Introduction

An anthropologist incurs a number of debts during his journeys: he owes something to whoever supported him financially, to the thoughts of other anthropologists and to the many people who helped him both practically and with friendship in the countries he has visited[1]

This book is the result of anthropological research that began in April 1989 and continued through to August 1992. It was part of the paediatric project which CUAMM, Doctors with Africa, was implementing in the government hospital of Dodoma and in the whole of the District.[2] This health intervention was centred on the problem of malnutrition and was led by Italian paediatricians, assisted by local health personnel, both in the hospital and in the territory.

In the area of Dodoma, the nutritional status of children under five years of age did not differ from the average national statistics. Around 50–60 percent of children suffered from moderate malnutrition, while 6–7 percent were severely malnourished, some peaks reaching 8–9 percent (MCH Report 1989/90). The health staff had found that, in general, a child that had been breast fed grew well for the first six months of life. The first slowing down of the growth curve occurred around this period, with a gradual worsening of the child's physical conditions accompanied by various pathologies, until reaching marasma and *kwashiorkor*.

The paediatricians' experience in the field, even more than simple data, indicated the existence of complex problems, many of which lay outside medical competence. From the indigestible integrated food to the precarious hygiene conditions, from the frequency, intensity and duration of breast feeding to the rules governing weaning processes, from the qualities attributed to breast milk to breast feeding from one breast only, from the changing availability of the mother to her conception of her newborn's growth rate – all of these factors indicated the presence and action of dynamics which interacted *in some way* with both the baby's process of growth and medical intervention. The health workers were in fact, beginning to be aware of a 'shadow zone', not immediately perceivable, but which deviously emerged when all the attention was focused on saving a child's life and which affected their efforts.

The anthropological research was included in this problem area, to discover which cultural and social organisational elements interacted in the infant feeding methods and what were the consequences of these on a

child's development and health. Therefore, the mother–baby dyad, during the entire breast-feeding period of a time span between 24 and 30 months, became my preferred reference point.

I had planned to enter into the research by degrees, bearing in mind just how much an event which is so closely linked to female physiology is, in reality, loaded with complex cultural and symbolic values. Did I not come from a cultural area which, for the last two decades, had given up breast feeding its children as a sign of conquest for the emancipation of women? Renouncing breast feeding, isn't it perhaps an open manifestation of that move away from woman's 'most manifest animalism' as compared to man, of which Simone de Beauvoir spoke in her book, *The Second Sex* (De Beauvoir, 1961)? Was there not a lack, on women's part, of a careful reflection on the ever-increasing *medicalisation* of their reproductive health, including breast feeding?[3]

The reading undertaken in preparation for my research included, as well as the works of Rigby and Thiele, who preceded me in the field among the Wagogo, and of other anthropologist experts of East Africa, works on breast feeding and a series of medical manuals which were to help me understand female physiology and the great advantages of breast milk when compared to any other nutrient in the first months of an infant's life.[4]

My reaction to this latter reading was of 'discomfort' and reductivity: a woman was seen above all, if not exclusively, as a nurturer. Her being the mother of other children, a wife and also a daughter – and in any case a person with her own marked individuality – was never articulated. I asked myself how all of these aspects, through which a human being interacts with more or less defined and articulated social, relational and symbolic spaces could remain *silent*. Furthermore, the costs that a woman pays in terms of health in those countries in which breast feeding is the *condicio sine qua non* of the survival of her offspring, were rarely considered. The international organisations, in their public health programmes aimed at promoting the health of individuals, continued – and continue – to regard women always and only as mothers (the last, in order of time, are programmes aimed at the prevention of transmission of the HIV-1 virus in pregnancy). For women and their health needs the programmes tend to use the term 'mother and child', a binomial in which the second element is highly favoured, while their interdependency is evaluated only by the quality of the care that a mother gives her offspring.

Such a viewpoint seems not to realise two basic things: firstly, that a long period of breast feeding signifies that the baby has a long period of access to the mother's breast, an access which is accompanied, often much earlier than six months, by mixed feeding which puts at risk or impoverishes the advantages of breast feeding; secondly, it seems that they do not ask themselves about the incidence of cultural, social and economic reasons which can undermine the advantages of breast feeding in consideration of the high infant mortality precisely in those countries where mother's milk is offered to the infant for such a long time. These two

aspects, furthermore, should be accompanied by more careful consideration of the health of women who pass from one pregnancy to another and who have to expend a great deal of energy fulfilling the role models and tasks that belong to their lifestyles, which has serious consequences for their well-being. A subsistence economy which sees them as producers of food for the family nucleus, and to which other daily tasks are added – gathering firewood, collecting water, caring for the family and the children – together with the more general conditions of poverty, insecurity and even violence, takes a hard toll from a physique which is often malnourished as well.

A woman's health, therefore, together with that of her child, is not only the result of her reproductive health, but also of her productive health, because, as for a man, her life is based on the weaving together of both levels. Not to consider this means not to understand, in its entirety and complexity, that group of risk factors present in the environment and in daily life which mean, for example, that a woman, who lives in what we continue to call 'developing countries', has 300 times more probability of dying while giving birth than a woman in the so-called north of the world.[5]

My contact with village reality was to lead me to study aspects in which the mother-child dyad was very far from the 'biological niche' which most of medical literature was proclaiming. My interest in the relationship between the physiology of breast feeding and the behaviour of the nurturer found, from the biocultural point of view, fertile ground for reflection on the connection between 'nature' and 'culture', so mobile in the story of humanity – a mobility charged with implications for social and biological life and, at the same time, dense with meaning for the understanding of phenomena which see the human organism responding, adapting itself to new conditions, to new life models.[6]

It was only on my return from the field, and thanks to the work of Vanessa Maher (1992), that I found a viewpoint that supported my own ideas and that would give content and depth to what I had felt in the preparation phase and then experimented later in the field.

If, as Maher wrote (1992: 153) 'factors [such] as political and economic insecurity, ill health and overwork of mothers, gender inequality and the dangerous and unhygienic environment that goes with sheer poverty' are aspects which put the infant's health at risk, the same beliefs about this nutritional practice can sanction its lack of success.

When I think back to the articulation of my work, to my daily contacts with the women, to the different tracks, more or less explicitly suggested to me by the women themselves on focusing and understanding the dynamics connected to ways and attitudes, to those beliefs responding to that particular nutritional system which is breast feeding, I can see that my work was assuming such a value as to make an aspect of human physiology an act of culture – an act of culture which, also among the Wagogo, assumes an importance, an absolute priority over any other role, expectancy or need of a woman.

To give the breast, to give one's own milk, to have a healthy baby were to project a woman into a series of beliefs about the quality of her milk, dependent on behaviour, choices, obligations and rules, aimed at defining not merely the correct growth of her child but also her correct behaviour as a nurturer and, finally, as a mother.

This would lead me to consider the observation of a series of post-partum taboos, the first of which was total sexual abstinence during the breast-feeding period, a condition for the good quality of the nurturer's milk and guarantee for the correct growth of the infant. However, as proof of the sociocultural values of which the alimentary model, centred on breast feeding (a peculiarity of the female body), avails itself, the quality of maternal milk did in fact act as a control over the woman's behaviour in her role as nurturer and mother, thereby controlling her sexual behaviour as a wife and, in the last analysis, as a woman.

In the light of these considerations, breast feeding could have been configured in the dynamics of gift, a concept which, from Marcel Mauss (1965) to today, represents a key point in the analysis of those 'social facts' which also call into play, with the network of 'primary sociality', that *aimance* (Caillé, 2001) that binds a mother to her child with affection and emotion. This viewpoint will project the mother–child dyad into a wider context, delineating, above all, the outline of a woman who is complex and carrier of several instances which must be carefully considered.

I was in the field thirty years after Rigby and if, apparently, there seemed to be no difference between my time and what the British anthropologist dealt with in his experience, in my ethnographic reality I was considering how those changes present *in nuce* in the 1960s had assumed precise values with regard to social control. Those rules belonging to the Gogo tradition, those rules which gave order through initiation and marriage to family relationships, upset by economic changes or events influencing traditional pastoral economy, which had forced the men to emigrate to nearby urban centres, or to live on the margins of an economy that had marked their vision of the world for ever, had found, or perhaps just accentuated, a channel of control which had in the female body a strong ground of confirmation and denial.

Dealing with the study of breast feeding in order to try to understand the problems of malnutrition in the very first years of life meant an articulated study of women's sexual behaviour, thereby proving that it is not possible to comprehend the complex and composite dynamics of breast feeding, without asking oneself about the different roles that individuals are called upon to assume during their existence, without an articulated knowledge of the basic models on which the survival of a community are founded and, last but not least, without a vision of *gender*.

Once again, the fascinating research of the confines between nature and culture and their possible interrelations would give rise to more questions than answers. Furthermore, for the paediatricians working in the field, although the anthropological research would answer some of their questions, at the same time it would place their intervention in a con-

frontation with the mothers' beliefs, behaviours and choices, which needed to be understood and taken into consideration, with the aim of searching for and experimenting communicative contents having *reciprocal sense* in a continual, not always easy and taken-for-granted, labour of mediation. Therefore, even the paediatricians would be faced with the problem of the '*otherness* of thought and word' in individuals who were looking to them to alleviate the suffering of their loved ones.

Notes

1. Bateson (1980), 'Forward' to *Naven*.
2. CUAMM, Doctors with Africa is a nongovernmental organization from Padua, Italy, which has been working for fifty years in health cooperation in Africa.
3. For Italy see the interesting work of Elizabeth Dixon Whitaker (1994, 2000), which in an historical prospective considers the cultural dynamics through which the body and its functions are conditioned, moulded. In the same light, I mention Scheper-Hughes and Lock's interesting article (1987) and I recall the work of Merchant (1988), which emphasises the processuality of the dynamics through which culture models the body and its functions. More generally, all that we perceive as 'natural' feeds on cultural conceptions, prospectives and interpretations.
4. These readings were to give rise to a work written by more than one author, aimed at creating an interdisciplinary bibliography on maternal breast feeding (Campus et al., 1998).
5. *Osservatorio Italiano* on Global Health 2004 and WHO 2002.
6. Some readings were particularly useful: Wilson (1978); Konner (1982); Anderson (1983); Barash (1986); Cohen (1989); Durham (1991). Others will be indicated throughout the work.