salud, al desarrollar acciones e interacciones durante la lactancia, se constituyen en bases para un nuevo modelo de atención en lactancia, que considere las diversidades de esta práctica, adecuándolas a la pluralidad de ser madre/lactante/esposa/trabajadora dentro de su contexto social.

DESCRIPTORES: lactancia materna; salud de la mujer; enfermería materno-infantil

O ESPAÇO SOCIAL DAS MULHERES E A REFERÊNCIA PARA O CUIDADO NA PRÁTICA DA AMAMENTAÇÃO

Este estudo teve como objetivo identificar os agentes ou instituições tomadas por referência pelas nutrizes, na prática da amamentação. Realizou-se pesquisa qualitativa, cujos sujeitos foram 20 puérperas que procuraram, por razões alheias à amamentação, as 5 Unidades Básicas de Saúde, selecionadas neste estudo. Os dados foram coletados por entrevista do tipo semi-estruturada realizada no domicílio e a análise foi baseada na técnica de análise de conteúdo-modalidade temática. Identificou-se que o profissional de saúde assume papel normatizador da amamentação, respaldando-se em conhecimentos científicos. No cotidiano da amamentação, a família ocupa o primeiro lugar de referência para as mulheres, transmitindo crenças, hábitos e condutas. Acredita-se na valorização do contexto familiar pelo profissional de saúde, desenvolvendo ações e interação nas questões da amamentação, constituindo-se as bases de um novo modelo de assistência em amamentação, que considere as diversidades dessa prática, adequando as ações à pluralidade de ser mãe/nutriz/esposa/trabalhadora no contexto social.

DESCRIPTORES: aleitamento materno; saúde da mulher; enfermagem materno-infantil

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INTRODUCTION

Despite the advancements accomplished in women's adherence to breastfeeding in recent years, early weaning is still a concern, and occupies space in the public agenda related to breastfeeding policies⁽¹⁾.

Actions to stimulate, protect and support breastfeeding are sustained by the acknowledgement of breastfeeding as an important factor in the maintenance and development of a country's economic structures of a country and by its influence on children's survival. Early weaning puts the child's life at risk, increasing infant morbidity and mortality rates. One of the causes appointed for early weaning is the mother's lack of knowledge about the quality of her milk, both to feed and to conduct the adequate development of her child. Women's knowledge is an important factor in the process of changing behaviors. However, knowledge per se does not assure the attitude change. Information and inadequate practices by health professionals also have a negative influence in the establishment and maintenance of breastfeeding. These include the lack of ability to support mothers who breastfeed and the inadequate clinical handling of breastfeeding. Another obstacle is related to the healthcare practices that are based on norms and routines that delay the first nursing, separating mother and child, establishing times for breastfeeding and frequently indicating non-human milk, bottle nipples and pacifiers unnecessarily⁽²⁾.

Biological reductionism is present in the women's breastfeeding routine, while other dimensions of this practice, such as the psychological, social and cultural dimensions are left aside. The breastfeeding practice overwhelms women when it is reduced to biological reductionism, because they expect it to be an easy process, natural, instinctive process while, in fact, they experience a complicated process that demands learning, which in turn makes them feel inappropriate for their breastfeeding function⁽³⁾.

The period in which the binomial stays in the puerperal units is not always sufficient for women to get the necessary orientation in order to feel apt and confident to handle breastfeeding at home. According to scientific literature, problems in the lactation period tend to appear in the first weeks after birth, when women are outside the healthcare environment, at their homes. Many times, they do not have the necessary social support to minimize or solve their

problems, which tends to complicate the interferences and constitutes an early weaning factor.

The missing or insufficient support the family context, health professionals and the community provide to those breastfeeding has affected women's confidence in their ability to fully breastfeed⁽²⁾. The condition of breastfeeding women is far from being affected by policies in favor of breastfeeding. The actions undertaken are centered in biologically focused technical abilities and are fragmented, as opposed to what is expected from a new health paradigm that contemplates the integrality of the subject⁽⁴⁾. In a professional health care perspective, it can be identified that, although these professionals recognize the social and emotional elements in the breastfeeding process, in practice, they do not seem to master them yet.

We can consider breastfeeding a sociocultural process with a history. Thus, the linear explanation of the facts and causes determining breastfeeding is not suitable as an interpretation. It is under the range of this new perspective that we attempted to understand the experiences of women in the breastfeeding process.

In the context of our health services, emergency care is the predominant care model of assistance and actions result from biological complaints. This makes it impossible to apprehend what lies beyond the presented signs and symptoms.

If, on the one hand, health professionals look at the body as a mere depository of biological processes that indicate health and illness, on the other, there are the women who tend to interpret body sensations according to codes that are specific of their environment and not always in agreement with those of health professionals.

In this particular aspect, we have observed in our practice, in a not systemized way, that women facing breastfeeding problems tend to take too long to seek professional help, primarily turning to their relational environment. Therefore, we inquire about the role of health professionals as a reference element for help in breastfeeding questions?

In this study, we attempted to understand the breastfeeding experience in a group of female health service users in Ribeirão Preto, SP, Brazil, aiming to identify the acting properties of agents and institutions in the construction of meanings of breastfeeding for the women. This objective is part of a larger research about the difficulties women face in breastfeeding⁽⁵⁾.

We believe that understanding these questions will allow us to visualize more effective strategies for care delivery to women, as we get to know the representation they attribute to their breastfeeding experiences. This will allow us demystify the technical discourse in order to adequate it to the presented reality.

OBJECTIVE

Identify the agents or institutions taken as references by breastfeeding women in care regarding breastfeeding difficulties.

METHODOLOGY

The understanding and analysis of the references for care which breastfeeding women consider in case of breastfeeding difficulties were based on the qualitative approach, which focuses on the meanings and intentionality of actions in the contexts of social structures⁽⁶⁾.

The field work was developed at five Basic Health Units of the Ribeirão Preto Health Secretary. From the 35 basic units that existed at the time of data collection, for this research, we selected the five units that, according to the results of epidemiological research about feeding in the first year of life in Ribeirão Preto in 1999 and 2003, obtained the highest and lowest scores on the Exclusive Breastfeeding indicator (EB)⁽⁷⁾.

The empirical extract of the study consisted of 20 puerperal women who attended the basic health units and were selected for this research due to other reasons besides breastfeeding, independently of whether they were breastfeeding. These women were included based on the following criteria: first-time mothers, aiming at greater homogenization among the study subjects; less than one month after birth, since most breastfeeding problems occur in this period. None of the women had premature babies, with malformation or any other intercurrent interfering with breastfeeding.

The research subjects were contacted at the basic health units, where interview dates and places were scheduled. All interviews were held at the women's homes and took an average of 1h30min. We used a semi-structured interview, which included

contents related to identification data, reproductive process, particularly about breastfeeding as a description of experiences; procedures; habits and routines; knowledge; perceptions and values regarding difficulties and information about the family unit/relational context. All interviews were recorded after the interviewees' informed consent.

The *corpus* of the analysis was composed by data from the interviews and observations described in the field diaries. Thematic content analysis⁽⁸⁾ was used for data treatment, which consists of "(...) discovering the 'nuclei of meaning' that compose communication and whose presence, or frequency of appearance may mean something for the chosen analytical objective"⁽⁶⁾. In this analytical process, the "nucleus of meaning" is seen as a unit of meaning in a communication⁽⁶⁾. In this study, the nuclei of meaning were understood as ideas-axes surrounded by other ideas. According to the thematic analysis, one can also move towards the "discovery of what lies behind the manifested contents, moving beyond the appearances of what is communicated"⁽⁹⁾.

The analysis involved the following steps: (a) initial reading to have a global understanding of the material; (b) identification of the units of meaning that emerged from the interviewees' reports; (c) discovery of nuclei of meaning surrounded by the thematic categories and d) interpretation and discussion.

In this sense, the research attempted to work with two thematic categories: "the situations of difficulty in breastfeeding" and "the agents acting in care". The discussions of the inferred thematic categories are based on the conceptions of body and motherhood.

In our society, motherhood is socially valued and established as the woman's responsibility/duty to take care of the child, which is partially based on her ability to get pregnant, deliver and breastfeed, and on social constructions of women being more kind, affective and skillful to care for their offspring. The social appropriateness of the female body to exercise motherhood and specifically breastfeeding is strategically important to be analyzed as a category in itself. The representations of body and health are directly linked to the different forms of perceiving, representing and acting on the social world individuals share with their social group⁽¹⁰⁾.

The research was approved by the Ethics Committee at. To assure the anonymity of the research subjects, in the interview fragments, fictitious names will be used.

RESULTS AND DISCUSSION

Ribeirão Preto has a unique structure for care in breastfeeding questions. Since 1988, the Municipal Health Secretary, through the Breastfeeding Program, invests in training people for breastfeeding care, jointly with the Breastfeeding Nucleus at the University of São Paulo at Ribeirão Preto College of Nursing - NALMA-EERP/USP. Besides these basic health services, the city offers the Human Milk Bank at the the University of São Paulo at Ribeirão Preto Medical School *Hospital das Clínicas*, which is a referral institution in the state in terms of Human Milk Banks in the interior of São Paulo. Currently, the city has three Child-Friendly Hospitals.

The study group was composed of 20 puerperal women of low income who lived in peripheral neighborhoods. Thirteen of them were adolescents between 15 and 19 years old, and seven were between 20 and 26 years old. Only six women in the study had finished high school; ten had abandoned school, six of whom primary and four secondary education. During the research, four women were taking secondary education and were on maternity leave from the school. Five women were married, eight lived in consensual union and seven were single. Regarding their occupation, only two had a formal job, while all the others were unemployed with future plans for insertion in the job market, depending on their maternal obligations and on the support they would receive from their families.

In the set of reports, we identified two articulated thematic nuclei: "the situations of difficulty in breastfeeding" and "the agents acting in care", which characterize the breastfeeding practice of a group of women in different social spaces (institutional and family).

The woman begins her breastfeeding experience based on the technical and normative limits of actions to stimulate breastfeeding. The health professional, who is an authority in scientific knowledge, assumes the role of standardizer and regulator of the breastfeeding practice, based on a body of knowledge centered on the nutritional, immunological, emotional and physiological benefits to the child's health.

I breastfed him at the delivery room, the nurse held him, put him on my breast (Selma, 19y., 1st SC, single).

For the Child-Friendly Hospital (CFH) program, breastfeeding in the first half hour of life is

a recommended procedure, and has been implemented at maternity hospitals since the 1990s. However, we have not observed homogeneity in the adoption of these procedures among health professionals. The CFH action program has produced advancements in the elimination of barriers to breastfeeding practices, questioning established practices at the institutions and proposing a reorganization of the physical structure and care philosophy delivered at hospitals and maternities. This requires adjustments that go beyond the technical-instrumental care, involving the deconstruction of a practice based on crystallized conceptions, allowing the health team to have a critical and open view on the understanding of new approaches in breastfeeding practice.

Regarding the field of professional action, health professionals are conditioned by and conditions their role in the encouragement of breastfeeding as educators and promoters of this practice, which is characterized by the disciplinary action of breastfeeding⁽⁴⁾.

Using scientific rationality, health professionals, as agents, assume a strategic position in the social space of the health institution. The active aspect of their scientific discourse about breastfeeding can be identified in the meaning the women of this study attributed to breastfeeding: "giving the best to the baby", based on the social experience, taking the medical discourse and reinterpreting it, as we inferred in the report below.

Mother's milk is the best food for the child to develop, it has everything, water, vitamin, sugar, it is the normal temperature for the child and the milk does not need to be heated or a bottle does not have to be prepared. Mother's milk has all that. It prevents several diseases, an allergy, we also prevent cancer that affect the breast, and other things, so mother's milk is very important for growth as well as for good feeding (Lucila, 20y., 2nd SC, consensual union).

It is in the health institution's space that the breastfeeding pattern is established for mothers and children, in a game of permissions and restrictions.

The pediatrician said that there is no need to wake him up...that sleep sustains (...) when he wakes up... he will catch up(...) At the hospital, they said that the right thing is to breastfeed the baby every hour (Tais, 16y., 1st IC, consensual union).

The acting proprieties of health professionals are present to the extent that they are considered as a construction principle of the social space⁽¹¹⁾ - breastfeeding in the context of the health institution.

Such properties are a set of relationships among objective forces imposed to anyone who enters this field, and do not succumb to the intentions of individual agents, nor even to direct interactions between agents⁽¹¹⁾.

We have learned that, sometimes, health professionals transmit contradictory information, making women insecure and concerned about their breastfeeding practice. In the hospital's institutional context, where breastfeeding is a norm that all hospitalized women have to comply with, the fact that "the baby does not want to get the breast" acquires the dimension of a problem.

The nurse helped me, she said that he had to get the breast like this, the areolas ...He has to get the whole areola...I did it, I just don't know if I did it right, he couldn't get it(...). She said that I had to keep trying, force him to get it (Sonia, 26y., 1st CS, consensual union).

The health professionals assume the posture of supervisors of breastfeeding practice, giving orientation, technical care and using scientific rationalizations to justify the situation-problem. However, these rationalizations are not always based on practice, because they involve psychosocial dimensions, which the clinical management of breastfeeding does not contemplate. Another aspect to be considered is health professionals' lack of training to deal with the presented diversity presented, because health practices involve a set of procedures, standards and routines, leaving little room for expressing differences. In the interactive process between professionals and women, educative actions attempt to transmit information based on the biomedical model, restricted to the development of cognitive abilities.

The current breastfeeding policy, through the CFH, established that breastfeeding is a practice that tends to be obligatory and should be adopted as a norm in hospitals. Recommended actions include the indication of hospital discharge only when this practice is effective according to the health professional. In our study, adherence to these norms was revealed by Suzana.

At the hospital, they told me to be patient, that she is pretty young (...) a nurse always passes by and asked if she hadn't taken the breast yet (...) she taught me (...), said that later I would like to breastfeed, imagine! But it is true, now I do (...). If she didn't breastfeed, I would not be able to leave...I was afraid she would stay there (...). The baby does not have a specific time to breastfeed, if he is sleeping too much I have to offer (Suzana, 15y., 2nd IS, single).

At the health institution, professionals' power is shown in their actions with the breastfeeding women. However, this power is temporary, limited to the hospitalization period, which is short to guarantee the women's adherence to established breastfeeding standards. These aspects make us rethink care practice, in which health professionals, who possess the technique and scientific knowledge, act without considering the contextual elements of the breastfeeding women's experience.

It is important to consider that, for the women, the breastfeeding practice will only be consolidated in another field, outside the health institution, where other powers operate. The different species of *power* or *capital* depend on the position the agent occupies in the different fields. The *capital species* include the economic, cultural, social, symbolic, generally called prestige, reputation and/or fame⁽¹¹⁾.

In the social field of these women's daily breastfeeding experiences, the position of health professionals/institutions is hierarchically secondary in decisions and actions in the context of breastfeeding difficulties.

Beyond what is considered appropriate in terms of service structure for care in breastfeeding questions, the women in this study seem to orient themselves, at first, by other values present in the family context. Another aspect to be considered is that the search for care from health services is related with what they perceive as pathological, going back to a necessary allusion to the origins of clinical practice, which starts to concentrate on the study of the body as the space of disease, becoming a text that allows for different readings of the signs and symptoms manifested in it.

When breastfeeding, women experience body sensations in lactation problems. This makes their view different from the clinical interpretation of health professionals. In clinical practice, breast trauma and the engorgement are considered lactation problems that require preventive and treatment measures. According to health professionals, the body is a depositary of biological processes that indicate health or disease. The body sensations individuals experience (symptoms) and the objective manifestations that are part of the visible aspect of the disease (signs) constitute elements of the representation system that supports the construction of a diagnosis and the inference of a prognosis for the presented situation.

However, the interpretation is not done on the basis of physiological sensations only, but also on the social construction. This means that the perception of feelings as alteration or normality, is part of a structure of socially shared meanings.

The interpretation of the body manifestations according to culture, particularly those occurring in the mother's body, is related to the mother's abnegation towards the child⁽¹²⁾.

It started to hurt, I was a little concerned...then you get used, you know! (Tais, 16y., 1st GI, consensual union).

The cultural construction that women are resilient to pain can complicate the technical conception and instruments of medical semiology, because it delays the early detection of breast traumas, aggravating them. Both the perception of pain and the search for medical resources to alleviate it are directed related to the representation of the body⁽¹³⁾, which makes it possible to understand why women in our study tended not to seek early care given the signs of breast interurrences as, for them, it is a natural and characteristic part of the mother's condition to bear everything in favor of the child's well being. Likewise, women bear the intensity of pain because of her own and natural condition of being a woman⁽¹⁴⁾.

Divergent interpretations between health professionals and women about what is normal are evidenced in the manifestation of the body itself, of engorgement, "hard breasts". In clinical semiology, preventive and treatment actions for the engorgement are based on the control of milk production, which seems to disagree with the cultural elements presented by the women in our study. For them, good milk production is a condition of a healthy and functional body, disarticulating the notion of full breasts as a sign of unbalanced and abnormal milk production, according to the report below.

It is getting hard because of the milk; I am having a lot of milk, thanks God... (Marisa, 20y., 2nd SC, consensual union).

It allows us to understand why preventive and curative measures of removing accumulated milk health professionals prescribe generally are not met with the expected adherence among women.

For the women in the study, the family context carries a significant power of constructing reality. This reality tends to establish an order or an immediate sense of the social world, and these women construct, through family bonds, the meaning of the breastfeeding observations and experiences, a practice that little by little adapts itself to the routine.

It is in daily life that individuals acquire all the *essential abilities*... for their maturity development, as they assimilate how to *handle things* (learn how to breastfeed) and establish a *mediation between customs, norms and the ethics of other larger integrations*. These mediations include the family and relational group and health professionals, expanding to other social environments in general⁽¹⁵⁾.

It is in the social space of the family that women seek welcoming and help to organize the household and maternal tasks, help which traditionally comes from their own gender: mothers, mothers-in-law, sisters, sisters-in-law and friends, as we can observe in the report below:

The baby starts to cry, you don't know what to do...my mother-in-law takes care and gives orientation...she's experienced (...) she passed confidence, I started to value my mother-in-law ...I realized how much I miss her (Maria, 19y., 2nd IS, married).

The acknowledgement of the social value of women's care practice is based on the prestige of the experience interiorized and experienced in her own body⁽¹⁶⁾. However, this condition is not available to all women in the group, as we identified in the case of *Josiana*. The absence of the family affects her more deeply than not actually having anyone to share tasks with, because she lacks a safe base to anchor on in her role as a mother, wife and housewife, a fact that she expresses through resentment of not having someone of her family to talk with.

Through the reports, we identify that milk production was an aspect women highly valued in their family context and was sometimes seen as a problem.

My sister said that the milk is not enough for him.(...) he was crying too much, crying of hunger(...) it doesn't leak(...) she said to consult M. at the basic care unit(...) My mother, my mother-in-law said: give him tea!(...) I didn't want to give him tea (...) I was afraid he would get the bottle and not get the breast(...), when I finished giving him the tea, he burped and slept. For me it was good because I was tired (Janete, 18y., 2nd SC, single).

Despite being informed about recommended breastfeeding procedures and counter-indications, the women in general act according to the experienced situation, adopting practices of their cultural group. In that sense, tea is culturally accepted as a remedy to alleviate common discomfort in the first months of life, such as abdominal colic. Used as a strategy to calm the child, it gains space in the reality the women face and, as this measure shows satisfactory results, it is established as practice.

Among the practices and popular knowledge that make it possible to keep up milk production, the women in this study recognize that good eating habits and a peaceful state of mind are essential.

My neighbor says that I have to eat well to give milk to the baby...I don't feel like eating (...) my milk might dry (...) I'm not eating right, no (...) if my milk dries it is bad for him (Josiana, 18y., Inc primary school, consensual union).

It is culturally believed that the ingestion of certain foods increases milk production. However, a study performed in Pará shows that the condition of the mother's eating habits and tiredness as a result of some activities she performs are determining factors in the decision of whether to adopt mother's milk for their children in the first year of life⁽¹⁷⁾.

In the family environment, women get involved in a game of constant attacks, charges and evaluations of their behavior and attitudes regarding their breastfeeding performance.

My mom says that I have to be patient and do things right, that it would not hurt. Then I started to sunbathe, to massage the nipple (...) (Selma, 19y., 2nd CS, single).

In this game of relationships, "capital species" are important in the construction of the elements that constitute the breastfeeding practice, depending on the extent to which people are meaningful to these women in the social sphere, which is "a multidimensional space of positions"⁽¹¹⁾.

Historically, women have been in the spotlight in the reproductive cycle and the prestige they are attributed results from experiences accumulated through other maternal experiences. Through actions, interactions and interpretations, the agents express their solidarity to women, at the same time as they retransmit and reaffirm the existence of ethical and moral precepts related to "being a good mother"⁽¹²⁾. The hierarchical relations are confronted depending on each agent's position in the social sphere, in the family context. These relationships can generate dependency and responsibility among those involved, like in Selma's, where the grandmother's authority seeks to be imposed because of her experience.

He (baby) likes my mother's lap more than mine (...). When my mom is at home, she wants to stay with him (...), I stay close to learn how she does it, everything...(Selma, 19y., 2nd CS, single).

The grandmother's prestige results from the ability to deal with small situations inherent to maternal care, which, for these women, constitute highly intense moments, due to their feeling of inability to execute them.

The domestic and maternal aspects are socially strange to men/partners; however, as agents, they are "entrenched in a position", evidencing their "acting proprieties"⁽¹¹⁾.

He (child's father) gets nervous because he thinks that I don't want to breastfeed (...), he thinks that I'm afraid of my breast getting flabby ...I stay quiet, get a little sad also because he says this, I did not feel like breastfeeding (...)(Rosimeire, 18yo., 1st IS, single).

The male participation presents itself in a peculiar way. Their actions implicitly contain the role that integrates the reference of the gender system, moral authority and family provider.

He (husband) worries about how she (baby) is, if she is breastfeeding, if complementation is needed (...). He asked if she wasn't getting hungry...I hadn't even paid attention yet (...) he gets worried because I said the nipple was sore, he saw it (...) he gets worried about the baby, but about me too (Aline, 22y., 2nd CS, married).

Some partners of the women in our study exercise a more flexible and affective style. They propose to socialize the tasks of care and looking after the child. This is an important starting point to revise or update the fatherhood model.

When he (partner) is at home...because he works a lot...he tries to take care of the baby for me, he tries to pay attention at the time of the burp, when I breastfeed at night, because sometimes I get very tired (Tais, 16y., 1st IS, consensual union).

It was in the family context that the women under analysis primarily sought help to recognize what they considered as a problem, in view of the presented breast problems.

I mentioned it to my sister-in-law, she said that she was having a lot of milk, but that it wasn't engorged. I went to make the newborn screening test, the lady talked to me and said the milk was engorging, that if I didn't remove it, it would engorge, get painful (...) that I could donate (...)(Silvia, 23y., 2nd CS, married).

In this regard, the family is the primary source of health care in any society and, traditionally, it are women who deliver care⁽¹⁸⁾. In the identification of care practice with women, since the remotest times of human history in western society, the role of "the woman who helps" is established by cultural heritage⁽¹⁶⁾.

The family's knowledge of care in "engorged breast" and "sore nipple" situations, just like for the health-disease process, is the result of an experienced practice, in which home remedies, orientation and/or

neighbors' counseling, diagnosis and medications of academic medical professionals are associated⁽¹⁹⁾. We add that the fact of using improper procedures aggravates the woman's clinical condition.

They told me (friend of the sister who had a baby a little while before) to put the breast pump to remove some milk in order to stop hurting (...) The doctors said that it is not good, that it makes the breast sore (...) but the pain was so bad that I used it, I wouldn't bear it until the following day (...) I took some milk out but the pain didn't go away because I couldn't remove enough. Then it continued engorged, till the next day (Janete, 18y., 2nd S, single).

In the private domain, although the women in our study seemed to be informed about the counter-indications of certain care practices, in the concrete breastfeeding experience, their actions are guided more by emotions and urgency than by rationality. In that sense, we can say that the awareness of facing a problem and feeling bad originates in a "*conscience in situation*", related to projects and specific existential contexts.

Their interpretation of "sore nipple" and "engorged breast" and the care these require have a temporal dimension, due to the concrete experience lived and the confrontation with diverse references constructed in the relational environment, being, thus, recurrent and in process. This can be inferred from the women's reports when they attribute reasons like "sore nipple" and "engorged breast" and relief measures.

It was painful because the breast was sore (...). When I went to work in the morning, it was pretty cold, got that wind, then it got hurt like this...dry (...). I thought about applying some cocoa butter, it would be good to alleviate the dryness (...) they told me the skin would get smooth...and the baby would not be able to get the nipple, that I had to apply milk (...) I applied milk and the dryness was gone (...) my mother-in-law says that, if the child burps, wind gets in and then the breast gets hard and if you don't put the baby to breastfeed, it gets harder and even forms hardened glands that explode towards the outside (Maria, 19y., 2nd IS, married).

The women associated cold weather with "dryness" and "soreness", and the child's burp at the breast as the cause of internal unbalance in the organism. In their reinterpretation of the medical discourse about diseases, popular classes in general use categories that "*correspond to the most universal properties of things*", using the spatial notion to describe the movement of the disease, its path in the agent's body⁽¹⁰⁾.

The experiences, choices and initiatives refer to the way people and social groups assume the situation or are situated in it. We identified that the family context fundamentally contributes to the configuration of meanings and the development of routine ways of dealing with the situations presented in breastfeeding practice, establishing and consolidating a specific breastfeeding pattern for each of the women in this study.

FINAL CONSIDERATIONS

Through the results of this study, it is reaffirmed that the order of cultural meanings that orient the women, in terms of breastfeeding reference, orientation, care and support, are sustained by affective bonds and relations of proximity. The family relational environment occupies the first place in the women's reference, and the family transmits beliefs, habits, attitudes and conducts.

Among relatives, the women in the family exert a decisive influence in the counseling, support and care of mothers and newborns. Our findings confirm female dominance in the reproductive sphere. However, despite the gender inequalities that can still be identified in modern society, changes are occurring and can be inferred in the family arrangements which some women in this study are inserted in. Moreover, women seem to start and acknowledge men's participation in a sphere that traditionally puts them as deviant.

In breastfeeding practice, the family nucleus exerts social functions, supported by relations of intimacy, affect and solidarity. In family dynamics, reserves are mobilized that allow women to articulate or disarticulate before daily breastfeeding experiences. These reserves go beyond the physical and include family members' mental and sociocultural resources.

In this study, we identified that the care delivered in the family context, in view of breastfeeding difficulties the women presented, includes actions guided by emotion and urgency to the detriment of rationality, showing that failures in health professionals' actions are not justified by the technical inability to handle breastfeeding, but because they do not consider the plurality that involves breastfeeding and these women's life context.

In that sense, as health professionals, we must consider that breastfeeding care cannot only be

based on the mother-child binomial, and that it should integrate other health care participants, such as the family. Getting to know the family's reality requires seeking information about the life history, the support and resources used, as well as the family's needs and potentialities to share responsibilities⁽²⁰⁾.

Considering the family as an essential part of breastfeeding care constitutes a concrete strategy for the construction of a new breastfeeding care conception, including actions in teaching, research and care, references where actions are structured and health professionals are structured as care agents. It means making the knowledge available to train these agents in order to think and act with the family,

constructing health practices on other bases, without the normative, vertical and authoritarian bias of their actions, so that they understand breastfeeding not only as a biological, but also as a socio-psycho-cultural process.

We believe that the valuation of the family context by health professionals and the development of their actions through the interaction process with the family in breastfeeding questions, can constitute the bases for a new breastfeeding care model, which considers the diversity operating in this practice and which adapts the actions to the plurality of being a mother, giving breastfeeding, being a wife and worker in the social context.

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