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‘Luring the Infant into Life’: Exploring Infant Mortality and Infant-feeding in Khayelitsha, Cape Town

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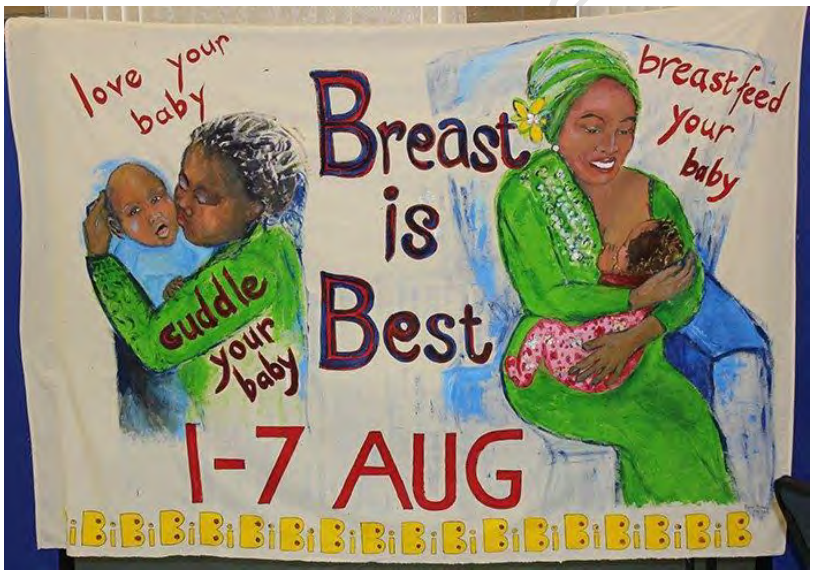

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Ziyanda Majombozi

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DEFINITIONS[1]

Bottle feeding: Feeding from a bottle, regardless of content in the bottle.

Breast-milk substitute: Any foods used as a partial or total replacement for breast milk.

Complementary feeding: The practise of giving complementary foods.

Complementary food: Any food, whether manufactured or locally prepared, suitable as a complement to or substitute for breast milk.

Exclusive breastfeeding: Feeding an infant no food or drink, not even water, other than breast milk, except for drops or syrups of vitamins, mineral supplements, or medicines.

Infant: A child from birth to 12 months of age.

Infant mortality: The death of an infant within 28 days of birth.

Mixed feeding: The feeding of both breast milk and other foods or liquids.

Mother-to-child transmission (MTCT): Transmission of HIV to a child from an HIV infected mother during pregnancy, delivery, or breastfeeding.

ACRONYMS

DoH: Department of Health

HIA: Health Impact Assessment Unit (of the Provincial Government of the Western Cape, South Africa

MBFHI: Mother and Baby Friendly Hospital Initiative

PMTCT: Prevention of Mother to Child Transmission

UNICEF: United Nations Children's Fund

WHO: World Health Organisation

[1]The definitions provided above have been derived from the UNICEF report on HIV and infant feeding

TABLE OF CONTENTS

INTRODUCTION: SAVING BABIES

'The First Thousand Days of Life' - measured from conception to approximately two years of age - has become a field of inquiry with direct implications for policy at all levels, from global policymaking to local governments.Findings in neurosciences and epigenetics indicate that the material and emotional contexts of these early days are crucial in establishing the child's well-being. According to Thompson and Nelson (2001), brain development occurs rapidly during the first thousand days of life. Solutions to improve life in the first thousand days window are widely available, and various governments have engaged with some of these solutions. These include ensuring that mothers and young children get the necessary vitamins and minerals they need, promoting good nutritional practices such as breastfeeding and appropriate, healthy foods for infants, and a focus on early childhood development. Some of these recommendations have translated into policy changes, including South Africa's nutrition policy, breastfeeding policies, and policies on early childhood development (Why 1000 Days, 2015). However, South Africa still has many challenges in sustaining these first thousand days of life.

Infant mortality rates in South Africa are high[2]. To deal with this issue, the South African Minister of Health, Dr Aaron Motsoaledi, issued the *'Tshwane Declaration of Support for Breastfeeding'* in 2011. The declaration emphasized that exclusive breastfeeding for the first six months of life would be a government-promoted intervention to decrease infant mortality. The South African government adopted an exclusive breastfeeding policy for all mothers, including HIV-positive mothers[3]. In adopting the new policy, the department effectively declared the end of the distribution of free infant formula (Department of Health, 2011). Since 2001, the government had provided HIV-positive mothers with free infant formula as a way to prevent mother-to-child infection through breastfeeding (Ijumba et al, 2013). In 2003, the World Health Organisation (hereafter, WHO) published guidelines on HIV and infant feeding, recommending that HIV infected mothers bottle-feed (WHO, 2003). Since then, new evidence has emerged that antiretroviral (ARV) interventions – to either the HIV infected mother or HIV exposed infant – could reduce the risk of post-natal transmission of HIV via breastfeeding (Iliff et al, 2005; Coovadia et al, 2007; Kuhn et al, 2007; WHO, 2010).

[2]See Appendix 1- State Of the World's Children, UNICEF 2015 report for statistics
[3]There are numerous different questions and concerns surrounding infant feeding and HIV. However, given the scope of this dissertation and the fact that fieldwork was not done with HIV+ mothers, these issues will not be discussed herein.

The exclusive breastfeeding recommendations were based on research that supports breastfeeding and its ability to keep infants safe. For example, according to Doherty et al (2010:62-63), breastfeeding reduces the risk of HIV transmission for HIV-infected mothers, amongst other benefits. Drawing on a study conducted in South Africa's Prevention of Mother to Child Transmission (PMTCT) sites, Doherty et al (2010:62-63) argue that infants between zero to five months who are not breastfed have an increased risk of death from diarrhoea and pneumonia, compared to infants who are exclusively breastfed. Moreover, infants who are mixed-fed have an increased risk of malnutrition and illnesses such as diarrhoea and pneumonia. Doherty et al (2010:62-63) argue that exclusive breastfeeding reduces infant mortality and morbidity associated with infectious diseases, both in resource poor and rich settings. Breastfeeding has also been associated with reduced risk of asthma, obesity in childhood, lowered systolic blood pressure, reduced risk of type 1 diabetes, and reduced atopic and allergic respiratory diseases up to age 17 (Wilson et al. 1998; Oddy et al. 1999). The research cited shows that the promotion of exclusive breastfeeding is indeed seen as a way of addressing the risk of infant mortality.

Although many infants in South African are breastfed, many are not exclusively breastfed. Exclusive breastfeeding is a method chosen by few women (Department of Health, 2011). This is despite a number of child health programmes, interventions, current policies and recommendations on breast feeding, such as the 2011 *Tshwane Declaration of Support for Breastfeeding in South Africa* and the 2010 WHO *Guidelines on HIV and Infant Feeding*. Amongst other studies, data from the 2013 South African Demographic and Health Survey (SADHS) indicates that, although initiation of breastfeeding immediately post-delivery is a common practice, mixed feeding rather than exclusive breastfeeding is the norm. Some infants are reported to have received complementary feeds before the age of six months (Department of Health 2013a).

Responding to the factors mentioned above, the Health Impact Assessment unit (hereafter HIA) of the Provincial Government of the Western Cape, South Africa, approached the University of Cape Town (hereafter, UCT) Knowledge Co-op[4] with a central question: why do many women not exclusively breastfeed their infants for the first six months of life? (UCT

[4]The Knowledge Co-op helps initiate joint projects that benefit both the community and the university. It links community groups with appropriately qualified staff and students at UCT - See more at: http://www.knowledgeco-op.uct.ac.za/#sthash.wDk2ap1y.dpuf

Knowledge Co-op, Project #81, 2013)[5]. To begin answering this question posed by the HIA it was necessary to trace women's understandings and practices of breastfeeding. As a way to begin engaging with the question at hand, my research question had two aspects: Firstly, what were women's experiences of breastfeeding and infant feeding? Secondly, what influenced women's infant feeding choices? I explored the local knowledge that existed around breastfeeding and infant feeding which influenced infant feeding decisions, and which acted as a barrier to exclusive breastfeeding. I also explored notions of 'good mothering', and how these influence infant feeding choices. However, after weeks of fieldwork, I realised that a focus on understanding infant feeding, in order to address the issue of infant mortality, was too simplistic.

The question of infant mortality is one that deals with the loss of life and the risk of the loss of life is one that concerns many people. However, a focus on exclusive breastfeeding was too limiting. It did not allow for a depth understanding of life or how, in the face of potential death, mothers keep their children alive. Engaging with the narrower question of exclusive breastfeeding closed spaces to engage with understandings of life itself, and the different ways that one can sustain the life of one's infant. Equally, the question ignored the various actors, beyond the mother, who are involved in sustaining infants' lives. I therefore explored the mothers' different actions and behaviours intended to nurture and protect their infants from harm. This provided the opportunity to gain different kinds of knowledge about infant feeding and child care, rather than focus merely on exclusive breastfeeding and its barriers.

Hoffman (2010) argues that parents raise children in increasingly risky environments, in terms of health and well-being, and that risk has become a key concept in understanding and explaining contemporary social life. Risk has been used to explain why families suffer negative impacts of poverty, marital problems, and lack of social support. Furthermore, parents who are have limited or no ability to manage risk factors face the possibility of being labelled as 'bad parents' who expose their children to social and physical harms. Similarly, Lee (2008) argues that an infant's wellbeing is considered to be at constant risk from a growing range of threats posed by everyday life. The mother is considered central in ensuring that their infant is not negatively affected or damaged by those threats.

Lee (2008) further argues that the mother is seen (by health professionals) as being unable to manage risk to their infant effectively without professional support. Conversely, by managing

[5] For further information, see: http://www.knowledgeco-op.uct.ac.za/kco/proj/current

these risks with professional assistance, one is understood as a good and responsible mother. Mothers need not have given birth to become subject to the risk management and medicalisation discourse of motherhood. Lee (2008:469) argues that pregnancy is a state in which the 'good mother in waiting' needs both to express excitement for the coming baby, as well as an awareness of the range of risks awaiting the baby, and risks before the baby is born. The mother also needs to be aware of expert opinion on managing risks from alcohol, food, exercise, and stress, and must adjust her behaviour to manage these risks effectively.

Infant feeding is one of the risks that mothers keep in mind and respond to. Lupton (2011) echoes Lee (2008) and Hoffman's (2010) ideas of how life, particularly that of an infant, is saturated with ideas of risk. Drawing on studies by Cunningham-Burley (1990); Irvine and Cunningham-Burley (1991) and Cunningham-Burley et al. (2006), Lupton (2011) argues that mothers are aware of the risk discourse and their responsibility for managing and protecting their children's health, and are anxious to conform to the norms of 'good motherhood'. Furthermore, Lupton (2011) argues that an important factor to recognise is that women have different priorities and concerns, and thus may conceptualise their children's bodies and health in different ways. The common thread here is that there are risks and threats to the life of an infant, ranging from poverty or marital problems. These make it difficult to raise a child, and make it even more important for a parent to stay alert and continually improvise, finding effective ways of sustaining the life of the child in spite of the risks or threat of the loss of life. As Gottlieb (2000a) puts it, mothers feel the need to constantly try and 'lure the child to this earth' by managing the multiple risks.

Drawing on notions of managing risk, this dissertation shows that in a world where life is precarious, and always at the risk of death due to illnesses, poverty and other social ills that reflect the political economy of the different spaces, child care is about sustaining the life of an infant, or protecting this life from being lost. In arguing this, I explore the different ways in which the state (here, the South African Department of Health) and mothers understand themselves to be sustaining infant life. Furthermore, I examine the complexities that arise when the state, in conjunction with other external health institutions, and the mother, together with family and friends, imagine the process of sustaining that life differently. This dissertation argues that infant feeding choices embody the different discourses that surround 'sustaining life'. In doing so, I demonstrate the ways in which the state, represented by the Department of Health, and Khayelitsha residents imagine both the sustaining of infant life and the managing of risks in the infant's life. In particular, the introduction argues that the

introduction of exclusive breastfeeding policies is one manifestation of the state's ideas for sustaining life and, by contrast, the introduction of medicine and complimentary feeds reflects how mothers sustain the lives of their infants.

Chapter Outline

This dissertation is divided into five chapters. Chapter 1 details my ethical positioning and the methodological strategies I employed. I argue that from shifting the focus of agency from the mother to the baby, a different and more ethical understanding of breastfeeding can be achieved. Chapter two provides context to the political climate of infant feeding in South Africa – detailing the rules and regulations that have been put in place with the aim of promoting exclusive breastfeeding. The chapter also discusses the creation of the ideal 'good mother' and describes the language used by the government to this effect. In effect, this chapter argues that the South African government's idea of sustaining infant life is enforcing exclusive breastfeeding for the first six months of life and the various aggressive policies in place reflect the commitment to exclusive breastfeeding. Chapter three is an ethnographic chapter detailing the mothers' ideas and thoughts around the importance of breastfeeding and also details some of the barriers to exclusive breastfeeding that the mothers experienced. This chapter argues that, despite barriers to exclusive breastfeeding, mothers enjoy breastfeeding and the closeness they feel with their children as a result of the breastfeeding. Chapter four discusses the different ways in which mothers 'lure the lives of their children to earth' (Gottlieb, 2000a). It argues that the use of medicines and complementary feeds are some of the ways that mothers use to sustain the life of their children. Lastly, chapter five concludes by showing the idea of conflicted cure in dealing with child care (conflicted between the state and mothers) and the importance of trust in particular relationships in the process of infant feeding decisions. This chapter describes some of the differences and contradictions in the process of childcare and how these play out in the complex ways that mothers, nurses, grandmothers, fathers and others understand sustaining infant life.

CHAPTER 1: DOES THIS BABY LIKE BREAST MILK? - THINKING CAREFULLY ABOUT ETHICS AND METHODS

Andiswa, one of my informants, has a two-year-old niece named Niko. On one of my visits to her home, Niko was crying as her mother was feeding her from a jar of 'Purity'[6]. Andiswa gave up trying to feed Niko, and gave the other children in the house the jar of Purity to finish. Andiswa's mother asked 'Does Niko not want it?' to which Andiswa responded, 'Niko does not like tasteless food, she prefers fruit flavoured purity'.

It was not the first time a mother spoke of what the infant eats in terms of what the baby liked, rather than in terms of what the mother decided to feed the baby. Many of the mothers I worked with spoke of their breastfeeding schedules not as a plan they create, but one that the baby creates for them. When they spoke of breastfeeding, they would either say that they do it because the baby 'likes it', or do not breastfeed because the baby 'does not like it'. The questions I had planned to ask the mothers were all phrased in a way that did not account for the baby as influencing the mother's decisions on how to feed and what to feed[7].

I then decided to be strategic in the ways that I phrased questions to the mothers and the kind of questions I asked. For example, I stopped asking, 'do you breastfeed the baby?' which may have come across as judgemental, given the aggressive breastfeeding promotion mothers face at clinics (discussed in the next chapter). Instead, I would ask 'does this baby like breast milk?', or 'what other things does the baby like to eat?'

Doing so meant that the mothers were more excited and willing to share stories about their babies and what their babies liked, rather than answering questions about what the mothers do, which might sound like a confrontation or a judgement of their infant feeding practices based on knowledge from the nurses. This also provided the mothers an opportunity to teach me, as a woman who does not have a baby, about baby issues. The mothers seemed to enjoy this, and laughed every time I asked them about what their babies liked, casually saying to me 'oh Ziyanda, you do not know these things' or 'oh yes, you know nothing'. Questions of this sort seemed to elicit fewer uneasy reactions, compared to asking the mothers if they breastfed, and then continuing to ask questions from my list of things recommended by the national DoH. The mothers tended to react to the latter by asking me if their answers were correct.

[6]A brand of baby food that is so popular that the word 'purity' comes to stand metaphorically for processed baby food in general

[7]See appendix 2 for initial set of interview questions

Focusing on the baby as the centre of analysis also explicitly recognised the baby as the object of study and as someone who makes decisions about what they eat and do not eat. Drawing on Gottlieb (2000b), Marais (2014) explores an anthropology of infants with regards to the six reasons presented by Gottlieb (2000b) on why infants have remained absent from anthropological discussions. Gottlieb argues that '…the bodies of babies are significant markers pointing to critical cultural values' (2000b: 56), Marais (2014) extends this and argues that 'the bodies of infants overflow with various leaks (tears, sound, mucus, urine, faeces, vomit), which act as valuable sites that reveal information, not only about the infants' social worlds, but also about the care relationships that develop between the infants and their (parental or non-parental) caregivers' (Marais, 2014:9).

For this research, the most important question is that of the agency of infants. Gottlieb (2000b: 124) states that the child is seen as being dependent on the caregiver for biological sustenance and, because of this, anthropologists render children less interesting sites of research. Additionally, in many contexts, infants are classified as minors with no legal consequences. This leads to what Gottlieb (2000b) terms the 'ethnographic invisibility' of infants, which is not a true reflection of infants, who demand to be accounted for from an early age. In her research in Côte d'Ivoire, Gottlieb (2000a) found that a multitude of daily decisions were made in relation to infants, as infants were seen as reincarnations of ancestors, with desires from their previous lives that parents needed to satisfy. In this case, babies are thus not at all passive creatures.

Anthropologists' disregard for infants may also stem from the babies' perceived (in) ability to communicate, according to Gottlieb (2000b). Because babies are seen to be incapable of speaking, anthropologists are concerned that they cannot interpret the infant's wishes, and therefore cannot be objects of study. She then proposes that the noises made by young babies may be seen as meaningful in other spaces, although dismissed as meaningless by Western observers. Paying attention to these noises, and how they are interpreted by those surrounding the infant, produces sites of intellectual inquiry, argues Gottlieb (2000b). She further suggests that as other communication systems such as clothing, adornments, games, and table manners can be analysed productively, infants can also be considered as texts to be read with a new lens. Understanding this would require asking adults how they think their babies communicate, and the local understandings of how infants communicate may require us to move away from our strictly verbal models, towards considering multiple kinds of communication. I took this seriously in my research, particularly in how I thought about the

questions I would ask, and how I would receive the information relayed to me by mothers about their infants, as shown in the opening paragraph of this chapter. I tried to see the baby as an active decision-maker in how the mothers care for them, and thus focused sincerely on the mothers' interpretation of their communication with their infants.

Location of Study and Participants

I conducted my fieldwork in Khayelitsha. Khayelitsha (translated from isiXhosa meaning 'new home') is about 35 kilometres from the Cape Town city centre and is the second-largest township[8] in South Africa. According to the 2011 City of Cape Town, Khayelitsha had a population of 391,749, with isiXhosa being the predominant language amongst residents. Khayelitsha is also one of the poorest areas of Cape Town; the median average income per family in 2011 was R20, 000 (US$1,872) per year, compared to the city-wide median of R40, 000 (US$3,743).

This dissertation is based on the lives of six isiXhosa speaking women from Khayelitsha - Sontombi, Nolwazi, Thandiwe, Vuyiswa, Dumisa, and Andiswa. My fieldwork took place from March 2014 to June 2014, and consisted of both face to face and online interactions. I then returned for further fieldwork in December 2014 to February 2015. At the time that I conducted fieldwork, the children were between the ages of 2 days and 2 years old, and the mothers I worked with were between the ages of 24 and 40 years old. I chose to do my research in Khayelitsha because it was one of the areas identified by the HIA as having the capacity and a need for research on exclusive breastfeeding. I worked with isiXhosa speaking women because of the dominance of the language in Khayelitsha, and because it is my mother tongue. This made it easier for me to communicate with my participants without requiring a research assistant, or putting my participants in a position where they had to step out of the comfort of speaking their primary language. I chose only six mothers because, in conversations with my potential participants, I realised that child care is not a task dealt with solely by the mother. Other family members make suggestions and play a role in how the child is fed, bathed, amongst other activities related to child care. Although the mothers were my main participants, I knew I would spend considerable time with other family members.

[8]In South Africa, the term township usually refers urban living areas that are often underdeveloped. These are usually built on the periphery of towns and cities and dominant residents are usually racialized as 'non-whites' (black Africans, Coloureds and Indians).For more information, see: https://www.capetown.gov.za/en/stats/2011CensusSuburbs/2011_Census_CT_Suburb_Khayelitsha_Profile.pdf

PARTICIPANT Pseudonym	RECRUITMENT PROCESS	AGE	OCCUPATION	NUMBER OF CHILDREN	PERIOD OF EXCLUSIVE BREAST FEEDING	START OF MIXED FEEDING	OTHER FAMILY MEMBERS I ENGAGED WITH
Sontombi	She is my cousin	40	Stay at home mother	5	Less than 2 months	Less than 2 months	mother
Nolwazi	Met in a taxi	Early 30s	Student	2	2 months	At 2 months	none
Thandiwe	Her home is in the same street as childhood home	27	Student	2	6 months	After 6 months	none
Vuyiswa	Family friend	29	Grade R teacher	1	2 months	At 2 months	mother
Dumisa	High-School friend	24	Student	1	3 months	At 3 months	none
Andiswa	High-School friend	24	Student	1	2 days	On day 2	mother and aunt

Table 1: Profile of participants

Methods: Ethnography Across Offline and Online Spaces

> *It was around 2pm when I walked in to do 'fieldwork'. There were three toddlers running around the house, admiring and touching my handbag, my necklace and my braids. I sat in the lounge and had a conversation with them- we paged through a magazine and picked our dream houses, cars, clothes and many other things we liked. Andiswa finally appeared from the bedroom, announcing that the baby had finally gone to sleep and she could now take a bath which frustrated me because it meant more time with the three toddlers and I was already feeling overwhelmed. I heard a baby cry, thought it was too grown up to be Andiswa's baby, and then Andiswa's aunt came out of the room carrying a little girl. Other people were washing dishes, others doing laundry, and I just sat there not sure what to do with myself as the three toddlers ran off to the crying baby. Luckily, Thando (Andiswa's baby) woke up and started crying, so I got up. His mother and grandmother were still busy. His mom shouted from the bathroom that I should take him, and so for a while I was just holding him trying to stop him from crying. Oh well, that's it for the day.* [Extract from field notes.]

I initially went into fieldwork with many ideas on what I would do - thinking that there was scope in master's research to experiment with different kinds of methods, such as asking the mothers to keep diaries (Zimmerman, 1977), or to use visual methods, such as taking pictures and making collages. However, I soon realised that doing research with mothers of infants and toddlers makes it difficult to explore some of the methods I had in mind. In fact, any time spent with them felt as though I was in their way, while they tried to dance frantically to the rhythm of the cries of their children. As a result, I had to be creative about the methods I chose to use and the amount of time I would spend in their homes.

One of my data collection methods was participant observation, which was useful in allowing me to observe the living experiences of the mothers. I was able to be there, in the moment, as babies cried frantically from hunger or from discomfort, and watched the mothers do all they could to comfort their babies. It allowed me to see the process of mothers preparing meals for themselves and their infants, observe their feeding practices, and see what was in the baby cabinets. Furthermore, participant observation allowed me to have a clear picture of how the mothers' other roles in the household impacted the time they had for child care and feeding. Most of my participation was keeping the mother company: talking with her while she went

on with her daily activities. In homes where there were also toddlers, I would play with the toddlers in order to distract them while the mother focused on the infant, helping where I could - under guidance from the mother or grandmother. Although this was a useful method, there were several challenges to using it. The houses in which mothers resided felt as though they were not big enough for a curious researcher, a mother with a busy schedule, a crying baby and family members walking in and out, along with other friends and family interested in seeing the baby. Thus, at times, my presence felt like an inconvenience. I would be mid-sentence, asking my first question of the day, when the mother would have to go hang clothes outside as the sun finally came out or as the rain unexpectedly stopped. And as soon as that was done, the baby would wake up and start crying, forcing the mother to feed the child. Although I had thought of babysitting as part of participant observation, the mothers were sometimes concerned with my child care skills (or lack thereof), and would frequently come and adjust the way I placed the baby on the bed, or the way I was holding the baby after a feed. Eventually, the mothers would take over, or ask the grandmother to do so. Therefore, babysitting as a method of participation was not possible.

When I visited Sontombi, one of her five children Lunga walked in laughing with tears in his eyes, wet from the rain. Aija, Sontombi's youngest son, ran to the stove and Sontombi rushed to stop him. After that commotion, Sontombi asked why Lunga was wet and then took off his wet clothes. Aija took the wet pants and shoes and cried when his mother tried to take these items from him. At this moment, I was overwhelmed with all the activity and confusion. Unsure about what to do - I just looked around and helped the mother scold and, along with the mother, shouted: 'sit down', 'why are you crying', 'don't touch that'. I then tucked my notebook away as I had already had a little wrestle with the youngest when he kept trying to grab it. In that moment, Sizwe, Sontombi's other son walked in with sand on his face and with a friend. After a long period of issuing commands for everyone to calm down, we resumed our discussion with Sontombi.

It was after these moments of screams, reprimanding and (what felt to me like) chaos that I felt like I kept going home having not asked 'enough' questions. I started thinking of new ways to communicate with the mothers that would not interrupt their busy schedules during

the day. I noticed that some of the mothers would post pictures of their babies on Facebook[9], and dedicate status updates to their babies on WhatsApp[10] and Facebook. I would also notice that, in the middle of the night, some of the mothers would be awake (online). We would chat about the inability to sleep, as I also stayed awake, worried by lack of data and wondering about ways to gather data. At first, I would just comment on the pictures of adorable babies and the status updates about the baby on Facebook. However, I realised that I could use these platforms for data collection. Here, Malkki's (2007) perspective about fieldwork as improvisation became very clear for me, because I recognised that I needed to improvise.

Citing Clifford (1992), Leander & Mckim (2003:3) state that:

> Ethnography has always been, in some sense, a geographic project, traditionally involving practices of dwelling in physical locations, mapping and understanding the practices within these locations, and retreating to other spaces to write research reports. When the research site or location for ethnographic study moves into the virtual worlds of the Internet, what happens to the meanings and uses of spatial constructs of ethnographic research, such as 'place,' knowledge about local identities, and participant observation?

According to Leander and Mckim (2003), moving from conventional research sites to online spaces forces a researcher to make a shift: from thinking about bounded physical sites, to thinking of fields of relations. They further argue that researchers have often created a binary between 'online' and 'offline' spaces. They attempt to disrupt this binary by showing that there is a misconception that the Internet is radically separate from everyday offline life, arguing instead that online technologies extend, rather than replace, offline relationships. Participants make meaning of their experiences across online and offline spaces. These points resonated with me, as most of my participants would share what happened offline on Facebook, and vice-versa[11]. The mothers would often use what they saw on Facebook to start a conversation, and often posted about their babies on Facebook and WhatsApp.

The South African government, particularly the health sector, has recognised the widespread use of cellphones and the internet, and has started using these platforms to provide health

[9]Facebook is an online social network on which many of the mothers share updates and photos. See figure 3, 4, 5 and 6 for examples from my participants.
[10]WhatsApp Messenger is a messaging app available for smartphones which the mothers frequently used.
[11]See Appendix 3 for examples

services and information. This approach is referred to as mobile health (mHealth). One such products aimed at pregnant women is MomConnect, a service using mHealth tools, messaging services and other platforms to create awareness among pregnant women about available health services for their infants (Department of Health, 2014).[12]

Figure 1: MomConnect Poster available on DOH website

Given the considerations above, I started using WhatsApp and Facebook updates, posts and conversations as stimulus for our face-to-face conversations. I asked questions about a picture or status update I had seen, and asked what the mother was doing or how the baby was. The mother would eventually start talking about things that had happened during the day, such as feeding. I then prepared some questions to ask the mother when we met. I also started setting up times where I would prepare a set of questions, and have informal interviews over WhatsApp with the mothers. I frequently reminded the mothers that I would use our conversations, both online and offline for my dissertation, and asked for additional consent.

[12]More information on MomConnect found at https://www.westerncape.gov.za/general-publication/new-project-connects-expectant-moms-government-health-services

After spending time on chat rooms, Facebook groups[13], and blogs about babies and infant feeding, I asked the mothers how they would feel about a chat group to discuss babies, infant feeding, and whatever else they wish to talk about. With their permission, I started a WhatsApp chat group and introduced them to each other. I used the group when I had follow-up or general questions for the mothers, and they answered whenever they had the time. As a result of the busy schedule and time constraints for mothers, I was not able to do face-to-face focus groups as I had initially planned on. However, the WhatsApp chat group was an effective alternative. It also gave the mothers space to talk about other things and ask each other for advice when a baby was ill[14].

Figure 2: Example of topics in Facebook groups I visited

I started structuring the WhatsApp group chat, setting meeting times where we would all be online and discuss a certain topic. Using the online space to conduct interviews and focus groups is not a foreign method to research. According to Fox et al (2007), doing focus groups online is an attempt by the research community to adjust conventional methods to keep pace with advances in communication technology. These online approaches also provide an alternative way of doing research with people who are either unable or unwilling to participate in orthodox face-to-face focus groups.

[13]See figure 2 for example
[14]See Figure 3 for example

Like other research methodologies, this approach had challenges. For example, I did not have physical and facial cues to determine whether or not participants were still comfortable with questions asked. When I sensed that participants were becoming distressed by long silences, or knowing from our one-on-one conversations that a certain topic was sensitive, I would chat with them separately and assure them that they did not have to answer when uncomfortable, or I would ask them how they were doing.

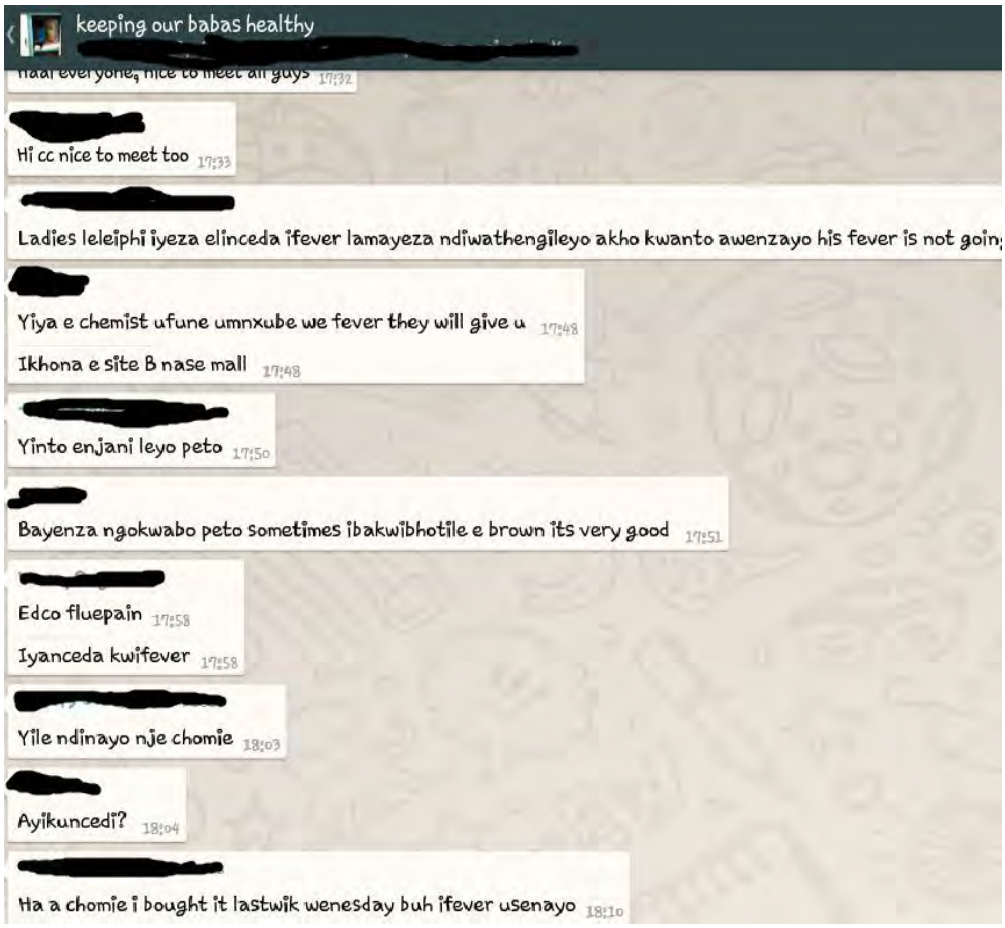

Figure 3: Dumisa asking for advice about which medicine to use for her son's fever on the WhatsApp focus group

Face-to-face informal interviews were a good platform for my participants to elaborate more, and for me to get clarification on issues I observed on Facebook and WhatsApp, as well as issues I observed during participant observation with the two mothers who were not on Facebook (Sontombi and Nolwazi). I asked open-ended questions, so as to allow the mothers to elaborate on their answers and to provide their own interpretations of their experiences without me proposing such interpretations.

I made an effort to pay attention to personal discomforts by noticing the kinds of questions that lead to silences, using these as an indicator of discomfort (Anderson & Jack, 1991). Henderson (2005: 82) speaks about the importance of sensitivity towards one's participants, which includes asking questions at appropriate times, so as to avoid being intrusive or disrespectful. This was important for me to consider. The literature associates breastfeeding with 'good mothering', and alongside the discourse of risk and other pressures mothers deal with, it was thus crucial to be sensitive and aware of how emotionally charged and potentially judgemental such topics can get. For example, Andiswa was unable to breastfeed. In one of our first conversations about breastfeeding, folding the clothes for her baby Thando, she paused and said '*Yhu ntombi* (wow girl*)*, I was so disappointed; I did not even think that it is possible that I might not breastfeed. It was always a given that I will also breastfeed like other women'. I therefore avoided bringing this topic directly into our conversations, and instead allowed for it to emerge on her terms, as she was sharing her experiences.

I also used voice recordings when I could. It was useful in terms of keeping the conversations flowing, not to irritate and distract the participant with my frantic note taking. It also served as a useful tool to go back to when I forgot pieces of our conversation. It was particularly important as the mothers were busy most of the times and would talk as they moved around the house. It was easier to follow them around with the recording device, rather than a notebook and a pen. Additionally, in places where there were excited toddlers (such as with Sontombi, Thandiwe, Vuyiswa, and Andiswa), I did not need to worry about them grabbing my pen and notebook, as they had done in the first meeting with Sontombi. Voice recording also gave me the time to observe other things during the interviews, especially since there were always activities in which children were involved.

I also tried to take pictures to get an idea of what other things the mothers felt were important in feeding practices to sustain their babies. I asked the mothers to take pictures of the things they thought were healthy for their children and that they fed their babies, and to take pictures of unhealthy things that they felt were not to be fed to babies. While this seemed like a good idea initially, I was ignorant of significant economic issues in the realities of the mothers I worked with. After patiently waiting for the pictures, I asked the mothers why it was taking so long. They all talked about how they did not currently have the healthy things that they would like to feed their babies, and so could not send me the photos. After a conversation about how it was not urgent, or how we could abandon the idea entirely, the mothers

suggested that they could take and send pictures of these items when in a grocery shop, or when they had them prepared at home. I initially wanted to create a collage from these pictures, but the mothers either did not have time or, for the ones that had other toddlers in the house, felt that the toddlers would get too excited and disturb the process.

The need for improvisation in methods that involve food is similar to that of Truyts (2013), who attempted to use photo voice methods. Drawing on Schmidt (2012:31), Truyts (2013) argues that asking to 'look in the fridge' can be ethically and methodologically complicated. Although Truyts (2013) had the notion of looking into the fridge to get to know the lives of her participants, she soon realised that she had to improvise her methods to be individually appropriate. In one case, there was no fridge, and in others, there was a fridge with no food. The sensitive consideration toward ethical engagement and the flexibility to use different methods enabled individuals to shape their own ways of talking about food, tuberculosis (TB), and the body, and allowed for methods to be tailored specifically to each informant's needs.

Ethical Considerations

My methods and ethical considerations were shaped by the *Ethical Guidelines and Principles of Conduct for Anthropologists*, produced by Anthropology Southern Africa (hereafter, ASnA) (2005). This code of ethics outlines the importance of obtaining consent and providing participants with all the information about the research project. This information includes, alerting one's participants to any potential harm such as the chance of unintentional exposure despite the anthropologist's efforts to secure the anonymity of the participants. As per these guidelines, I informed my participants about the research, my research question and explained what I was going to do with the information that they had shared with me. I obtained consent from my participants to record, take notes and to tell their stories in my Master's dissertation. Consent was constantly negotiated. As I was using multiple spaces-online and offline to gather data, I ensured that the mothers knew that I would be using our conversation on Facebook and on WhatsApp not only as stimulus for our face-to-face conversations but also as data for my final write up. I also had to constantly negotiate consent with Andiswa's mother Vuyokazi's mother who already knew me as a friend and would always share stories with me. I had to do the same with Sontombi as she was my cousin. I needed to make sure that they knew that these stories would form part of my dissertation. This for me was an important ethical issue to take seriously and not unintentionally take

advantage of my participants and use their stories that were not meant for me as a researcher but as a friend, a daughter or sister to my participants. Mcconnell-Henry et al. (2009:4) noted the possibility of over disclosure and regret at a later stage when we interview people that we know which may put participants in vulnerable positions. I therefore was comforted by my participants' enthusiasm about topics around breastfeeding and infant feeding in general and sometimes asking me where my recorder was so we could start talking about babies. In line with ASnA's (2005:142) ethical guidelines, all my participants were aware that they could withdraw from the research project at any time. They were also aware that I would use pseudonyms to maintain their anonymity and protect their identity. The constant negotiation of consent and reminder that they could withdraw at any point allowed me to be certain that I had obtained full consent.

However, the mothers I worked with were not always enthusiastic about sharing their ideas with me. Due to the exclusive breastfeeding promotion in the clinics and the fact that I had told my participants about the association of the project with the HIA, mothers would often ask me if they should tell me what they 'really fed the child', even though it might not go hand in hand with what the nurses taught them. In one conversation, Andiswa looked at the recorder and whispered '*iright phofu lento ndiythethayo*'/ 'is what I am saying correct?' She explained that although she fed the child formula, she knew that she was meant to be exclusively breastfeeding and she wanted to make sure that my dissertation had 'accurate' information about infant feeding. There were many moments like this - where in telling their stories; the mothers felt that they needed to align what they said to what the nurses taught them at the clinic. I had to constantly remind the mothers that this research was not about what nurses told them, but that I was interested in their own realities around infant feeding and that as a person who was not an expert in infant feeding and not a representative of the Department of Health, there were no wrong or right answers, I was genuinely interested in their own stories.

Scholars and public health specialists sometimes fail to recognise that mothers are aware of the risks associated with child care and are trying their best to manage these risks in ways they understand. Instead, scholars and public health specialists constantly ask questions around infant care with the aim of changing mothers' perspectives and promote very particular ways of managing the risks. This can lead to being unable to understand various experiences of child care and the insights on how different people respond to risks around infants and the opportunity to explore and understand these different responses. For example,

in their paper on the use of non-prescribed medication in the first three months of life, Bland et al (2004) argue that giving non-prescribed medicines to infants disqualifies exclusive breastfeeding as defined by the World Health Organisation and also prevents the infant from getting immediate help from the hospital. They further argue that health professionals need to be aware of the extent of, and reasons for the use of non-prescribed so that 'effective health messages can be targeted at mothers and caregivers' (Bland et al, 2004:118). This article does not make that much of an attempt to understand what the use of these non-prescribed medications means for the mothers ideas of child health. Instead, it focuses on how these hinder exclusive breastfeeding and are dangerous for the infants. This also strips the infant of any agency and assumes that all decisions on what to feed the infant are solely made by the mother. Recognising the agency of the infant displayed by actions like spitting 'tasteless' food and 'enjoying' certain foods, I continued to ask the mothers if their babies liked the medications they used and why they did certain things such as the use of certain medications as opposed to asking them about why they did not exclusively breastfeed as recommended by health professionals.

Chilisa (2012:192) warns against participating in the deficit discourses and literature that portrays the people researched as the problem. In this case, viewing mothers' infant care decisions as a problem that needs to be solved before allowing them to share their experiences and attempting to understand them would be a manifestation of a deficit discourse. Chilisa (2012) urges researchers to not be co-opted into these kinds of discourses that have normalised ideas of the researched as a problem; instead, the researcher must review, critique and think afresh as they carry out the research. The researcher must also think about the assumptions and prejudices, stereotypes that have for example, influenced their literature review and how the literature they have reviewed portray the researched. For example, I had already read literature that positions lack of exclusive breastfeeding as a problem that needed to be solved in order to improve infant mortality and encourage optimal growth. The question of 'why women do not exclusively breastfeed' already positioned the mothers who do not exclusively breastfeed as a problem that needed to be solved. I believe a question that looks at the experiences and ideas of how to sustain their infants is less likely to continue with the problematic issue of positioning participants as a problem. That is why this dissertation explored some of the ways that mothers and the South African government have opted to manage risks around infant care and sustain the lives of infants in South Africa with

the question of 'What are the kinds of things mothers do in order to sustain the lives of their infants?' as opposed to 'why mothers do not exclusively breastfeed?'

Chilisa (2012:166) also discusses reflexivity in research. By reflexivity, she refers to the researcher's ability to assess the influence of his or her own background, ways of perceiving reality, perceptions, experiences, ideological biases, and interests during the research. Chilisa (2012:168) suggests that the researcher journals their '…thoughts, feelings, frustrations, fears, concerns, problems and ideas…' throughout the research process. I made use of reflection in order to understand my relationship with the participants on the online space, what it meant and whether or not our relationship on and offline was similar. I also needed to stay reflexive about doing research with infants and discussing a topic such as infant feeding that might in many ways be linked to a mother's ability to provide financially and emotionally for her child. I also had to be very reflexive throughout the research process since I had been reading a lot of research around breastfeeding and the health benefits. I therefore needed to be aware of my bias to the public health messages around infant feeding and not make the mothers feel as though I was judging their feeding practices. Although there would be times where I wanted to say something when a mother was about to feed an infant purity when the child was less than six months, I had to take a step back and allow the mothers to live out their realities and not be insensitive to the different ideas around infant feeding. To deal with such situations, I was open with my participants about my role as a researcher and a woman who has never breastfed before. It helped that I was familiar with the women and spoke the same language. Reminding them that I knew nothing about babies since I had no child made them more comfortable and they would teach me about infant feeding and enjoyed constantly saying '*yoh, awazi nto'* (*yoh*, you know nothing) as they explained to me the complexities of child care that no book, nurse or grandmother could prepare them for.

CHAPTER 2: BREASTFEEDING- NATURE'S HEALTH PLAN

Introduction

Figure 4: Poster from the 2013 Breastfeeding week seminar held at the University of the Western Cape

In 2012, I assisted a Masters student doing her fieldwork with a Non-Governmental Organisations (NGO) that focused on health issues in Khayelitsha. In the NGO offices, there was a poster that stood out among the many educational posters affixed to the walls. Pictured with a woman breastfeeding, the text read 'show love and care… breastfeed your child'. This poster led to a discussion between us that centred on the implicit questioning message: 'so if you do not breastfeed for various reasons, do you not love or care about your child?' Other phrases that have been popular in breastfeeding promotion included, 'improving child survival' when talking about exclusive breastfeeding and 'risk of death' when talking about illnesses to which infants not exclusively breastfed could be exposed to and made vulnerable. The poster – aimed at inspiring breastfeeding yet felt aggressive and forceful to me - spoke not only to breastfeeding but to notions of good mothering.

Pregnancy and child birth are politicised and medicalised in South Africa today. One can witness from the language used in the poster that it is impossible to talk about child care and infant feeding in isolation from the politics and the political manifestations that surround

these topics. This language shows that there is the risk of death of infants and the way one chooses to feed their infant could potentially kill or sustain the life of their infant. As evident in the *Tswane Declaration*, South Africa sees exclusive breastfeeding as an answer or a public health tool to sustaining infant lives. How one feeds and cares for their child is not an individual matter in the privacy of their own homes with their families. In this chapter I argue that breast feeding is also a project of the nation. Although this promotion of exclusive breastfeeding is necessary, based on strong research evidence, I argue that the language used by the government creates a 'good mother' who helps 'save' her child by exclusive breastfeeding (an issue I return to later in this chapter). On the other hand, there is the 'bad mother' who puts her child at risk by not exclusively breastfeeding. This allows the government to relinquish its other responsibilities such as good housing, clean water and sanitation, good health care etc. as the emphasis of responsibility falls to the 'mother' alone (devoid of context), leaving out the agency of the infant who might or might not like breast milk as shown in the previous chapter. This chapter demonstrates how the state (SA government) sees exclusive breastfeeding as a tool to sustain infant life and has implemented policies and regulations to that effect. This chapter argues that the South African government's idea of sustaining infant life is enforcing exclusive breastfeeding for the first six months of life and the various aggressive policies and recommendations in place reflect the commitment to exclusive breastfeeding.

South Africa and the Global Standards for Infant Care

According to studies by Kruger and Gericke (2003: 220) and Sibeko et al (2005: 35), Cape Town has an 88% breastfeeding initiation rate where breastfeeding takes place within one to two hours of birth. A small study of mothers in a peri-urban settlement in Cape Town showed that mothers identified nurses as primary encouragers and promoters of breastfeeding rather than formula feeding (Mushapi et al, 2008: 38). However, numerous reasons such as a lack of privacy both at home and in the work place, as discussed by Sowden et al (2009: 39), can be attributed to lack of exclusive breastfeeding. As a result of such factors, in 2013, exclusive breastfeeding for six months in the South Africa remained at a low 8% (Doherty et al., 2011: 64).

However, breastfeeding in South Africa cannot be understood in isolation from the rest of the world. The South African government clearly supports the WHO position on breastfeeding which states that infants should be exclusively breastfed for the first six months of life in

order to achieve optimal growth, development and health. The WHO (2003) *Global Strategy for Infant Feeding and Young Child Feeding* states that:

> Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

The SA government adopts this view and this is seen clearly in the *Tshwane Declaration* issued by the Department of Health which also promotes exclusive breastfeeding. Furthermore, South Africa adopted the Baby Friendly Hospital Initiative (BFHI) which aimed to address the lack of structural breastfeeding support in hospitals - launched by UNICEF and WHO in 1991. This initiative is known as the Mother and Baby Friendly Hospital Initiative (MBFHI) in South Africa (Nikodem et al, 2010: 67). South African maternity facilities are certified as mother and baby friendly if they promote skin-to-skin contact between mother and baby, and breastfeeding and cup feeding as opposed to bottle feeding. Facilities are also MBFHI certified if the facility follows the ten specific steps published on the Western Cape DoH website and outlined by the WHO:[15]

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
6. Give new born infants no milk feeds or water other than breastmilk, unless indicated for a medical reason.
7. Allow mothers and infants to remain together 24-hours a day from birth.

[15]For more information see: https://www.westerncape.gov.za/general-publication/re-establishing-breastfeeding-culture-south-africa?toc_page=2

8. Encourage natural breastfeeding frequently and on demand.
9. Not give or encourage the use of artificial teats or dummies to breastfeeding infants.
10. Promote the establishment of breastfeeding support groups and refer mothers to these on discharge from hospital or clinic.

In light of these initiatives, hospitals strive to obtain this Mother Baby Friendly Hospital standard by adopting strict ways of ensuring that mothers exclusively breastfeed and refrain from bottle feeding. When I asked the mothers I worked with about breastfeeding promotion at the hospital, Dumisa said: 'They hang posters in the clinic and when you go for your visits, they talk with you, telling you about the advantages of breastfeeding and disadvantages of bottle feeding'. When I visited one of the hospitals in Khayelitsha accompanying one of the mothers, I saw a sign indicating that bottle feeding was not allowed in the facility. I asked the other mothers on the WhatsApp group if they had similar experiences. Thandiwe said '*Yes dear bathi ibotile is nt allowed in bayazithatha bazifake in the box ugoduke ungenayo, most mothers bayazifihla xa bencancisa abantwana*' (Yes dear, they say the bottle is not allowed. They put them in a box and you go home without it. Most mothers hide them when they feed their babies.) Dumisa responded with:

> '*thy tell us abt tht each nd evryday... 1tym i was @ da clinic so ths lady takes out a bottle to feed her baby, da nurse took it nd syd if umselisa ubisi umntana she shud use da cup tht da clinic supply u wit. Evn nedummy is nt allowed ke yona bayithathe bayifake emqomeni.'*
>
> (They tell us about that everyday… first time I was at the clinic, so this lady takes out a bottle to feed her baby. The nurse took it and said if she feeds the child formula, she should use the cup that the clinic supplies. Even the dummy is not allowed; they take it and put in in the rubbish bin).

This kind of behaviour by the hospitals and nurses reflects a very aggressive promotion of breastfeeding in order to achieve exclusive breastfeeding and the standard of being a Mother and Baby Friendly Hospital. It also re-emphasizes the idea that health professionals have authority over how one cares for their child and the practices with which a good mother should comply. In addition to promoting breastfeeding by use of the initiative described above, there is also policing of how breastmilk substitutes are advertised.

Regulations Relating to Breast-milk Substitutes Promotion

As part of restoring exclusive breastfeeding as the optimal choice of infant feeding, there has been marketing regulations introduced relating to breastmilk substitutes and infant food. In a breastfeeding seminar I attended at UWC in 2013 as part of my fieldwork - Ann Behr who was one of the presenters described the process that South Africa had undergone in attempting to regulate the promotion of breast milk substitutes. This presentation drew my attention to the role of government, not only in promoting breastfeeding by making mothers aware of the benefits of breastfeeding, but also the political role the government plays in regulating breastmilk substitutes in order to achieve exclusive breastfeeding. The Department of Health (2013c) developed a Code in 1986 with regards to breast milk substitutes based on the WHO 1981 *International Code of Marketing of Breast-milk Substitutes*. In December 2012, the UNICEF and the WHO welcomed the publication of the *Regulations Relating to Foodstuffs for Infants and Young Children,* which is the South African adoption of the WHO *International Code of Marketing of Breast-milk Substitutes*[16]. The aim of these regulations is to remove what governments and WHO believe is commercial pressure on the parents with regards to infant feeding choices, to ensure that all parents receive objective information about feeding, and finally to ensure that mothers who wish to breastfeed are supported. The Code is summarised on the Western Cape Department of Health website as follows:[17]

- No advertising of breastmilk substitutes in the health care system or to the public
- No free samples to be given to mothers or pregnant women
- No free or subsidised supplies to hospitals
- No contact between the company marketing personnel and mothers
- Materials for mothers should be non-promotional and should carry clear and full information and warnings
- Companies should not give gifts to health workers
- No free samples to health workers, except for professional evaluation or research at the institutional level
- Materials for health workers should contain only scientific and factual information
- No pictures of babies or other idealising images on infant formula labels
- The labels of other products must provide the information needed for appropriate use, so as not to discourage breastfeeding

[16]For more information see: http://www.unicef.org/southafrica/media_12088.html
[17]For more information see: https://www.westerncape.gov.za/general-publication/re-establishing-breastfeeding-culture-south-africa?toc_page=3

In complying with such regulations companies made shifts in the way that they sell and promote breastmilk substitutes. For example, in 2013, the Pick n Pay group (one of Africa's largest retailers of food, clothing and general merchandise) published the following:

> 'With immediate effect, designated products can't be discounted and samples can't be given out to anyone. In addition to this, from June 2013 a retailer or manufacturer can't provide any nutritional information relating to infants and young children. However we are able to answer your question and provide nutritional advice for a baby or young child so please contact the Health Hotline on healthhotline@pnp.co.za or 0800 11 22 88. We can also help you to find a reliable health professional that will be able to answer any detailed questions you have about your child's nutritional needs… Smart Shopper points can't be awarded to formula, powdered milks or drinks targeting infants and young children, or to feeding bottles, cups and teats, and these products will not be advertised, promoted or discounted… Retailers are not permitted to provide educational information, so the Health Corner on our website will have to change.'[18]

According to *Roadmap for Nutrition in South Africa* (Department of Health, 2013b), from December 2014 the new regulations included that all formula, complementary foods for infants and young children must have tamper-proof packaging and the images on the container need to show the correct way of using the products with no health or nutrition claims or recommendations such as 'suitable for all children' on the labels. There are also regulations with regards to providing free gifts when one buys infant formula milk, with the rule that the only free item allowed is the measuring scoop. In terms of the messaging that is allowed on these labels, referring to infant feeding specialists in the field of breastmilk substitutes is not allowed and certain messages are required to be written on the label such as 'Does not contain breast milk. Breast milk is the best food for babies.' Beyond infant formula, feeding bottles, cups and teats must not display pictures of babies and packaging must contain required statements that breast milk is better than infant formula. In terms of regulation 17 of the 2012 *Regulations Relating to Foodstuffs for Infants and Young Children,* all noncompliant products must be removed from the market by 12 December 2015. Failure to do so and to comply with any of these regulations has consequences.

[18]For More Information see: http://www.picknpay.co.za/news/infant-foodstuffs-regulations-explained

The judgements and regulations explained above are used with the purpose to improve exclusive breastfeeding and show how the state uses its power in certain ways in order to promote exclusive breastfeeding and forbid the promotion of breastmilk substitutes. Another factor that has been instrumental in the promotion of exclusive breastfeeding by the South African government has been the creation of the ideal 'good mother' as the one who exclusively breastfeed and as one who complies with health professionals' recommendations.

The 'Good Mother'

Drawing on Avishai (2007), Waltz (2013) extensively discusses the notion of a 'good mother'. She argues that the persistent assumption is that for one to be a 'good mother,' they need to learn mothering practices and that this process can only be supervised successfully by authorised personnel such as nurses or lactation specialists within the biomedical sector. One of Miriam Waltz's research participants named Liz put it in this way: 'breastfeeding is a difficult thing to do in the beginning, and back-up from professionals is important.' Prospective mothers like Liz were strongly influenced by scientific findings on what is good for their babies as they saw this 'scientific' information as a model of being a good mother. Waltz (2013) argues that women felt more ready for infant feeding when they complied with and relied on 'expert advice'. Therefore the construction of a good mother, making use of scientific knowledge predisposed women to a commitment to breastfeeding, obtained by reading about breastfeeding and gaining expert advice.

Despite variations between women in terms of race, class, Hays (1996) argues that good mothering is understood in relation to a set of key characteristics that all attach a high level of intensive mothering. In explaining the concept of intensive mothering, Hays (1996) states that good mothering is defined as being child-centred. Following up on this concept, Furedi 2001) argued that notions of intensive mothering result in a professionalization of parenthood. It sees the model of mothering as based on the mother executing a range of activities in a way that experts see as best for the child's development. Therefore, seeing that intensive mothering involves complying with expert advice and doing so makes one a good mother, Murphy (2004;209) argues that women thus view motherhood activities such as breastfeeding as a performance of 'identity work' which will then qualify them good mothers whereas mothers who choose to formula feed perform identity work that renders them 'bad mothers'.

Knaak (2010) speaks about the notion of good mothering and its association to breastfeeding in Canada. Knaak (2010) worked with 33 Canadian mothers of varying ages - from 20 to 36

at the time their first child was born, with income levels ranging from dependence on social assistance to a household income of over C$100,000 per year. Based on interviews on the topic of breastfeeding experiences with these women, Knaak (2010) discussed the problematic idea that breastfeeding means good mothering and to not breast feed invokes a 'risk' of being labelled as a bad mother. She argues that the pro- breastfeeding discourse medicalises breastfeeding and creates a risk management discourse around it. This discourse emphasizes the nutritional health risks and/or benefits of various infant food sources. The clear position in this discourse however is one which identifies breastfeeding as the proper and 'moral' choice. According to Knaak (2010), mothers are seen as to have a moral responsibility to be risk conscious and to breastfeed their children as a way to manage the risks that might come with infants that are not breastfed and also to focus on the health benefits of breastfeeding outlined by health professionals.

Knaak (2010) also argues that there is the moral discourse around breastfeeding in public health which makes infant feeding choices less of a personal choice but more of a responsibility to do the 'right thing'. In this framework, breastfeeding becomes part of how good motherhood is defined and breastfeeding becomes a marker of good mothering whilst formula feeding is framed as the opposite. The mothers that Knaak (2010) worked with saw breastfeeding as a core mothering belief and as a thing that identified mothers as good mothers. Therefore, the risk discourse is not only about the health benefits of breastfeeding but is also about the risk of being viewed as a bad mother and therefore their identity as mothers threatened. In this sense, breastfeeding failure, be it one struggled to breastfeed, the baby would not latch on or the mother's breasts were sore and she did not know how to breastfeed properly, all these made the mother feel like she had failed to protect her child from preventable illness, had failed to give the child good nutrition and therefore had failed to be a good mother.

In a collection of essays on breastfeeding and anthropology, Maher (1992:151) explores some of the concepts that we make use of in the discourse of breastfeeding, especially the concepts that international agencies deploy when analysing what women in the developing countries should be doing in terms of infant feeding. She argues that women's sexuality is seen as a field of action by these agencies, people that they can act upon. Science is used in the way that identifies breastfeeding as a 'natural law' rather than something that women can negotiate and have choices about or something that can be influenced by culture. Maher

(1992: 152) shows that in Britain in 1980, only 26 per cent of women breastfed for up to four months as recommended by the Britain Department of Health and Social Security Working party in 1974. There is however an assumption that in the developing countries, it is more likely that women will breastfeed because it is cheaper than formula milk and also because they are 'traditional' societies that are' closer to nature'. However, Maher (1992: 153) argues that the reality is that breastfeeding is hardly ever done exclusively and that many societies give children various kinds of supplements very early in their life. Regardless of the reality of infant feeding behaviours in different contexts, breastfeeding continues to be seen as a preventative 'medicine' to the infant, one that is supposed to protect them from infant illnesses.

In this process of medicalising breast milk, there is not enough attention paid to other issues that affect the health of an infant and Maher (1992) names some of these factors as political and economic insecurity, ill health and over work of mothers, gender inequality and the dangerous and unhygienic environments that poverty usually exists in. She challenges the association of infant mortality and lack of exclusive breastfeeding. She then poses important questions about how the requirement for women to breastfeed for longer periods is another way where women are required to use their own resources to remedy a bigger issue such as infant mortality and an issue that its real causes lie in social and political inequalities in both international and local level. Furthermore, Maher (1992:154) criticises the focus of breastfeeding literature on the infant and its nutrition with very little attention paid to wellbeing of the mother. She argues that the dependence of the child's welfare on the mother is taken too lightly. It is taken for granted that when a mother is not well; her children are also likely to suffer. In this process, the mother is held as the only one responsible for the infant's life. This kind of responsibility and reemphasis on ideals of good mothering was evident in a breastfeeding seminar to optimise breastfeeding as the best choice where there was a constant request or call to mothers to imagine how they could save a life by breastfeeding.

In the breastfeeding seminar I attended at UWC as part of my fieldwork in 2013 that is already mentioned above, there were persistent messages such as: 'As a mother, you have the potential to save your baby's life', 'if our mothers exclusively breastfed, many babies lives would be saved'. Those messages were followed by comments such as: 'even though we respect grandmother's perspectives on breastfeeding, the only accurate information that one can get and should be implementing is that coming from a health professional'. My

experience in that seminar echoes Knaak's (2010) views on the moralising messages passed on by public health representatives (nurses, doctors) and also the idea that mothers need to follow guidelines from health professionals in order to effectively 'save' their infants from risks. This leads to asking questions about which knowledge matters, an issue that will be raised later in the paper. Furthermore, this approach also depoliticises the socio-economic context in which these mothers become responsible yet ironically arises from their very context. Not enough attention is paid on issues of lack of clean water - such a huge emphasis is being placed on breast feeding by emphasising the 'medicine' of the breast.

However, Waltz (2013) suggests that the process of breastfeeding based on expect advice is complicated by the fact that the act of breastfeeding is an embodied experience or a skill that is learned by interaction between the mother and the baby. She further argues that professional assistance can impact the learning of breastfeeding experience negatively and mothers would rather rely on relationships involving trust and emotional closeness in this process. Considering the aggressive breastfeeding promotion described in this chapter, the next chapter explores how the mothers felt about breastfeeding and some of the barriers to exclusive breastfeeding.

Figure 5: The poster for the 2014 World Alliance for Breastfeeding Action World Breastfeeding Week

CHAPTER 3: BARRIERS TO EXCLUSIVE BREASTFEEDING

Introduction

When one observes the aggressive breastfeeding promotion that comes from the Department of Health and health facilities in South Africa described in the previous chapter, one might assume that breastfeeding is an act only regarded as important by biomedical health professionals. However, despite the low breastfeeding rates and the even lower exclusive breastfeeding rates, breastfeeding is regarded as important by others who are not in the biomedical frame work. Wright et al (1993) discuss Navajo beliefs around breastfeeding and its benefits for the child and the mother. Breastfeeding among the Navajo was a way for a mother to show that her infant belonged to her - a sense of ownership over the child - a way to mark the infant as human and part of a larger society. If a mother did not breastfeed her infant, it was said to be hard for her to claim it, as though it did not belong to her, says Wright et al (1993). Thus, breastfeeding became a very important part of mothers' identity. Furthermore, according to Wright et al (1993), nursing one's infant also meant that it would be easier to discipline the child as the mother and the infant have an original relationship of solidarity and nurturing whilst bottle- fed infants were assumed to be hard to discipline.

Wright et al (1993)'s paper is useful in understanding the role of society, cultural beliefs and local knowledge in making infant feeding decisions and understanding that it is not always an autonomous decision made by the mother of the infant. It also illustrates the value ascribed to breastfeeding by people other than health professionals even though the understandings of why breastfeeding is important might differ. For example, breastfeeding in the previous chapter is hailed for its nutritional value for the infant whilst the Navajo understood it as an important aspect of person making and building a relationship with the infant. During my fieldwork, I became aware of the pronounced feelings of enjoyment by mothers who breastfed as well as a longing for breastfeeding by mothers who were unable to breastfeed. This illustrated that despite the quantitative facts on lack of breastfeeding, most mothers still held it in high regard especially the women I worked with. Thus, this chapter argues that, despite barriers to exclusive breastfeeding, mothers enjoy breastfeeding and the closeness they feel with their children as a result of the breastfeeding

***Kumnandi Ukuncancisa* (It is Nice to Breastfeed)**

When talking with the mothers, I would ask about the things they enjoyed doing with their babies. This was a question I enjoyed asking as it was always met with a resounding smile by doting mothers, followed by compassionate tales of their motherhood experiences. Breastfeeding was one among the many things that the mothers enjoyed doing and they gave a variety of reasons for this pleasure. In a conversation with Vuyiswa, I asked if she had friends who were breastfeeding and what kinds of things they shared with each other. She smiled and responded *'we brag about our breastfeeding experiences and talk about how nice it is'*, 'what is nice, breastfeeding?' I asked, '*kumnandi uncancisa* (it is nice to breastfeed); *you get to bond with your baby the more you breastfeed, and the more you bond and get to play together'*. Curious, I asked if it was not more painful than enjoyable. Vuyiswa explained that, even though it was painful and took a while for one to get used to; it was such a lovely thing to do. She continued by telling of her breastfeeding struggles. She mentioned that despite having been taught how to breastfeed at the clinic and by her mother at home, she only managed to get breastfeeding 'right' when her baby was a month old. Even with this challenge, she said she was happy that she did not give up and got to experience breastfeeding.

Sontombi agreed with Vuyiswa's points adding that she also enjoyed the idea of watching her baby while breastfeeding him- watching him as he kicked and moved around his hands while he suckled. Both mothers believed that breastfeeding was good for their baby's health.

In a focus group discussion on WhatsApp, the mothers' views were unanimous in their ideas around the importance of breastfeeding. They spoke about the nutritional value of breastfeeding that they had learned in the clinic. In this discussion, Vuyiswa was the first one to comment and said 'it is good for the baby because breast milk has all the nutrients that your baby needs'- followed by Dumisa who echoed Vuyiswa's words and said- 'it is very, very good for the baby, they [nurses] say a breastfed baby does not get sick all the time'. Both sentiments were shared by Thandiwe, who was proud of her decision to exclusively breastfeed, making known that 'I am breastfeeding him, no water no *nix* (nothing)'. Nolwazi had told me that she was surprised at the clinic when they asked if she would breastfeed because she thought everyone knew it was the thing that had to be done, not a choice. Andiswa, although she was formula feeding, also spoke highly of breastfeeding and said it was good for babies, unlike formula.

Andiswa further mentioned that she had made the decision to breastfeed during her pregnancy, but unforeseen circumstances led to her using formula. When discussing challenges with formula feeding and her reasons for wanting to breastfeed, she said 'I knew that it is the best to breastfeed your child. Breast milk is nutritious and a breastfed baby does not give you problems'- 'what do you mean they do not give you problems?' I prompted. Andiswa explained:

> 'You don't need to use a bottle, you don't use anything. When you use a bottle, you need to constantly worry about hygiene, there is too much work but with the breast, you just breastfeed, that's all. And bottle fed babies have too many problems, they get diarrhoea and all sorts of things that require you to do more work. And money wise, you save because you don't have to buy milk…'

In all their statements, you can see how important breastfeeding was to the mothers. The mothers also spoke about their intentions to exclusively breastfeed for six months when they were pregnant and after they gave birth. However - with the exception of Thandiwe - none of the mothers exclusively breastfed for six months. Sontombi started giving the child water and formula in less than two months- Andiswa started giving the baby water in two days- Vuyiswa gave formula and water at two months- Dumisa introduced formula at three months and Nolwazi introduced water at two months. When I asked why they did not exclusively breastfeed, I got varied responses such as mothers realising that it was impossible and doubt that anyone actually went through with exclusive breastfeeding for over two months. The reasons included physical difficulties with the act of breastfeeding, need to go back to work/school and breast milk being insufficient in satisfying the baby's hunger. These are discussed in detail later in the paper.

In summary breastfeeding was seen as very important by the mothers. They understood the nutritional value of breast milk and appreciated the intimacy it created with their babies and as a result, they decided to breastfeed. While most of them had hoped to exclusively breastfeed for six months only one of them was able to exclusively breastfeed for six months. They were also aware of the concerns with bottle feeding and just like Andiswa; the other mothers were also worried about the implications of formula feeding. The barriers to exclusive breastfeeding briefly introduced above are similar to what Andrew and Harvey (2011) found in the Royal Berkshire Hospital in the United Kingdom. The belief in the health benefits associated with breastfeeding was one of the factors women considered in initiating

breastfeeding. However, there were factors that led to mothers using formula feeding and some ceasing to breastfeed all together and only using formula. Although the mothers in Andrew and Harvey (2011) initiated breastfeeding, decreased independence and self-identity influenced the duration of breastfeeding. This was a concern even more when mothers had to go back to work or school. The work of Andrew and Harvey (2011) is echoed by Thairu (2006), who speaks about some of the issues that hinder exclusive breast feeding among South African women in Hlabisa, KwaZulu Natal. The women that Thairu (2006) worked with spoke about how they had to go to work and the caregiver had to feed the baby something else. The separation of the mother from the infant due to either work or schooling was a factor that led to non-exclusive breastfeeding in Mmabolo et al (2004) as well.

In both Andrew and Harvey (2011) and Thairu's (2006)'s research, we see the impact of the mothers' other roles on infant feeding choices. And the impact was no different in my research. Andiswa started seeking employment when her baby was two months old. She attended her graduation at the Cape Peninsula University of Technology when her baby was less than a week old. Vuyiswa started working when her baby was four months old, but had been a student throughout her pregnancy and continued to study after her baby was born. Nolwazi also had to go back to school immediately after her baby was born. She said: 'I went back immediately, probably four of five days, I can't remember. She was born when I was about to start exams.' Nolwazi was studying towards a teaching diploma at the Cape Peninsula University of Technology. Dumisa was almost finished with her Diploma at West Coast College towards the end of her pregnancy and also started seeking employment when the baby was four months old. It was only Sontombi and Thandiwe who were unemployed and not actively looking for work in the first six months of the life of their babies.

What these women have in common is that they had other responsibilities such as school and work. They were all working class women and not coming from financially stable backgrounds. There were concerns regarding how they would feed their babies and this heightened their need to work so as to ensure that their babies would not starve. Nolwazi and Sontombi were the only ones married and who had employed husbands who provided for them and the baby. The others had supportive families and also the fathers of their babies were supporting them financially. Thandiwe was a stay at home mother and supported by her mother. Dumisa was supported by her sister and the father of her baby. Vuyiswa's mother was a house wife and her father was the bread winner. Andiswa's mother was a stay at home mother to twins that were less than two years old at the time of this research, her employed

father was the bread winner. Andiswa had created a savings account for her baby but felt that the unexpected expense of formula and other expenses meant that she needed to get a job.

It is clear from the financial circumstances painted above that these mothers were under financial pressure and felt they needed to seek employment. They would leave their babies with their own mothers (the infant's maternal grandmother) to take care of most of the time. This made exclusive breastfeeding a concern for these women. Even when some of them (Vuyiswa and Andiswa) tried to express at the beginning, the milk would not be enough for the baby for the whole day that they are away and by the time they got back home, the grandmother or whoever was caring for the baby would have fed the baby something else. They were not able to stay at home to breastfeed and even though exclusive breastfeeding is something that they had thought of, they felt that there was no time to express or sit down and exclusively breastfeed.

The women in Waltz (2013:40) also experienced a sense of shifting priorities and values as a result of becoming mothers. One of her participants, Penny had been a career woman most of her life and had never thought that she would find that having a happy family was more rewarding than work. Although she still loved her job, she found herself in a conflicted position as she missed her children very much when she was away. Penny was not the only one who felt this way. There was a dominant notion of sacrifice- good mothering involved sacrifice for mothers as a key cultural symbol of a good mother. However, unlike the women who have more privileged financial circumstance and the luxury of paid maternity leave like the middle class mothers discussed in Waltz (2013), the women I worked with had to seek employment as sitting at home meant that there was no regular income to help care for the infant. The idea of sacrifice in Waltz (2013) to be a good mother included sacrificing being a career working woman to staying at home. However, sacrifice for the mothers in my research was to sacrifice staying at home and to pursue employment opportunities in order to survive for both the mother and the child as they did not have the luxury of maternity leave or financially stable partners. Andiswa's words articulated this well when she said: '…*if bekusthiwa imali iyazizela, bendizohlala naye 24/7 apha ekamereni yam*' (if money just came, I would stay with him in my room 24/7). Here, financial circumstances that demanded job seeking and going to school acted as one of the barriers to exclusive breastfeeding but not in isolation from other factors such as physical difficulties and the idea already hinted at: of milk not being a sufficient food source, which I discuss in detail in chapter 4.

Physical Challenges

Andiswa had just taken a bath and she was telling me about how painful and swollen her body was. She was also explaining that she was worried that her breasts did not seem to produce any milk. Almost as if she heard that and took it as her cue, her mother walked in and asked about what 'they' [Andiswa and her mother] would do about the 'feeding situation'. Andiswa, topless at this point said she was not sure and looked at her breasts and squeezed them for milk. Nothing came out; her mother went to her and also started squeezing Andiswa's breasts for milk- nothing came out. Her breasts had no milk and even when she tried to breastfeed the baby, hoping that if the baby suckled, something would come out – still, no milk came out. To make matters worse, the baby could not latch on because the breasts were so swollen. From panic and exhaustion, Andiswa threw herself on the bed. Her mother and aunt continued to squeeze her breasts and kept repositioning the baby in different ways, trying to help him latch on. They suggested that she drink Stoney[19] and that maybe then she might have some milk. At the end of approximately thirty minutes of me awkwardly standing there watching as her mother and aunt took turns in repositioning the baby and squeezing Andiswa's breasts, they stopped. Andiswa's mother gave the baby water to 'calm him down' she said as she felt he was probably getting frustrated with the fact that there was no milk coming out and that he was probably hungry by now. '*hayi uzode acaphuke lomntana, inoba ulambile*' (No this baby is going to get irritated, he is probably hungry', said Andiswa's mother. This story illustrates some of the difficulties with breastfeeding that lead to introduction of other fluids. Here, even though Andiswa wanted to breastfeed, she was unable to. On a different day when we were reflecting on the day described above she said:

> 'My mom woke up and went to buy formula because we could see that the baby was hungry. He had formula, that was Monday and he was three days old. Then on day five, it seemed like my breasts were full of milk. And then besides not having milk earlier, I had another problem with my nipples. I am one of those people with inverted nipples. It was not my plan to formula feed my baby so I went back to breast feeding since they were heavy and full of milk. But then the baby had a hard time, he was crying because the nipples were making it difficult for him to latch on. I bought something to draw them out but nothing changed. My baby was getting hungry whilst I was busy trying

[19]Cool drink produced by Coca-Cola

> to teach him to breastfeed when nothing was coming out so I just decided to bottle feed… I tried expressing at the clinic but there was such a small amount of milk coming out, I tried everything I could.'

The story above is not uncommon, many women cease to breastfeed due to physical difficulties and problems such as the baby not latching on. Andrew and Harvey (2011) also found that some mothers experienced practical problems with breastfeeding which lead to non-exclusive breastfeeding or no breastfeeding at all such as experiencing pain. Although she continued to breastfeed, Vuyiswa also experienced problems with breastfeeding, after telling me that it was nice to breastfeed as described earlier she said: 'But at the beginning it is sore. It can be sore the whole week when you start out. Even when she latches on, it feels like she is biting even though she has no teeth… I also had back pains, my back was sore. I think they said I have too much milk. But after a week I felt better'. Vuyiswa continued to breastfeed, regardless of how painful it was but other women such as Andiswa were not able to do so. Andiswa went to the hospital for assistance and was advised to buy an ointment for her sore nipples and a tool to draw her inverted nipples out. But even after her nipples healed, she was still not able to produce milk and out of their fear that the child was hungry, along with her mother they decided to formula feed.

Other factors that hindered exclusive breastfeeding discussed by Thairu (2006) and Andrew and Harvey (2011) included that mothers were not confident about their milk supply and described how their infants were particularly hungry and demanded more milk than they could supply. They would then feed their infants other foods when they felt that their breast milk was not enough. Mamabolo et al (2004) studied feeding practices in villages in the Limpopo province, South Africa. Some of the most common supplementary and complementary foods included maize meal and mabella (sorghum). The infants were usually given these foods, in some cases as early as their first month of life. Infants were also fed commercial infant cereals such as Nestum, Purity, and Cerelac as a form of supplementation to maize and/or sorghum, while some infants received a combination of maize meal and sorghum. There was also the commonly held idea that introducing food early would develop the infant's digestive system function. Moreover, in the area Mamabolo et al (2004) worked in, it was a common understanding that infants should be given herbal mixtures early in life, and mothers took advice from older relatives as to how to feed their children. These ideas rendered exclusive breastfeeding difficult and sometimes impossible. I return to the idea that infants need herbal mixtures and other medicines and introduction of food in chapter 4.

Kakute et al (2005) also speak about some of the cultural barriers to exclusive breastfeeding in the Ndu subdivision in Cameroon. They argue that even though women were aware of the public health message on exclusive breastfeeding and were encouraged by local health care workers, there was a very strong sense that mixed feeding has always been the way to do things and that women should not allow ideas from the 'west' (health care providers) to change that. As a result, young mothers feared that insisting on exclusive breastfeeding might lead to quarrels between co-wives, husbands, in-laws and family elders, and could result in curses and bad luck. Breast milk was also understood to be an incomplete food source, satisfying the thirst but not the hunger of a child. Breast milk therefore would not increase the infant's weight. It was also said that the infant's intestines needed something solid. Similarly to Andrew and Harvey (2011); Thairu (2004) and my findings- Kakute et al (2005) and Mamabolo et al(2004) also argue that many women could not maintain exclusive breastfeeding as they had to go to work or to the farming fields and leave the child in the care of other people. In these cases, pap, cow's milk, eggs, and fruit juices and unfermented palm wine, were given when the baby cried to induce sleep when the mother was away.

The factors that acted as barriers to exclusive breastfeeding discussed above highlight the tensions between the public health message on breastfeeding and realities of women's lives and the contexts in which they live. Socio economic standards might mean that a mother has to work and therefore not allow for exclusive breastfeeding. The idea of having to go to work not only points to the impact of socio economic standards in decision making around breastfeeding but also shows the impact of the mother's different roles or duties on infant feeding choices and decisions.

The common thing however with both the health professional, the mothers and the people in the mothers' network is that they were all attempting to sustain the health and life of the infant. Their varying understandings and approaches shed light on some of the other ways of sustaining the lives of infants and ultimately keeping their infants alive and satisfied. This could be by introduction of water to quench their thirst, introduction of food to assist with their digestive system or to make sure they have enough food or by introduction of medicines, or by exclusive breastfeeding as encouraged by health professionals. The next chapter aims to continue to explore the different ways people used to sustain lives of their infants and also continues to show the tensions between the different ideas of sustaining infant lives by looking at the ideas that mothers hold about what a healthy baby looks like and how it can be achieved and also what a baby needs in terms of food and medication.

CHAPTER 4: LURING YOUR CHILD INTO THIS LIFE

Introduction

For DeLoache and Gottlieb (2000) in their edited collection entitled: *A world of babies: Imagined childcare guides for seven societies*, the idea of sustaining the life of an infant saturates many chapters in the book and has been very useful in framing the chapters of this dissertation. Introducing the collection, Bruner (2000) explains how child rearing manuals are testament to the variety of ways that different people approach child care. The different practices and beliefs that people adopt reflect the ways in which particular groups of people conceptualise the world and how the child needs to be readied or prepared for living in this world. The overarching message from this book is the idea that child care is based on one's conceptualisation of how and what can make life manageable, safe, and therefore how one should nurture their infant to achieve manageability and safety. There are many ways that one provides the aforementioned things in the life of an infant. These ideas are not usually easy to comprehend and accept because according to DeLoache and Gottlieb (2000:5), one always imagines their way of doing things as the only way that is right especially with deeply ingrained ideas such as those of child rearing. However strange and exotic one's way of doing things might seem, it can make more sense when understood in the context of the society in question and the ways in which the life of that infant is managed and sustained will depend on that society, argues Bruner (2000).

Gottlieb (2000a) offers a useful description of the ways that the Beng view and practice infant care. The Beng believe that one dies on earth and is reborn as an infant on earth after their time in the spiritual place called *wrugbe*. Therefore, since these infants were from *wrugbe*, a place that the Beng described as a beautiful spiritual life, the mothers needed to do all they could to lure their children into the life on earth and ensure that the child does not return to *wrugbe* as at times, when they are not happy, infants may wish to return to *wrugbe*. This process of luring the baby to life on earth and nurturing the life of the baby began when a woman was pregnant. One needed to start taking precautions to keep the unborn baby alive and healthy.

These precautions involved practices such as covering your breasts to avoid bewitchment that might harm the foetus or mother during child birth, or wearing clothes that are loose fitting so as to allow the foetus to breathe freely. Mothers were advised by diviners and grandmothers on the kinds of food they could ingest during pregnancy to avoid harming themselves and the

foetus. Some of the ways that Beng mothers kept their infants alive and thriving was a long bathing routine to ensure that the baby does not get the 'dirt' illness. Moreover, mothers put strands of jewellery on their infants to protect them from diseases and the more jewellery the baby had the more protection it had. Another way that a Beng mother protected their infant was by painting the face and head of their baby with colourful medicines every day. All of these actions were done in order to lure the life of this baby to earth and to avoid the baby returning to *wrugbe*. The actions of Beng mothers demonstrate an idea of mothering as a constant risk management, managing the life of the infant and keeping it safe so that they do not die (return to *wrugbe*). Although risk management is performed in different ways with different techniques and technologies, it is a concept that I have found to be prominent in mothering discourse, regardless of culture, class, race and gender.

As discussed in previous chapters, the South African government, drawing from the WHO guidelines has decided to implement exclusive breastfeeding for all infants. This is done in order to address the infant mortality rates in South Africa. And as seen in the previous chapters, infants are seen to be at a risk of dying or having ill health when not exclusively breastfed. As a result, in order to manage this risk and avoid mortality, exclusive breastfeeding has been implemented to lure children to life. This current chapter moves beyond the discussion of breastfeeding as a way to sustain life and discusses medicines; introduction of supplementary feeds and other practices that mothers perform that they understood to be useful in sustaining the baby's life. It argues that women have different priorities, understandings and concerns from those prescribed by the South African government. They conceptualise their children's bodies and health in different ways which leads them to perform practices that they think are needed for the survival of their children, although these practices may differ from the exclusive breastfeeding recommended by the South African Department of Health. These women do take on board biomedical information and they 'tinker' with it in response to other conceptualisations of risk management.

Keeping Babies Safe

When I asked the mothers in the WhatsApp focus group for the different things that they do to keep their babies safe, Andiswa replied: 'It is giving the child healthy food and enough food. I give my son four meals of cereal everyday plus some vegies or fruits. Another important thing is water because babies get thirsty, and besides that, they need water in their system.' Vuyiswa followed and said 'It is feeding them healthy food and taking the baby to

the doctor. At the hospital they actually get their immunisation and medication for when they are sick. Healthy food is like vegetables.' Along the same lines Thandiwe said, 'You visit the clinic when it is the date for his check-up so that he can get his immunizations so that he can be strong. Also, you must make sure that the place where he is cared for is a clean environment.' These were some of the ideas that the mothers had about how to keep their infants healthy.

The Department of Health is aware of the use of supplementary feeds and medicine for infants before the age of six months and they position breast milk as both food and medicine. This is evident in the DOH information brochure on breastfeeding (available on the Western Cape DoH website). Below is an extract from the DOH brochure on the topic of water and medicines, both substances that the mothers felt are needed for their babies:

Question: My neighbour said that I should get some medicine to clean my baby's stomach. Is this important?
Answer: Colostrum (the first milk your breast will produce) cleans the stomach. You will not need any medicines for further cleaning as breast milk is clean and actually lines the stomach, protecting it from bacteria.
Question: Does the baby need water when it is hot?
Answer: No, the first milk (fore milk) has lots of water and quenches the baby's thirst. Just make sure you feed your baby often in hot weather.
Question: In the first few days, if I do not have enough milk, can I give water or other milk as well?
Answer: The colostrum is all the baby needs. You just need to feed the baby often, so that more milk is produced. Ask the midwife to leave your baby with you after birth so you can put the baby to the breast. The baby will quickly learn how to suckle and this will help you to produce more milk. Mixed feeding is not recommended.
Question: I am giving breast milk, but my baby is not satisfied. Do I need to give formula as well?
Answer: No, you can produce more milk by feeding the baby more often. Allow the baby time to drink until satisfied on one breast to make sure the baby gets hind milk before offering the second breast, which the baby may or may not want. The more the baby suckles, the more milk is produced. Remember: mixed feeding is not recommended.
Question: My baby wants to feed so often; maybe I don't have enough milk?
Answer: Maybe the baby is growing quickly and needs more milk. By feeding often, you can produce enough milk for the baby's need. The milk will not run out! Allow extra time for the baby to suckle; don't pull the baby off the breast. If the baby has more than six wet nappies every day, is being fed often (at least eight to 12 times a day) and the baby is gaining at least 500 g every month, then you are producing enough milk.

Although the mothers I worked with were aware of the DOH position on the use of medicines, water and food, they had a different understanding about the role of water, food and medicines and this chapter aims to explore those ideas.

'He had pharmacy before he was even born'

One afternoon after talking to Andiswa, I walked into the kitchen and noticed a number of medicines in the glass cabinet and jokingly asked if that was 'Thando's pharmacy'. She said 'Yes that is his pharmacy, this is not much, and there should be more.' I asked her what it was all for, and if it was because Thando currently had flu. She explained that it was not because he was sick at that moment and added: 'he had a pharmacy before he was even born'. She then explained that they did not buy a lot of medicines because some of them were really expensive. Since Andiswa's mother had twins that were just over a year old, she had also recently experienced caring for infants. She was familiar with how the medicines work and had now discovered which ones were essential and which ones were not. Proudly displaying her knowledge of medicines for infants she explained:

> I can now tell which one combines most of the stuff. So for example there is this other one (holding up uMuthi Wenyoni[20]), that is really expensive but if you buy that one, you will not need a lot of these ones (pointing at the rest of the medicines). But for now we just bought the essential ones. There are so many baby medicines Ziyanda. When you get there, [to the pharmacy/ shops that sell medicines] you will see all these medicines. They are on a row and you just pick what is important, so we have picked some for him.

Throughout my research process, mothers mentioned feeding some form of medicine to the infant. Medicines in this context did not just include over the counter medicines but included water. The idea that 'water is life' became very important in child care. The infants were given water daily to quench their thirst -and also because mothers felt it was healthy to drink water like Andiswa said: 'They need water in their system' and therefore an important aspect of maintaining the life of an infant. Although there was no way of knowing if the baby was thirsty, mothers used their own judgement on whether it was time to give the baby water or not. They believed that breastmilk was liquid food but was not the same as water.

[20]Medicine used as an antacid, with the capability of neutralizing stomach acid

The most popular medicine was gripe water (a solution given to babies for the relief of colic, wind, and indigestion. Its ingredients vary, and may include alcohol, bicarbonate, ginger, dill, fennel and chamomile. It is typically given to an infant with a dropper in liquid form. There was also *uMuthi Wenyoni* (see Figure 6) which is used when the child has trapped wind. One of the grandmothers explained that 'you could see that when a child seems to be stiff and they clench their fists or you can see they do not want move their neck'. And there was also saccheroi syrup (see Figure 5), for *uxakaxa*[21] -when it is difficult for the baby to breathe. Explaining the use of saccheroi, Andiswa said: 'Yes, it is important because you do not want your baby to breathe funny' and when I asked Vuyiswa what the gripe water was for she said 'Gripe water helps with trapped wind and other baby illnesses'. Sontombi used gripe water to add taste to the water in order for her baby to enjoy. It was only Nolwazi and Thandiwe who did not make use of medicines. Thandiwe refrained from medicines because she was exclusively breastfeeding and Nolwazi says she did not know about them and her mother never asked her to use medicines. Although she knew other nursing mothers who used medicines, she felt that her child was not sick and therefore did not need medicines.

Figure 5: Picture of Saccheroi Syrup

[21] *Xakaxa* refers to a thick mucoid secretion present in the child at birth that needs to be removed by the birth attendant to prevent it increasing and accumulating until it causes chest diseases. Children who have chronic chest diseases are suffering due to the presence of *xakaxa* in the chest.

Figure 6: A picture of *Umthi Wenyoni*

The use of these kinds of medicines is not exclusive to my research. I found multiple research studies on the use of non-prescribed medicines. Some researchers described the use of non-prescribed medicines as a practice performed by people from different socio economic classes around the world (Cocks & Dold 2000).

Furthermore, the use of non-prescribed medicines is not limited to rural spaces, uneducated or elderly people but many people engage with different kinds of medicines, both in the biomedical sector and traditional medicines (de Wet, 1998). Based on research conducted in Australia with forty parents of children five years old and younger, Allotey et al (2004) argue that the use of over the counter medications (OTC) to treat minor illnesses is common despite the lack of evidence that such medicines are effective. Some of the reasons why mothers used these medications were to gain control over their children's behaviour such as when the child is being irritable, argues Allotey et al (2004). Another reason for the use of OTC medications was for parents to prevent illness in order to avoid the inconvenience of having a sick child. Lastly, parents used acetaminophen[22] because they believed it had a calming effect on the

[22]Acetaminophen also known as Paracetamol or APAP, is a widely used over-the-counter pain medication and antipyretic (fever reducer)

child and cheered up the child, therefore, medication as a way to both heal and/or protect but also to control social behaviour of the child.

In discussing medicine as a barrier to exclusive breastfeeding, Bland et al (2004) argue that giving non-prescribed medicines to infants disqualifies exclusive breastfeeding as defined by WHO and also prevents the infant from getting immediate help from the hospital. They described non-prescribed medicines as any medication that was not prescribed by a medical doctor or nurse. Bland et al (2004) noted that although many of the traditional healers the mothers made use of were registered, they [Bland et al] considered medicines prescribed by these traditional healers as non-prescribed in this study. The mothers commonly gave infants enemas that contained Zulu traditional medicine, water and sunlight soap. The reasons given to explain the use of enemas included constipation, the belief that an infant need to be cleaned out and to heal *inkaba*. The process of cleaning out an infant is believed to protect the baby from harmful spirits and keep them cool. The healing of *inkaba* is believed to be the healing of an internal wound infants are thought to have due to severance of the umbilical cord. Other reasons included using enemas in order to protect the baby from stomach pains caused by the changes in weather. Oral medications were commonly given for wind, colic and abdominal pain regardless of the fact that there is no proven cure for colic (Bland et al 2004).

Bland et al (2004) described stomach pains and *inyoni* as the vulnerability of all infants to supernatural elements that may cause illness such as diarrhoea and dehydration. In KwaZulu Natal where Bland et al (2004) conducted their research, *Umuthi Wenyoni* which is the medicine for *inyoni*, was popular. They argue that the use of this medication is problematic and dangerous for infants who might have severe diarrhoea and dehydration and are given u*Muthi Wenyoni* instead of being given quick access to medical help (Bland et al, 2004). They added that childcare can be overwhelming, especially in areas that have high mortality and morbidity rates. As a result it is important for health professionals to understand why mothers use non-prescribed medications, and also to know which medications are commonly used in order for the health professionals to be able to ask about their use. Although the use of non-prescribed medicines might not always cause clinical problems, they might still be dangerous and may interrupt 'appropriate health seeking behaviour' and cause mothers not to comply with exclusive breastfeeding (Bland et al, 2004).

One cannot deny the evidence of the importance of exclusive breastfeeding and the dangers that may come with using non-prescribed medicines. That said, it is still important to understand why the mothers chose to continue making use of non-prescribed medications, regardless of the information that they received from the nurses about the dangers of these medicines and also being told that the infant does not need these medicines.

However, although the use of these medications might be harmful and hinder exclusive breastfeeding, the intention of the mothers I worked with was not to harm their infants. Instead, they were working on a different model of sustaining the lives of their infants which included using medicines in order to protect one's infant from harmful spirits and illnesses that either result from the harmful spirits or the environment that the baby is in. Ross (2010) argues that illnesses that a person is vulnerable to are not a matter of chance and are not always related to biology but also have to do with the political economy. Drawing from Farmer et al's (2006: 1686) concept of 'structural violence' as the entrenched violence that allows and prolongs inequalities in society, Ross (2010) adds that illness has to do with societal organisation and structural inequalities that exist and that allow for health and sickness to be unevenly distributed among different populations. Furthermore, Ross (2010) addresses important questions about how people understand the body and respond to illness, as well as how they live with the uncertainty of illness.

In The Park, where Ross (2010) worked, many people were terribly ill and the area had one of highest tuberculosis infection rates where more than 30 of the 800 people living in the Park/ Village died from diseases related to TB and HIV - the common denominator was poverty. During her time in The Park, Ross (2010) noted trends of malnutrition and alcohol dependence. Importantly, and given my research, Ross (2010) noted the ways in which daily routines had been shaped by medical regimes and the need to care for sick family members. People in The Park had become accustomed to social instability and management of a life where disease is so rampant and, to lend from Helman (2006:4), could be described as 'time poor'. In this context, the concept of being 'time poor' refers to the lifespan of people in the Park falling short in comparison to those who are 'time rich' and can afford new 'life extension' and 'life enhancement' medical technologies. Here we see very clearly how socioeconomic class becomes a proxy for health and wellness and how bodies are affected by society and the environment in which they are produced. We also see how residents of such areas might feel the need to arm themselves against illness before they are infected by it.

To further illustrate how people in the Park had become accustomed to how illness had saturated their lives, one respondent told Fiona Ross: 'We're born sick. New-borns come into this world sick and they stay that way'. This acknowledgement of the structural violence that was explicit in The Park was also seen in how the customary gift at a baby shower would be items such as a remedy (for colic, sleeplessness, irritability, teething, sore stomachs, coughs, running noses, wind, etc) whereas in middle-class communities, the gift that was usually given was that of clothing - medicines were seldom given. In The Park, people were concerned with saving a life of a baby before it was born into an environment that does not automatically facilitate life. The babies in The Park, just like Andiswa's baby – had a pharmacy before they were even born. Therefore, both in Ross (2010) and in my research, the women understood the precariousness of life due to illnesses, evil spirits, feeding, and poverty and so on. To this end, they have built tools to manage life as it is and to find ways to sustain the life of their infants and new-borns through medicines even though non-prescribed in some cases.

Makatye Akhule **(He Must Eat and Grow)**

> *I was visiting my cousin in hospital. Her baby was not well and the doctors suspected tuberculosis. I picked him up and started playing with him. My cousin started to speak and was clearly agitated. 'Look at how small he is. They say he needs to lose weight, bayamlambisa umntanam (they are making my baby go hungry)'. She continued to talk, 'People will say that I am making him go hungry. He's so small and ugly, not the same as he was before.' One of the many things that doctors had told her was to stop feeding the baby 'too much' because the baby needed to lose weight. And indeed on this visit I noticed that the baby had lost a fairly significant amount of weight.* [Extract from field notes]

Throughout my fieldwork, this idea of a well fed baby was consistent. The mothers emphasized weight as one of the indicators of whether or not their baby was healthy and/or whether or not the mother was treating her baby well. Months later when we were talking about feeding again, my cousin – Sontombi returned to the doctors who asked for her baby to lose weight. 'I still don't get it', she said, 'it's silly and other people saw my baby and agreed with me that he was beautiful, looked happy and well fed'. When I had conversations with the other mothers, it kept coming up that a healthy baby is a baby *owondlekileyo* which translates as 'well fed'. In explaining what well-fed means, some referred to how the baby

should be big, the skin of the baby should clear up and their eyes should be bright. In this perspective, a big baby, was beautiful and healthy, as opposed to small and with dull eyes. From the above discussion, we are able to note how the mothers were worried about how their baby looked as it was an indicator of whether or not they were treating their babies well and feeding them sufficiently.

On the other hand mothers were encouraged by health professionals to breastfeed exclusively because it is healthier, better for the baby and that breast milk is enough for the baby. Regardless of the teachings of the Department of Health, the mothers expressed the need to feed their babies so that they can be big and beautiful. In addition to that, there was the constant reminder to me that exclusive breastfeeding cannot work because breast milk is not enough for a baby to grow, become big and/or feel full. The question I was asked often was, 'have you heard the cry of a hungry baby?' One of my participants answered her own question quoted below:

> Have you heard the excruciating cry of a hungry baby? Because that is what happens when you exclusively breastfeed… the baby gets hungry and the baby does not get bigger and more nourished… that is what purity, sweet water, formula and other complimentary feeds achieve, the baby gets bigger and happier, the skin glows a bit more.

In these cases, being big, and being full is something mothers felt they needed to achieve. Exclusive breastfeeding would not achieve this because according to the mothers, 'breast milk is not enough' because of its liquid state and the idea that water or liquids alone cannot be filling. This idea of insufficiency of breastmilk is also discussed by Kakute et al (2005) as they argue that breast milk was understood as an incomplete food source that only satisfied the thirst and not the hunger of a child. In Kakute et al (2005), mothers were concerned that breast milk would not increase the infant's weight and not address the need for solids in the infant's intestines. Mamabolo et al (2004) also argue that the people they worked with believed that introducing food early would assist in developing the infant's digestive system function which resulted in infants being fed a variety of supplementary and complementary feeds such as maize meal, mabella (sorghum), commercial infant cereals such as Nestum, Purity, and Cerelac.

The aforesaid ideas of people's understandings and classifications of food are discussed extensively by Schmidt (2012) on her thesis about the role of food in TB treatment. She

introduced the notion of 'strong' foods and 'healthy' foods as binaries through which TB patients in the village she worked in made meaning of the side-effects of TB treatment. 'Strong' foods were believed to help combat the side effects of TB treatment. She concluded that foods were given various roles in TB treatment. When she asked one of her informants, Discho what the difference was between pap and porridge, he said that pap was 'thick' and 'strong', and that it helped combat the side effects of TB treatment by 'strengthening' his stomach. Although not actively pursued in this study, mothers had different ideas about what role is played by breastmilk, medicines, water and solids. Breastmilk was valuable because the mothers believed that every baby needs it, it does not cost money and it opened doors for bonding with the child. Medicines were important because of their role in mitigating the various threats to the baby's health. Water was seen as valuable because it quenches the baby's thirst and is also useful for everyone to drink. Solid food was also held in high regard as it was considered to be more filling and almost served to fortify the baby's stomach and made a baby stronger and importantly, bigger.

The need for the above was as a result of mothers being unable to provide sufficient breast milk for their infants. This shows that the public health message to breastfeed exclusively is not always a convincing message to mothers as they came to hospital with learned ideas about infant feeding from their own mothers and the role played by food in the development of their children. Therefore, this chapter shows that there are different discourses around infant feeding and breastfeeding- it sheds light on some of the disjuncture between public health messages and locally held knowledge. The public health message promoted is that an infant needs to be exclusively breastfed for six months so that the infant can be healthy and protected from illnesses. This is contrary to local knowledge that seeks to introduce infants to solid food and medicines to promote health, protection from harm and develop the infants' digestive system. There was also the commonly held idea that a baby who eats grows faster. In one of my visits to Andiswa, Thando was drinking formula when I got there. In less than an hour later Andiswa came with Nestum in a bottle and argued that he likes food. He kept sticking his tongue out and Andiswa's mom and aunt said *'*look at him, look at his face and tongue, he likes to eat*'*

After hearing all the mentions of the association of food with weight and health, I asked what a healthy baby looks like and if she thinks Thando looked healthy. Andiswa responded:

> His weight, they tell you at the clinic what it should be. But I am struggling with Thando now, if he gets too fat he will lose cuteness. At some point he was too big. People and my mom said he is beautiful because they believe that a baby must be big. Most people feel that the beauty of the baby depends on the weight. A baby must not be small because it will look like they do not eat. It must be clear from his weight that you feed him. I am happy when he eats because food makes babies grow. Most people do not think he is three months, they say he is five months but at the clinic they say his weight is fine. He eats and a baby who eats grows daily. Every morning you will see they have grown bigger. Look at this, these are his groceries, you would think it will be here the whole month but it is only for two weeks. But he must eat so he can grow.

I asked if milk was not enough, to which she responded:

> Milk is too light; there needs to be something solid in his tummy. The baby will cry. And you will see that even though you just gave him milk, he has not had enough and they cry. Well, I can tell that he has not had enough when he cries. It is like when I give him Nestum in his bottle, after that he wants something to drink so I need to make sure that I prepare both because he will want to have the porridge and milk immediately after. So I must have both of them at the same time.

In an interview with Vuyiswa when I visited her, she also had similar views about food, she said: 'She was a baby that liked to eat. I could tell that she is not well when she does not like to eat and is quiet.' When I asked how she knew that her baby was healthy, she said:

> They eat, the skin is beautiful and clean eyes, not red. So her eyes were nice and clear. Her skin was beautiful and her weight, you can tell from the weight if your child is not well- when it goes down instead of going up. Or going up and down, it must at least be consistent or go up and not go down because the baby is healthy if they gain weight. Yes sometimes weight fluctuates but with my baby it goes down when she is not well.

In a similar conversation with Nolwazi she said: 'If she wants to eat and plays, and does not get sick often, I regard that as healthy.' 'And her weight, do you consider it?' I asked.

Nolwazi responded: ‘Yes, if she gains I think she is fine. But I do observe her to make sure she does not gain too much.’

Conclusion

In conclusion, from my research it became apparent that the mothers were concerned about what the nurses think of them [mothers] but they were also worried about what their friends, mothers and other people within their community thought of them when they look at the baby. Furthermore, it was clear that the mothers had different priorities and concerns, and as a consequence, they conceptualized their children’s bodies and health in different ways and as a result, acted differently from expectations of nurses. Mothers were taught that breast milk is sufficient when they visit the clinic.

However, they have concerns about their children having enough food and improving the digestive function of their babies. For the women I worked with, there were also different goals to be achieved with food as mentioned above. They also wanted to achieve a big beautiful baby, a subjective notion to each of them, and healthy babies. Accordingly they believed that these notions could not be achieved through exclusive breastfeeding, they needed to combine breastfeeding with complementary foods for their infants.

Non-prescribed Medicines are discouraged by the DoH but it is a practice that the mothers continued with, despite their knowledge of the DOH messaging on exclusive breastfeeding. This was due to a variety of reasons. The kinds of circumstances that the babies were born into put the mothers in a place where they were constantly worried about the risks involved in the lives of their infants and just like the South African government, mothers were trying to avoid infant mortality. The government does this in the form of implementing exclusive breastfeeding and communicating to mothers, via nurses, the importance of exclusive breastfeeding and breastmilk as both nutritious and medicine for the infants. However, the mothers I worked with conceptualized their children’s bodies, health and needs in different ways based on the norms in the environments in which they raised their children and also based on their gut feeling about what worked. This shows that although the common goal for both governments is to curb infant mortality, there were different views on how to ‘lure a child into life’.

CHAPTER 5: 'CONFLICTED CURE'

Who to Trust

In my conversations with the mothers, they expressed a level of distrust of the nurses and feelings that the nurses were from the same community and therefore should know the culture around infant feeding and probably also used that as guidance for their own children instead of recommendations from the Department of Health. For example, in a conversation during our *WhatsApp* focus group, I asked the mothers where they got guidance on feeding and how to care for their babies and the role of nurses, grandmothers, friends and others in their lives. Andiswa was the first one to protest against nurses saying:

> 'Nurses advise you to do things they do not do with their own children. They say the child must not have water whilst older people say the baby gets thirsty and needs water. And this thing of breastfeeding exclusively for six months, children do not get enough; you will find them crying all the time hungry because milk is a liquid…'

Still on the topic of who the mothers look at for guidance Dumisa followed and said: 'I have been told things by my cousin's mother. If I do not understand something, I ask the lady who babysits for me or ask the baby's father who then asks his uncle because he was a manager at ABC clinic[23] on the children's section'.

From both comments and throughout the thesis thus far, we can see that the mothers have multiple sources of information that they are in a position to pick and choose from. They draw on their different networks to get information on how to care for their babies. We can also see the level of distrust of how genuine the nurse's intentions and information is.

Furthermore, mothers did not simply take on the guidance but also used their own experience and own initiative when deciding on what to do. The baby's father's uncle who worked in the clinic told Dumisa to stop breastfeeding all together and said if she does not have the time to exclusively breastfeed, she must exclusively bottle feed[24]. Dumisa still mixed fed and said: '…but I give him milk and breast milk, he is not sick'. Dumisa continued with this train of

[23]Not the real name of the clinic
[24]According to the WHO (2010) Guidelines on HIV and Infant feeding, there is evidence from non-HIV settings that mixed feeding is associated with increased morbidity and mortality

thought when I asked if the nurses had not explained feeding information to them, she said 'They do but sometimes they say crazy things because nothing bad happens to the baby'.

The grandmothers also made strong suggestions about what the baby needed and should eat. For example, for Vuyiswa, who had just finished a teaching diploma and is now a grade R teacher, her mom insisted that the baby needed gripe water in addition to just milk. Vuyiswa protested because they had been warned against gripe water by the nurses at the clinic. However, she eventually gave the baby gripe water because she felt that her mother would not intentionally harm the baby and that her mom probably knew better because she had children of her own. Andiswa, who just finished an accounting diploma at CPUT, also, did not question her mother when her mother asked her to buy medication for the baby who was less than a week old. When she came in with a lot of medication ready to give the baby, I asked what it was for. Andiswa responded and said she was not sure about the purpose of all the medication but her mother had suggested that they buy it and she felt that her mother knew better and would not hurt the baby. Nolwazi had a similar experience, when talking about the introduction of water to infants in relation to the information they had received from the clinic, this is how our conversation proceeded:

> **Ziyanda**: So did they talk about exclusive breastfeeding at the clinic when you were still pregnant and after you gave birth?
>
> **Nolwazi**: Yes, they said when breastfeeding, you must not give water to the baby but you know we get home and listen to our mothers because I was even going to give the baby formula but she [her baby] did not like it.
>
> **Ziyanda**: So when did you give her water? Were you listening to your mother or mother in law?
>
> **Nolwazi**: In December I went home to Eastern Cape and they [her mother and aunts] said I must give her water, she was two months old.
>
> **Ziyanda**: What reason did they give, like why do you need to give the baby water?
>
> **Nolwazi**: I don't know hey…

This contrasting knowledge from public health officials and other individuals in the mother of the baby's life found in my research is also found in Mbanje's (2014) research. This

research indicates that the women in Mogoboya were aware of the country's exclusive breastfeeding policy, but disagreed with it and as a result, chose to not follow it. One of the mothers in the study- Masedi explained that when babies cry a lot, a mother gives them soft porridge at two or three weeks and says breast milk is not enough and as a result, a baby will cry a lot but settle down once fed porridge. Another mother- Rosina Shokane also says that after she gave her baby cereal, he would become quieter. To draw on Gottlieb's (2000a) notion of leakages as ways in which infants communicate, and the need to start considering that model of communication for analysis- here we see that the mothers have a particular understanding of the meaning of a crying baby. To them, crying communicates hunger. On a similar note, mothers get conflicting knowledge not only on the sufficiency of breast milk but also on its nutrition. Masedi from Mogoboya says that new mothers in the area are advised to express the yellowish liquid that comes before the milk and prevent the baby from drinking it. This is because the 'yellowish liquid' which is colostrum is believed to be 'dirty'. Mothers then squeeze their breasts with the purpose of getting rid of the dirt trapped in the breasts.

However, contrary to beliefs held by mothers in Mogoboya, the Department of Health argues that numerous research studies have shown that this liquid- colostrum is highly beneficial to a new-born and actually one of the most nutritious substances that a baby can be fed within the first few hours after birth. It is the same with the need for water or need for more food as breast milk is not a sufficient source of food.

According to the Department of Health, research[25] studies show that many mothers produce enough breast milk for their baby and can even produce enough milk for two babies if the baby latches on correctly and is breastfed as often as the baby wants. The amount of breast milk produced is dependent on the amount the baby takes and needs and increases as the baby needs and drinks more milk. The Department of Health echoes this research on their website and explains to readers that the baby has enough milk and if the baby is crying, mothers should look into other sources of the cry and not assume that the baby is hungry. Furthermore, contrary to the idea that the baby gets thirsty that was held by most of my participants and in the multiple studies cited thus far on barriers to exclusive breastfeeding, the Department of Health, in light of studies done ensures mothers that at the beginning a feed, foremilk which is the early milk has enough water to satisfy the baby's thirst.

[25]For more information on these studies see: https://www.westerncape.gov.za/general-publication/exclusive-breastfeeding

This dissertation illustrates how mothers do not necessarily disagree with what nurses tell them about infant feeding and the benefits of breast milk and decide to actively rebel against it. In fact to a certain extent, they embrace it and take the nurses' advice into account. Instead, the mothers I worked with were drawn to different knowledge about babies from health professionals, family and friends which led to mothers choosing to listen to whom they trusted and believed had the best interests of their baby at heart. This suggests ideas of who the mothers consider to be a knowledgeable person and also the impact of differing knowledge on the ability for a mother to exclusively breastfeed. There is an idea of the grand mothers' experience in being a mother and raising healthy babies as important, that frames the grandmother as a person who is a knower or has knowledge about infant feeding. Although nurses are also seen as knowers to a certain extent, there is an additional element of the grandmother not only being a knowledgeable person through experience but also because she was someone a mother can trust with their child. When the expectations and requirements from nurses clash with knowledge from grandmothers and friends, mothers then draw on their own experience and take initiative to decide which option is better for their baby.

An example on the issue of trust, Dumisa said: 'The nurses advise you to do things they do not do to their children. They say do not give the baby water while older people [mother and aunts] say a baby gets thirsty and needs water. And also this thing of breastfeeding exclusively until six months, children do not get full and they cry because they are not full, milk is liquid'

This demonstrates that the mothers are receiving as well as being pulled by different ideas of child care. Both women had their moms as primary carers for their babies as they had to pursue work. There is an idea of the grandmother's experience in being a mother before and raising healthy babies as something that frames the grand mom as a person who knows or has knowledge about infant feeding. There is a level of trust between mother and grandmother so much that even though one has no idea what some of the medicines are for, they would give it to their child if their mother said so.

'Conflicted Cure'

Winterton (2013:9) titled her Master's dissertation 'conflicted cure' as this best described the difficulty that some patients diagnosed with drug resistant tuberculosis faced throughout their treatment process along with the difficulty of delivering care to these patients. This title also reflected the contradictions in the experiences of having TB, such as severe side effects to

treatment and the loss of sexual identity. Drawing on Winterton's ideas of 'conflicted cure' I argue that mothers face 'conflicting cures' advocated by powerful actors. In a similar manner, this thesis has described some of the differences and contradictions in the process of childcare and how these play out in the complex ways that mothers, nurses, grandmothers, fathers and others understand sustaining infant life. There is the problem of infant mortality and the cure which is seen as exclusive breastfeeding by the state, solids, water and medicines by mothers and those in their lives.

This dissertation illustrates how mothers place a great deal of agency in their infant, more so than the DoH is prepared to acknowledge in their public health messaging. In fact public health messaging places the agency of breastfeeding and 'life saving' in the sole hands of the mother, with little regard to her lived reality or welfare and devoid of context. The notion of a 'good mother' as promoted by the South African DoH, does not account for the different kinds of sacrifices made by women who do not exclusively breastfeed. It also does not recognise the efforts made by mothers such as introduction of medicines and complementary feeds with the purpose of keeping their babies safe as an indicator of good mothering. Instead, these mothers are seen as non-compliant and therefore bad mothers. They continue to carry the 'blame' for their 'ignorance' as opposed to the blame being laid at the door of socio-economic conditions. The Public Health message blames women in a way that is devoid of the context in which they live.

This dissertation further shows that infants are able to express 'likes' and 'dislikes' towards food and therefore shape the mother's ability and desires to breast feed. Equally, babies' cries indicate their hunger. Breast feeding becomes a dialogic process. Hunger is a sad reality in everyday South Africa, so it is little surprise that a baby's cry when positioned against a mother's pressing desire to 'lure her child into life' will be understood through a framework of hunger. As seen in this dissertation, mothers view food as medicine in itself, making their babies stronger, beautiful. Drawing from Gottleib (2000) and Marais (2014), I argue that the national DoH and researchers need to pay more attention to a babies' agency and the way this is expressed through the lived conditions of their mothers. There is a need for more knowledge around exclusive breastfeeding.

The mothers were not always aware of the importance of exclusive breastfeeding which made it difficult for them to stand up for it when grandmothers suggested alternatives. Further, they were not equipped with enough knowledge to understand the difference between

breastfeeding and exclusive breastfeeding and how to respond to grandmothers' differing opinions and conventional ideas on infant feeding. There is also a need to include grandmothers in the messaging on infant feeding. The mothers see their own mothers as knowledgeable people, experts, and as people they trust to know what is best for the baby. In order to enable mothers to exclusively breastfeed, grandmothers need to also understand exclusive breastfeeding. The information cannot only be aimed at mothers and would be more effective if it is understood by the grandmothers that are already trusted and seen as knowers/experts in child care by the mothers.

APPENDICES

Appendix 1- Statistics from *State of the World's Children*

Child mortality estimates

Each year, in *The State of the World's Children*, UNICEF reports a series of mortality estimates for children – including the annual neonatal mortality rate, infant mortality rate, the under-five mortality rate (total, male and female) and the number of under-five deaths – for at least two reference years. These figures represent the best estimates available at the time of printing and are based on the work of the United Nations Inter-agency Group for Child Mortality Estimation (IGME), which includes UNICEF, the World Health Organization (WHO), the World Bank and the United Nations Population Division. IGME mortality estimates are updated annually through a detailed review of all newly available data points, which often results in adjustments to previously reported estimates. As a result, consecutive editions of *The State of the World's Children* should not be used for analysing mortality trends over time. Comparable global and regional under-five mortality estimates for the period 1970–2013 are presented on page 90–95. Country-specific mortality indicators for 1970–2013, based on the most recent IGME estimates, are presented in Table 10 (for the years 1970, 1990, 2000 and 2013) and are available at <data.unicef.org/child-mortality/under-five> and <www.childmortality.org>.

Under-five mortality rate (per 1,000 live births)

UNICEF Region	1970	1975	1980	1985	1990	1995	2000	2005	2010	2013
Sub-Saharan Africa	246	219	201	187	179	172	156	129	103	92
Eastern and Southern Africa	212	193	188	174	165	157	140	112	85	74
West and Central Africa	279	249	220	205	197	190	175	149	122	109
Middle East and North Africa	205	165	126	90	70	60	50	42	34	31
South Asia	213	195	171	149	129	112	94	77	64	57
East Asia and Pacific	117	94	76	63	58	51	41	30	23	19
Latin America and Caribbean	119	102	84	68	54	43	32	25	23	18
CEE/CIS	97	74	69	56	47	48	37	29	22	20
Least developed countries	243	230	211	190	174	158	139	113	91	80
World	**147**	**129**	**117**	**100**	**90**	**85**	**76**	**63**	**51**	**46**

Under-five deaths (millions)

UNICEF Region	1970	1975	1980	1985	1990	1995	2000	2005	2010	2013
Sub-Saharan Africa	3.2	3.2	3.4	3.6	3.8	4.0	4.1	3.8	3.3	3.1
Eastern and Southern Africa	1.3	1.4	1.5	1.6	1.7	1.7	1.8	1.5	1.3	1.1
West and Central Africa	1.7	1.8	1.8	1.9	2.0	2.2	2.2	2.1	2.0	1.9
Middle East and North Africa	1.3	1.1	1.0	0.8	0.6	0.5	0.4	0.4	0.3	0.3
South Asia	5.9	5.7	5.6	5.1	4.7	4.0	3.5	2.8	2.2	2.0
East Asia and Pacific	4.8	3.6	2.4	2.5	2.5	1.6	1.2	0.9	0.7	0.6
Latin America and Caribbean	1.2	1.1	1.0	0.8	0.6	0.5	0.4	0.3	0.2	0.2
CEE/CIS	0.6	0.5	0.5	0.4	0.4	0.3	0.2	0.2	0.1	0.1
Least developed countries	3.3	3.5	3.6	3.6	3.6	3.5	3.4	2.9	2.5	2.3
World	**17.3**	**15.5**	**13.9**	**13.3**	**12.7**	**10.9**	**9.7**	**8.2**	**6.9**	**6.3**

UNDER-FIVE MORTALITY RANKINGS

The following list ranks countries and areas in descending order of their estimated 2013 under-five mortality rate (U5MR), a critical indicator of the well-being of children. Countries and areas are listed alphabetically in the tables on the following pages.

HIGHEST UNDER-5 MORTALITY RATE

Countries and areas	Under-5 mortality rate (2013) Value	Rank
Angola	167	1
Sierra Leone	161	2
Chad	148	3
Somalia	146	4
Central African Republic	139	5
Guinea-Bissau	124	6
Mali	123	7
Democratic Republic of the Congo	119	8
Nigeria	117	9
Niger	104	10
Guinea	101	11
Côte d'Ivoire	100	12
South Sudan	99	13
Burkina Faso	98	14
Lesotho	98	14
Afghanistan	97	16
Equatorial Guinea	96	17
Cameroon	95	18
Mauritania	90	19
Zimbabwe	89	20
Mozambique	87	21
Zambia	87	21
Pakistan	86	23
Benin	85	24
Togo	85	24
Burundi	83	26
Swaziland	80	27
Comoros	78	28
Ghana	78	28
Sudan	77	30
Gambia	74	31
Haiti	73	32
Kenya	71	33
Lao People's Democratic Republic	71	33

Countries and areas	Under-5 mortality rate (2013) Value	Rank
Liberia	71	33
Djibouti	70	36
Malawi	68	37
Uganda	66	38
Ethiopia	64	39
Papua New Guinea	61	40
Kiribati	58	41
Gabon	56	42
Madagascar	56	42
Senegal	55	44
Timor-Leste	55	44
Turkmenistan	55	44
India	53	47
Rwanda	52	48
United Republic of Tanzania	52	48
Myanmar	51	50
Sao Tome and Principe	51	50
Yemen	51	50
Eritrea	50	53
Namibia	50	53
Congo	49	55
Tajikistan	48	56
Botswana	47	57
South Africa	44	58
Uzbekistan	43	59
Bangladesh	41	60
Nepal	40	61
Bolivia (Plurinational State of)	39	62
Cambodia	38	63
Marshall Islands	38	63
Guyana	37	65
Nauru	37	65
Bhutan	36	67
Micronesia (Federated States of)	36	67
Azerbaijan	34	69

Countries and areas	Under-5 mortality rate (2013) Value	Rank
Iraq	34	69
Mongolia	32	71
Guatemala	31	72
Morocco	30	73
Philippines	30	73
Solomon Islands	30	73
Indonesia	29	76
Tuvalu	29	76
Dominican Republic	28	78
Democratic People's Republic of Korea	27	79
Cabo Verde	26	80
Algeria	25	81
Niue	25	81
Fiji	24	83
Kyrgyzstan	24	83
Nicaragua	24	83
Viet Nam	24	83
Ecuador	23	87
Suriname	23	87
Egypt	22	89
Honduras	22	89
Paraguay	22	89
State of Palestine	22	89
Trinidad and Tobago	21	93
Jordan	19	94
Saint Vincent and the Grenadines	19	94
Turkey	19	94
Palau	18	97
Panama	18	97
Samoa	18	97
Belize	17	100
Colombia	17	100
Iran (Islamic Republic of)	17	100
Jamaica	17	100
Peru	17	100

ABOUT 17,000 CHILDREN UNDER FIVE YEARS OLD STILL DIE EVERY DAY.

LOWEST UNDER-5 MORTALITY RATE

Countries and areas	Under-5 mortality rate (2013) Value	Rank
Vanuatu	17	100
Armenia	16	106
El Salvador	16	106
Kazakhstan	16	106
Saudi Arabia	16	106
Albania	15	110
Libya	15	110
Mexico	15	110
Republic of Moldova	15	110
Saint Lucia	15	110
Syrian Arab Republic	15	110
Tunisia	15	110
Venezuela (Bolivarian Republic of)	15	110
Barbados	14	118
Brazil	14	118
Mauritius	14	118
Seychelles	14	118
Argentina	13	122
Bahamas	13	122
China	13	122
Georgia	13	122
Thailand	13	122
Bulgaria	12	127
Grenada	12	127
Romania	12	127
Tonga	12	127
Dominica	11	131
Oman	11	131
Uruguay	11	131
Brunei Darussalam	10	134
Costa Rica	10	134
Kuwait	10	134
Maldives	10	134
Russian Federation	10	134
Saint Kitts and Nevis	10	134
Sri Lanka	10	134
Ukraine	10	134
Antigua and Barbuda	9	142
Cook Islands	9	142
Lebanon	9	142
Malaysia	9	142
Chile	8	146
Latvia	8	146
Qatar	8	146
United Arab Emirates	8	146
Bosnia and Herzegovina	7	150
Serbia	7	150
Slovakia	7	150
The former Yugoslav Republic of Macedonia	7	150
United States	7	150
Bahrain	6	155
Cuba	6	155
Hungary	6	155
Malta	6	155
New Zealand	6	155
Belarus	5	160
Canada	5	160
Croatia	5	160
Lithuania	5	160
Montenegro	5	160
Poland	5	160
United Kingdom	5	160
Australia	4	167
Austria	4	167
Belgium	4	167
Cyprus	4	167
Czech Republic	4	167
Denmark	4	167
France	4	167
Germany	4	167
Greece	4	167
Ireland	4	167
Israel	4	167
Italy	4	167
Monaco	4	167
Netherlands	4	167
Portugal	4	167
Republic of Korea	4	167
Spain	4	167
Switzerland	4	167
Andorra	3	185
Estonia	3	185
Finland	3	185
Japan	3	185
Norway	3	185
San Marino	3	185
Singapore	3	185
Slovenia	3	185
Sweden	3	185
Iceland	2	194
Luxembourg	2	194
Holy See	-	-
Liechtenstein	-	-

Appendix 2: Initial set of interview questions

Interview Questions

General Questions about the mother and infant:

1. When was your child born?
2. Is this your first child?
3. What do you enjoy most about having a baby and being a mother?
4. How did you normally spend your days before the baby?
5. How has that changed? How do you spend your days now?
6. Are you employed?
    - If yes, where? Please tell me about your job
7. If not employed, what is your source of income?

Questions on pregnancy and birth:

8. How was your experience of being pregnant?
9. Did you have antenatal classes?
10. How was your birthing experience?
11. How was your time in hospital?

Questions on feeding:

12. When did you make decisions about how you will feed your baby? Was it before or after the baby was born?
13. Where did you receive most of information/ guidance on infant feeding methods from?
14. Which information did you draw from the most?

15. Please tell me about that decision making process

16. What and how do you feed your child?

    - (use answer to probe and ask more questions)
    - Do you feed the child other foods/ liquids besides breast milk?
    - Why?
    - Why not?
    - When?

17. Do you breastfeed?

18. Who are the people who taught you how to breastfeed?

19. How did you learn to breastfeed?

20. How long did it take you to learn to breastfeed?

21. Did the nurses in the hospital show you any breast feeding techniques?

22. What did they tell you about breastfeeding?

23. Was there pressure from the nurses to breast feed?

24. Do you have friends that breastfeed?

25. How many times do you breastfeed?

26. Do you have a set timetable? If not, how do you decide on when to breastfeed?

27. Have you breastfed before?

28. How long have you been breastfeeding this child/ How long did you breastfeed this child?

29. Do you know about exclusive breastfeeding?

30. Are you practicing exclusive breastfeeding or mixed feeding?

31. If you have more than one child, how did you feed the other child?
32. If there are differences, why did you do things differently?
33. How has breast feeding/ infant feeding/ having a baby affected your daily life schedule?

Questions on perceptions of breastfeeding:

34. How is breastfeeding? How does it feel? Have your feelings changed over time?
35. What does your partner say about breastfeeding?
36. Does your partner ever feed the child?
37. When do they feed the child?

Questions on expressing milk:

38. Have you heard about expressing milk?
39. Have you done it?
40. Why?
41. Why not?
42. What do you think of it?

Focus group discussion topic guide:

General introductions

Breastfeeding

Breastfeeding practice (technique/ style)

Breast health

Formula feeding

Other methods of infant feeding

Appendix 3: Examples of *Facebook* status updated from the mothers I worked with

Snapshots of Vuyiswa's Facebook Posts

Snapshots of Thandiwe's Facebook Posts

[redacted]
11 Dec 2014 at 4:41pm Edited

he is 6months today....nchoooooo yakhulu mntanam njena#lv-him-kodwa#

[redacted]

I gave birth to a bouncing baby.....I Wdnt u like to knw lol#winks# my angel. — feeling blessed at Tygerberg Hospital.

[redacted]
20 Feb 2015 at 10:54pm

ndizise nyanam ofresh ingathi akaguli, My son kodwa, his all smiles kuleclinic ncumela every1#andisedikwe

Khayelitsha Day Hospital Clinic(Site B)
Local Business

[redacted] added 4 new photos to the album: Me nd My Everythng #IsthararaSikamama.
19 Mar 2015 at 5:30pm

taking pics with my Son [redacted]

[redacted] added 4 new photos to the album: Me nd My Everythng #IsthararaSikamama.
05 Apr 2015 at 5:54pm

taking pics with my Son [redacted]

[redacted] added 3 new photos.
16 Jun 2014 at 1:14pm

Ths is for my mommies frnds bandibone lol#nyc to meet u all# — with [redacted]

[redacted]
15 Aug 2014 at 9:55pm

my angel

[redacted]
29 Aug 2014 at 2:28pm

he has been crying non stop today , i wonder utheni cz utyile nd its unlike him kulila oko

Dumisa's Facebook Posts

Snapshots of Andiswa's Facebook Posts

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