From Food and Nutrition Bulletin

Factors influencing quality of care

Care, caregiving, and caregivers

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Abstract

Research and common knowledge maintain that women are the primary caregivers of children and thus are crucial to explaining care. Yet most conceptual paradigms guiding the analysis of care allow little room for examining who is caring for the caregiver. A consideration of care must include a deconstruction of what constitutes care, the process of caregiving that influences child survival, the way caring acts are divided in a society, and how such acts are integrated into a matrix of other supportive activities. This paper reviews the meaning of care cross-culturally and the context in which care takes place, and focuses on child care and child-feeding as key activities. It concludes with action strategies and policy challenges following from a gender analysis of care.

Introduction

While I was contemplating the task presented by the Cornell/UNICEF Colloquium on Care and Nutrition, the voice providing emergency instructions on the plane from Washington to Toronto broke in: "In the event of an emergency, adults should ensure their own oxygen supply before attending to their children's mask," contradicting our conditioning to help a child first. Being responsible for caring for children means being able to respond, and that requires adults to be in a position of strength to offer care, support, and protection to children. In an air emergency, a woozy or dying parent is no help to a child [1]. Thus it is necessary to focus attention on the caregiver.

In the conceptual framework guiding these deliberations, household food security, health services, a healthy environment, and care for women and children are considered the underlying determinants of child survival and development. Since most reviews of past research begin with the very realistic premise that women are the caregivers of children, there is no place in the conceptual paradigm for examining who is caring for the caregiver. This confusion has also been identified in work on caregiving burden. Braithwaite writes, "Most researchers appear comfortable with using burden to refer to both personal reactions to caregiving and the effects of caregiving" [2]. A similar

distortion will result in our deliberations if we fail to ask who is providing the care for the women who care for the children. If care for women is included as a key underlying determinant of child survival, then the conceptual framework should begin from a deconstruction of what constitutes care, the process of caregiving influencing child survival, the way these caring acts are divided in a society, the persons who undertake most of these caring acts, and how they are integrated into a matrix of other supportive acts. We should not equate care for women (which is extremely rare) with women as caregivers (which is extremely common) with the consequences of care for child survival. The task of defining care is a necessary first step for conceptual clarification, determining research priorities, and designing culturally appropriate action strategies.

Measuring care

Access to health care and household food security are both easier to measure than care. Care requires attending to relationships, experiences, values, ethics, and emotions, the study of which runs counter to much of Western scientific tradition. Instead we rely on indicators or proxies that are measurable through psychological, economic, or nutritional instruments. Often these fail to capture the context within which caring relationships develop. These indicators include the time it takes the caregiver to respond to crying (distress signal), the proximity of the caregiver to the infant, caregiver availability, and breastfeeding rates as measures of care. Just as it would be difficult to find adequate indicators for spiritual values, there are few indicators that capture the complexity of care. Psychologists have identified some possible scales [3]. A working definition identifies caring capacity as "the ability to perform care behaviours, to use human, economic, and organizational resources to the benefit of infants and young children" [4]

Researchers select certain factors for particular attention, as was done in a study of child health in a Cairo settlement:

Among the multiplicity of resources which may be studied, we selected three as being particularly important in shaping the quality of the growth environment for children. These are the level of earned household income, the quality of housing as represented by the joint availability of piped water supply and a sewer connection, and the educational level of mothers ... Formal education for females, if sustained until a socially recognized minimum threshold such as primary schooling is thought to produce a different attitude towards one's personal relationship to the environment whereby one tends to view the world more as an actor than as a spectator [5].

However, variables such as women's education often presume a Western notion of self and result in policy suggestions such as consciousness-raising and assertiveness-training for women without adequately considering how nurturance fits within indigenous systems of gender ideology.

The following comments refer to care as a cultural construct and not to the person undertaking caring tasks. They might form the starting point for developing a cross-cultural model of care.

Caring acts are acts that create relationships between people. Most caring acts are reciprocal in that they benefit both the giver and the receiver of care. Care is "twice blessed." For example, breastfeeding is an activity that benefits both mother and child. Massaging another results in the massager being massaged as well.

Caring entails both direct and indirect reciprocity. That is, care is exchanged directly, as in reciprocal child care arrangements, and indirectly, as children care for elderly parents.

Caring work is characterized as high-periodicity work that is non-postponable and of high frequency. Consequently, it is usually low status and performed by people with little power over their time. Caring activities include preparing meals, feeding, carrying infants, dressing children, healing, body cleaning, breastfeeding, comforting, making comfortable, and generally nurturing others.

Caring work is simultaneously a source of pleasure and a burden. It often blurs the work-leisure divide (playing with children, talking to elders).

Caring acts are bodily based acts of personal intimacy.

Caring activities may be carried out by people exhibiting a wide range of skills (such as cooking), and yet these abilities may still be recognized as part of a system of care if they are performed in a certain manner-with warmth and affection. Thus, caring can refer to the way an act is performed, not just the act itself.

Caring is learned as part of socialization. Cross culturally, it is naturalized but not necessarily feminized [6]. That is, the capacity to care is a measure of humanity expressed as what it means to have an identity as Lao or Luo or Italian.

Finally, violence and abuse-epitomized in war- is the most consistent and universal disrupter of care.

Care as women's work

The Women in Development (WID) literature of the 1970s and 1980s confirmed the degree to which women's work is undercounted and undervalued. However, in most economic surveys, work is still defined as an activity that produces cash income, and women are classified as either economically active or inactive. Further distinctions are made between full-time or part-time work, more or fewer than 40 hours per week, year-round or seasonal work, work at home or away from home.

Even in time-budget or time-allocation studies, child care, breastfeeding, and other caring tasks are either ignored or considered leisure activities. Perhaps two of the most inappropriate census categories are the "economically inactive homemaker" and the "unpaid family worker." However, caring activities are very often carried out as part of joint production (occupying the same time and space as other tasks):

Patterns of women's time allocation were found to show great variability, both from household to household, and within households on different days .. . Child care which was analyzed as primary

(when no other task was being performed) or sec ondary (if there was no easily calculable "opportunity cost" to another activity such as food preparation or cash work) varied from 10% to 50% [7].

There already exist substantial literature reviews of the relation between women's work and child care, including breastfeeding. A review on breastfeeding and women's work reported studies that cited women's work as being influential in the mother's infant-feeding decision, starting the bottle, or stopping breastfeeding, and concluded that employment outside the home is not a major reason for not initiating breastfeeding starting bottle-feeding, or terminating breastfeeding [8]. A later review confirmed this conclusion:

In short, contrary to many common perceptions, there is little empirical evidence that women's employment of itself need necessarily affect breastfeeding negatively. This is not to suggest, however, that maternal employment is not a factor in decisions regarding breastfeeding. In most situations, modification of the work environment would increase women's options regarding infant feeding, so that women who choose to breastfeed would not incur a high opportunity cost for that decision [9].

Leslie's reviews of child care are also significant. She argues, "The majority of women of reproductive age in industrialized and less developed countries alike face the need at some point in their lives to combine economically productive work with nurturing their children" [10]. Mothers who are not working may be better able to ensure frequent meals and to monitor intrahousehold food distribution to ensure that weaning-aged children get their fair share. On the other hand, mothers who are working may be better able to purchase the more expensive oils, legumes, and animal source proteins needed to provide energy- and protein-dense diets for their weaning-aged children [10].

In reviewing the available empirical studies, Leslie critiques study design and data analysis as weak or as not taking into account the diversity of women's work or types of breastfeeding. Therefore only a few generalizations can be made. Previous studies confirm that the most consistent effect of working on breastfeeding is a shift from exclusive breastfeeding to mixed breastfeeding or early termination: most studies found remarkably similar patterns of infant feeding between employed and non-employed women, suggesting that local and temporal norms may be the main factors affecting infant-feeding decisions of all women, not employment status. Where employment is found to be a significant factor, its effect depends on, among other things, both the type and the location of women's work. The single finding that seems widespread enough to warrant a generalization is that women who work while breastfeeding are likely to start mixed feeding earlier than women who are not working. However, relatively few studies have looked at substitute child care while women worked [10]. Studies indicate the importance of maternal presence at home during the first year and the characteristics of

the child-care substitute. A careful review of the empirical re search to date does not suggest that maternal employment should be expected to have a negative effect on child nutrition, measured either in terms of infant-feeding practices or nutrition status [10].

On the other hand, a study on women's work and child care in the Philippines "points to the importance of looking more closely at how different dimensions of work facilitate the balancing of productive and reproductive roles as well as different work schedules. Future work must consider the possibility that mothers are fitting their work around the availability of others" [11].

Work contexts

Women with children must work out ways to integrate their productive and their reproductive lives. The following ethnographic examples illustrate the wide range of contexts in which women combine child care with other kinds of work. Note that, as with the integration of breastfeeding and other work, caregiving always requires trade-offs or adjustments; there is no one simple natural way to reconcile these tasks.

Caregiving In small-scale societies

Contemporary hunting and gathering societies provide examples of economic and social strategies that are almost forgotten as human alternatives. The relationship between the productive and the reproductive spheres of women's lives can be seen most clearly in small-scale societies such as the hunting and gathering people of northern Botswana, the !Kung San. Here, women are both producers of food and reproducers who bear and raise the next generation. Women are thus at the intersection of two critical systems within the foraging economy: the productive system and the reproductive system, each with its conflicting demands [12]. In this society, breastfeeding continues into the third or fourth year and is frequent, on demand, and spaced throughout the day and night. However, changes in the subsistence system-a shift to settled village life and use of more cereal gruels for child-feeding, for example-upset this delicate balance between productive and reproductive work (in this case, mediated by lactation amenorrhoea). The result is more children and less breastfeeding. "Clearly, marked changes in the patterns of child care and maternal behaviour will be required before the !Kung can adjust emotionally to their new economic and demographic realities" [12].

Care for the elderly is a task shared by all adult members of the community. Caregiving and sharing are considered a natural part of being human, and myths reinforce what the world would be like, should caring and reciprocity cease [6].

Peasant communities follow a wide range of practices that may limit women's capacity to care for their children. In Melivar, a village on the outskirts of Mysore, India, an anthropologist studied poor women who needed to work in the fields or at other menial jobs before their babies were six months old. A young mother coping with hard physical labour outside the home, and without another woman to share the workload, was ready, even eager to give up breastfeeding as soon as the baby could manage without it [13].

The lace makers of Narsapur, India, integrate domestic work and child care into commodity production by making lace at home [14]. Women shift between different types of work, none clearly demarcated from the other in spite of the Western terminological distinctions between productive and reproductive work. One 22-year-old mother whose labour time was carefully calculated worked about 13.5 hours per day, spending 5 hours and 55 minutes making lace, 1 hour and 17 minutes on other productive work, and 6 hours and 18 minutes in household work and child care, including breastfeeding (approximately 1 hour) [14].

A report on infant-feeding practices in a mountainous region of Nepal underscores the difficulties women face when they work in places physically (and spiritually) dangerous to infants [15]. The problems of transport and arduous travel in a region where there is a demand for women's agricultural labour result in breastfed infants receiving early cereal supplementation. When this is introduced depends on the seasonal cycle and other subsistence considerations, rather than religious or ethnic identity.

A study in Nepal showed that "a strategy of combining work with child care is conditional upon a particular combination of ecological and socio-demographic characteristics, such as the seasonal demand for labour, the geographical dispersion of family members in nuclear families, long birth intervals, and an egalitarian and flexible distribution of work" [16].

These examples from rural peasant communities suggest that our assumptions that women engaged in agricultural labour have no difficulties integrating work and child care are inaccurate or oversimplified, at best. In fact, rural women often face greater difficulties than urban women because there are seldom any child-care facilities available and the agricultural work is physically demanding. Policies addressing the integration of work and child care should also be directed to the work contexts of rural agricultural workers. Currently, few policies address this group of women.

Urbanization and change

Small-scale communal societies and even peasant villages are rapidly disappearing or being affected by global processes. These changes affect caregiving strategies. Although urban women will take advantage of opportunities for informal, temporary work, lack of preparation for the work opportunities and the inability to plan ahead cause disruption in child-care patterns for those women in the informal economy. Opportunities to bag charcoal, repair roads, collect and dry plastic bags, or sell a windfall of goods mysteriously obtained take priority over the needs of infants and young children. Mothers cannot plan for these occasions; they never know when work will be available. If they are able to obtain work for a few days, the pay is too low and the occasion too brief to employ household help. In this situation, infants are left in the care of neighbours or relatives.

Although these work opportunities cannot be anticipated, informal work can often be carried out at or near home. In these cases, work and care of infants are compatible. For

the majority of the urban poor, regular salaried employment is rare. It is only monthly salaried workers that receive either maternity leave or maternity entitlements of any kind. More often, women workers are fired when their pregnancy becomes obvious.

Another factor affecting women's capacity to care for their infants and young children is scheduling. Unpredictable shift changes, night work, and lack of control over work schedules make child care difficult. In addition, the patterns of feeding for infants and young children may change significantly from the beginning to the middle or end of the month or pay period, depending on available income.

There is a shortage of part-time jobs for women in cities like Singapore. Many do shift work in the electrical or electronic industries. It was reported that 58% of 16,017 shift workers in 419 manufacturing firms were women. Singapore women take up permanent night work nearly three times more often than men in order to meet their family obligations. A study of the child-care problems of low-income mothers found that 43% of the working mothers were shift workers. Often, women send their children out to board or to live with relatives and visit their children on weekends or less often. "The issue of whether a married woman can successfully combine home and a career arouses a strong emotional reaction from the public, which demonstrates that women's work is now defined as work outside the home and is therefore considered incompatible with family responsibilities" [17].

In a breastfeeding study in a small Iranian city, the investigator found that for those women who were well educated and employed outside the home, the schedule of working from 8 a.m. to 1 p.m. and from 3 p.m. to 6 p.m. allowed them to breastfeed. Those few working women expressed no difficulty with breastfeeding because of this work schedule. However, in larger Iranian cities such as Tehran, work schedules were from 8 a.m. to 5 p.m., a pattern particularly difficult for employed breastfeeding mothers [18].

Scheduling, transportation, and predictability of work emerge as particularly important factors influencing caregiving in urban settings.

In both homogeneous, small-scale societies and peasant communities, women are increasingly entering the cash economy and assuming new kinds of work in addition to domestic tasks. Even rural work is becoming more incompatible with child care, as population increase and environmental degradation encourage shifts to cash crops and increase the distance between home and fields. In addition, agriculture is becoming increasingly dependent on fertilizers and pesticides that make fields unsafe places for infants and children. The migration of male family members into urban areas further increases women's workloads. Work sites are often more distant from a woman's home and family, requiring longer transportation time and higher costs, and adherence to fixed schedules.

Cultural strategies that were effective in helping to integrate child care into old work contexts may well be unsuitable in these new work contexts. In addition, only rarely will newly industrialized countries implement legislation to protect working mothers. The

countries' need for export earnings to pay off international debts means that industries must reduce costs to remain competitive. Hiring women at low salaries with no benefits is the most common cost-saving strategy.

The pressure on women in developing countries to enter the industrial work force is triggered by the need to offset the drop in earnings or unemployment of other household members. This increase in women's labour force participation decreases the amount of time mothers can allot to child care. Yet conditions often make it increasingly difficult for women to arrange adequate child care. Structural adjustments imposed by the World Bank and International Monetary Fund discouraged further government expenditure on social services, health, and education [19]. In addition, national commissions on the status of women have not always been willing to give maternity entitlements priority over or even include them with other equity and justice policy issues.

Child care

Child-care difficulties epitomize the problems women face in integrating mother-work and other work. Only in child-focused societies do mothers have the social support necessary to delay their return to full-time work. Most women face questions about who will care for their infants, where this care will be located, and how much the care will cost-either in money, goods, or influence in the family.

Women who make use of reciprocal child care among informal groups of relatives or neighbours can only work part-time or sporadically because they must reciprocate by caring for other children. Women need dependable long-term child care with no reciprocal obligations if they are to take regular formal employment or travel long distances. However, informal and formal communal child care is compatible with shared breastfeeding, as has been demonstrated in the Philippines and elsewhere in Southeast Asia.

In capitalist economies in developed and developing countries, and even under socialist policies, employers are generally loath to take on the expense and responsibility of assisting their employees with child care unless required by the state to do so. They are even less likely to do so if employees and unions do not make such a demand. However, child care is beginning to be incorporated into the benefits packages of some corporations that need to retain their skilled women employees. Nevertheless, it is clear that in North America, this is not yet a priority.

Finding and paying for adequate infant and child care is a concern for all mothers whose household arrangements do not include a capable adult who is prepared to take on this task. It is not a problem faced by breastfeeding mothers alone. But the breastfeeding working mother faces additional problems if the child mincer is not supportive of breastfeeding. In small-scale and child-centered societies, this need not pose a problem if the mother can be called home to feed a hungry infant. In systems where work takes precedence over family responsibilities, it may be more difficult for mothers to respond to the changing demands of a growing infant when their workplaces are farther from

home. In these cases, it is important for the child mincer to be familiar with the care of breastfed babies and prepared to cope with a hungry breastfed baby whose mother is late from work.

Mothers of newborns take on new child-care tasks in addition to other tasks. Mothers simultaneously participate in social relationships that may affect how they relate to their infants. Those most likely to influence the care of infants include relations with siblings, grandmothers, and co-wives.

Sibling caretakers

In studies of custodial care, sibling caretaking is generally seen as inadequate when the sibling is young (< 15 years of age). This is because the sibling may be too young to physically carry and care for the child and too inexperienced to know how to meet the child's needs for food or cleaning; also, the caretaker may miss school or other valuable experiences by having to care for a sibling. "Evidence of failure to provide good care in humans exists but is anecdotal; child caretakers are likely to be clumsy ... neglectful of their duties ... and distracted by the games of other children" [20].

There is no consensus on the effect of sibling caretakers on infant health. "It has been suggested that the distress caused by the mother's absence is much lower if there are other individuals available who can substitute for the mother ... although the effects of using sibling caretakers on infant survival are as yet unknown in any society" [20].

What has not been stressed in the literature is the fact that sibling caretakers may form bonds with the sibling they helped raise that last a lifetime. In rural Thai society, adults will specifically identify the sibling to whom they are closest because they helped raise that child. Because the older sibling was totally responsible for the welfare of the younger sibling, the relationship between the two may be qualitatively different from relations with other older or younger siblings. There is a gender bias in sibling care incidence, but although sibling caretaking may be more common among girls, birth order may also be important.

In developing countries, sibling caretakers often take responsibilities for both infants and toddlers while mothers work, including entertaining, carrying, protecting, bathing, and feeding children. Children as young as five years of age care for their younger siblings and may be responsible for taking infants to their mothers while they are in the fields. The older sibling helps look after a baby when there is no caretaker available, as is often the case when nuclear families work singlehandedly rather than joining forces in a labour group [16].

In a review of sibling caretaking, the authors noted that social-structural conditions such as work pressures on parents, the structure of the daily routine, and kinship and residence patterns interact with demographic circumstances (such as numbers of children available in the household and family size) to determine the likelihood and incidence of non-parental, child-child caretaking ... sibling care was more likely to occur when more

children were present around the target child in the settings, the child was further from the home, and the daily schedule found the mother away from the home [21].

They concluded that we need to know more about the ethnography of the situations where cultural members (siblings among themselves, or mothers and their children) disagree regarding assignment of caretaking responsibility. Our analysis points to the kinds of circumstances where a more intensive study of how caretaking roles are assigned, self-ascribed, and denied would be most fruitful [21].

Twelve years later, such studies are still not available.

Grandmothers

In many societies, grandmothers are the preferred caretakers of infants and toddlers. There has not been enough research to determine just how often a grandmother's care extends to breastfeeding her grandchildren. In some circumstances, infants from urban slums are sent back to rural communities to be raised. In Thailand, for example, the mother's mother or father's mother might raise an infant with the assistance of occasional funds from the parents. The parents' low income might not be adequate to care for an infant in Bangkok, but the extra money sent upcountry can more than compensate for the extra mouth to feed. When grandmothers reside with the new grandchild in the city, they commonly assist their daughters after childbirth and might provide the support necessary for successful breastfeeding. Yet in Bangkok, for example, grandmothers are equally likely to encourage the use of breastmilk substitutes to relieve the mother entirely of her responsibility for feeding the child so that she can work full time. This may be one way an elderly member who no longer contributes financially to the household can increase her influence and importance in the household.

Similarly, in the Philippines, the "presence of a grandmother significantly increased the likelihood that these mothers of young children would be working outside the home or in wage work paid on a time basis ... This is not surprising since grandmothers (either maternal or paternal) are the most frequent care givers for children when mothers work" [11].

Co-wives and husbands

Few studies consider the effect of fathers or plural spouses on child care. However, in a study of infant care among the Kipsigis of Kenya, no difference was found in quality of care between married women in polygynous and monogynous households [20]. Although the mother may benefit from membership in a polygynous household insofar as the provisioning of infant care is concerned, the quality of infant care may not be affected. Infants may be affected by their mothers' marital status in that wives in a polygynous household individually may not be as well provided for, but cooperation between co-wives can be advantageous to both women and infants [20]. It is critically important to examine the practices of fathers with regard to caregiving.

Coping with child-feeding

In many societies, feeding is synonomous with care. Minimally, it is a metaphor for care. Consider the meanings of nurture in English. Child-feeding is a high-periodicity task; that is, it is non-postponable and must be undertaken frequently. It is generally seen as low-status work because it reduces the flexibility of the person assigned to this task. Although child-feeding is almost always considered the responsibility of the mother, she may delegate the task to a person of lower status, most commonly a young daughter.

The nutritional factors that influence dietary adequacy include: frequency of feeding;

- amount of food in meal;
- energy and nutrient content of food;
- utilization of food within the body.

These factors are part of the caregiver's strategy for integrating the feeding of a toddler into the feeding of the rest of the household. I refer to this as the process of integrating a child into the family circle. It has been demonstrated that the caregiver may not always have control over this process, but instead may allow the child to decide how much to eat [22].

Although much attention has been focused on the relationship between breastfeeding, hygiene, diarrhoeal diseases, and growth retardation [4], less attention has been focused on the number of meals per day that young children eat and the timing of these meals as indicators of nutrition status. A recent review of data from India documented hunger in terms of household meals per day (S. Zurbrigg, personal communication, 1994). Poor households do not have regular access to two meals a day of the local staple, and the poorest households do not have access to even one meal a day. Although two meals a day might meet basic caloric requirements, one meal is not enough, resulting in chronic hunger; no meals per day denotes acute hunger.

This starkly simple measure of household food security encompasses the two central types of hunger in human experience-chronic and acute. The implications for childfeeding are obvious. If meals are prepared only once a day, the odds of a toddler's being fed three or four times a day are very low. Goldman [23] found that children eating three meals a day obtained more calories than children eating two meals a day. Households dependent on seasonal employment or whose members become sick may easily drop from "nearly enough to eat" to "not nearly enough to eat" with subsequent risk to child survival.

The weaning interval

The weaning interval, the period between the first introduction of complementary foods and the completion of weaning, might be understood as an intensive period of food socialization. During this period, a number of important transformations take place in addition to the reduction of breastmilk intake. These include changes in feeding

techniques, including the introduction and mastery of new objects such as spoons, bottles, cups, or utensils such as chopsticks;

> -food provider, from the mother to the grandmother, sibling, or caretaker;
> foods consumed, from liquids to semi-solids and solids, and from finely ground to coarsely ground, to bite-sized chunks, and finally to adult foods;
> meal behaviour, from a passive, dependent infant to an individual expected to follow cultural rules about the correct way to eat.

These substitutions are not easily made, and can be thought of as trade-offs between the welfare of the mother (who may be pregnant or who may now have to give more time to other activities) and the toddler (who benefits from having the exclusive attention of the mother).

Circle of commensality

Infant-feeding has a dimension of commensality or food-sharing seldom recognized. Food is the context of the first social interaction experienced by all humans. This experience may be totally pleasurable or anxiety-producing. In fact, the pattern of infant feeding may set a pattern for food-sharing later in life. Infants begin to participate in a system of food sharing in utero, and at birth, with their lactating mothers (and possibly with close female relatives who may breastfeed them on occasion). In some societies, unrelated women breastfeed. each other's children for pay, as with wet nursing, or as part of cooperative work strategies among friends. Gradually, the circle of commensuality expands to other members of the family and beyond. The commensal circle includes only mother and infant during exclusive maternal breastfeeding and when mothers pre-chew food for their infants. For example, Thai mothers in Laos and northern and northeastern Thailand often pre-chew glutinous rice for their infants. Elsewhere mothers may squeeze fruit juice into an infant's mouth and then eat the pulp themselves.

The expansion of this circle of commensality is a key to understanding the transition to an adult diet. The next stage may be the ritual presentation of a highly valued food, either before or after breastfeeding begins. Honey, a common purifying substance according to Javanese mothers, is rapidly being replaced by glucose as hospital births increase. Glucose is routinely fed to newborns in hospitals in many third world countries. This second stage provides occasional tastes of key flavours in the adult diet: lemon, butter, banana, rice. The third stage includes special infant recipes not shared by other family members. Bubur (rice porridge) in Indonesia or pablum in Canada are examples of self-targeted complementary foods.

To this point infants and toddlers have protected access to the food supply, and as long as they are also breastfeeding, they are probably adequately fed. A crisis may occur when the circle of commensality enclosing mother and infant expands to include sharing food with other siblings and family members. For with this expansion, toddlers begin to lose protected access to their food supply. They are then most affected by the food system into

which they are being socialized. Future research on young child-feeding should take into consideration the wide range of meal systems existing cross-culturally.

New questions

What are the implications of this approach to child feeding for the study of care? Most significant, perhaps, is that it opens up a new line of questioning. Is child survival enhanced more by delaying the newest family member's entry into the commensal circle, giving the child a longer period of protected access to special weaning foods, or by encouraging and accelerating the child's entry into the commensal circle without a period of "special" infant foods? Do toddlers who are breastfeeding have more protected access to family foods?

The introduction of solid and semi-solid foods regularly into children's diet is typically delayed in Egypt. In Manshiet Nasser, mothers began to introduce solid foods regularly, on average, by around the ninth month. In terms of breastfeeding patterns, children receiving breastmilk sustain better weight-for-age than those who do not breastfeed during infancy [5].

The pattern of undernutrition among breastfeeding children in the second and third year of life suggests that in this urban context, breastmilk tends to replace rather than complement other items in the diets of young children, and it is also associated with less frequent feeding with outside foods. It is possible that once the child is no longer receiving breastmilk, mothers and others around the child make a greater effort to feed the child, to make sure it gets enough food, because it is no longer receiving mother's milk [5].

Are breastfed toddlers spared the need to compete with their other siblings until they are larger and stronger? Do these questions suggest alternative approaches to researching growth- faltering in children? The concept of care encourages us to consider the "how" and "why" of young child-feeding in addition to the "what" and "when."

Action

Anderson's touching story of the death of Alicia's ten-month-old daughter in the shanty town of Lima, Peru, underscores the danger of assuming that forming women's groups or providing more health education will solve the problem of care. While Alicia was at a meeting of her community women's council, where she participated in the primary health promoter's group, her daughter became dehydrated and, the following day, died. Even after health training, Alicia was not able to respond quickly enough to the symptoms of dehydration to use the therapies she had just learned. She took her mothering tasks seriously, but she left her 12-year-old daughter to care for the baby. Mothers' participation in these community-based self-help groups did not result in more favourable weight-to-age ratios or improved child development [24].

This study is a reminder of the fluid and ethically complex relationship between care, self-help, charity, and welfare. Meillassoux reminds us of the relation between the acts of caring that reproduce the patriarchal family, charity, public assistance, mutual aid, social security, and welfare [25]. Interventions to promote care must negotiate the different levels of analysis where care is institutionalized. Policy terminology, too, implies a kind of caring-intervention, protection, promotion, advocacy-without considering the different political and conceptual bases for each. Strategies to ensure care take place at several different levels.

Individual strategies

The biomedical literature provides very little evidence regarding women's experiences combining work and caring activities. However, ethnographic evidence suggests that there are always trade-offs in caring and coping. Most strategies are individual and short-term, entailing no institutional changes or community support. This reflects the fact that successful integration of caring activities and other work requires a strong, determined woman who can overcome obstacles. Women in industrialized societies who are highly motivated to breastfeed, for example, often take on multiple responsibilities as individual "superwomen," neither expecting, requesting, nor receiving assistance from other people, their institutions, or their communities. This "superwoman" model of care is totally inappropriate for export cross-culturally, and in fact has also been responsible for breastfeeding's being considered an unattainable mode of care for low-income mothers and immigrants to North America. "If you're not a superwoman, don't try it."

Cultural strategies

Cultural strategies are distinguished from individual strategies because they refer to beliefs and practices that may be widely shared in a society. They are thus indigenous resources that may be utilized by some individuals and not by others, and may also form the basis for culturally appropriate interventions.

Surrogate mothering and postpartum seclusion are cultural practices that in many cases assist mothers in learning to care for their children. Wet-nursing has a long history as a coping strategy. Now, however, wet nursing is most common within families in small scale and peasant societies. Even breastfeeding advocates express concern about the dangers of cross infections or of the infant's "bonding" to someone other than the mother.

Nevertheless, there is anecdotal evidence that wet nursing is far from rare when women with similar aged children organize for support and cooperative child care. Some wet-nursing exists among student mothers and others who work in unstructured jobs. In the Philippines, employed women organized a baby-care cooperative where babies were breastfed by surrogate mothers whose babies were also at the centre. Shared breastfeeding is the most intensive form of shared child care, and the practice emerges out of intimacy, mutual concern, cooperative work, and, usually, strong bonds of affection. Grandmothers who breastfeed their grandchildren may represent a more widespread caring strategy than many acknowledge. Support for cooperative child care

may foster this practice, but shared breastfeeding is seldom openly discussed in planning and policy meetings, particularly in the era of AIDS.

Mothers of infants suffer from fatigue and, in some cases, excessive energy demands. However, fatigue is also a major complaint of mothers who are not employed outside the home and of women who are not breastfeeding. Any practices that encourage a period of social seclusion, rest, and special foods for mothers for the first few weeks postpartum will probably assist in breastfeeding. Religious texts often support a period of seclusion of women after birth, usually around 40 days, the period necessary to establish full lactation.

However, the advent of Western biomedical practice in many parts of the world has hastened the decline of these so-called traditional practices. In fact, these practices probably sustained breastfeeding through countless generations. It is difficult to turn back the clock and tell the Malay or Thai midwives and traditional healers that the "old ways" had some useful features. However, with the recent sensitivity to indigenous medical practices in many parts of the world, it is worth reinforcing those cultural practices that encouraged women to rest, eat well, and be relieved of work in the first few weeks after birth.

National strategies

There is great variation in national legislation on maternity protection, some providing better coverage than the International Labour Organization (ILO) legislation, some worse coverage. The Brasilia workshop on breastfeeding and women's work reviewed a number of national initiatives in Latin America that were intended to provide strategic help for breastfeeding mothers.

In Honduras, enterprises employing more than 20 women are required to provide a suitable place for mothers to breastfeed their children. In Uruguay, workers in the public sector are allowed to work half time so they may breastfeed their infants for the first six months of life. Brazil's national breastfeeding programme established a committee to review women's employment and breastfeeding. The committee surveyed existing legislation and found that it was not uniform across federal, state, and municipal levels. It also developed a programme to teach mothers to express their breastmilk in order to take advantage of nursing breaks. Mexico offers examples of workers who have negotiated better contracts with provisions for child care [26].

Socialist approaches to the work of care should provide evidence for the successful integration of caring work with productive work. In theory, men and women are considered equal under socialism, although in China, as in many other socialist countries, behaviour does not always follow rhetoric. Generally, maternity entitlements are guaranteed and the competitive promotion of infant formula is discouraged. However, these conditions are changing rapidly with the collapse of socialist regimes. With regard to maternity entitlements and child care in socialist countries, it is difficult to determine "how much is owed to realistic planning and how much to totalitarian power structure"

[27]. We might also ask how restricted access to commercial infant formula has affected breastfeeding rates in socialist countries.

International strategies

International actions should build on existing international instruments such as the Innocenti Declaration, the Code for the Marketing of Breastmilk Substitutes, the Rights of the Child, and conventions to eliminate discrimination against women. The Clearinghouse on Infant Feeding and Maternal Nutrition regularly reports on existing legislation and policies to support breastfeeding mothers in the workplace, including information on maternity leave policy, salary during leave, provisions for nurseries, nursing breaks, and other considerations.

However, it is likely that data at the national level are unreliable and should be used only when confirmed by local professionals. Neither maternity entitlements nor lactation breaks are regularly implemented for formally employed women, and most working women are ineligible for these benefits because they work in subsistence agriculture or home based production, or are self-employed in a wide range of activities in the informal economy. Reviews of maternity legislation seldom specify how the laws are monitored at the local or national level.

The ILO is considering whether the best strategy is to revise the conventions on maternity protection legislation, encourage more countries to ratify and implement it, or develop policies on parental rights. Employed women with job security, maternity entitlements, and facilities for breastfeeding are exceptionally few in number in both developed and developing countries.

Policy challenges

Elimination of all forms of discrimination against women is a requirement for addressing caregiving and the rights of the child. Agencies providing nutrition interventions recognize the need for a life-cycle approach to women's health. Any projects that empower mothers, support effective local practices, and provide care to caregivers are likely to be useful, particularly those that improve the health and nutrition status of women [28].

But women are often mentioned in the nutrition literature as a risk group or a target group for needed interventions rather than as gatekeepers of family health. The recent International Congress of Nutrition (ICN) guidelines are a notable exception. The ICN World Declaration and Plan of Action for Nutrition is unusually sensitive to the importance of women as caregivers. The document explicitly recognizes that nutritional well-being is hindered by the continuation of social, economic, and gender disparities and discriminatory practices and laws. "All forms of discrimination including detrimental traditional practices against women must be eliminated in accordance with the 1979 Convention on Elimination of all forms of Discrimination Against Women" [29].

Women's nutritional needs should be met not simply because they are caregivers. "Women are inherently entitled to adequate nutrition in their own right as individuals" [29]. For women to provide the necessary care of others, priority must be given to enhancing the "legal and social status of women from birth onwards, assuring them of respect and equal access to caring, education, training, land, credit, equity in wages and renumeration and other services, including family planning services, and empower them economically so that they have better control over the family resources" [29]. Adding the concept of care to UNICEF's model of the determinants of undernutrition raises the possibility of a whole new approach to integrating gender concerns with child survival policies. But it raises many difficult questions, such as:

-How do we understand the extent of caregiver distress, a core concept of burden, when caregivers in many societies are socialized to downplay their distress?
-What policies will support women as caregivers without using them as an unpaid workforce, a cost-saving measure?
-How can we organize society to make care for dependants more just and humane, when current policy focuses on adjustment of caregivers rather than the adjustment of society?
-How can we insure that international caregiving does not undercut existing household and community caregiving strategies, particularly those based on reciprocity and commensality?
- How do we avoid masculinizing care, over bureaucratizing it, and proposing technology to solve human problems?

Acknowledgements

This paper has been prepared with the research assistance of Maggie MacDonald, a doctoral candidate in Social Anthropology, York University, and the suggestions of Dr. Pattanee Winichakul, Institute of Nutrition, Mahidol University, Thailand.

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