# ABSTRACT

This thesis investigates the unique type of breastfeeding counselling conducted by the online voluntary organization Ammenet.dk. The existing research indicates the importance of proper breastfeeding counselling for the physical and mental health of Danish mothers, their children, and Danish society at large. In a Danish context, breastfeeding counselling has been shown to improve the prevalence, frequency, and duration of breastfeeding, while inattentive or insufficient counselling might reduce these and, in the worst cases, result in unsuccessful breastfeeding. Given the health benefits associated with successful breastfeeding, unsatisfactory counselling can arguably be characterized as a *social problem* in contemporary Denmark. To deal with experiences of insufficient breastfeeding counselling, some mothers seek alternative forms of support provided by organizations within the voluntary sector. In particular, organizations using the internet to offer new forms of counselling that depart from the traditional face-to-face counselling provided by public health professionals have become increasingly popular. In Denmark, the organization Ammenet.dk offers such online voluntary breastfeeding counselling. Their alternative form of counselling consists primarily in sharing evidence-based knowledge and support via their Wiki, online peer-to-peer network groups on Facebook, and the weekly letterbox. Through an analysis of how mothers use and experience these alternative forms of counselling, I explore how Ammenet.dk's voluntary social work affects the ways in which Danish mothers' cope with their breastfeeding problems. They do so, I argue, by enabling *multiple* ways of understanding and handling these problems, in contrast to the more singular definitions and solutions offered by public counsellors not corresponding with the mothers' experiences of their problems, causing poor coordination of the health professionals' and the mothers' realities.

I show how Ammenet.dk embraces all forms of feeding a child with breastmilk in their counselling practices and share comprehensive knowledge of breastfeeding problems and alternatives to breastfeeding directly at the breast using various technologies. This knowledge is subsequently interwoven with the mothers' individual enactments of their problems and solutions in various ways, resulting in multiple, ontologically different but co-existing, versions of breastfeeding problems that the mothers can flexibly invoke to cope with their diffuse sense of something not quite working. By approaching counselling in this way, Ammenet.dk manages

to *enact* breastfeeding problems and solutions in ways that do not render them narrowly defined or singular. Instead, they acknowledge their *multiplicity,* which in turn makes them co-extensive with the mothers' experiences of diffuse and ambiguous problems and solutions. Through their confrontation with counselling that attempts to coordinate with their own experiences, the mothers can take responsibility for their breastfeeding by re-defining their problems and enacting suitable solutions using the resources supplied by Ammenet.dk. Building on Ammenet.dk's counselling, the mothers reconstitute the phenomenon of breastfeeding through the various practices they enact to potentially solve their problems.

The existence of breastfeeding in the multiple also facilitates new ways of experiencing *having a breastfeeding body* and *being a breastfeeding mother*. Just as breastfeeding problems do not exist in the singular, neither does breastfeeding bodies nor is there necessarily anything inherently *natural* about them. Instead of seeing a body that 'naturally' nourishes a child at the breast, the thesis understands the breastfeeding body as a particular objectified configuration that exists in multiple versions, built on combinations of personal experiences with medical knowledge, technological apparatuses, and community imaginaries. This, in turn, makes it impossible to describe the breastfeeding body as strictly a 'cultural' or 'natural' phenomenon. Instead, the breastfeeding body becomes a *hybrid* that fundamentally challenges such a strict 'nature/culture' dichotomy. I show how Ammenet.dk's counselling embodies an understanding of breastfeeding that includes different ways of feeding a child with breastmilk, regardless of the knowledge, techniques, or technologies involved, which helps facilitate the hybridity and multiplicity of the breastfeeding body. Lastly, I trace how different forms of knowledge, techniques, and technologies are combined and coordinated with financial and legal aspects of breastfeeding in an *ontological choreography* that enable the mothers to experience themselves as a *breastfeeding mother*.

# THE MULTIPLICITY OF BREASTFEEDING

## A CASE STUDY ON ONLINE VOLUNTARY BREASTFEEDING COUNSELLING

MASTER'S THESIS IN SOCIAL WORK

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# CHAPTER 1: INTRODUCTION

To improve the development of global health, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend, and actively promote, that women exclusively breastfeed their children the first 6 months after birth (WHO, 2021). A meta-analysis from 2016 convincingly shows that breastfeeding protects against childhood infections, is likely to prevent obesity and diabetes, as well as potentially increasing children's intelligence quotient. For mothers, the benefits are protection against breast cancer and possibly against ovarian cancer and type 2 diabetes (Victoria et al., 2016). Even though the health benefits of breastfeeding are well-documented and well-known, the duration of breastfeeding in both developed and developing countries are shorter than these recommendations (Kronborg & Foverskov, 2020). Some actively choose not to breastfeed, but the shorter breastfeeding periods are not always voluntary. For example, studies have shown that many Danish women breastfeed for shorter periods of time than they originally intended (Larsen & Kronborg, 2012, Nilson et al., 2020). Therefore, from a social investment perspective, sufficient counselling helping mothers to achieve successful breastfeeding is beneficial for Danish society improving public health. If the health of Danish citizens affects poverty and opportunities to enter the labor market, it pays off to invest in their health (European Commission, 2013, Engstrøm 2021) also regarding breastfeeding.

It is known that socio-demographic factors like age, educational background and marital status are affecting breastfeeding success and duration. But psycho-social factors also have an impact. These factors include breastfeeding knowledge, intentions of breastfeeding, support, and self-efficacy, defined as the mother's certainty or uncertainty about her ability to breastfeed (Nilson et al., 2020). Since these factors have an impact on the chances of successful breastfeeding, they should be included in the breastfeeding counselling practices (Kronborg & Foverskov, 2020). As such, appropriate counselling that takes all these factors into consideration is of great importance when attempting to enable successful breastfeeding. However, it is far from all Danish mothers who believe that the health professionals at the place of birth provide the help they need to breastfeed (Danske Regioner, 2021) and not all health visitors believe that they succeed in solving their primary tasks, breastfeeding counselling being one of them, with sufficiently high quality (Milling & Sørensen, 2018).

Facing the insufficiencies of public counselling, many women actively explore alternative ways of enabling full-time breastfeeding, despite their initial issues, or seek advanced knowledge on different infant feeding methods. Increasingly, mothers turn to internet-based online counselling and support forums that not only make new forms of counseling possible, but which also reconfigure the limitations of time and space imposed by the traditional face-to-face format offered by publicly employed healthcare providers (Newby et al., 2015, Cowie et al., 2011 & Burman, 2012). I find this tendency both personally interesting and relevant for Danish society at large, since online voluntary social work has the potential to improve breastfeeding prevalence and duration, which, in turn, constitute an investment in the health of Danish citizens. I wonder how changes in the location and medium (from physical to virtual, from face-to-face conversations to distributed and dislocated communication), as well as the 'experts' involved (from 'trained' public health professionals to peers and volunteers) affect the practices of counselling and how the mothers cope with their individual breastfeeding-related problems as a result.

In this thesis, I explore how the phenomena of breastfeeding, the breastfeeding body, and the subject-position of being a breastfeeding mother are enacted in the setting of online voluntary social work conducted by the organization Ammenet.dk. In doing so, I investigate and analyze how these phenomena are simultaneously affected and transformed by the material-semiotic networks which they shape and in which they occur. Material-semiotic approaches "*describes the enactment of materially and discursively heterogeneous relations that produce and reshuffle all kinds of actors including objects, subjects, human beings, machines, animals, 'nature,' ideas, organizations, inequalities, scale and sizes, and geographical arrangements*." (Law, 2008a, p. 141). Building on existing research on the multiplicity of so-called practical ontologies, the thesis is premised on a rejection of the traditional Euro-American understanding of reality as something in the singular. Instead of being of a permanent or universal character, reality is 'done' or enacted in the multiple (Mol, 1999, p. 75).

I examine how realities can be ontologically multiple and show how the practice of online voluntary counselling enact an ontologically different kind of breastfeeding than face-to-face counselling provided by publicly employed health professionals. This gives rise to rethinking breastfeeding problems, the breastfeeding body, and the subject-position of being a

breastfeeding mother while also offering new understandings of the life-giving practice of breastfeeding.

## PROBLEM STATEMENT AND OUTLINE OF THE THESIS

To explore online voluntary breastfeeding counselling, I conduct an in-depth case study of Ammenet.dk, where I investigate how the organization conducts a specific brand of voluntary social work and why this becomes an attractive alternative to some mothers. My problem statement and research questions are as follows:

**How does the Ammenet.dk's online voluntary alternative to public breastfeeding counselling affect how Danish mothers' cope with breastfeeding problems?**

*How does this mode of counselling affect the phenomena of breastfeeding and the various related problems that might emerge therein, and how does this differ from the traditional counselling provided by health professionals within the public sector?*

*How does online voluntary counselling impact the possibilities of having a breastfeeding body and being a breastfeeding mother?*

The problem statement addresses how Ammenet.dk conducts their counselling practices differently from the traditional services offered by the public sector, while focusing on how such alternative forms of counselling affect how the mothers' experience of having a breastfeeding body and being a breastfeeding mother.

My argument is that Ammenet.dk's unique mode of counselling allows the mothers to cope with their diffuse breastfeeding problems constructively, since the counselling provides comprehensive, attentive, and, importantly, *multiple* ways of understanding and dealing with breastfeeding problems, while also providing alternative ways of breastfeeding. Such alternative understandings of what constitute breastfeeding embraces all forms of feeding a child with breastmilk using various techniques and technologies suitable to the specific mother. Breastfeeding in the multiple also enables new ways of experiencing *having a breastfeeding body* and the subject-position of *being a breastfeeding mother*.

Throughout the thesis chapters, I slowly build up to this argument. In the next chapter I thoroughly introduce the reader to the field of investigation. In chapter 3, I outline the theoretical framework that informs how I approach the case of Ammenet.dk. I introduce

relevant concepts from Annemarie Mol's, Donna Haraway's and Charis Thompson's work in the interdisciplinary field STS (Science and technology studies) and their implications for my analysis. Chapter 4 extends this discussion by covering the methodological and analytical considerations that shapes the coming chapters. In chapter 5 I draw on Mol's work to trace Ammenet.dk's counselling practices through the local concepts that figures in my empirical material. I explore how online voluntary counselling, as an alternative to traditional forms of breastfeeding counselling, involves different configurations of knowledge and practice, wherein breastfeeding problems are enacted. Chapter 6 turns towards the experience of having a breastfeeding body and being a breastfeeding mother by thinking with concepts from Haraway and Thompson's work, in discussion with feminist STS scholar Martha McCaughey's reflections on her own breastfeeding journey.

I close my thesis by reflexively suggesting the utility and possible consequences of producing it. I consider how my thesis provides Ammenet.dk with knowledge that allow *them* to evaluate their organization and counselling services. It is my hope that the thesis can help them to improve their practices and to ensure that their online voluntary counselling complements the public services in the best way possible. But first I present the field of investigation.

# CHAPTER 2: THE FIELD OF INVESTIGATION

Generally, the Scandinavian countries have high breastfeeding rates and in Denmark we have a long tradition of mothers breastfeeding their children. After a period with frequent use of wet nurses, in the late 18th century it became 'trendy' among mothers of the upper class to breastfeed their children themselves. The literature describes how breastfeeding could improve the infant's chance of survival and increase the mother's physical and psychological wellbeing. A prominent figure counselling at the time was the midwife Marie Angélique le Rebours, whose literature offered breastfeeding advice and described factors affecting the chances of successful breastfeeding (Løkke, 2012). A new medical childcare program marked the period between 1890 and 1975, which included an intensification in the promotion of health information. The program aimed to reduce infant mortality and it recommended exclusive breastfeeding for the first six months of the child's life. Among these recommendations was a specific, and highly problematic, breastfeeding rhythm, where the suggested feeding frequency and duration meant that many mothers could not produce enough milk. Today, it is well-documented that optimal breastfeeding follows a 'mother-child response cycle,' where the baby demands milk when hungry, thus initiating the feeding, which, in turn, stimulates the breast to produce milk in accordance with the infant's needs (ibid.).

These recommendations caused the prevalence of breastfeeding in Denmark to drop, until the early 1970s when it started increasing again as women began rejecting this practice as health professionals and mothers around the world founded organizations promoting breastfeeding. From the 1990s, the mother-child cycle was incorporated in the official recommendations based on scientific documentation. The current counselling material on breastfeeding is described almost exclusively in relation to health (Løkke, 2012.). According to the database Children's Health (Børns Sundhed)[1], data on children born in 2014 shows that 95.6% of children are exclusively breastfed the first week, 78.8% by the first month, 60.6% by the fourth month and 16.9% of Danish children are exclusively breastfed at 6 months (Sundhedsstyrelsen, 2021). Despite the improvement of prevalence, one in five stops breastfeeding within the first five

[1] Unless otherwise indicated all the translations from Danish to English are my own.

weeks after birth regardless of their initial intentions of longer breastfeeding periods (Nilson et al., 2020).

## THE IMPORTANCE OF COUNSELLING

In Denmark, it is established by law that that the municipality must help to ensure that children have both a healthy upbringing and good conditions for a healthy adult life. According to Chapter 36, §121 in the Health Act (Sundhedsloven), all children have the right to free health counselling, assistance, and functional examination by a health visitor until the end of the compulsory education (Sundhedsloven, 2019). Since 1937 health visitors have visited families in the beginning of a newborn's life, typically a few days to a couple of weeks after being discharged from the hospital, depending on the specific municipality and the assessment of the mother's needs (Kronborg et al., 2012). A natural experiment from 2012 showed that postpartum home visits helped mothers achieve longer breastfeeding duration compared to mothers who lacked these visits due to a strike by health visitors (ibid.).

However, the outcome of the counselling depends on the specific family's needs and choices regarding how they feed their child. The handbook on breastfeeding for health professionals, published by The National Board of Health (Sundhedsstyrelsen) in 2021, states that health professionals' care work should be based on documented knowledge, while also respecting and supporting the individual family's choices and needs. It is emphasized that insufficient counselling should never be the reason for a mother to stop breastfeeding. Conversely, mothers should never feel pressured into breastfeeding and health professionals should actively support the mother's choice of alternative feeding methods (Sundhedsstyrelsen, 2021). Breastfeeding can fail for various physical reasons like damaged nipples, breast infections, or pain. In such cases, it is not a conscious choice to quit breastfeeding, but an imposed necessity. This means that health professionals need to be mindful of the individual mother's circumstances. However, in any case, sufficient and attentive counselling is crucial in helping new mothers to overcome infant feeding obstacles, and in such situations, health professionals should have the tools to teach families how to deal with these difficulties productively (Kronborg & Kok, 2011).

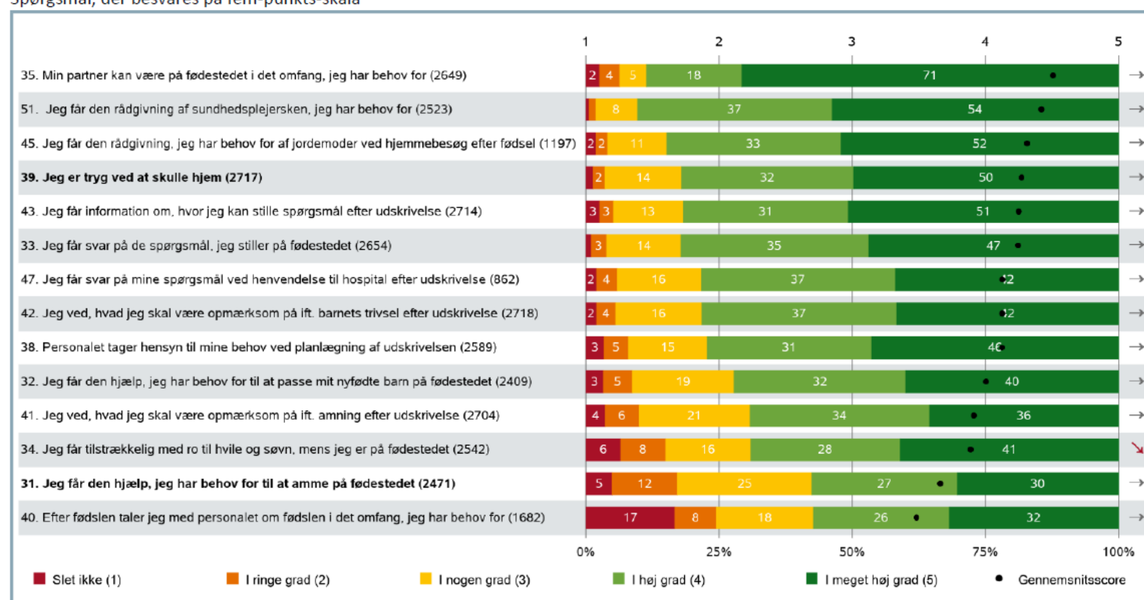
## BREASTFEEDING COUNSELLING AS A SOCIAL PROBLEM

The official narrative's focus on the importance of proper and attentive counselling seems to conflict with mothers' evaluations of their experiences during birth and aftercare in the Danish hospitals. The Nationwide Survey of Patient Experiences (Landsdækkende Undersøgelse af Patientoplevelser) revealed that far from all Danish mothers felt that the place where they gave birth provided the help they needed to breastfeed successfully.

**Figure 1: Women giving birth, after the birth: National results.**

**Fødende, efter fødslen: Landsresultatet**

Spørgsmål, der besvares på fem-punkts-skala




Note: Spørgsmålene i figuren er sorteret efter gennemsnitsscore. Teksten angiver spørgsmålsformuleringer i afkortet form. Spørgsmålenes fulde formulering fremgår af spørgeskemaet. Antal besvarelser er angivet i parentes. Spørgsmålene der står med fed skrift, er de nationale nøglespørgsmål, som LUP omfatter fra 2022. Pile viser, om resultatet er bedre (↗), dårligere (↘) eller ikke signifikant forskelligt i forhold til sidste år (→). Læs mere om LUP her: www.patientoplevelser.dk/lup

*Source: Danske Regioner (2021) LUP 2021: Fødende*

5% of the mothers reported that they did not get any of the necessary help to breastfeed at the place, where they gave birth and 12% answered only got the required help to a very small degree. 25% got the help they needed to some extent while 26% received the help to a high degree. Finally, 32% received the help they needed to a very high degree. In other words, almost 1 in 5 experienced a considerable lack of breastfeeding help immediately following birth, even though Danish mothers on average answered that they got the necessary help to breastfeed at the birth location to a high degree (Danske Regioner, 2021).

The above survey reveals that a significant number of mothers in Denmark do not get the counselling required to initiate successful breastfeeding. In some way, this is unsurprising

when considering how the Danish health care system is suffering from increased pressure allover. From 2009-2015, the activity in the Danish hospitals has increased by more than 25% while the number of employees has increased by less than 4 percent. This means that the health professionals must take care of more patients and activities than earlier (Danske Regioner, 2017), which arguably leads to a decline in the quality of care and guidance. Since 2009, the number of patients at the Danish hospitals has increased with 300.000. Further, as citizens are getting older on average and an increasing number of patients are suffering from chronic diseases the population requires more intensive, extensive, and advance treatment (Danske Regioner, 2018), putting even more pressure on an already strained health care system.

Moreover, these problems are not limited to the mother and infant care in a hospital context. The Health Visitor Survey (Sundhedsplejerske undersøgelsen) from 2018 revealed that while 71% of the health visitors feel that it is possible to solve their primary tasks with sufficiently high quality, 24% experience that it is mostly *not* possible. They explain that one of the reasons for this insufficiency is a lack of health visitors and that increased employment would make it easier to offer better breastfeeding counselling. The group of health visitors, who answered that their municipal health scheme does not live up to the national health recommendations, judge that a consequence hereof is unestablished breastfeeding or low breastfeeding frequency due to inadequate number of visits and support (Milling & Sørensen, 2018).

To conclude, breastfeeding counselling in Denmark today is undisputedly a social problem, insofar as mothers do not always receive the help they are legally entitled to and require. At a personal level, both mother and child are deprived of the health benefits of breastfeeding. Moreover, studies have associated breastfeeding with lower levels of depressive symptomatology (Dennis & McQueen, 2009, p. 748) adding positive psychological outcomes of the practice. At a societal level, Denmark is missing out on an investment in the health of Danish citizens which, as mentioned, has a positive impact on poverty and possibilities to enter the labor market. Yet, this problem can easily be overlooked or de-emphasized, since many health care professionals assume "*breastmilk can be replaced with artificial products without detrimental consequences*" (Victoria et al., 2016, p. 485).

## VOLUNTARY WORK

When the public sector fails to offer the help needed to establish breastfeeding, some mothers instead turn to counselling within the voluntary sector. Among the dominant political actors in Denmark, there is broad consensus that participation from civil society and volunteers in the development of the welfare state is especially important. The welfare state is under severe financial pressure and suffers from significant labor shortage (Boje, 2019) as seen above in the case health visitors. Especially within the social- and health care sector, the voluntary labor force is seen as a substantial resource in several areas. By functioning on behalf of the welfare state in certain settings, civil society and volunteer organizations in turn become an extension of the state (bid.). In line with my present concerns, the Health Information Committee (Komitéen for Sundhedsoplysning) recognizes the benefits of voluntary breastfeeding counselling. To ensure consistency in the counselling offered by volunteer counselors and publicly employed health professionals, the Committee suggests that voluntary organizations like Ammenet.dk takes part in distributing the national guidelines (Nilson et al., 2019). As such, voluntary breastfeeding counselling serves as an example of how civil society can act on behalf of the welfare state in helping families overcome difficulties in relation to breastfeeding.

In this thesis, the organization Ammenet.dk serves as a case of such new forms of online voluntary breastfeeding counselling, which provide alternative modes of support to mothers in need of support, information, or advice in relation to infant feeding. They primarily provide such support and advice by sharing evidence-based knowledge on their website and social media accounts, by managing peer-to-peer network groups on Facebook, and by providing counselling via their letterbox (Ammenet.dk, n.d.). In short, Ammenet.dk only provides counselling and support via different online channels, which differs significantly from the services offered by public health professionals, who are, predominantly, working with face-to-face counselling or, alternatively, via phone calls. Taking this difference as a point of departure, this thesis investigates the unique online mode of breastfeeding counselling conducted by Ammenet.dk, to explore the phenomenon of online voluntary breastfeeding counselling.

## EXPLORING RELATED LITERATURE ON THE SUBJECT

In the existing literature, online voluntary breastfeeding support has been addressed in different ways. For example, Pate (2009) conducted a systematic literature review on the efficiency of using the internet in the delivery of both professional and peer-support

breastfeeding promotion programs. She concluded internet-based counselling offers an appealing alternative to traditional face-to-face programs, as the latter is more time-consuming and expensive. By using the internet, new mothers gain access to the same health information as their health professionals. Additionally, the information is accessible anytime from anywhere (Pate, 2009). Five years after Pate's review, Giglia & Binns (2014) made a similar review, where they observed that the significant number of websites on covering the topic testifies to the need for easily accessible information regarding breastfeeding. However, they also noted that a lack of thorough studies on the subject makes it difficult to establish how internet-based counselling directly impacts breastfeeding support (Giglia & Binns, 2014). Following Giglia and Binns' observations, Geoghegan-Morphet et al. (2014) implemented an innovative and cost-effective online infant nutrition support solution where they provided a combination of professional help and peer-support to Canadian mothers. The mothers' feedback was largely encouraging, convincing the authors that the support tool had a positive effect on breastfeeding outcomes (Geoghegan-Morphet et al., 2014).

The internet makes social contact and information sharing among mothers in the same situation easily accessible (Cowie et al., 2011). Following the widespread global adoption of smartphones, online social networking is also increasingly becoming a valuable resource for breastfeeding mothers (Lebron et al., 2019). The ubiquity of internet access and the growth of online communities dedicated to breastfeeding extends the reach of existing supports systems, while also making access to such communities and systems largely independent of time and space (Burman, 2012). Furthermore, Burman (2012) showed that additional online social support can be effective in increasing the mothers' breastfeeding self-efficacy being their perceived capability to breastfeed. This is corroborated by Black et al. (2020), in a study of how membership of social media groups can provide mothers with increased faith in their ability to breastfeed successfully, which likewise concludes that online support potentially provides mothers with improved self-efficacy. Further, the social media groups create networks of relatable peers, thus doubling down on their ability to offer social support (Black et al., 2020). Lastly, Angell et al. suggest that health professionals should encourage self-efficacy by referring mothers to relevant websites, for information as well as social support (Angell et al., 2015).

Online breastfeeding support is also advantageous in reaching vulnerable mothers. Cowie et al. found the posts in an online breastfeeding support forum to be emotionally supportive and

they recommend the website especially to mothers who do not have social support in their everyday lives (Cowie et al. 2011). In the same vein, Pate points to the benefits of anonymity, which can make mothers at risk of stigmatization feel comfortable discussing sensitive topics (Pate, 2009).

Several studies emphasize the value of peer-to-peer support and the perceived authenticity of online voluntary counselling. Herron et al. (2015) describe breastfeeding support as "*a sustainable mother-generated system based on indirect reciprocity, which offers easily accessible, highly responsive, tailored support from more experienced others in a discrete online environment*" (Herron et al., 2015, p. 81). They found that the main type of reciprocity enacted between mothers on a website was upstream and indirect, meaning that the mothers who received support afterwards offered to help other mothers (Herron et al., 2015). Based on their online ethnography in a private Facebook group providing both informational and emotional support to mothers in need of help with breastfeeding, Bridges et al. (2018) argue for the significance of 'authentic presence' being supportive care indicative of a trustful relation between the mother and her peer-supporter. They show how the ability to provide both modes of support successfully rely on the providers' maintaining authentic presence in the group (Bridges et al, 2018).

In another study, Gray (2013) argued that some mothers find peer support to be better than professional support. Through an investigation of popular online breastfeeding discussion boards, she concluded that some women feel that only other breastfeeding mothers understand the complexity of breastfeeding. New mothers might experience confusing messages from health professionals who, on the one hand, medicalize and promote breastfeeding as the best way to feed their infants, while, on the other, provide them with and encourage them to use formula in case the breastfeeding fails. The debates on the discussion boards revealed that for these mothers, breastfeeding is about more than just medical facts and instrumental feeding (Gray, 2013). As such, when professionals do not acknowledge the emotional complexity attached to breastfeeding, the ambiguity expressed in their opposing suggestions can lead the mothers to seek support elsewhere, for example from other mothers on the internet who have had similar experiences.

Angell et al. (2015) confirm these claims in their study of users of healthtalk.org. They found that mothers were primarily interested in hearing other women's personal stories, and they

expressed a slight preference for the personal over the informational websites (Angell et al., 2015). Similarly, Lebron et al. (2019) found that mothers primarily asked for technical advice on breastfeeding in the online support group on babycenter.com, where peer mothers provided them with both encouragement, personal knowledge, and detailed experiences (Lebron, 2019).

Skelton et al. (2018) studied mothers' use of breastfeeding support groups on social media in the US and found that the groups created a sense of community, which normalized breastfeeding experiences and helped the mothers define realistic expectations. As such, breastfeeding groups had a positive impact on knowledge, attitudes, and behaviors concerning breastfeeding (Skelton et al, 2018). Caes et al. (2021) extend these findings in their work on women, who turn to online forums for support after experiencing pain in relation to breastfeeding and how their participation on such forums affects breastfeeding duration. Pain is one of the primary reasons for breastfeeding cessation, often producing a sense of guilt that leads to increased risk of postnatal depression. This sense of guilt can be diminished by how communities of peers on the online forums help normalize experiences of breastfeeding difficulties and attempted solutions like the use of breast pumps (Caes et al., 2021).

## THESIS CONTRIBUTION TO THE CURRENT STATE OF KNOWLEDGE

As my above review clarifies, the topic of online voluntary breastfeeding support has already been studied from a variety of empirical and thematic angles. Most of these studies reveal that such emerging online groups and resources offer attentive and non-judgmental support drawn from authentic personal experiences shared by relatable peers, who acknowledge both the technical, physical, social, and emotional complexity of breastfeeding. This, in turn, offers a both accessible and, for some, more desirable alternative to traditional forms of counselling offered by publicly employed health professionals. Indeed, as the studies by Cowie et al. (2011), Caes et al. (2021), and others indicate, online breastfeeding support might even be a more approachable solution for mothers in marginalized positions. Still, beyond issues of emotional support, attentive encouragement, and community-building, there might still be a need for studies measuring the breastfeeding *outcome* of online interventions, as Giglia and Binns suggest (2014). However important, measuring the instrumental outcomes of online breastfeeding support is not the objective of this thesis. Instead, I follow the studies introduced in the review by approaching online voluntary breastfeeding counselling as a particular kind of

social phenomenon. I contribute to the current state of knowledge by exploring an online voluntary counselling practice including all kinds of human and non-human actors in my investigation of how this specific mode of support affects how mothers experience, understand, and cope with breastfeeding problems in new productive ways. Moreover, I show how it enables the on-going production and co-existence of several new ways of having a breastfeeding body and being a breastfeeding mother. In so doing, I contribute to research on voluntary online breastfeeding support, both in a Danish and Western context. Additionally, I add knowledge to the field of online volunteer research, which currently remains at a nascent stage (Eimhjellen in Grubb, 2021, p.74).

Further, by mobilizing and combining notions of enactment, multiplicity, situated knowledges, cyborgs, and ontological choreographies from branches of Science and Technology Studies (STS) popularly known as *post-ANT* (see Gad & Jensen, 2010) and *feminist STS*, my thesis contributes to broader discussions of ontologies in practice in STS (Mol 2002) through a case study of the enactment of breastfeeding problems, bodies, and mothers in a Danish voluntary online organization.

# CHAPTER 3: THEORETICAL FRAMEWORK

Methodologically and theoretically, the project primarily draws on the work of three different scholars within the interdisciplinary field of Science and Technology Studies (STS). In brief, scholarship within STS addresses and explores science and technology in a broadly 'social' context, based on the premise that neither scientific knowledge nor technological innovations develop independently of the social world. As John Law explains, knowledge and technology "*participate in the social world, being shaped by it, and simultaneously shaping it*" (2004, p. 12).

In contemporary Denmark, breastfeeding and breastfeeding counselling are embedded in complex configurations of technology and scientific knowledge of various sorts. In the present case, the most obvious of such technological dimensions result from Ammenet.dk's reliance on the internet to offer counselling via Facebook and their website. The less apparent examples are, among others, the daily usage of technologies like breast pumps, breastfeeding shields, Supplemental Nursing Systems (SNS) [2] and so forth, as well as specialized knowledge of hormone production and the milk ejection reflex, of infants' growth spurts and weight curves, the mother-child response cycle, and so forth. Such technologies and knowledge in various combinations are consistently employed both in breastfeeding and counselling practices.

I employ an STS-inspired approach to investigate experiences of Ammenet.dk's online voluntary counselling system since it enables a practice-near study that not only foregrounds the mothers' and volunteers' experience of participating in the complex field of negotiations that emerge in breastfeeding counselling, but it also allows me to include the multitude of different actors, both human and nonhuman – like the various configuration of technologies and knowledge described above - that populate my empirical material. In short, the sensitivity to heterogeneity, multiplicity, and difference afforded by an STS-inspired approach both reveals and foregrounds the complex relations between humans and nonhumans involved in socio-material practices like online voluntary breastfeeding counselling.

[2] An SNS system is a tube system consisting of a bottle of milk with a tube attached to the nipple during breastfeeding.

In the analysis, I combine Annemarie Mol's work on *enactment* and *multiplicity* with Donna Haraway's thinking on *cyborgs* and *situated knowledge* and Charis Thompson's notion of *ontological choreography* to explore, trace, and analyze the experiences and practices of Ammenet.dk's online voluntary breastfeeding counselling that appear in my empirical material.

## POST-ANT & THE BODY MULTIPLE

Mol's work belongs to a particular branch of STS sometimes referred to as post-actor-network theory (post-ANT for short). A fundamental argument within 'classical' ANT (actor-network theory, see Latour, 2005) is that *both* the world *and* the theories we build to understand it are unstable, contingent, and complex. Naturally, ANT itself is no exception (Gad & Jensen, 2007). As such, ANT cannot be defined in simple or concrete terms, since it is anything but a stable conceptual entity in the first place. Similarly, post-ANT provides no fixed and coherent theoretical direction that you can "apply" or depart from in any simple sense (ibid.). Instead, if post-ANT is *anything,* then it is a *reflection on ANT;* an attempt to use the insights gained from ANT to rethink ANT itself (ibid., see also Gad & Jensen, 2010).

As Bruno Latour notes, ANT "*was never a theory of what the social is made of, contrary to the reading of many sociologists who believed it was one more school trying to explain the behavior of social actors"* (Latour, 1999, p. 19). Rather, it is a method that attempts to develop a particular form of open terminological access to empirical sites by emphasizing the importance of learning from the human and non-human actors themselves and the networked associations they continuously invoke (Latour, 1999, p. 19-20, see also Latour, 2005). By extension, post-ANT becomes an attempt at incorporate ANT's central tenets of learning from the actors and the associations they draw to the analysis itself. This is practically achieved by recognizing how analysis always involve interferences that participate in producing new networks of complex associations that also come to shape the very phenomena we investigate.

In this thesis, I lean on Mol's concept of enactment and her sensitivity to the practical multiplicity of objects, which she introduces most thoroughly in *The Body Multiple* (2002). Here, Mol analyzes various practices related to the disease atherosclerosis in a Dutch hospital. She reveals the multiplicity of atherosclerosis as it is enacted in various clinical practices across

the hospital. The pathological and the clinical version of atherosclerosis is not the same *thing*, sharing a common and uncontested *identity*. The two versions are vastly different as to where they take place, which people they involve, the instruments and techniques used to reveal and treat them, and so forth. The clinical version requires a doctor and a living patient in pain whereas the pathological version requires dead limbs and microscopes. Even though the two versions exclude each other *in situ*, they co-exist and are coordinated in ways that enable frictions between the versions of the disease but does not displace each other (Mol, 2002). "In practice, objects are *enacted*" (Mol, 2002, p. 41, my emphasis) and I am deeply inspired by the concept of *enactment* in studying how mothers, health professionals and Ammenet.dk perform multiple and ontologically different versions of breastfeeding problems and breastfeeding, and how these versions interfere sometimes harmonically and, occasionally, in unproductive ways.

In the study of practices, Mol suggests that we abandon the division between subject-people and object-nature as well as between actively knowing subjects and passive "objects-that-are-known" (Mol, 2002, p. 33). Inspired by Bruno Latour's similar rejection of the subject/object dichotomy, she invites us to "*admit that in our daily lives we are engaged in practices that are thick, fleshy and warm as well as made out of metal, glass, and numbers"* (Mol, 2002, p. 31). Instead, we should explore knowledge embedded in daily events and activities – in what she calls *practices* – and work to escape both dichotomies by examining *both* the activity of the material world and how objects and their fluid identities are multiplied in practice (Mol, 2002, 50). Consequently, Mol draws a *symmetrical* image of the complex webs of relations between human and nonhuman actors that avoids devoting singular attention to *one* specific actor's understanding or presentation of a particular phenomenon. This, in turn, leads her to investigate how heterogeneous actors participate in the networks of practices that emerge through the relational encounters of even the most mundane of daily events (Gad & Jensen, 2010, p. 65).

By adopting Mol's principle of symmetry, I favor neither how the mothers nor the volunteers *understand* the breastfeeding problems, and I do not limit myself to considering just *human* actors as participants in the enactment of breastfeeding problems. Instead, I follow how particular forms of counselling are *enacted in practice*, which human *and* non-human actors participate in shaping how online counselling is performed and how they are connected in

doing so, and, finally, how breastfeeding problems might emerge and be *multiplied* as a result depending on the practice.

## FEMINIST STS, CYBORGS AND ONTOLOGICAL CHOREOGRAPHY

My second source of theoretical inspiration is work in feminist STS, pioneered by scholars like Donna Haraway and Charis Thompson. Feminist STS intellectuals have examined both the pregnant body and reproductive technologies, but the subject of the breastfeeding body has hardly been touched upon (McCaughey, 2010). However, I find both Haraway and Thompson's work productive to think with in my investigations of how contemporary breastfeeding in Denmark, for both mothers and volunteers at Ammenet.dk, is embedded in complex configurations of practices, scientific knowledge, and technology. In "A Cyborg Manifesto" (1999), Haraway contests the conventional polarization between human/non-human actors and, by extension, mounts a challenge to the dichotomy of nature/culture. She argues that technologies should be analyzed in the situated practices in which they are significantly present (Adrian et al., 2018) and in the late 20$^{th}$ century Western societies, "*we are all chimeras, theorized and fabricated hybrids of machine and organism. In short, we are cyborgs*" (Haraway, 1999, p. 272).

In other words, we are always already entangled with the technologies we use, and which shape who we are and how we live our lives. As such, any analysis of situated technological practices is also an analysis of human existence and experiences, and vice versa. By engaging the concept of the cyborg and Haraway's problematization of the category 'female' developed therein, I consider how the use of technologies and scientific knowledge in the practice of breastfeeding can rework the nature/culture dichotomy, while also contributing to rethinking and challenging the singular understanding of the *breastfeeding body*.

Building on Haraway's cyborg, Thompson explores the agency of materiality in the interfaces between biological reproduction and fertility treatment, and how, in the context of assisted reproductive technologies, the biological also becomes personal, political, and technological (Thompson, 2005, see also Cussins, 1996[3]). Her work is centered around the concept of *ontological choreography* which she defines as "*the dynamic coordination of the technical,*

[3] Charis Cussins later publishes her work under the name Charis Thompson

*scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics*" (Thompson, 2005, p. 8). Here, I employ the concept of ontological choreography to emphasize the complex coordinative practices that needs to click and cohere for breastfeeding counselling to result in ontological innovations that make new breastfeeding practices possible and thus reconfigure the mothers' subject-positions.

My insistence on involving the mothers' subject-positions in this thesis is admittedly atypical when my theoretical point of departure is Mol's work. Thompson differs remarkably from Mol regarding her incorporation of subjectivity, identity, and selves into her studies. Mol does focus on subjectivity and selves due to her symmetrical sensitivity to objects, but Thompson believes that *"[t]he dependence of selves on technology has not received as much STS attention as its inverse, the dependence of science and technology on social, individual, and political factors*. (Thompson, 2005, pp. 180-181). In drawing on Thompsons work, I examine how agency is distributed in counseling practices via ontological choreographies and how the multiplicities of breastfeeding and their ontological innovations enable mothers to obtain the highly desired subject-position referred to as *a breastfeeding mother*. That is, a mother who successfully manages to breastfeed despite the presence of associated problems. After elaborating on my theoretical inspirations, I turn to my specific methodological and analytical considerations in the following chapter.

# CHAPTER 4: METHODOLOGICAL AND ANALYTICAL CONSIDERATIONS

My interest in online voluntary breastfeeding counselling was first sparked in the spring of 2021. Back then, I learned that Ammenet.dk and the Breastfeeding Competence Center (Kompetencecenter for amning), which is a project under the Health Information Committee, was looking for a student to collaborate with them on a thesis project examining Danish mothers' experiences with counselling within the public and the voluntary sector. They were specifically concerned with mothers' experiences of counselling via Ammenet.dk's online letterbox and wanted to use the knowledge produced in the thesis project to improve the online voluntary counselling and to ensure that it complements the public counselling in the best way possible. They were interested in similarities and differences between the two modes of counselling, which, coincidentally, I had experienced first-hand myself using Ammenet.dk's services, where I found support and advice while I was dealing with my own difficulties breastfeeding my son. At that time, I used Ammenet.dk in addition to the counselling provided by the nurses in the maternity ward, my general practitioner, and my health visitor.

Therefore, I knew about Ammenet.dk 'from the other side', as well, and as such, I was curious how online voluntary counselling might supplement and differ from conventional counselling offered by public health professionals. I approached Ammenet.dk with my interest in joining the project, and they established a collaboration between their organization, the Breastfeeding Competence Center, and myself. Practically, my contact person at Ammenet.dk was in many ways my gatekeeper to the field as she provided access to the internal Facebook groups and to their education material. She also invited me to the annual general meeting that I participated in. Here I gained a thorough introduction to the organization and their mode of breastfeeding support. After several meetings with her, we agreed on the overall objectives of the project.

I am aware that both Ammenet.dk and The Breastfeeding Competence Center have interests in this thesis, and their involvement can potentially affect the results of the study in different ways (Carlsen, 2018). For example, their interests are undeniably incorporated in the problem statement and research design. As mentioned earlier, they were originally interested in a project primarily focusing on counselling via the letterbox. However, I could not fully meet their

request of solely examining the letterbox and I had to adjust my research design to include forms of counselling beyond the letterbox. I was in continuous dialogue with Ammenet.dk and my contact person expressed complete understanding for the adjustments I made. In that way, I attempted to balance both what I *could* and *should* do.

## CASING

Ammenet.dk is a case of online voluntary breastfeeding counselling. But what does it mean to say that Ammenet.dk is *a case?* To explain this, I follow Ragin (1992) and his concept of *casing*. Ragin argues that a case is neither a theoretical category nor an empirical unit, but a product of *doing research*. Casing is a selective practice done at various levels of abstraction and enables the researcher to progressively narrow down her empirical focus throughout as the research proceeds (Ragin, 1992). Similar practices of casing on several levels were also evident in my own work, wherein I attempted to variously delineate my focus without losing track of the broader themes that initially guided my inquiry. However, this process has certainly not been linear and the starting point for this thesis were never a general phenomenon of interest, despite the presence of such broader themes.

Instead, my first casing took place on a specific level by virtue of my collaboration with Ammenet.dk. and The Breastfeeding Competence Center. At the outset, I wanted to focus on the mothers and their accounts, but as I started my interviews with the mothers, it became increasingly clear that the volunteers' accounts of the counselling practices would be needed to produce a more rounded analysis of the themes and issues raised by the mothers. I chose to focus analytically on mothers, who have experiences with counselling from the voluntary and the public sector, volunteers of the organization and, due to the importance accorded to materiality in my theoretical inspiration, Ammenet.dk's educational material. This selection *within* the case of Ammenet.dk was also an instance of casing, as it involved the deliberate collection of different kinds of empirical material within a previously delineated field (Ragin, 1992).

Knowing my specific case, I started reflecting on the overall phenomenon of interest doing casing on a more general level (Ragin, 1992) by determining the phenomenon to be breastfeeding counselling in Denmark. The introductory chapter illustrates some of the findings connected to this initial casing, where I focused why this phenomenon can be

considered a social problem. From here, I embarked on a "*theoretically motivated narrowing of the empirical focus*" (Ragin, 1992, p. 222), which continued throughout the research process. Narrowing down the empirical focus leaves other empirical parts of the world silent, making them partly disappear from view (ibid.). On the most general level, breastfeeding counselling is a vast phenomenon, involving a multitude of different kinds of work done by various actors within diverse fields. It varies both locally, from hospital to hospital, clinic to clinic, and counselor to counselor. But also, globally from country to country, from high-income to low-income nations, and along other lines of difference and similarity at multiple scales. Yet, since my interests specifically concern the breastfeeding counselling conducted by Ammenet.dk, my next casing was done by determining my interest as *online voluntary* breastfeeding counselling in Denmark.

In his discussions of casing, Ragin raises the concern that definitions of concepts lead to particular findings, and how, by extension, invoking different definitions could lead to different findings (Ragin, 1992, p. 222). As such, the definitions that guide the process of casing needs to be carefully considered. From the beginning, I have been particularly aware of how to conceptually delineate the phenomenon of *counselling*. What, in short, defines counselling in my case? Can 'proper' counselling only be provided by counsellors with an acknowledged education, like the internationally recognized IBCLC (International Board-Certified Lactation Consultant) certification? What about all the other forms of counselling, formal and informal, that emerge through Ammenet.dk's various practices? In my case, it would make little sense to use the IBCLC certificate as the defining factor for what constitutes counselling, since the certification is not required for the volunteers at Ammenet.dk.

Instead, to become a breastfeeding counsellor on Ammnet.dk, the candidate must complete Ammenet.dk's own in-house training course in breastfeeding and communication. Then, 'proper' counselling could be said to require that the volunteer has at least completed Ammenet.dk's training course. In the project's early phases I followed this logic by defining 'counselling' as the counselling offered by the educated volunteers via the online letterbox, partly to satisfy Ammenet.dk's request for research on this mode of counselling. However, few of my informants had actively used the letterbox and, as it turned out, had gotten more help from the online networking groups or the Wiki, while others again had used more than one of the options. The Facebook groups have volunteer moderators attached, who are *not* required

to complete Ammenet.dk's training course. As I quickly found out, all the mothers had used to peer-to-peer support offered in this groups and viewed them very favorably. Consequently, I had to return to the process of casing by broadening the scope of what might count as 'counselling'.

Based on my interviews with the mothers, I defined three broad categories of counselling that Ammenet.dk provides: letterbox counselling by educated counsellors, peer-to-peer support in the Facebook network groups, and the Ammenet.dk Wiki that mothers can individually consult. The different forms of counselling, in turn, involves different practices that require investigation. In the end, broadening my focus from just the counselling done via the online letterbox seemed beneficial because it acknowledges the multiple ways that mothers use Ammenet.dk's options for counselling. Including the Wiki in defining the concept of 'counselling' is also in line with my symmetrical focus on both human and nonhuman actors. Additionally, this also entails a process of casing, as far as the symmetrical sensitivities that post-ANT involves motivates the inclusion of technologically mediated material-semiotic practices as the empirical focus, thus partly shaping how I delineate the case in question. The casing in this phase of the research process is also empirically motivated as it evolved during my collection of the data. In this way, the concept of 'counselling' is also generated in the encounter with the part of the world that I am investigating (Ragin, 1992, p. 222).

If I had been doing the casing differently, the findings would have been different too. "*When cases are made, the process of casing consists of matching ideas and evidence*" (Ragin, 1992, p. 221), which also means that casing is continuous as the research progresses and reveals how theoretical ideas and empirical evidence is mutually interdependent (ibid.). Unsurprisingly, producing this thesis has been no different.

## DATA COLLECTION METHODS

The case study design is not tied to a specific discipline or scientific paradigm. It is "*a transparadigmatic and transdisciplinary heuristic*" (Van Wynsberghe & Khan, 2007, p. 80), which means that I am not required to approach the case with a specific methodology or to think within a specific scientific paradigm. Instead, the case study enables the case itself to partly dictate the choice and combination of methods and empirical material. In this case, I employ two distinct approaches to data collection, which produces two different 'kinds' of

empirical material that help me address the problem statement. Firstly, my data is collected through qualitative research interviews with Ammenet.dk's volunteers and individual mothers who have received counselling from Ammenet.dk in addition to public counselling. Secondly, I use the educational documents that the organization use to introduce and educate new voluntary counselors and Wiki authors. By using multiple methods and sources of data, I develop "*converging lines of inquiry, which facilitates triangulation and offers findings that are likely to be much more convincing and accurate* (Van Wynsberghe and Khan, 2007, p. 84).

### *Interviews and Interview guide*

By conducting interviews, I explore both the volunteers' and the mothers' accounts of how breastfeeding problems are "done in practice" (Mol 2002, p. 15). With STS being my epistemological and ontological perspective, I deliberately focus on the informants' descriptions of practices (Høybye-Mortensen, 2021, p. 223). Concomitantly, as Mol explains, *"What people say in an interview doesn't only reveal their perspective, but also tells about events they have lived through*" (Mol, 2002, p. 15). Through my analytical focus on practices, I approach the informants' accounts of counselling as windows into the events they have experienced (ibid., p. 14-15). In this way, the interviews reveal more than just their perspectives by enabling detailed descriptions of how the events of breastfeeding counselling were done in practice.

As previously mentioned, I am interested in how all manners of humans, objects, and practices, including (but not limited to) people, technologies, materials, discourses, correspondences, and so forth, interface in the mothers' accounts of voluntary breastfeeding counselling. By taking such heterogeneous actors and objects into account I move beyond the divide between subjects and objects and acknowledge the co-constitutive enactment of both (Mol, 2002). Therefore, I already had to consider both human and nonhuman entities and objects from the initial interview preparations. In practice, I did so by designing two semi-structured interview guides with topics related to counselling events while I made sure to explore the presence, roles, and effects of various objects in these events.

I did not prepare specific questions in a particular order but concentrated on chosen topics I wanted to know about (see appendix 1 and 2). The interview guide for the volunteers were directed at the work and configuration of the organization. In the interview guide for the

mothers, I included more general topics such as 'differences between the two modes of counselling' and 'main problem'. I asked curiously about the use and importance of different objects, as their involvement was revealed throughout the interviews. For example, when a mother told me that she started pumping, I asked her to elaborate on the role of the pump and what it meant to her breastfeeding. This allowed the informants to recount their experiences in their own words (Packer, 2011), while simultaneously ensuring symmetrical attention to the interactive intertwinement of both human and nonhuman agents (see, e.g., Latour, 2005).

To help the informants unfold their experiences in their own words I used probing techniques. According to Bernard (1994), it is important to know how to probe to do a successful interview. Probing means that the interviewer "*stimulate a respondent to produce more information, without injecting yourself so much into the interaction that you only get a reflection of yourself in the data* "(Bernard, 1994, p. 217). I wanted my informants to explore and reflect on their own thoughts, using their own words, as the interviews progressed. I tried to stop myself from overt interruptions and interfering too much. Therefore, I primarily used directive probes by asking leading questions based on information that the informant had already shared. In that way, I nudged the informants to elaborate further, even if the information already shared seemed obvious to them (ibid.).

### *Recruitment*

The case design allows me to investigate a complex phenomenon with a small sample size (Van Wynsberghe and Khan, 2007). I initially aimed to do a focus group interview with 4-8 mothers since my priority was to make comprehensive descriptions of the mothers' experiences of the counselling practices. However, the recruitment proved to be challenging and it took several re-posts in the various Facebook groups to recruit 8 mothers in total. When I interviewed the mothers, it became clear that they had very different experiences of the breastfeeding counselling as well as different outcomes. Additionally, at the time of the interview, they lived rather different lives. Some were breastfeeding children over 2 years old, some were on parental leave and breastfeeding their babies, and some were expressing or pumping milk fulltime:

Table 1: Overview of informants, mothers

| NAME | CHILDREN | PROBLEM |
|---|---|---|
| SOPHIE | A boy of seven months | Infections, pain, and incorrect sucking technique |
| KAREN | A boy of five months | Pain during breastfeeding |
| JANE | Two children, a girl of 2,5 years and a girl of 2,5 months | Tight tongue band and lack of weight gain |
| MONA | A boy of 3 years and seven months | Inward-facing nipples |
| ERIKA | A girl of 3 years and 3 months | Corona isolation, not able to breastfeed her child |
| EVA | Two children, a boy of 5 years and a girl of 1,5 years | Tight tongue band lack of weight gain |
| MARIE | Two children, a girl of 3,5 years and a boy of 3 months | Tight tongue band and high palate |
| SIMONE | A boy of six months | Tight tongue-, lip- and cheek band |

I contacted one of the mothers through a voluntary counsellor and I recruited the rest through the dedicated groups on Facebook, largely by making posts that briefly described my project and how I was looking for participants. I clarified that participants should have received counselling within the public sector (e.g., in the maternity ward, from health professionals in their homes or their general practitioner), as well as Ammenet.dk's voluntary counselling. As they are personally involved in the study, I made sure to obtain informed consent from all the informants and assured them of anonymity (Carlsen, 2018). I asked for consent to use their anonymized accounts in my thesis and for Aalborg University to publish it on their website. In addition, I made sure that everyone consented to Ammenet.dk using the thesis and my findings in the improvement of their work. Finally, I asked whether it would be okay for me to send the thesis to the other participating mothers.

I also obtained consent for the above from the two participating volunteers who have various roles and responsibilities in the organization:

Table 2: Overview of informants, volunteers

| NAME | ROLE IN THE ORGANIZATION |
|---|---|
| *Sara* | Board member<br>Counsellor (currently inactive)<br>Moderator and responsible for organizing the voluntary work in the network groups |
| *Ann* | Board member<br>Counsellor and responsible for the counsellor foals<br>Moderator in the network groups<br>Organizer in the work with the Wiki and the website as well as SOME responsible for Ammenet.dk's Instagram profile together with another volunteer |

I recruited one of the volunteers through one of Ammenet.dk's internal groups on Facebook and the other by contacting her directly on Facebook messenger, knowing that she had been a valued member of the organization for years. I had met both volunteers at the annual general meeting, so I knew a bit about their responsibilities and their work in the organization. I found it important to recruit volunteers, who have in-depth knowledge of the organization and the various types of counselling offered, both historically and presently, which the two volunteers had.

It was not possible to offer the volunteers full internal anonymity, as other volunteers in the organization know about their participation in this project (Carlsen, 2018). At the same time, their roles and responsibilities in the organization makes them easily recognizable for the other volunteers. However, I have omitted their names and other personal information in the reporting. I made both informants aware of this, which they fully accepted.

### Online interviewing

Even though I initially wanted to do a face-to-face focus group interview with the mothers, I ended up doing individual interviews online with both the mothers and the volunteers. Due to lack of responses to my first posts in the Facebook groups, I decided to suggest individual interviews online if the mothers preferred. As a result, I recruited the 8 mothers in the study. Indeed, as I had anticipated, practical circumstances made the online interviews preferable.

Besides one face-to-face interview, I did the interviews through video calls on Facebook messenger. When interviewing the mothers about their breastfeeding difficulties on Messenger, the platform also becomes an intimate virtual space. It was important to me that

the mothers were comfortable sharing their experiences in this space. I assumed that they were able and willing to use Facebook for the interviews, since I recruited the informants via this platform, meaning that they are already familiar with using Facebook for different forms of communication (Lo Iacono et al., 2016). Using Facebook to conduct interviews can be challenging to the kind of intimacy that emerges in interviews between the researcher and her informants (Dalsgaard, 2016). Based on their membership of the Facebook groups, I assessed that these mothers were used to sharing and reading personal stories about breastfeeding problems on an internet-based platform, also concerning sensitive topics like motherhood and breastfeeding. I also expected that the volunteers would be comfortable doing the interviews online, as they are volunteers in an organization that primarily works online, and they are the ones receiving and responding to sensitive questions of breastfeeding difficulties.

Regarding the concern of losing intimacy in the online interviews, the contemporary Internet is for many people a meaningful element embedded in their everyday lives that they do not even notice as *separate* (Hine, 2015, pp. 35-46). Though I recognize that it can, potentially, be difficult to construct an intimate space online, I also follow Hine in arguing that embeddedness of internet-based forms of communication in informants' everyday lives goes someway to cancel out such difficulties.

### *Document analysis*

To supplement the interviews, I investigate the educational documents that Ammenet.dk uses in their training of new voluntary letterbox counsellors. One advantage of using the latter method is that the documents are produced in a social process outside the context of my research, and I thereby avoid the consequences of how the volunteers would react to me studying them (Dahler-Larsen, 2005). That is, they are not made to answer questions that I would pose. This provides an opening into an understanding of the practices of the organization that is not immediately shaped by how I approach it and with whom I happen to speak. At the same time, I acknowledge that these documents themselves present *their* reality (Gad, 2010), and in doing so they also participate in shaping various organizational practices, like the practice of educating new voluntary counsellors.

I work with a distinction between two ways of analytically approaching a document. The first is a form of critical reading specified as *reading against the text.* This is opposed to the second

strategy, which is to *read with the text*. The former aims to uncover the text's agenda, ideology, or conflicts in the logic it presents. The latter is an STS approach considering texts as material-semiotic actors, who contribute with ontological practices by circulating and interacting with other actors and thereby participate in the construction and maintenance of realities (Jensen & Lauritsen, 2005, Gad, 2010). Not surprisingly it is the latter analytical approach with which I engage the documents in my thesis.

## ANALYTICAL STRATEGY

I approached my data through what, for lack of a better term, could be called a practice-oriented analytical strategy inspired by post-ANT and feminist STS. However, it is important to emphasize that post-ANT discourages the illusion of 'applying an analytical strategy,' insofar as this would imply the existence of a stable and fixed 'strategy' that can be applied in the first place. This, as we saw above, goes against the general premise of post-ANT. Thus, moving towards an analytical perspective consistent with the post-ANT approach I detailed above includes accepting the absence of a stable, consistent, and fixed perspective or the application of an abstracted, detached, and prescriptive procedure. This, however, should not be taken as an attempt to hide the process or practice of analysis. Therefore, to offer transparency of how the thesis came to be, I specify my analytical procedure as it developed in dialogue with the practices I explored, as objects of study and tools of study intermingled and shaped each other.

### *SENSITIZING CONCEPTS AND THEORY BUILDING*

In her reflections on actor-network theory, Mol argues that ANT is *"[…]an adaptable, open repository. A list of terms. A set of sensitivities. The strength of ANT, then, is not that it is solid, but rather that it is adaptable. It has assembled a rich array of explorative and experimental ways of attuning to the world"* (Mol, 2010, p. 265). In this thesis, I am inspired by this adaptability, wherefore I follow Mol in rejecting a fixed framework or perspective in which I try to 'fit' my empirical material. Rather, I try to develop a set of sensitivities that allow me to follow and learn from the actors themselves, insofar as "*it is a central tenet in ANT that the researcher's categories and presumptions should not be allowed to dominate descriptions. Instead, actors ought to be given voice in their own categories*" (Gad & Jensen, 2010, p. 76). This does not mean that I reject the use of theoretical concepts. Rather my point of departure is characterized by an empirical proximity that involves being sensitive to local concepts and

from there I include Mol's, Haraway's and Thompson's concepts in dialogue with my case-based material and concepts.

From the perspective of Mol, Haraway and others, the theoretical and the empirical are not in contradiction, nor are they intrinsically distinct. On the contrary, they are always already reflections of the realities that shaped them and which they render multiple in practice. In other words, I explore online voluntary breastfeeding counselling by experimentally adapting and developing the theoretical framework according to how the actors in my empirical material give voice to their own categories, observations, and practices, and how this both constructs and challenges new 'frameworks' as a result.

### *FROM EMPIRICAL PROXIMITY TO ANALYTICAL CONSIDERATIONS*

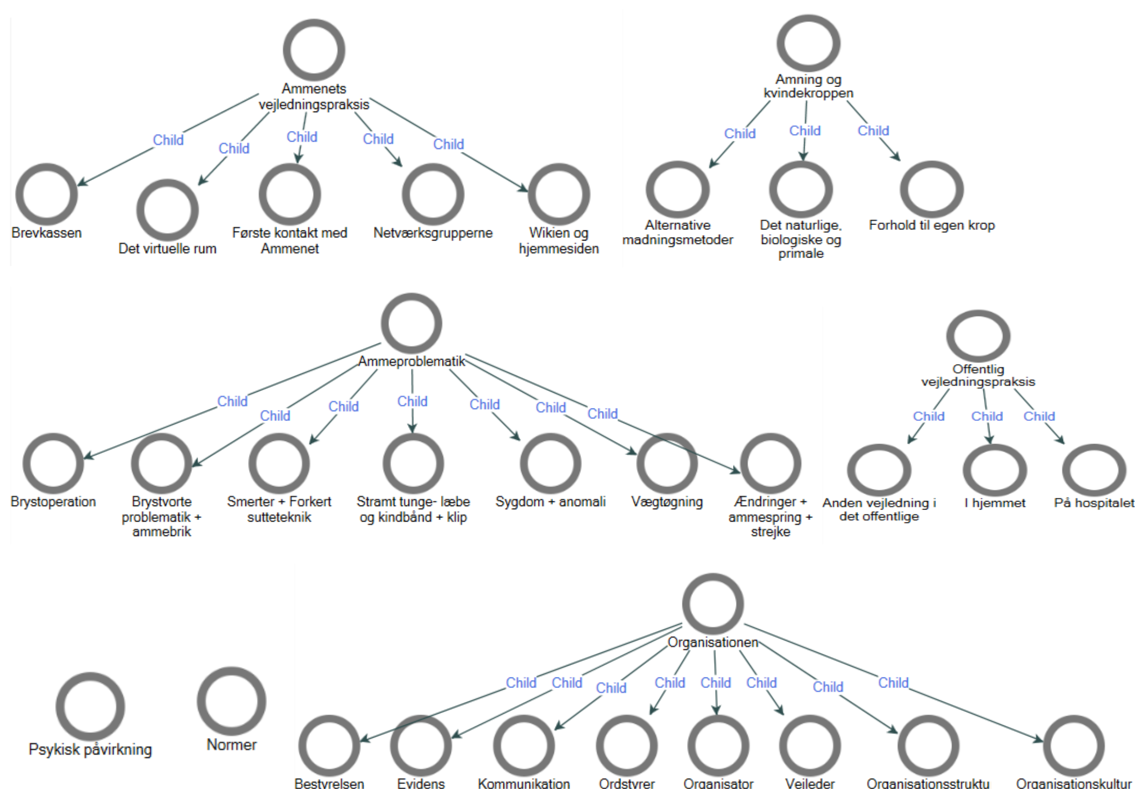
The interviews with my informants were recorded and subsequently transcribed in the program NVivo. Due to my sensitivity to materiality, Ammenet.dk's educational material was also imported into the program, and both were processed similarly by coding the material in the same way. This means that I considered both interviews and documents as equal openings into practices related to online volunteer breastfeeding counselling.

The coding took place in two stages. Firstly, I coded the interviews with the mothers. Secondly, I coded the interviews with volunteers along with the educational documents. I divided the coding into these stages, since I initially wanted to sensitize myself to the mothers' experience of and engagement with Ammenet.dk's different practices. As I began the coding process, the amount of data seemed almost unmanageable. The transcriptions of my 8 interviews with the mothers were overwhelming, especially due to my semi-structured and open approach to the interviews. Even though my interview guide was divided into themes, the diversity among the informants, their experiences, and their use of Ammenet.dk implies that I had a large amount of data which initially did not seem to offer any obvious patterns.

To reveal the outline of how specific objects were enacted in different practice, I had to impose some form of structure on the collected material. To do this, I thematically coded the interviews with broad codes like 'Ammeproblematik', 'Amning og kvindekroppen' and 'psykisk påvirkning', alongside a special attentiveness to practices, actions, objects, and the relations between them as they appeared through thorough readings of the interviews. The sensitivity to objects, actions, and practices was the only thing I consciously brought to the thematic

coding, and the rest of the themes emerged as patterns through the process itself. None were pre-determined. The result of this process was a disorganized codebook that I revised by sorting out the codes that turned out to be irrelevant to my focus and by merging the once that had remarkable similarities. For example, I filtered out the code 'Brug af privat behandlingspraksis' as other themes turned out to be more obvious and thereby relevant. Using the new codebook, I thematically coded the volunteers' interviews and the educational documents. New relevant codes, especially regarding organizational arrangements, visions, and working procedures, emerged, and were included in the codebook. I revised the codebook once again by merging and sorting codes. I ended up with the following codes and subcodes:

Figure 2: Codes and subcodes




The thematic coding helped me gain a much-needed overview of my data. I continuously wrote down various points of attention and contours of patterns pointing towards the networks of practices and the different actors involved.

The process of analysis consisted of three stages involving different but layered ways of working with the same material: a descriptive stage, an analytical stage, and a reflexive stage. In the first stage of description, I outlined the networks of practices, actors, and situations that

were present in the coded material. Here I focused primarily on the different concepts, categories, and perspectives that were readily apparent through my informants' accounts of the actors and practices involved with the online counselling.

In the second stage of analysis, I began bringing the conceptual apparatus introduced above – enactment, cyborgs, and ontological choreography – into dialogue with the concepts, categories, and theories outlined in the first stage. I also experimented with other relevant concepts in the processing of the first stage.

Finally in the third layer of reflexivity, I worked through the material once again considering possible consequences of producing the thesis. Thereby I initiate the reflexive 'trick' characteristic of research in the post-ANT 'tradition'.

### *A Note on Enacting Knowledge and Situatedness*

Although my ambition is to describe practices, objects, and connections, I cannot deny that I encounter the world from my own 'somewhere' (Haraway, 1988). Haraway's feminist critique, introduced above, is elaborated through her concept of situated knowledge, which produces a version of 'feminist objectivity' that challenges the so-called 'God Trick', that is, the myth of the researcher looking at everything from nowhere. In contrast, Haraway claims that all knowledge is situated, it always involves a view from somewhere that is conditioned by a particular sensory system (ibid., p. 581). As Law has written elsewhere: "*we are part of that complexity, we are helping to create that complexity, and we could never get outside the social to view it from above and as a whole*." (Law, 2008b, p. 640).

This means that I distance myself from the 'God trick' since the knowledge I produce through my research process and which this thesis is the result of, is determined by my situatedness. This entails that I accept that the 'strategies' we use to understand the phenomena in the world are somehow both distinct and detached from the empirical.

Being mindful of my situatedness, I sought to prevent my own theoretical and personal presuppositions from dominating the initial steps of coding and analysis. Admittedly, through various stages of the project, different conceptual framings have been appealing to me and informed the analytical course, regardless of my desire to follow the directions revealed through my material. Because of my situatedness this attempt at avoiding a priori assumptions is largely impossible insofar as I can never escape my own situatedness.

# CHAPTER 5: THE MULTIPLICITY OF BREASTFEEDING PROBLEMS

I begin my analysis by unpacking some of the 'local' concepts that emerge from the empirical material and relating them Mol's concepts of *enactment* and *multiple ontologies*. In Mol's words, *"[...] an illness takes shape that is both material and active. [...] It is an illness made up of scars on your legs [...] This illness is something being done to you, the patient. And something that, as a patient, you do* (Mol, 2002, p. 20). Following Mol's analysis of the enactment of illness and the theoretical apparatus she develops therein, I argue that breastfeeding problems, like atherosclerosis, are material and active at the same time, they both *are* and *do* something. It is material when, for example, a baby does not latch on to the breast, the breastfeeding position is ineffective or the milk production is challenged due to hormonal disturbances, and so forth. At the same time, a breastfeeding problem is something the mothers actively *do* as well as something that health professionals and Ammenet.dk *do with and to them*. These 'doings' or enactments are rooted in the practices of breastfeeding counselling in the maternity ward, the homes of new mothers and in the virtual space hosting Ammenet.dk's counselling through the letterbox, the peer-to-peer groups, and the Wiki. By presenting several instances of breastfeeding counselling situations from the informants' accounts as well as descriptions in the education documents, I elaborate on how a breastfeeding problem can be enacted in different ways, as both material and active.

## DIFFUSE PROBLEMS: WHEN IT DOES NOT QUITE WORK

A common feature for a lot of the mothers is that their breastfeeding problems took diffuse forms after coming home from the hospital:

*"[I] løbet af, jamen hendes tredje uge, der er det så jeg begynder også at kunne se at der er nok nogle ting der ikke sådan helt fungerer. Med den amning. Hun falder nok lidt for meget hen og så videre."* Interview, Eva

*"Det var meget, meget hårdt også fordi jeg havde jo ondt hele tiden, og jeg følte ikke rigtig at det blev bedre, og man blev sådan helt hvorfor ligger han der så meget, er det så fordi han ikke får nok og... Altså virkelig mange sådan tvivlsspørgsmål."* Interview, Karen

*" [J]amen jeg synes ikke det fungerer helt."* Interview, Marie

*"[E]n uge efter har det været, vi tog til lægen og var sådan "hvad er det der foregår?""* Interview, Sophie

As the examples illustrate, the mothers have an initial confusing concern about their breastfeeding because, as one word it, 'something does not quite work'. Being new mothers, they have many 'questions of doubt' and find it hard not knowing 'what is going on'.

Mol argues that the existence of a 'problem' requires that *"[t]he patient must worry or wonder about something and the doctor be willing and able to attend to it*" (Mol, 2002, p. 23). Likewise, the very existence of a breastfeeding problem requires a worried or wondering mother and someone that can and will address the problem, be it a midwife, a health visitor, or a volunteer. In her study on intermittent claudication, Mol describes how a woman's diffuse pain takes the form of a diagnosis at a doctor's consultation: *"She didn't actually have a condition called 'intermittent claudication' until she presented herself at the surgery. Before that the pain was 'diffuse'"* (Mol, 2002, 22). Prior to the doctor diagnosing the phenomenon as intermittent claudication, for the woman it was nothing but diffuse pain. Before the patient entered the consultation room, there was no phenomenon for the doctor to diagnose. The problem *was not* intermittent claudication. Not yet at least. The point is that for a diagnosis to be enacted, both the physician and the patient are required to meet around the diagnosis (Mol, 2002, p. 22-23). The same goes for enacting breastfeeding problems.

In the mothers' situations, they do not have a delineated problem, as a problem definition or diagnosis requires an actor, a public health professional or a volunteer, who has the ability and willingness to attend to and characterize the diffuse challenges they face and a patient, or a mother, agreeing to and acting alongside the diagnosis and characterization. In the context of public breastfeeding counselling, the first actors willing to attend these are the health professionals.

## PUBLIC COUNSELLING: POORLY COORDINATED REALITIES

The use of the voluntary counselling is connected to counselling in the public health sector, insofar as Ammenet.dk can be seen to work on behalf of the welfare state, thereby establishing an association between the two heterogeneous actors. As the analysis will reveal, the mothers' difficulties are certainly not identical, but cross-cutting theme in their accounts is that they, to a greater or lesser degree, have not received appropriate public counselling, either in

diagnosing or solving their problems. Since breastfeeding counselling as a *concept* shapes practices and is shaped by practices, it is not possible to detach the *conception* of counselling from the practices in which it is enacted. Consequently, I do not claim that these specific cases say anything general about counselling in the public or the voluntary sector. But what I can say is that there are cross-cutting similarities my informants' accounts, which suggests that the public counselling practices *they* have been a part of have not met *their* needs.

One example is Jane's description of the insufficient breastfeeding counselling she experienced at the maternity ward after giving birth to her first child. The nurses or midwifes at the ward judged that she had no complications in breastfeeding her newborn baby girl, even though Jane herself feels substantial pain when feeding her daughter:

*"Altså hospitals staffet syntes egentlig, og de har skrevet overalt i min journal, at amningen kører, amningen skidegod og bla, ej men det kører bare, Og det var bare overhovedet ikke min egen opfattelse fordi at det gjorde bare pissehamrende ondt."* Interview, Jane

Jane's account of her stay at the maternity ward offers insights into the immediate consequences of ineffective counselling. She describes that breastfeeding is 'immensely painful' and that she does not consider the breastfeeding to be working at all. The health professionals, on the other hand, believe that the breastfeeding is working better than expected, which is highlighted several times in Jane's journal.

Jane herself does not suspect a tight tongue band at this point, and she is convinced by the hospital staff, when they tell her that she is 'doing it right' despite the almost unbearable pain. She describes a maternity ward where the initiative for breastfeeding support must come from the mother herself, and that the health professionals do not examine her baby to exclude the possibility of a tight tongue band as the cause of the pain she experiences:

*"Man skulle selv spørge man, skulle selv opsøge og den tilgang fungerer ikke, når man tror at man gør det rigtigt […] Hvem er det der rent faktisk kigger, der var ingen der observerede barnet inde i munden for at finde ud af om noget omkring det stramme tungebånd og det har 100 % noget at skulle have sagt i forhold til at det gjorde fucking ondt […]"* Interview, Jane

Jane is convinced that she is 'doing it right' despite her immense pain and therefore she does not take the initiative to get further help. Because if she wanted further counselling, she

needed to ask for it herself, and they kept telling her that everything worked perfectly. A few days later, during a home consultation with her health visitor, Jane could not shake the feeling that something was not quite right. She tells the health visitor about her concerns that the 'tongue band is too tight':

*"[…] Der gik jo ikke særlig lang tid, altså vi snakker to dage, så kom sundhedsplejersken jo så også på besøg og kunne konstatere at hun havde jo tabt sig rigtig meget, og så spurgte jeg hende hvad fordi det gør så ondt når jeg giver hende mad du ved, altså jeg havde en veninde der havde, hvis barn havde stramt tungebånd, så jeg vidste en lille smule til det overhovedet ikke særlig meget, og spurgte altså hvis man har det hvem er det så der tjekker det? Ej men det har jeg tjekket. Det har hun ikke, så der… det… så sad hun der og kiggede på mig og sagde at jeg skulle bare blive ved og det ser rigtig godt ud […]"* Interview, Jane

Due to Jane's knowledge of a friend dealing with her child's tight tongue band, Jane believes that there could be a possibility that her own girl faces similar feeding challenges. The health visitor quickly refutes this suggestion, telling Jane that her child does not have problems with the tongue band, and she encourages Jane to continue breastfeeding because 'it looks really good'. She continues breastfeeding, not without problem mind you, and it is not until the girl is seven months old that Jane's suspicions are confirmed:

*"Vi fandt først ud af med den første at hun havde stramt tungebånd da hun var syv måneder, fordi hun blev ved med at sutte yderligt på min brystvorte ikke […] Og så havde vi Mie fra Funktionel Terapi ude, som ja er ergoterapeut, og hun kiggede og sagde at det var stramt."* Interview, Jane

A private occupational therapist's diagnosis introduces a third counselling event. I will not dive into the complex of private counseling practices, even though the private market is certainly not absent in mothers' accounts. The point here is that the diagnosis 'tight tongue band' that corresponds with Jane's experience is given but not by the public health professionals. It also takes quite some time to arrive properly, in a stabilized version, and not just as one possible manifestation of Jane's diffuse, but quite painful, problems.

The object of the tongue band plays a crucial role in Jane's enactment of the pain she experiences and thereby in the enactment of her breastfeeding problem. But the health professionals in the maternity ward and in her home do not enact this object the same way as

Jane does. Instead of enacting the tongue band as a possible problem, they hold her breastfeeding to be unproblematic. The same practice, that of Jane feeding her baby, is both a painful problem that won't go away and an almost too-perfect example of proper breastfeeding, that 'looks really good.' They conclude that her daughter could not possibly have a tight tongue band, because, from their professional point of view, her breastfeeding is well-functioning and thus unproblematic. *Regardless of her pain*. As a result of this disjunction between the professionals' enactment of Jane's breastfeeding problems and her own, a problem is never defined, and no actions are taken to fix it. No counselling in how Jane *ought to solve the problem is provided*. For a problem to exist, it entails both the worrying mother and a counsellor able and willing to deal with it. It is not my place to discuss neither the willingness nor ability of the health professionals in recognizing painful problems. Nonetheless, the situation lacks a counsellor, who attentively registers Jane's worries and explores them alongside her. As such, before consulting the private occupational therapist, Jane still enacts a diffuse problem, which in its diffuseness is dismissed by the very professionals required to solidify it.

The next example of counselling practices I explore is Marie's encounter with public counselling during home visits after giving birth to her first child. She describes how their breastfeeding problems consist of the baby's restlessness and inexplicable crying at the breast:

*"Og så når hun ammede, så gik der 5 minutter så hoppede hun fra og så græd hun når hun hoppede fra brystet. Så det var ligesom om at hun simpelthen var så sulten, men bare ikke kunne få den mælk hun gerne ville have. […] [S]å var det igen altså en sundhedsplejerske der lige viste en enkelt stilling og hvordan han, hun skulle ligge og så var det det ikke?"* Interview, Marie

Marie associates her child's agitation with continued hunger because the baby does not get the appropriate amount of milk during breastfeeding. At this point, the only counselling provided is a health visitor who demonstrates a new breastfeeding position, which Marie considers to be insufficient in defining and solving the problem. But when her baby is only one *week old, the health visitor diagnoses Marie's girl with tight tongue band:*

*"Jamen altså allerede da hun var en uge gammel fik vi [tungebåndet] klippet første gang. Det var sundhedsplejersken [der konstaterede det], og det var fordi at hun ikke kunne få tunge ud*

*af munden. […] [S]å fik vi at vide af jeg tror det var en behandler at det stadig godt kunne være lidt stramt. […] Og så prøvede vi at tage til en der egentlig skulle klippe det en gang til, men jeg tror ikke rigtig det bliver klippet fordi det virkede ikke som om der var nogen ændring overhovedet med hende. […] Og så, så da hun er de der to måneder i hvert fald, ja så ryger hun mere eller mindre ja på fuld flaske”* Interview, Marie

The health visitor makes the diagnosis based on the criterion that a newborn with 'a normal tongue band' can stick out its tongue, which the girl cannot do. Although the diagnosis leads to a treatment by cutting the tongue band, Marie does not experience any changes after two attempts, and she ends up bottle-feeding her girl. She does not think the tongue band has been cut properly at any of the attempts, and therefore the solution becomes feeding by bottle. But Marie still needs a health professional to explain the cause of the breastfeeding problems, even after the two cuts of the tongue band:

*”[…] [S]å var det bare at man til sidst fik det svar, det kan være at du bare ikke har det der skal til for hendes vedkommende, hun er for sulten og for ivrig og det går ikke hurtigt nok. Så derfor så hellere give flaske. […] Altså den der med at få at vide at du har nok ikke nok mælk, eller I passer nok ikke sammen. Og jeg følte at hver gang at jeg nævnte det, så var […] Ja, det mere at jeg havde noget psykisk, end at det egentlig var amningen der var noget galt med. Det var ligesom om at jeg havde for meget uro med denne her amning så det måske var det der var årsagen til at det var det der gik ud over det. […] Der var noget for mig der ikke gav mening, men der var bare ikke noget at hente nogle steder. Hos nogle fagfolk rigtigt, og støtte. Der var ikke rigtig nogen der kunne vejlede i hvorfor at det var som det var.”* Interview, Marie

In Marie's search for a convincing explanation, the health visitor presents several possible causes of the breastfeeding problems, none of which make sense to Marie. They explain the problems by reference to how she might not have 'enough milk' or 'what is needed' and perhaps her mental state is the crux of the problems. The health visitor at the first counselling practice in Marie’s home enacts a specific problem; the tight tongue band. In locating an attempt to fix an obvious problem, Marie tacks along. By enacting this diagnosis, her counselling leads to a treatment that unfortunately does not have the intended effect. Marie accepts the bottle but still has an unresolved feeling of not knowing the cause of the failed breastfeeding. In the health professionals’ rendition of Marie’s position as a breastfeeding mother, she experiences feelings of inadequacy because ‘they [Marie and her child] are not a

good fit,' for one vaguely defined reason or another. These reasons do not make sense to Marie, and she does not believe that anyone could explain why the breastfeeding was the way it was and therefore her problem remains diffuse, despite being offered several treatments and explanations.

I find it curious that in Marie's case, the tight tongue band is unproblematically enacted by the health professionals in a way that differs remarkably from Jane's. At the hospital, no one observed the child inside the mouth and the health visitor at her home claims to have checked the tongue band even though she did not. Comparing Marie's and Jane's situations relative to the 'tight tongue band', in Marie's case, the health visitor performs a test observing the child's mouth and her ability to stick out her tongue. This test absent in the counselling practices Jane experiences. This comparison demonstrates how crucial the *practical enactment* of an object, the way in which something is made to exist in a particular way in specific situations, – in this case the tongue band and the method for examining it – is for the enactment of a breastfeeding problem in both counselling and for further treatment. This shows precisely how it depends on its enactment, which is always embedded in specific networks of heterogeneous actors, be they humans, objects, methods, knowledge, organizations and so forth, who are all 'doing' the object together.

The mothers' breastfeeding problems and experiences with different counselling practices within the public sector are, without a doubt, extremely diverse. However, what they do share is the experience that traditional counselling does not meet their individual needs, nor does it recognize their particular problems. In that regard, public health professionals arguably fail to live up to the official guidelines of respecting and supporting the individual family's needs and that insufficient counselling should not hinder breastfeeding (Sundhedsstyrelsen, 2021). But I want to suggest a different argument. By working from the premise of ontological multiplicity, the mothers' sense of insufficiency can be caused by a lack of correspondence and coordination between the health professionals' enactments of the problems they are presented with, the solutions they propose, and how the problems and solutions are experienced by the mothers. In her work on atherosclerosis, Mol depicts a similar situation where the patient Mr. Somers is assessed by a technician, who checks the condition of his legs using cuffs, a stethoscope, and a Doppler apparatus. After examining the leg and doing some calculations, she reports that all numbers are normal and that nothing is wrong with his legs.

Since it is very painful for him to walk, Mr. Somers finds this highly strange and hard to believe. To generate coherency, a hierarchy is established where "*subjective 'complaints' and objectifying 'laboratory findings' is institutionalized*" (Mol, 2002, p. 62-63). Although neither the mothers nor the health professionals work with 'laboratory findings', strictly speaking, the objectifying assessments of breastfeeding problems are still those that correspond to the professionals' institutionalized expertise, which is implicitly understood to be hierarchically superior to the subjective complaints. In John Law's reading of Mol's analysis, he argues that the surgeons *"assume that they are all addressing the same reality. And, to be sure, sometimes everything works out smoothly [...] But sometimes relevant practitioners instead find that they are faced with poorly co-ordinated realities* (Law, 2004, p. 51).

I argue that the mothers' encounters with public health professionals are examples of such poorly coordinated realities. It is not a question of poor abilities, a lack of professionality, or a desire to enforce inefficient and painful breastfeeding. Instead, what happens is that healthcare professionals enact breastfeeding problems, and related solutions, in ways that are poorly coordinated with how the mothers, from their situation with their experiences, enact the problems and possible solutions. The health professionals do not *misunderstand* the diffuse problems that the mothers experience, because the problems they are faced with are *different things,* ontologically speaking. Their enactment of breastfeeding problems produces different realities, in which the problems have distinct causes, consequences, and solutions. To be sure, they overlap on some accounts, and they are not thoroughly distinct. But they are not *identical* either. Instead, they are *multiple*, and it is the failure to recognize this multiplicity that produce the poorly coordinated realities both professionals and mothers experience.

It is precisely the lack of coordination that leaves the mothers' problems remaining diffuse. When their diffuse problems refuse the definitions and solutions that public counselling offers, these mothers turn to the voluntary sector. And with that said, let us move to Ammenet.dk's practice.

## THE CASE OF AMMENET.DK

Where the realities of health professionals and the mothers' described above are poorly coordinated, Ammenet.dk enact breastfeeding problems in ways that are meant to converge with the mothers' versions. As we shall see, Ammenet.dk and the mothers do not enact the

*same* problems, but their coordination work allows them to co-exist without displacing one another, just like the doctor's and the pathologist's versions of atherosclerosis do (Mol, 2002). But before introducing the details of my analysis, it is appropriate to present how Ammenet.dk conducts breastfeeding counselling.

### WHAT IS BREASTFEEDING COUNSELLING?

Ammenet.dk's online social work, is more than one practice. As I argued in the section on casing, I expanded understanding of 'counselling' in line with the mothers' use of Ammenet.dk. All eight mothers use the network groups on Facebook, three of the mothers use the Wiki and three use both the network groups, the Wiki, and the letterbox. Thus, what counts as 'counselling' in this case is both peer-to-peer support and moderators' guiding in the Facebook network groups, the private counselling through the weekly letterbox, and the mothers' use of the Wiki. In the following, I elaborate on the specific modes of counselling that take place in the different practices.

### A DIGITAL VILLAGE

The Facebook groups are by far the most popular form of counselling offered by Ammenet.dk. Hosting three groups - one for 0-2 years of age, one for 2+ years of age and one for milk expression – Ammenet.dk's counselling is primarily based on a combination of peer-to-peer support, consisting of advice and counselling from other users, small pieces of advice from the voluntary moderators, references or links to the Wiki and the letterbox, and the occasional suggestion to call the general practitioner. The volunteer Sara describes the function of the moderators as somewhat like 'gatekeepers':

*"Det altså det er sådan en, ja næsten en form for gatekeeper funktion eller hvad man kan sige ikke?"* Interview, Sara

The moderators 'gatekeep' the groups when assessing whether the mothers' posts are appropriate, or alternatively guiding them towards the suitable location for further support according to their situation:

*"[M]eget af arbejdet er egentlig i 0-2, og der har vi opslagsgodkendelse på [...] fordi at 0-2 det omhandler også rigtig mange af de nyfødte. Og der er rigtig mange af de her, vi kalder den røde flag, hvor det kan være en baby der måske er sløv, eller en baby der måske er født for tidligt*

*som lige har brug for lidt ekstra hjælp. Så vi går ind og vurderer alle de her opslag I forhold til jamen er det her noget der skal sendes videre til noget vejledning, eller skal sendes videre til egen læge, eller bare skal have et link med fra en af vores Wikier vores FAQ eller et eller andet.".* Interview, Ann

When outlining the moderators' practices, the volunteer Ann describes how they primarily provide guidance to mothers in the group dealing with children of 0-2 years of age. Depending on the nature of the post, the moderators might add some links to the Wiki, where the mothers can find comprehensive information themselves. For more complex issues, they refer them to guides in the letterbox. In the case of so-called red flags, the moderator encourages the mother to contact their general practitioner. The interaction between the moderators and the mothers on the Facebook groups is only brief:

*"[V]i stiller ikke opfølgende spørgsmål [...], så på den måde inviterer vi ikke til dialog"* Interview, Sara

The moderator's objective is to function as a 'gatekeeper' and to point the mothers towards the right location to gain the support and counselling that fits their specific situation, and not to enter into further dialogue with the mothers. In contrast, the other users are free to comment and thus initiate a more comprehensive dialogue. In fact, many of Ammenet.dk's users are ready to provide extensive and detailed peer-to-peer support. Indeed, this peer-to-peer support is a part of Ammenet.dk that the mothers really appreciate. Here, I would like to highlight how Mona, who is breastfeeding her child of about 3.5 years long-term, feels supported and encouraged by the other mothers in the 2+ group:

*"[N]etværksgrupperne det har været udelukkende positivt vil jeg sige, fordi vi er jo alle sammen, vi forstår alle sammen hinanden. Vi ved allesammen at det vil gøre det er det mest naturlige i verden selvom det ikke opfattes sådan i samfundet generelt. Så på den måde har man hinandens ryg."* Interview, Mona

Mona explains that they 'have each other's backs', supporting each other in the choice breastfeed long-term, despite how society in general does not consider it to be 'natural'. Similarly, Sophie, who expresses her milk full-time, has felt alone with her choice of how to feed her child:

*"[B]are det at følge med i den gruppe i hvad andre stiller af spørgsmålet og hvad andre kommer med af svar ikke mindst altså, både måske i sådan, for at have en fornemmelse af at man ikke er alene. Det kan man lynhurtigt få en følelse af især når man malker ud, at man er helt alene i verden og føde sit barn på den måde. […] Så på den måde var der også en eller anden genkendelse som jeg tror jeg havde brug for i det netværk"* Interview, Sophie

Both accounts illustrate how recognizability and understanding from other users in similar situations are helpful for the mothers. Both feel *different* in light of how they have chosen to feed their children and the nature of peer-to-peer counselling in the Facebook groups contributes to normalizing their choices and experiences. As previously explained, such feelings of recognition and normalization are not unique to the mothers I include in this thesis. As other studies have demonstrated, online peer-to-peer support can be helpful for normalizing different breastfeeding experiences (Skelton et al., 2018, Caes et al., 2021). The volunteers, who are mothers themselves, have often used Ammenet.dk's counselling services before they entered the decided to volunteer. An example hereof is Sara, who also believes strongly in the normalizing potential of the online network groups:

*"Det kan give rigtig meget at man ikke er alene. Og jeg tror det er ekstremt vigtigt for amning fordi vi har et samfund hvor amning i mange instanser er […] rigtig usynligt […]. Og jeg kan huske den gang der gav det […] mig faktisk rigtig meget at vide okay jeg er faktisk ikke alene. Jeg er ikke fucking sindssyg som min familie siger, jeg er faktisk ret normal. […] Så det der med at kunne henvende sig til nogen der både har samme viden men måske også har mere viden og erfaring end en selv altså det er ligesom, en form for digital landsby"* Interview, Sara

Speaking from a user perspective, Sara believes that breastfeeding is largely invisible in contemporary Danish society and explains how Ammenet.dk's network groups work as a 'digital village' that contribute to normalizing her breastfeeding and to making her feel less alone. Ammenet.dk provides a space for the mothers to gather in this 'digital village', to care for and help each other in difficult situations. Thereby, Ammenet.dk and the mothers collectively create a space for coordinating the enactment of their breastfeeding problems and experiences in ways that enable them to cope and co-exist with what is generally considered 'normal' outside the groups, where they usually feel different and alone.

It is no coincidence that the handling of these specific issues is left to the digital village. The fact that the mothers are not pointed elsewhere for support is the result of a voluntary moderator carefully considering what would be the most appropriate location for them to get the help they need individually. Other mothers' issues are assessed to be more complex and those who need the most detailed counselling are referred to the letterbox.

### WHEN HEARING HOOVES THINK HORSES NOT ZEBRAS

When a mother is referred to the letterbox or chooses to seek this mode of counselling on her own initiative, it takes place on Ammenet.dk's website on Wednesdays from 12 noon. At this time, the mothers can describe their problems and questions in detail, which an internally trained counsellor then answers before the end of the week. The length of the answers and the degree of detail reflect how questions posed to the letterbox are often more complex than those dealt with in the digital village. Sara describes her working process when she is on counsellor duty:

*"Altså vores svar nu er væsentligt længere i brevkassen fordi vi både skriver det som vi tænker er det altså det primære problem ikke? Og så siger man ved sådan og sådan og sådan, så kan det være du skal være opmærksom på det her […] Nogle gange så får man et spørgsmål i brevkassen, det gør så ondt så ondt når jeg ammer hvorfor? Så kan man være sådan ja, det er faktisk et rigtig, rigtig godt spørgsmål. Og så ville jeg typisk starte med at forklare helt vildt meget om sutteteknik og hvordan man lægger barnet til, og så sige men smerter kan også opstå af andre årsager; svamp, og beskrive hvordan føles svamp typisk, og hvad kan vi ligesom gøre og sige brystbetændelse og sådan noget... og på den måde ligesom få bredt ud."* Interview, Sara

Sara describes the practice of counselling a mother, who experiences pain during breastfeeding. She begins with sucking technique and ends in mastitis. This way of responding is deliberately moving from the most to the least likely scenario, characterized by initially describing the most common breastfeeding problems and ending with the rarer ones. As Ann describes 'when hearing hooves think horses, not zebras':

*"[V]i har lidt det her mantra blandt vejlederne med at når de hører hovslag så skal de tænke heste først, og ikke zebraer. Det mest sandsynlige først. Og så går svaret jo selvfølgelig videre og siger jamen hvis det så ikke virker, jamen så er der de her muligheder"* Interview, Ann

Simone is one of the mothers, who have used the counselling offered via the letterbox. Feeling increasingly disheartened that her infant is hungry and crying, Simone writes a question about her boy who does not gain weight and has difficulties both breast- and bottle feeding. She happily receives one of these very long replies from a counselor:

*"[H]un skrev verdens længste mail, jeg har aldrig nogensinde fået så lang en mail før. […] Og så kom hun med 12 eller 13 forskellige ting jeg kunne prøve at gøre. Og virkelig, virkelig godt! Han kom ikke til fuldamme, men vi ammede hver eneste nat en måned efter hendes mail. Fordi at der, at hun skrev noget med at han var mere, der var mere instinkter, om natten, og at han ikke var så opmærksom […] [J]eg var så lykkelig over hendes mail. Jeg var så glad, og hun svarede jo så hurtigt, med denne her helt exceptionelt lange mail, og jeg var bare sådan helt ja! Det var lige præcis det jeg havde behov for!"* Interview, Simone

It is clear from Simone's account that she is beyond satisfied with the counsellor's response. It more than matched her needs and exceeded her expectations. She is given a list of several possible problems from which she can evaluate her own situation, and she actually succeeds in breastfeeding at night for a period of time because she, based on the knowledge the counsellor provides, can explore different options for dealing with the diffuse problem. *The problem does not become less diffuse immediately after Simone receives the answer nor does the counsellor narrowly determine precisely what the problem is*. Rather, based on Simone's description, she *multiplies* the potential problem to include various possible scenarios, while providing solutions that might help in each of them. In Simone's own attempt at defining the possible problem, she enacts her breastfeeding problem quite specifically. In the quote above, she describes how the boy is too attentive during the day, making it hard for to concentrate on breast- and bottle feeding. As a possible solution to her unfortunate situation, she uses the counselling from the letterbox to enact a specific practice, namely breastfeeding at night. The counsellor's response becomes a gamechanger, not by narrowly defining the problem, but by providing what Simone needs to enact her reality anew: knowledge. Until she receives the detailed email, the repertoire of knowledge that the counsellor brings to the table does not figure as an actor in the material-semiotic network in which Simone's problem is embedded. However, once it enters the scene, the information and the possible worlds it enacts becomes an active actor along with the counsellor, the technical devices (telephones, computers) they communicate through, Simone's descriptions of the problems, perhaps other counsellors the

first one has consulted with, all become a part of the material-semiotic network that contribute to the practical enactment of *a different breastfeeding problem*. One that is no less diffuse and multiple, but which has solutions and hope.

The succinct form of counselling does not only characterize the work of moderators in the Facebook groups. Dialogue, understood as a continued back-and-forth interaction, is also notably absent from the letterbox:

*"Altså svaret det bliver ligesom sendt til deres mailadresse, men der er ikke nogen altså returmulighed."* Interview, Sara

Once the answer has been sent, the mothers are individually responsible for using the knowledge it contains to deal with their diffuse problems and to experiment with different solutions. To be sure, it is a substantial resource, but it is neither final nor determinate. It does not erase breastfeeding problems but acknowledges their diffuseness and multiplicity. It attends not to what is, in the singular, but to *what might be going on*. In that way, the letterbox counselling enacts breastfeeding problems in ways that can co-exist with Simone's.

### EVIDENCE-BASED KNOWLEDGE

Most of the mothers I spoke with also use the Wiki, some more than others. Karen describes how she uses it to get an overview of various topics from breastfeeding strikes to the baby's stool:

*"jeg har været inde og kigge [i Wikien] mange gange med forskellige ting. Både med ammestrejke og med afføring og med alt muligt, har jeg været inde og se ikke. Fordi det giver et meget godt overblik, synes jeg. Jeg synes at det er et meget fint opslagsværk."* Interview, Karen

In addition to being an online encyclopedia that mothers can use independently of the other modes of counselling, the Facebook moderators and the letterbox counsellors often refer mothers to the Wiki:

*"Wikien har jeg brugt i forhold til at kigge op på de ting som hun [vejlederen] linkede til, i hendes... Ja, hvor der var fem eller seks forskellige links, og hvor det var at jeg har læst op på det. Og jeg synes at det var virkelig godt, fordi der kommer man omkring det meste af det, det er ikke bare sådan, nu kan jeg huske det der bottle paced, hvor at det er, at der ikke bare står*

*at det er sådan her man gør. Der står også mere om at hvorfor er det man gør det"* Interview, Simone

Simone uses the Wiki in her search for specific knowledge about her breastfeeding challenges, for example information about the 'paced-bottle-feeding' technique. But some also use the Wiki to learn more general things about breastfeeding, for example during pregnancy, where mothers like Eva turn into 'breastfeeding nerds' and read almost all the articles:

*"Jamen i min første graviditet der har jeg nok læst cirka alle deres artikler vil jeg tro. Da jeg gik rigtig meget graviditetsnørd og ammenørd i den, og læste alt hvad jeg kunne finde af litteratur. Og havde længe inden han blev født besluttet mig for at han skulle ammes lige så længe at han havde lyst til."* Interview, Eva

As Eva describes, she already had deepfelt desire to learn about breastfeeding before giving birth. As we shall see later, my material shows that the mothers actively seek out knowledge on breastfeeding regardless of whether their interests or needs are general or more problem-specific information. At Ammenet.dk, the knowledge they provide is described as 'evidence-based':

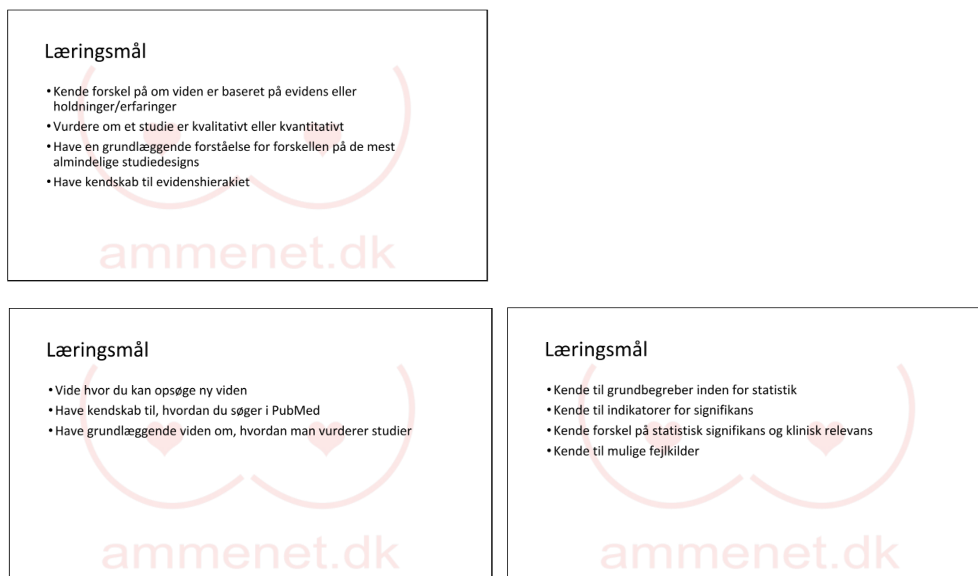
*"[J]amen det er jo det vi vejleder ud fra, det er i evidensen. Og det er jo nok også derfor vi møder noget modstand en gang imellem, når man kommer ud og siger jamen det her det er altså ikke normalt. Ej med min sundhedsplejerske siger, ja det kan godt være hun siger det og det skal hun have lov til, men det her det hvad forskningen siger så vælger du selv ikke?"* Interview, Ann

Ann positions herself and Ammenet.dk in relation to potential knowledge conflicts, here exemplified by differences in the *professional assessments* made by health visitors and Ammenet.dk's *evidence-based knowledge*. However, what does the distinction between evidence-based and, as it were, non-evidence-based knowledge amount to? From a post-ANT perspective that assumes the possibility of ontological multiplicity, Ammenet.dk's fixation on evidence-based knowledge reveals a commitment to an ontological singularity that conceives *one* reality that natural science is the best way of comprehending. Evidence, from this perspective, is authoritative because it is based on objective *scientific research*, and not the individual assessments of health visitors or midwives. This is evident in the educational material, where an entire theme deals with evidence:

*"I tema 8 ser vi nærmere på forskning - hvad evidens er, hvordan man kan søge efter litteratur, og hvordan man tolker statistik. Det er tungt stof, og derfor er kun første del obligatorisk. De to følgende lektioner er påkrævede for dem, der skal skrive Wikier og derfor har brug for at kunne søge efter litteratur, men ellers ikke obligatoriske for alle."* Introduktion til vejlederuddannelsen

It is required that the Wikipedia authors complete the entire theme on research. The theme is divided into three parts with different learning objectives:

Figure 3: Introduction to the counsellor training




*Source: Ammenet.dk, educational material*

All counsellors and Wikipedia writers must know the difference between evidence-based knowledge and experiences or attitudes, distinguish between qualitative and quantitative studies, know and be able to distinguish between the most common study designs, and recognize the hierarchy of evidence. Organizers, who write the Wiki sections, must also be able to seek out new knowledge, evaluate studies, and have basic familiarity with statistics.

In sum, Ammenet.dk enacts *breastfeeding problems as knowledge.* They do so either directly, when mothers read the Wiki or receive a reply in the letterbox, or indirectly, through guidance that either refers to or is tied to knowledge drawn from Ammenet.dk's repertoire. In other words, actors that enact the figure of 'evidence-based knowledge', such as articles, research databases, and educational material, are just as important as volunteers, computers, Facebook groups, and so forth, in the material-semiotic networks in which Ammenet.dk's work is

embedded. Knowledge 'does something' in its associations with all these actors, by affecting and co-creating the counselling practice as well as breastfeeding problems and solutions.

## THE PRODUCTS OF PRACTICES: EVALUATIONS AND KNOWLEDGE

The descriptions of Ammenet.dk's counselling illustrates a network of relations between humans, objects, organizations, and ideas that constitute on way of understanding *their* approach to enacting breastfeeding problems. Rather than being three separate practices, Ammenet.dk's breastfeeding counselling works through how the volunteers refer to and mediate between the network groups, the letterbox, the Wiki, and other locations external to the organization. In doing so, they not only take advantage of this interconnectedness, but they also produce and *reproduce it,* time and time again. In contrast to traditional counselling, described above through the mothers' accounts of encounters with health professionals in the public sector, Ammenet.dk works entirely online and mothers never meet moderators or counsellors face-to-face. Further, only the peer-to-peer support on the Facebook groups is dialogue-based. Taken together, the dislocated and simultaneously unidirectional (via the letterbox) and distributed (via the peer-to-peer support) form of counselling enables multiple and diverse forms of support, rather than narrowing down the possibilities to produce a single diagnosis of the diffuse problems the mothers describe. In the spaces of physical proximity produced by traditional, face-to-face counselling, health visitors or midwives visually and physically interpret bodily signs that, based on their professional knowledge, *excludes some possibilities for diagnosis while enabling others.* As in the case of atherosclerosis bodily signs are important *"One foot is warmer than the other – a sign of a poor blood supply to the second. The skin is poor on the second too, a further sign. And the pulsations in the same leg are weak at the ankle, which is a third sign. So the body is important too"* (Law, 2004, p. 46). Bodies are likewise important in health professionals' enactment of breastfeeding problems. But rather than producing attentive and individually tailored forms of counselling that acknowledges the mothers' diffuse problems, traditional counselling has failed to coordinate with the enactments of breastfeeding problems that the mothers in this thesis describe. In the case of Ammenet.dk, the absence of the body exempts the volunteers from assessing any visual bodily signs:

*"[D]et [er] også mere distanceret fordi vi kan jo ikke, vi kan jo ikke se dem. Vi kan jo ikke se […] en mor der siger "Det gør simpelthen så ondt når jeg ammer", og så kan jeg pege på hendes*

*arm og sige "Det er fordi baby ligger der, prøv og ryk din baby 20 cm ned og så prøv at lægge til igen". Og så har du lige pludselig en baby der ligger korrekt på brystet […]. Og den del af det mister man ved det online."* Interview, Sara

What Sara sees as something 'lost' by working online without physical proximity is, on my analysis, actually a strength. The fact that the volunteers lack access to direct physical examinations, which would arguably make it easier to define the problem in narrow and singular terms, enables them to enact the problems in ways that can be coordinated with and co-existence alongside the mothers' experiences and enactments. In other words, Ammenet.dk does not provide answers, evaluations, or diagnosis. Instead, they provide *usable and multiple forms of knowledge*. Ammenet.dk gives mothers the opportunity to reduce and rework, but never *remove*, the diffuse and ambiguous dimensions of their breastfeeding problems that emerge both in their individual enactments, the support and knowledge Ammenet.dk offers, and the combination of the two.

*"[V]i afholder os fra at lave sådan vurderinger og komme med et rigtigt svar, men ligesom sige sådan og sådan og sådan kan tingene ser ud, og hvis de her forhold gør sig gældende, så kan det og det være normalt. Altså ligesom at møderne selv skulle tage ansvar for deres situation. […] Det er ligesom, i sidste ende dem der skal gøre det, vi skal ikke fortælle dem hvordan de skal gøre deres ammeforløb."* Interview, Sara

Sara describes how the mothers must 'take responsibility for their situation', and that the knowledge Ammenet.dk provides is intended to help them do so. Several mothers report that knowledge, or lack thereof, have a major impact on their mental health:

*"Det var en enorm usikkerhed, og udover at det er altså følelsesmæssig roller coaster at blive mor, det er en kolbøtte. Så var det et kæmpe nederlag at måtte give op på amningen og så samtidigt skulle stå i en situation hvor jeg ingen information kunne få. […] Det er hårdt at få et barn, men projekt amning det satte virkelig en kæp i hjulet for mit mentale helbred."* Interview, Sophie

*"jeg tror på den måde, der er amningen, den kæder, jeg kæder den ret hurtigt sammen med efterfødselsreaktionen. Altså for mig var det ved amningen at jeg kunne mærke starten på min efterfødselsreaktion. […] altså er jeg overhovedet, var det overhovedet klog at få et barn når jeg ikke engang kan give hende mad?"* Interview, Jane

*"[J]eg havde brug for at have så meget viden omkring det hele [i graviditeten], men jeg var bare angst for alle mulige ting sådan."* Interview, Erika

The mothers turn to Ammenet.dk because they lack 'information', 'wisdom', and 'knowledge,' which, in turn, produces of a negative state of mind. As mentioned earlier, mothers are at increased risk of feeling insecure since they are primarily responsible for feeding their children and fulfilling their basic needs, especially the first weeks after birth (Kronborg et al., 2012). Here, psycho-social factors, like detailed and sufficient breastfeeding knowledge, influence breastfeeding success and duration (Nilson et al., 2020). As the mothers I interviewed indicate, they seek knowledge as a way to deal with their diffuse problems, which, consequently, enables them to re-enact the problems as something they can be responsible for and act upon. The quotes below are examples of how knowledge allows the mothers to listen more carefully to themselves:

*"[E]fterhånden som jeg selv har tilegnet mig mere og mere viden omkring amning, så vil jeg i hvert fald, hvis jeg fik et barn mere, hvad jeg jo ikke gør på grund af min alder, men hvis jeg skulle få et barn mere, så ville jeg have lyttet mere til mig selv […]"* Interview, Mona

*"Men jeg synes det positive ved det var at jeg faktisk mærkede okay jeg kan godt gå efter min mavefornemmelse med nogle ting"* Interview, Erika

I suggest that the mothers find Ammenet.dk's counselling practices usable, constructive, and relevant because they *produce knowledge* that empowers enactments of breastfeeding problems and solutions that are tailored to their lives and experiences. This argument calls for a clarification of the concept of a *product,* as in the knowledge produced through counselling. In Law's elaboration of Mol's work on enactment and multiplicity, he argues that "*Like the pathology laboratory, the radiology department has its own methods and practices. Its hinterland includes: the X-ray machine; the dyes; the catheters; the lead screens; the surgical incision; the antisepsis; the sedated patient; the table on which he lies; and a whole lot more. But here the product is not a microscope slide. Instead it is an angiograph, another quite different version and visualisation of lower-limb atherosclerosis*." (Law, 2004, p. 48). My claim is that, just like the difference between the pathology laboratory and the radiology department, the hinterland of Ammenet.dk *differs* from other organizations dealing with breastfeeding problems in its methods and practices. For example, the mothers describe how

health professions use face-to-face counselling to assess bodily connections between mothers and babies during breastfeeding. But these assessments are enacted to produce a *diagnosis,* one definition and one answer, which the mothers find inconsistent with their experience. Even in cases when a diagnosis is impossible, traditional counselling still produces an evaluation of the breastfeeding situation. As such, the mothers are faced with two possible outcomes. Either a definitive answer they must agree to or no final diagnosis/answer/solution whatsoever. Either something they can act upon in *one way,* or something that makes action impossible.

In contrast, Ammenet.dk's methods, practices, and products are markedly different. To be sure, health professionals also produce knowledge through their attempts at diagnosis. But they do so in a way that enacts answers as singular evaluations which assumes that the phenomenon both professionals and mothers attend to belong to the same, equally singular, reality. This makes no room for difference and multiplicity. Importantly, the work of the volunteers does exclude evaluations of bodily signs and physical connections. Both the Facebook moderators and the letterbox counsellors try to evaluate and interpret the mothers' descriptions of their issues, regardless of whether these take the form of bloody nipples, baby bodies that tighten up, mouths that release vacuum and so forth. But because they only have access to descriptions, and that both bodies and the physical contexts in which they are embedded are absent, their evaluations are cautious, bordering on the agnostic. This caution makes them describe many different possibilities, providing knowledge *of possible problems and solutions* that is simultaneous detailed and broad, or suggesting alternative sources of knowledge. In the enactment of breastfeeding problems, the body and its connections to other bodies are crucial actors both in physical and online counselling. But in Ammenet.dk's practice bodies are not limbs, mouths, nipples, and milk but written words, descriptions and only sometimes a picture in a Facebook post, an email, or an article. A very uncertain basis for making specific evaluations.

Therefore, the product of the practices are not evaluations, but *knowledge*. It is enactments of the problems that emerge between the descriptions that the counsellors receive and the experiences that mothers have attempt to describe verbally. No one presupposes singular, unambiguous, or definitive problems, answers, diagnosis, or solutions. Neither does it project certainty with regards to precisely *what* the problem is in the first place. Different and multiple

enactments are allowed to exist, overlap, and grow. Something is not *quite right*, but maybe this might help? Or this? Or this? Maybe all three things at once?

As we saw above, the mothers enact their problems in particular ways, but they are not in any direct sense "choosing" a version of their problem that stabilizes it, even though it might seem like it (Mol, 1999, p. 79). Like everything else, their problems are anything but stable. They might change from moment to moment, day to day. The mothers can have different breastfeeding problems at det same time, and they do not have to abandon either one of them (Mol, 2002, p. 66). The knowledge a mother gains from Ammenet.dk allows her to "*slide in her work from one performance to another*" (Mol, 1999, p. 79). Knowledge expands the mothers' repertoire of practices by providing multiple, both distinct and overlapping, enactments she can activate, experience, and embody according to momentary changes or persistent difficulties. By offering multiple knowledge instead of single evaluations, Ammenet.dk discourages definitive answers and solutions by emphasizing that no stories or experiences are wrong or misguided. Every story fits somewhere.

However, by insisting that the knowledge they offer is 'evidence-based', Ammenet.dk seem to work against this diffuse multiplicity. Are they not also trying to bring about a singular, shared reality, with definitive answers produced via 'evidence', as noted above? Perhaps. But this is where *practice* becomes central. Because by attending not only to how they *describe* their work but also how they *do it in practice,* multiplicity becomes easily detectable. In the *practices* of breastfeeding counselling, the singularity of evidence disappears, as my above analysis of Ammenet.dk's three modes of counselling testify to. Here, neither objects, practices, descriptions, nor knowledge adhere to any stable or singular identity. Their presences and identities are fragile and differ between settings and situations, precisely because they are made manifest in practice (Mol, 2002, 43). In short, when comparing the volunteers accounts and the educational material, it becomes evident that even Ammenet.dk's own internal visions *of themselves* are multiple and contingent. Where 'evidence-based' knowledge might be valued for its singularity in one place, its stability and certainty disappear in others, making room for ambiguity, fluidity, and multiplicity. This, I argue, is how Ammenet.dk creates the conditions for their success and not only, as they might say, by being evidence-based.

# CHAPTER 6: HAVING A BREASTFEEDING BODY, BECOMING A BREASTFEEDING MOTHER

In the first part of the analysis, I focused primarily on how Ammenet.dk's different counselling practices enable different enactments of breastfeeding problems through their production of kinds of knowledge that acknowledge the diffuseness of the mothers' experiences by likewise embodying multiplicity and difference. Here, in the second part, I draw on Haraway, Thompson, and other STS scholars to explore the concepts of the *breastfeeding body* and the subject-positions of a *breastfeeding mother.*

I begin with the breastfeeding body. Similar to how breastfeeding problems are inseparable from the practices in which they become enacted; bodies are also 'done' in practice: "*They emerge in different circumstances. They happen in different situations. [...] Versions of the body are performed, orchestrated, enacted. They are done in practices.*" (Mol, 2012, p. 120). With reference to Judith Butler, Mol argues that gender is also a product of practices, it is done in various sites, involving not just social constructions but also material objects, including the physical body (Mol, 2002, pp. 36-39). As we will see shortly, a female body exclusively nourishing a child at the breast is only one way of enacting a breastfeeding body. Following the multiplicity of a breastfeeding problem, the outcome of counselling and the solutions invoked to feed a child and thereby *what counts as breastfeeding* multiplies. This reconceptualization of breastfeeding itself entails simultaneous enactments of the breastfeeding body in the multiple.

## ALL THINGS ARE BREASTFEEDING

Something slightly embarrassing happened in my interview with Sara, one of the volunteers. My ignorance of what 'counts' as breastfeeding become painfully obvious, when I ask her if Amment.dk also provide counselling in other ways of feeding a baby such as methods for giving a bottle, pumping, and using an SNS system:

*"[A]mning er ikke kun at fuldernære sit barn ved brystet uden hjælpemidler. Amning, altså vi vejleder også i hvordan at man kan altså fuld udmalke f.eks. Til dem der af den ene eller anden årsag ikke ønsker eller har mulighed for a lægge barnet til brystet ikke også? Så på den måde så er, altså for mig er det et rigtig sjovt spørgsmål du stiller fordi at jeg tænkte jamen selvfølgelig det er en del af amningen det hele altså. Alle ting er amning ikke også? Men jeg ved godt at for*

*mange andre der altså, der er amning at barnet kun spiser ved brystet ikke? Og man ikke ammer rigtigt eller at man ikke kan finde ordentligt ud af det hvis man giver lidt ved siden af og hvad er nu alle de der underlige hjælpemidler?"* Interview, Sara

Sara explains that the aids I ask about *already* count as breastfeeding and that breastfeeding is not only exclusively nourishing a child at the breast. At the same time, she acknowledges that I am not alone with this misconception of what breastfeeding is. This notion of the singularity of breastfeeding is visible in several of the informants' accounts, by referring to the 'norms' of Danish society:

*"[D]et har noget med samfundets normer eller hvad siger man, der er en eller anden forherligelse i at amme sig barn. […] Jeg tror de fleste regner med at skulle amme sit barn. Og det er sådan fordi det gør man."* Interview, Sophie

*"Jeg havde aldrig forestillet mig at min rejse skulle udvikle sig sådan som den har gjort. Men jeg vil nok have haft nogle andre tanker hvis jeg havde vidst at det faktisk var naturligt, ikke normen med naturligt, at amme så længe som jeg gør."* Interview, Mona

*"Det [at finde støtte online] kunne man ikke før, der tror jeg virkelig at det er vores generations heldighed […] jeg tror virkelig at det er en styrke på rigtig mange punkter. Og også til at få brudt de normer der har hersket."* Interview, Sara

Sophie, Mona, and Sara describe the presence of 'norms' about breastfeeding. These norms are also actors in the material-semiotic networks in which the mothers' breastfeeding practices are embedded, as their presence, however imaginary, have an impact on their understanding of breastfeeding as something in the singular. As such, these norms become invested with an agency to shape what counts as breastfeeding, and how breastfeeding problems and solutions are enacted. But notes that norms alone do not define, nor *enact,* breastfeeding. Rather, by attending to how norms become embedded in, extended, and challenges in *practices* makes it possible to acknowledge that breastfeeding always exists in the multiple. Likewise, what counts as being a breastfeeding mother who enacts a breastfeeding body is neither singular, nor does it even require the biological birthmother's breast. Sara explains that transgender people can also enact a breastfeeding body:

*"[D]et er jo også muligt for altså for transkønnede at gøre det. Altså så fædrene også vil kunne amme såfremt de ikke har fået fjernet deres brystvæv f.eks. Og selv hvis de har fået fjernet deres brystvæv så kan man jo faktisk stadigvæk lægge altså en baby til brystet. En baby tager en brystvorte uanset om der er mælk i eller ej, og så vil man f.eks. kunne bruge sådan et SNS-system til at barnet får mælk ind ved den amning ikke også?"* Interview, Sara

Here, Sara helps enact a world where 'all things are breastfeeding' and in doing so, she is supported by Ammenet.dk's educational material. As mentioned, documents participate in the constitution and enactment of particular realities (Gad, 2010, p. 3). Since Ammenet.dk's education takes place virtually and is primarily based on documents written by members of the organization and filled with references to 'evidence-based' scientific studies, this material is central for enacting a reality where 'all things are breastfeeding'. The first theme on communication in the educational documents contains links to material on LGBT parents, lesbian women's opportunities for breastfeeding, support for transgender parents, breastfeeding after sexual trauma, and cultural differences in relation to breastfeeding (Ammenet.dk, educational material). In Ammenet.dk's material, they describe how it is crucial that the volunteers are aware of the needs of different people with diverse backgrounds and dissimilar frames of reference. The volunteers must avoid basing their counselling on unwarranted assumptions:

Figure 4: Avoid assumptions

Undgå antagelser

- vi har en tendens til at gå ud fra os selv
- man glemmer nemt, at alle ikke er præcis som os
- vores valg reflekterer vores baggrund
  - opvækst
  - støttenetværk
  - overskud
  - meget andet, vi ikke selv er herre over

ammenet.dk

*Source: Ammenet.dk, educational material*

Ammenet.dk's enactment of breastfeeding in the multiple stands in contrast to the informants' 'norms', wherein breastfeeding is regularly enacted in the singular.

## NATURAL MOTHERING

If 'all things are breastfeeding', the breastfeeding body is not attached to a pre-defined category of being 'female'. The bodies of transgender people, fathers, women who have not given birth and so forth can be breastfeeding bodies if the material-semiotic network enact them as such. Haraway contests the category of 'female' and claims that there is no such thing. She argues that there is *"[N]othing about being 'female' that naturally binds women*" (Haraway, 1999, p. 276). However, in a standard Euro-American way of thinking, involving both a singular ontology and a strict separation between nature and culture, the mothers describe the ability to breastfeed as something both 'natural' and 'female':

*"Kvindekroppen har gjort det her i du ved thousands of years, det her er det mest naturlige din krop kan, selvfølgelig kan den det det er de færreste kvinder der ikke har nok mælk."* Interview, Jane

*"Jeg tænker også at altså, selvfølgelig skal vi ikke leve i stenalderen, men det er jo det der er naturligt."* Interview, Eva

*"Og [jeg] har måske ligesom så mange andre været lidt naiv og været sådan, nå ja, selvfølgelig kan man det. Det giver da ikke nogen problemer, det er naturligt, det gør alle."* Interview, Karen

*"Altså jeg følte mig fejlslagen som mor. […] Og den der sådan følelse af at jeg kunne overhovedet ikke give mit barn noget af det som jeg fra naturens side skulle kunne give ham. Det er den der følelse af fuldstændig at slå fejl som mor, altså hendes grundessens."* Interview, Sophie

In the mothers' accounts, the singular and 'natural' breastfeeding body is defined by exclusively nourishing a child at the mother's breast. To explore such sentiments, it is appropriate to draw attention to one of the few feminist STS scholars, Martha McCaughey, who has addressed the topic of breastfeeding. In her work, she explores her own position as a mother who, despite her intellectual knowledge about the collapse between nature/culture distinction and the subsequent rejection of naturalistic and singularizing discourses, finds herself assessing her breastfeeding based on an ethos of 'natural mothering,' which advocates the belief that motherhood should be 're-attached' to nature and thereby reject the technological innovations and consumerism of modern society (McCaughey, 2010, p. 82). The discourse of natural mothering considers nature as superior to and separate from technology.

Here, breastfeeding becomes something ‘natural’ and something that mothers are ‘destined’ to do, which means that many mothers expect it to be simpler than it is (ibid. p. 94). McCaughey argue that “*[N]atural mothering is construed most often as an individual commitment and choice made by an individual mother who is willing to buck the technological system and instead do what nature intended*” (McCaughey, 2010, p. 94). In facing her own breastfeeding problems, she slowly realizes that her idea of breastfeeding as a warm intimate experience is not the reality, she is lives through. Instead, it turns out to be more complicated than she had anticipated (ibid., p. 81). Although McCaughey reflects on her exposure to pro-breastfeeding materials through friends, breastfeeding classes, consultations with her midwife, and peacefully ideal representations of breastfeeding on TV, she cannot determine who or what to blame for her naive expectations (ibid., p. 81, 83). Likewise, I cannot determine from the present empirical material the origins of this naturalistic idea of the breastfeeding body in the women's accounts. But the mothers seem to share with McCaughey a somewhat naïve expectation of breastfeeding as something ‘simple’ that 'nature intended'.

The idea that breastfeeding is best because it embodies ‘human nature’ also smell a bit of Neo-Darwinism. A Neo-Darwinian approach to breastfeeding disregards the political contexts of present-day motherhood: “*Articulating evolutionary theory in the context of breastfeeding advocacy often ignores the political contexts of contemporary motherhood in favor of an essentialist notion of universal, biologically-determined, maternal practice*” (Hausman in McCaughey, 2010, 92). From this way, breastfeeding is detached from the circumstances in which it is practiced. As a counterpoint, McCaughey gives the following proposal, which I will take as my point of departure in the next sections: *“Instead of focusing on what is natural or how women's bodies were designed, we might instead focus on the circumstances in which women find themselves-and altering those to support the practice of breastfeeding*” (McCaughey, 2010, p. 94). To obviate a naturalistic and moralistic understanding of breastfeeding and the breastfeeding bodies, we must recognize that the breastfeeding body is just like the category ‘female’: a complex material-semiotic category conditioned by social practices (Haraway, 1999, p. 276). Consequently, the breastfeeding body cannot be considered a fixed category that is inherently ‘natural’, insofar as it is always affected by both biological and technological actors that produce the networks that enact mothers’ breastfeeding practices.

## CYBORG BREASTFEEDING

To elaborate on the mothers' practices of enacting the breastfeeding body, I think with Haraway's figure of the *cyborg*. She defines present day humans as cyborgs, and she states that the dualism between human and machine has long since collapsed in practice if not in principle. Further, by simultaneously rewriting the nature/culture dichotomy, she claims that nature as a source of insight and progress is undermined, and thereby the ontology that Western epistemology is based upon is lost. Instead, the cyborg is our ontology (Haraway, 1999, p. 272-275). In line with this *cyborg ontology,* the female body *as a cyborg* is not exclusively 'biological' or 'natural' insofar as it is always 'hooked up to' extensive networks of technologies. Accordingly, the breastfeeding body is also no more *and no less* than a cyborg. Referring to Haraway, McCaughey writes that "*Breastfeeding is not a natural, instinctual biological drive and that alone. It is […] a combination of nature and culture, of instinct and learning, of biology and environment*." (McCaughey, 2010, p. 88). Even though several mothers define breastfeeding as 'natural', their own breastfeeding practices are certainly not devoid of 'unnatural' objects, technologies, or knowledge which deviate from the ideal of breastfeeding as exclusively nourishing the child at the breast. One example is Simone describing how she breastfeed with her pump:

*"Hvor hun kigger på mig, og så spørger hun om jeg ammer, og så siger jeg "Ja det gør jeg. Med min maskine". Og hun sidder lige ved siden af pumpen […]. Og så skrev hun det så ned i journalen"* Interview, Simone

The quote clearly illustrates that Simone's enactment of her breastfeeding body includes her pump and that the health visitor acknowledges this. In this situation, the two enactments of breastfeeding are coordinated. Another example is Sophie who practice milk expression full-time to bottle-feed her son. She describes a situation where her mother-in-law convinces her that the feeding-bottle can be the 'natural choice':

*"Altså jeg kan huske noget af det der står tydeligst for mig det var at han [Sophies mand] ringede til sin mor […] og sagde "Det kører bare så dårligt med det amning, Sophie er så ked af det" og så sagde min svigermor "Så giver i ham da vel bare en flaske?" og det var bare sådan [sukker lettet]! Det var virkelig bare sådan en sten der faldt ned, der var nogen der bare sådan tog det som det mest naturlige i hele verden […]. Jeg bliver helt rørt lidt nu. Fordi det [begynder*

*at græde]. Det var faktisk virkelig stort. Fordi at alle andre man er stødt på […]. Der var aldrig nogen der så til den flaske som det naturlige valg."* Interview, Sophie

Sophie's account demonstrates a need to enact her breastfeeding body in ways that are different from what she had otherwise been confronted with. To do so, her mother-in-law helps her enact the bottle as 'the natural choice'. Both the breast, the pump, the drops of milk being expressed, the bottle, the baby that eats, the mouth it eats with, etc. are part of this material-semiotic network enabling Sophie to enact her new breastfeeding body. The collapse of the biological/technological divide in her enactment is further elaborated in her description of gaining back trust in the 'her body's biology:

*"[J]eg havde igen den her stolthed over at jeg producerer mere mælk end mit barn kan spise, så han sulter ikke. […] Og det er en stolthed over hvad min krop har præsteret, og hvad den kan gøre for mit barn. Så det er klart at pumpning har måske været med til at jeg har kunnet genvinde en smule tillid og tiltro til min krops biologi."* Interview, Sophie

Simone and Sophie's accounts show how the biological and the technological are entangled in the mothers' breastfeeding practices. The use of technology is also clearly present in Eva's case. Besides using a pump to maintain her milk production, she also takes her daughter to doctors, who cut her tight tongue band twice, the second time in the Netherlands:

*"Klippet i Holland […] reagerede hun meget, meget voldsomt på. Det var en rigtig rigtig ubehagelig oplevelse. Men det havde så også effekt. Altså der kunne jeg virkelig mærke at hun fik bedre vakuum"* Interview, Eva

Eva is determined to breastfeed exclusively by breast, but her baby's tight tongue band prevents her from doing so. Having it cut by a doctor, first in Denmark and then in the Netherlands, is an example of how medical technology and knowledge become crucial actors in material-semiotic network through which Eva enacts her breastfeeding body. The second time, the cut has the intended effect as the child's vacuum improves. Here, tight tongue bands, Dutch doctors, cutting lasers, improved vacuum effects, and so on are just a few of the actors, human and nonhuman, arranged in complex networks that enact Eva's breastfeeding body. Even though the result is close to the ideal of 'natural mothering', it still involves expert knowledge and technology which are not, as it happens, 'natural' themselves (McCaughey, 2010, p. 89).

In line with Ammenet.dk's mantra, 'all things are breastfeeding', Sophie, Simone, Eva and the other mothers enact their breastfeeding bodies using the resources available to them, without reproducing the ideology of 'natural breastfeeding' they otherwise seem to subscribe to. Rather, they enact their breastfeeding bodies using knowledge from Ammenet.dk's three modes of counselling, accessed via smartphones, computers, tables, discussed with friends, families, and doctors, who suggest bottles, share stories, or cut tight tongue bands. These actors all participate in the complex and multiple material-semiotic networks that destabilize the singular definition of the 'natural' breastfeeding body where the child is fed exclusively by breast. Attentiveness to the importance of such actors once again show how maintaining the strict divide between the natural/cultural and the biological/technological is impossible in practice. By transgressing such dichotomies, the mothers can enact breastfeeding in a way that suits their individual needs, lives, and experiences. In that sense, my argument corresponds with Haraway's observation that the collapse of Euro-American ontological certainty is a source of pleasure because it enables ultimate independence (Haraway 1999, p. 273). 'Doing' a breastfeeding body does not require a woman's breast in some singular 'naturally' defined way. In fact, no 'women', however understood, needs to be present for breastfeeding bodies to exist.

## ONTOLOGICAL CHOREOGRAPHY

Until now, I have been mostly silent about the internal relationships between the different actors involved in enacting practices of breastfeeding and how they mutually affect and are affected by each other. To elaborate on these relations, I suggest thinking with Thomson's concept of *ontological choreography.* As the concept implies, ontological choreography is a dynamic process of coordination between different actors in specific practices. In her own work, Thompson explores the processes of ontological choreography in fertility treatment ethnographically. She argues that in fertility treatment, *things* otherwise understood as belonging to different ontological orders are coordinated to produce children, and if the treatment fails – be it for financial, legal, or biological reasons – it is the ontological choreography that goes wrong. When the outcome of the treatment is a successful pregnancy, thereby making new parents and children, the choreography produces ontological innovations through new kinds of reproduction and new ways of making parents. She argues that

ontological choreographies are, to some degree, prevalent in all sorts of human activities (Thompson, 2005, p. 8-9, see also Cussins 1996).

In their respective analytical approaches, Mol and Thompson both work with focus on practice and objects. However, Thompson departs from Mol in her preoccupation with examining how subjectification, objectification, and agency co-exist in practices. She argues that a coherent self-narrative necessitates ontological heterogeneity and therefore "*we cannot presuppose an ontology of the unified subject*" (Thompson, 2005, p. 182). Reminiscent of Mol's figure of the *body multiple,* Thompson multiplies *the subject* insofar as the illusion of a unified subject vanishes through the practical variations of ontological choreographies.  In the case of fertility treatment, the patient is sometimes a person sitting in a waiting room, sometimes ovaries and follicles on the ultrasound screen and sometimes a body on the surgical table (ibid., p. 182). The two latter examples exhibit practices wherein the patient is *objectified.* These are not necessarily reductive practices that result in the loss of personhood, nor do they automatically conflict with the subject's goals.  On the contrary, patients can enact their subjectivity through this objectification by manifesting agency in distinct ways (ibid., p. 179). Following Thompson, I find it relevant to illustrate how the subject-position I call *a breastfeeding mother* emerges via practices of objectification and ontological choreography involving of the coordination of objects and subjects such as volunteers, laws, knowledge, computers, breasts, pumps, bottles, money, and so forth.

### THE ISSUE OF STRIKING NURSES AND THE PRICE OF PROPER COUNSELLING

To exemplify both how ontological choreography can go wrong and, conversely, how it can produce ontological innovation and the new subject-position as a breastfeeding mother, I unfold Sophie's account in detail. Her experiences illustrate how objectification under certain circumstances can lead to the loss of personhood, but under other circumstances objectification can produce new forms of agency that enables ontological innovations and new types of subjecthood (Thompson, 2005, p. 179).

Sophie gives birth to her son in the summer of 2021, right around the time that nurses, including health visitors, are on a nationwide strike to fight for better salaries and working conditions. As a result, the health visitors' home visits are reduced to just one after the birth. This makes it difficult for her to get the help she needs for her problematic breastfeeding from

the public health professionals, who usually support new mothers with feeding-related issues. As such, the fallout from a nationwide political dispute has a substantial impact on Sophie's experiences and problems with breastfeeding:

*"Altså, der kom en sundhedsplejerske, og det er fordi det skal de gøre, var det dag 5? […] Og jeg var sådan: "Det her amning det kører bare overhovedet ikke" og hun var sådan: "Må jeg se?" og så ja det kunne hun godt se, at det var måske ikke så godt. Men altså det hun sagde det var, at der var privat ammevejledning […] Og så siger hun at normalt, når der ikke er strejke, så er der også en offentlig ammevejledning."* Interview, Sophie

According to Thompson, in the case of fertility treatment, "*patients willingly accept the role of being the object of the medical gaze and in fact actively participate in it*" (Thompson, 2005, p. 191). Comparably, Sophie submits to a distinct object-position by letting the health visitor evaluate her breastfeeding from a medical perspective, hoping to learn why her breastfeeding does not work. She seeks help in achieving her goal of becoming a breastfeeding mother:

*"[F]orud for min fødsel havde jeg en klar ide om og forhåbning om at jeg skulle amme min søn"* Interview, Sophie

To become a breastfeeding mother, Sophie's acceptance of objectification is a case of intentional subordination, that is "subordinating the will to the structural power of another person or organization to achieve some overarching goal" (Thompson, 2005, p. 191). The health visitor acknowledges that the breastfeeding does not work at all and under normal circumstances, the health visitors offer breastfeeding counselling. But in the extraordinary situation produced by the strike, she suggests private breastfeeding counselling. But paying for private counselling is not an option for Sophie and her family:

*" […] for os gav det ikke mening økonomisk at skulle til at give 4000kr for en times ammevejledning, det er vi ikke økonomisk i stand til. Så det blev flasken."* Interview, Sophie

Despite her intentional subordination, the health visitor's objectification of Sophie only results in an evaluation which clarifies that there is, indeed, a problem. But she offers no tenable solution, except the reference to self-paid counselling in the private sector. The absence of sufficient public counselling has huge consequences for Sophie's mental health:

*”Jeg har jo forsøgt at ringe til alle de der vagt telefoner, og min mor ringede til vagttelefonen og var sådan "Vi er simpelthen nødt til at gøre noget", fordi at jeg nok var på vej ud af et sidespor. Altså mentalt havde jeg det ikke særligt godt. Og klart at det også hang sammen med projekt amning som bare sejlede fuldstændigt. […] Hvor de havde sagt til hende i telefonen, at hvis vi havde en klage så kunne vi kontakte Christiansborg.”* Interview, Sophie

Seeing her daughter’s mental health severely worsening, Sophie’s mother contacts a hotline in desperation. The health nurse at the other end of the line cannot offer any counselling and she suggests that they contact Christansborg, the Danish parliament, if they want to make a complaint. This case illustrates how breastfeeding counselling involves so much more than health professionals, mothers and babies, breasts, and milk, to name just a few. When Sophie’s mother calls the hotline, the network in which the counselling practice is embedded expands to include, however momentarily and superficially, The Danish parliament as an actor. Which goes to underline how Sophie’s experience with counselling practices is fundamentally intertwined with a political struggle over the working conditions of nurses in the Danish labor market. This is not to say that the Danish parliament is not always, to some extent, an important actor in the material-semiotic networks that shape breastfeeding counselling. Regardless of labor strikes. As the highest legislative authority in Denmark, the Danish parliament is always partly responsible for enacting the rights of Danish children. For example, as mentioned earlier, through §121 in the Health Act (Sundhedsloven, 2019).

But the associations between breastfeeding counselling practices and the institution of The Danish Parliament becomes particularly apparent in a situation that deviates significantly from a reality that *seems* stable. Under ‘normal’ circumstances, Sophie has a legal right to receive help and the health visitors are obliged to provide this. In Sophie’s case, the health visitors enact their counselling differently due to the political conflict, in a way that does not correspond with the life of Sophie. Her problems cannot be solved by consulting an actor in the private sector, neither by complaining to the Danish Parliament.

In Sophie’s case, economical and legal factors, among other things, participate in preventing Sophie from successfully enacting the ontological choreography that would make her into a breastfeeding mother. First, Sophie’s possibility of producing, and thus inhabiting, the highly desired subject-position, is complicated both by her breastfeeding problems but also her inability to access the resources that *might* help her solve these problems. In short, her legal

right to breastfeeding counselling from her health visitor is void by the strike. Second, to pay a private breastfeeding counselor requires certain economic resources, which Sophie and her family do not have. Had the legal right to free counselling still been in effect, their financial abilities would not be an issue, because public counselling would have been available. Concomitantly, if the family had been in a different financial situation, they might have been able to pay a private counsellor, wherefore the strike would not necessarily be an obstacle. Certainly, there is no guarantee that either private or public counselling would have solved the problem. But they *might* have, had they been available. In any case, for Sophie the choreography goes wrong, and at first, she fails at becoming a breastfeeding mother.

### THE POTENTIALITY OF THE BREAST AND ONTOLOGICAL INNOVATION

Just as Sophie's subject-position is changeable, something as tangible as the object of a breast undergoes ontological changes in a breastfeeding course, just like an embryo does in a fertility treatment. Thompson describes how an embryo at the fertility clinic can go from being *"a potential person (when they are part of the treatment process), to being in suspended animation (when they are frozen), to not being a potential person (when it has been decided that they will be discarded or donated to research) […]"* (Thompson, 2005, p. 182). Likewise, a mother's breast can be a potential source of nutrition, often beginning with hormonal changes during pregnancy, which brings changes in breast structure and activates milk-producing cells until after the baby is born and the milk flows. But when mothers face unsolvable breastfeeding problems that occurs because of failing ontological choreography, like in Sophie's case above, the breast is no longer a potential source of infant nutrition. The failed ontological choreography might have biological or physiological causes, but they might as well be political, legal, or economic.  However, when Sophie begins expressing her milk to bottle feed her son, the breast is once again source of infant nutrition:

"Og den gyldne mellemvej blev så for mig at malke ud. Og det har fungeret helt vildt godt for vores familie." Interview, Sophie

She learns about milk expression from Ammenet.dk, whose repertoire of knowledge becomes crucial for the ontological innovation that make her into a breastfeeding mother. If we compare Sophie's encounter with Ammenet.dk's counselling to her experiences with public health professionals, the differences become obvious. Finances are not an immediate obstacle and

the politico-legal aspect also disappears as the volunteers are not publicly employed professionals, wherefore they are not subject to strikes nor to the directives of §121 in the Health Act (Sundhedsloven, 2019). To make breastfeeding by milk expression possible, and thus realize the potential contribution of the breast in making her a breastfeeding mother, Sophie needs specific knowledge on methods that Ammenet.dk's Wiki provides:

*"Altså det [Ammenet.dk] har jeg brugt rigtig meget, da vi kørte over på flaske og da jeg kørte over på udmalkning, fordi det var jo, altså det er jo en helt ny verden som jeg så overhovedet ikke havde forberedt mig på. […] Men der brugte jeg det frivillige. Især wikien, til at starte med til sådan at finde hoved og hale i, hvad er der af metoder?"* Interview, Sophie

The complex interactions between knowledge about milk expression methods, the pump, the bottle, the right timing for maintaining milk production, the baby's ability and willingness to take the bottle, among many other things, allow Sophie to feed her son with her own milk. To do so, Sophie once again intentionally subjects herself to a specific medical take on breastfeeding by letting the primarily 'evidence-based' knowledge that Ammenet.dk offers be a crucial part of the solution to her breastfeeding problems. The agency of knowledge itself becomes very apparent, as this mode of virtual counselling does not require the presence of another human being. The knowledge, embedded in and acting through the material-semiotic network, does fine by 'itself', without a human to communicate it. This objectification is not opposed to neither Sophie's experiences of being an intentional subject nor her goals of becoming a breastfeeding mother. Rather, Sophie's case illustrates "*that the subject is dependent on the constant ontological entwining between ourselves and our environments*" (Thompson, 2005, p. 182). The ontological choreography succeeds since the environments of knowledge enacted through Ammenet.dk's counselling enable Sophie to embody and enact the subject-position of a *breastfeeding mother*. Not according to the definitions offered by 'natural mothering' or Neo-Darwinist attitudes, but according to Ammenet.dk's concomitant enactment of breastfeeding as *everything*, which reworks the importance of breastfeeding in 'natural' way. In short, ontological innovation occurs since a new way of being a breastfeeding mother emerges, just like new ways of becoming parents do in the fertility clinic.

# CONCLUDING REMARKS

In this thesis, I explored how breastfeeding problems, the breastfeeding body, and the subject-position of a breastfeeding mother are *multiply enacted* in practice through Ammenet.dk's online voluntary breastfeeding counselling. I argued that Ammenet.dk counselling enacts both breastfeeding and attendant problems that correspond to and are coextensive with the lives of eight mothers, who have experienced issues with breastfeeding. Ammenet.dk achieves this coordination by producing knowledge that acknowledges the diffuseness and multiplicity of breastfeeding problems rather than produces singular and definitive evaluations and diagnosis. In contrast, the offered by public health professionals was experienced as insufficient, since the realities they enacted through evaluations and diagnosis were poorly coordinated with the mothers' experiences.

Part of what distinguishes Ammenet.dk's counselling from the services offered by public health professionals emerges from differences in their formats. Where Ammenet.dk works exclusively online, the public sector favors physical face-to-face sessions. In such sessions, problems are diagnosed primarily with reference to the physical body, assessing bodily signals and signs of abnormalities. Interpreting such signals are expected to lead to *one* definitive answer, a diagnosis of the problem, or none, and thus the absence of a problem. In contrast, Ammenet.dk cannot assess problems based on bodies, but provide instead a plethora of evidence-based knowledge that attends to multiple possible problems. At the same time, they advance an understanding of breastfeeding that is not limited to nourishing a baby exclusively at the breast, but which can instead mutate to fit the circumstances of individual mothers. As Ammenet.dk argue, *all things are breastfeeding,* and it includes all forms of feeding a child with breastmilk using various techniques and technologies as needed. It can be exclusive breastfeeding by the breast, but it can also be a transgender person feeding a baby by virtue of an SNS system or a mother bottle-feeding her child with expressed milk. Such multiple understandings of breastfeeding and related issues are embodied in the general knowledge that Ammenet.dk disseminate through counselling in their letterbox, the Wiki and in the network groups on Facebook.

This generality, embodying an openness to the possibility of multiple and different problems and solutions, reveals how Ammenet.dk's counselling differs from the mothers' encounters with the public health professionals. In the former, realities are coordinated and can co-exist

without replacing one another, since Ammenet.dk knowledge enables mothers to take responsibility for their breastfeeding by defining problems and finding solutions themselves.

How the mothers take responsibility for their breastfeeding does not necessarily correspond with the understanding of breastfeeding practices and norms they describe explicitly. Instead, when asked many of the mothers I spoke with voice views on breastfeeding that are similar to perspectives from the 'natural mothering' movement or Neo-Darwinist attitudes. In both cases, breastfeeding is singularized, understood as feeding babies at the breast without technological interventions. But what the mothers *say* and what they *do* does not always match. In practice, they enact breastfeeding problems and bodies in ways that make distinctions between culture/nature and technology/biology collapse. By enacting a breastfeeding body using technological tools and different techniques, the mothers initiate an ontological choreography that enables them to achieve the desired subject-position of a *breastfeeding mother.* In doing so, they also accept objectification to produce ontological innovations and new ways of being a breastfeeding mother. In short, Ammenet.dk contributes to Danish mothers' processes of coping with breastfeeding problems by offering new ways of enacting breastfeeding and its problems, breastfeeding bodies, and breastfeeding mothers.

Finally, I close the thesis by engaging a more, for want of a better word, reflexive layer in the analysis. The purpose of this reflexive re-reading of my own work is to open a space for discussing both practical and ontological consequences of the thesis for the people involved, including myself.  While doing this reflexive exercise, it dawned on me that I was, in fact, doing a form of document analysis on my own thesis. Not as an attempt to 'read against the text' and thus my analysis for any hidden agendas that I might be unaware of (Jensen & Lauritsen 2005, Gad, 2010). Rather, 'reading with the text' involves seeing the text I have produced as an actor in its own right, also contributing to the enactment of the material-semiotic networks in which it occurs. In other words, by attending analytically to how various actors participate in enacting breastfeeding problems, breastfeeding bodies, and the subject-positions of being a breastfeeding mother, the thesis also enacts its own versions of such phenomena, through some form of ontological innovation. As such, I find it relevant to consider the impact this thesis might have when confronted with the world outside itself.

Firstly, since my project is based on a collaboration with Ammenet.dk that they originally initiated, it is likely that some of the insights from the thesis will be a part of the material-

semiotic network in which Ammenet.dk and their counselling practices are embedded. Obviously, I cannot predict the future agency of this document or how Ammenet.dk might find it relevant. But from the very beginning, they requested a thesis documenting and analyzing mothers' experiences with breastfeeding counselling, with a focus on how mothers navigate between public and voluntary forms of support. Ideally, a detailed study of the differences between public and voluntary counselling should help strengthen the cooperation between the two and thereby ensure that the services they offer complement each other in the best way possible. As such, if proven useful, the thesis might have an impact on both. For example, finishing my analysis, I received an email from my contact person at Ammenet.dk asking if she could present some of my findings at a networking meeting on breastfeeding at the Breastfeeding Competence Center. This partly shows how the thesis will, in some way, become entangled with the material-semiotic networks that are enacted within and between both public and voluntary breastfeeding counselling in Denmark.

Documents, like my thesis, always interfere with the world in ways that might cause things to change (Law, 2004, p. 7). In short, the production of knowledge always involves the potential to make a difference and "*it is about how to make good differences in circumstances where reality is both unknowable and generative*" (Law, 2004, p. 7). However, making 'good' differences requires a normative stance on which realities are preferable. I have refrained from taking a normative stance, not to maintain an allusion of objectivity, but rather to emphasize my focus on the multiplicity of practices and the complexity of their interrelations. However, my thesis may provoke readers who are strongly wedded to a Euro-American notion of a singular reality and the existence of one truth. This provocation might, in turn, produce some kind of change through interference. As Law describes: "*[W]e might hope […] to interfere, to make some realities realer, others less so. The good of making a difference will live alongside – and sometimes displace – that of enacting truth.*" (Law, 2004, p. 67).

Again, though I have consciously avoided normative claims, I have been trying to make a 'good difference', not by enacting truth, but by showing how practices that enhance the multiplicity of breastfeeding problems, bodies, and mothers are more easily coordinated with the needs, experiences, and lives of the mothers I spoke with. In that sense, I might appear to be 'promoting' a particular perspective on breastfeeding that does not necessarily square fully with what Ammenet.dk themselves promote. That is, by trying to make the mothers' realities

'realer' I have emphasized the multiplicity, diffuseness, ambiguity of Ammenet.dk's breastfeeding definitions and counselling practices. But in doing so, I have also challenged the claim to 'evidence-based' knowledge that Ammenet.dk celebrate. Again, my take on multiplicity and good differences can, as Law notes above, co-exist – while sometimes displacing – claims to superior forms of knowledge and even truth. That is, I propose that my work can easily live alongside Ammenet.dk's own 'realities', it can even contribute to multiplying these, without involving any strong conflict. This is partly because my analysis, as should be obvious by now, attend to the multiple definitions of breastfeeding, the breastfeeding body, and breastfeeding mothers that emerge in and through Ammenet.dk's *practices of breastfeeding counselling.* In doing so, it also reconceptualizes claims to singular definitions, and by extension, the claims that breastfeeding becomes 'natural' when exclusively nourishing by the breast without any technological interference.

Such attempts at reconceptualization, I argue, are the result of how my analysis interferes with Ammenet.dk's practices and the mothers' experiences, and, importantly, *vice versa*. In that way, the thesis also aligns itself "*the writings of a new generation of STS and feminist scholars of technoscience who do not reject science and technology but try to negotiate a politics in use and development, paying attention to the possibilities of places of scientific, technological, or medical practice for different women."* (Thompson, 2005, p. 189). This simultaneously makes the thesis relevant outside of research fields explicitly dedicated to post-ANT and feminist STS, because it shows how things *can be different in practice,* and that the singular reality that many of us take for granted can be resisted in some form. Nonetheless, looking beyond Ammenet.dk, other actors, like nurses, midwives, or health visitors involved in the material-semiotic networks that enact breastfeeding counselling in different settings, might refuse to accept the instability and multiplicity of realities for their own reasons. In doing so, they would seem to reject the very premise of the thesis. Again, from my perspective, their rejection can co-exist with my analysis and the realities it enacts without too much trouble.

In short, Ammenet.dk's take home message is that their online voluntary social work is sufficient in helping mothers overcome their breastfeeding issues, at least for the mothers I spoke with. It might be that their recognition of diffuse problems combined with their production and dissemination of knowledge that embrace the multiplicity of breastfeeding is already a good way to completement the services offered by the public sector. Future studies

might try to test whether disseminating and implementing Ammenet.dk's mantra, 'all things are breastfeeding', beyond their own letterbox, network groups, and Wiki would improve the prevalence and duration of breastfeeding in Denmark and whether this, in turn, would improve the physical and mental health at individual and societal levels.

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