

# Milk, Meaning and Morality: Tracing Donated Breast Milk from Donor to Baby

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## Abstract

This thesis follows the trajectory of donated breast milk as it leaves the dyadic mother-child relationship and is reconfigured through a series of transformations as bodily fluid, food, or medicine, depending on its context and the practices and discursive structures that seek to stabilise it as a particular object. Research was conducted between November 2014 and May 2015 in Cape Town, South Africa, including interviews with eleven donating women and eight weeks of participant observation at a level two maternity hospital. Donors use a rhetoric of ‘saving babies’, the effect of which is to deny the social tie between donor and recipient, or the potential for consubstantiation. Technologies play a crucial role in aiding the milk’s transformation as it follows its trajectory through four nodal points (expressing and storage, pasteurisation and testing, packaging, and prescription) from donors’ homes into the clinical setting, where it is framed in terms of safety and risk. Care enters into the constellation of relations that the milk ensures in unexpected ways and figures into the ways the milk is distributed in the hospital. Thus, donated breast milk shifts back and forth between being a bodily fluid, food, and medicine as its trajectory takes it through different constellations of saving, motherhood, technologies, care, safety, risk and medical authority. Different techniques foreground particular properties of the milk, as ultimately a set of moral decisions converges around saving, securing and sustaining life, materialising relationships and forming the milk form one entity into another and back again.

Key words: Donation, Breastfeeding, Motherhood, Technologies, Risk, Affect, Care

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# Chapter 1

## Introduction

I had never been in a neonatal unit before I visited a level two maternity hospital in Cape Town<sup>1</sup> in April 2014 to talk about the research project that forms the basis for this thesis. The high tech unit is internationally renowned for its sophisticated design and accomplished efficiency. While admiring the bundles of wires feeding from the ceiling to blue-lit glass cases, I was distracted by a fragile little leg kicking in the air, a reminder of the patients of this hospital ward – babies, infants, tiny human beings. Some weighing less than a kilogram, most babies in this unit are born prematurely and suffer from a range of medical conditions as a consequence. According to Dr Muller, a paediatrician and consultant at the hospital, about 1,000 babies are delivered in the hospital each month, of which 15-18% are premature. Premature babies, especially those weighing less than 1.5 kilograms, who are fed formula-milk (even when it is especially designed for premature babies) are highly susceptible to necrotising enterocolitis.<sup>2</sup> Here, breastmilk offers a critical intervention into securing life; ‘breast is best’. Thus, for these babies receiving breast milk is not merely about often-cited advantages such as higher IQ, less allergies and better bonding (Blum 1999; Hinde and German 2012), but can be a matter of life and death.

Yet, even in a context of privilege, social support and economic wealth breastfeeding is no easy task or sure success (see Waltz 2013, 2014). The mothers of the babies in the hospital are typically not from this privileged bracket. The hospital is a public hospital with specialty maternity functions. With a sharp distinction between public and private health care in terms of access and costs in South Africa, the patients in the hospital are generally from a materially impoverished background and find themselves at the lower end of the severe socioeconomic inequalities in South Africa. Many new mothers of babies at the hospital may not settle into breastfeeding in the early weeks or might not be able to at all, because they do

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<sup>1</sup> To ensure the anonymity of the research participants, the hospital will be referred to as ‘the hospital’, and pseudonyms are used throughout.

<sup>2</sup> A lethal digestion problem in infants (see Neu and Walker 2011).

not have regular access to the hospital, or are malnourished, drug- or alcohol dependent or too sick.

In situations like these, donated breast milk can offer a solution. Breastmilk donations are usually mediated by milk banks, which collect expressed<sup>3</sup> breastmilk from breastfeeding mothers, test and pasteurise the milk and distribute it through hospitals or clinics. The first milk bank opened in 1910 in Boston, and by 1929 they existed in over 20 cities in the USA (Golden 1996: 77). Currently milk banks are a widespread phenomenon, with three voluntary non-governmental (NGO) milk banks active in South Africa (Bolton 2012: 7). Some hospitals have their own in-house milk banks, and the government is in the process of setting up the South African Breastmilk Reserve.

The milk bank<sup>4</sup> featuring in this research is an NGO housed inside the hospital, supplying about forty babies at a time with milk across six different hospitals in Cape Town (mainly large public hospitals, and occasionally private hospitals). Given that in South Africa only 8% of mothers are reported as breastfeeding exclusively until six months as recommended by the South African government and the WHO (National Breastfeeding Consultative Meeting, 2011; Doherty et al., 2011) it is not surprising that milk banks face shortages of donated milk and cannot supply to the demand of hospitals.

### **Research Question: Following the Trajectory of the Milk**

“Part food, part medicine, part human tissue”, is how Dr Muller described breast milk in our first meeting, indicating it has some unique properties that are accentuated when this intimate substance is distanced from a particular mother-child dyad through donation. Part of its symbolic nurturing power is that its dispensing creates moments of bonding and care (see Marshall et al. 2007). The critical question is how this is transposed, how this element of care can enter a chain of distribution as a generalisable product while also retaining its quality as not-quite a commodity<sup>5</sup>, since breastmilk is generally not bought or sold today (according to the Human Tissue Act only authorised institutions and persons are allowed to receive payment for human tissue<sup>6</sup>). In this context the consubstantiation<sup>7</sup> is both acknowledged

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<sup>3</sup> Expressing is the process of collecting breast milk through an electric pump or by hand.

<sup>4</sup> To ensure the anonymity of the research participants, the milk bank will be referred to as ‘the milk bank’.

<sup>5</sup> See chapter two for a detailed discussion of this term.

<sup>6</sup> Breast milk is not mentioned explicitly in the Human Tissue Act, but falls under ‘tissue’: “Any human tissue, including any flesh bone, organ, gland or bodily fluid, but excluding any blood or gamete” (Act 65 of 1983).

<sup>7</sup> I use this term to refer to the idea of simultaneously ‘making a person’ and ‘becoming a mother’ through breastfeeding (Waltz 2013), which parallels Carsten (2004).



(breastmilk is preferred even when baby is not biogenetically related) and denied (in that the donor and recipient baby do not meet). Beside this, concerns about contamination, infection and issues of repulsion arise. A second set of questions this raises is around the donation and notions of altruism and reciprocity. Why do women who are already coping with a new-born baby take the time and effort to express and store milk for anonymous others, especially given that many women find expressing uncomfortable? What does it mean for a baby's caregivers that the infant is receiving another woman's milk? And how does this relate to the kinds of futures that are envisaged through the sharing of this substance: the child's well-being and yet the denial of consubstantiation?

This research project seeks to examine questions around breastmilk by following its trajectory from donating mother through its separation and emergence as a product of some kind (marketable yet not tradable), its incorporation in the clinic setting and its distribution and reception. By following the trajectory of the milk different actors, institutions and practices will come into view. The central question is: *What transformations does breastmilk undergo when, through donation, it enters a nexus that brings a range of entities into relation with one another?* My work aims to examine the transformations of milk as the unique mother-child dyad in which it is produced becomes open to others. This allows the milk to enter into a distribution network as something that is not quite a commodity but is nevertheless an alienable product, as the donor becomes anonymous and the milk pasteurised and standardised through packaging. As I will show, breastmilk means different things to different people and it shifts in meaning and ontological status across time and through its networks of distribution. Empirical work demonstrates how breastmilk is thought of at different points in this network, thus mapping the modes of intimacy and care that it frames and enables. The milk, seen as a gift, is traced through the extended route that takes it from breast to mouth in a political economic context that shapes who donates and who receives.

### **Contribution of the Research**

From an anthropological point of view the research contributes to a broad body of literature on the circulation of human tissue, and ongoing debates around the nature of gifts and commodities as they enter specific networks of circulation. I show that milk's ontological status is secured in a variety of ways across different sites.

The value of this research outside the anthropological circuit lies in its ability to bring the complex meanings given to donating, distributing and receiving milk into view. For the

milk bank insights in the role of altruism, reciprocity and exchange in donation may alter donor recruitment strategies. (I have prepared a set of recommendations for the milk bank on the basis of my findings). For the hospital, the research could highlight how practices of care beyond the protocol play a role in the prescription and administration of donor milk and play into how medical facts are construed. (A meeting will be arranged to discuss these findings).

### **Sample and Methodology**

This thesis is the result of a small-scale ethnographic study that aims to understand people's lived experience of donating, distributing, and receiving breastmilk. Anthropology, with detailed examination of individual experience, allows us to examine where and when disjuncture occurs between what is intended, possible, and actual in the giving and receipt of breast milk. This project offers an iterative<sup>8</sup>, multi-sited way of doing ethnography that focuses on relations, as it acknowledges a range of actors and the ways in which they are interconnected (see Marcus 1995). Following the milk's trajectory was inspired by work in science and technology studies, especially Latour (1994, 2013) and Rabinow (1996). The project focuses on linkages between people of varying socioeconomic backgrounds and geographical locations. It links Rondebosch to Mitchell's Plain, high-end technologies to mother's milk, and crosses all sorts of social and geographic boundaries that run across Cape Town and differentiate its inhabitants.

This research includes three main groups of participants: donating mothers, milk bank and hospital staff, and recipient mothers. Research with donating mothers offers insight into their motives and rationales for milk donation and their attitudes to and feelings about donation, thus eliciting the ways they make meaning of the process they frequently define in terms of charity. This was based on semi-structured interviewing at the participants' homes. The milk bank staff contacted potential participants telephonically to provide them with information about the research, and if they indicated they were interested in participating I contacted them to further explain the research project. The milk bank recruited donors mainly through posters at hospitals and clinics and talks at antenatal classes. All new donors filled out a lifestyle questionnaire and underwent a blood screening. Before each interview I sent an information sheet via email and I provided a consent form before the start of each interview (see appendix). Milk bank staff selected the interview sample based in part on their sense that

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<sup>8</sup> This included inviting participants to review my field notes and interview transcriptions to create an ongoing conversation, allowing them to engage with the research process more deeply.

these women were 'better donors'. As a result, the sample may be skewed. I address this in chapter three.

Between November and December 2014 I interviewed ten 'private' donors: breastfeeding mothers whose babies were not patients at the hospital. The majority of private donors are (upper) middle-class in terms of socioeconomic backgrounds, highly educated, in their thirties and living in nuclear families. This parallels research findings elsewhere (Bolton 2012, see also Obsaldiston and Mingle 2007). My sample reflected this (see table below). However, the milk bank also relied on 'in-house' donors who are resident in the hospital or whose babies are at the hospital. This hospital draws on a very different demographic of mainly materially impoverished patients with little education and varying family arrangements. 'In-house' donors account for a small part of donations to the milk bank; indeed, there was only one in-house donor present during my eight weeks in the hospital.

Secondly, fieldwork involved people who collected and distributed milk. The main participants here were the staff of the milk bank, and doctors, nurses and other hospital staff who work in the neonatal unit. Through observation and informal conversation I found out what processes the donated milk went through before it was administered to a particular baby. Through observing the everyday routines in the neonatal unit and conducting semi-structured interviews with participants I uncovered meaning-making surrounding ideas about risk and potentiality, premature births and breast milk. Both the milk bank and the hospital assisted in recruitment of participants by introducing staff to me and my research. I provided staff with information sheets and consent forms. If they were interested in participating, I approached them to explain the research project further. Participants in this stage of the research were of various backgrounds, but consisted of medical professionals ranging from nurses to specialists, aged between twenty and sixty-five and with varying lengths of work experience.

Engagement with these participants took place in the hospital over the course of April and May 2015. The first weeks consisted mainly of observation and informal conversation, after which the questions that arose became guiding in semi-structured interviews. Generally, one interview of twenty minutes to 1.5 hours took place, although some participants took on the role of key informants and were engaged in conversation more regularly. The number and duration of the interviews was negotiated with the participants and suited to their convenience, to ensure that the research did not interfere with their professional activities. This turned out to be quite a restraining factor – I conducted seven 'sit-down' interviews with

nurses, four with doctors, three with the milk bank staff and three with milk kitchen staff. This number is disproportionately low for nurses, given that there were about an estimated twenty to thirty nurses working on a given day, and there were two 'shifts' that rotated every few days. In all the other categories I interviewed almost everyone present at the time. Nurses were particularly difficult to interview because they have a high workload and their time is highly scheduled.

Finally, my research included the mothers of the babies who received donated breast milk. The aim was to include any family member or caretaker, but only mothers were present during the time of research. The number of babies on donor milk at the hospital determined the sample size. I had aimed to include ten infants and their caregivers. During the research period there were thirteen babies who received donated milk. However, the number of recipient mothers I encountered in these two months was relatively low, because most babies who received donor milk did so precisely because of their mothers' absence. In the neonatal unit there were seven recipient infants whose mothers were present. Two of those mothers had recently experienced infant deaths (in both cases, the death of a twin), and a third was reportedly experiencing psychological problems, and for these reasons I did not consider interviewing them. The mother of a fourth recipient was discharged before I had a chance to meet her. I therefore interviewed three mothers of breastmilk recipients.

Potential participants were identified and approached by the hospital staff. They were given information sheets and consent forms if they indicated an interest in participating, after I approached them to provide further explanation. Mothers of infants that were identified by hospital staff as critically ill or dying were not approached to participate in this research. Observation, informal conversation and semi-structured interviews of about thirty minutes with this group took place in the hospital. These mothers were from low-income suburbs surrounding Cape Town, were all formally employed, in their late thirties, had several older children and lived with their husbands.

I was involved in some of the different sites simultaneously. This allowed me to let findings from these different stages to feed into each other. Bounded by the trajectory of the milk, I attempted to identify the process bringing the factors, objects, relations, institutions and qualities into play and noted how they reframed human breastmilk in different ways, alienated or abstracted from a primary anchoring dyadic relation that is its source.

## **Ethics**

I observed the Anthropology Southern Africa (2005) ethical guidelines and went through a thorough ethics review and consent process by the UCT Anthropology department, the Faculty of Health Sciences at UCT, Western Cape Province Department of Health, the milk bank and the hospital. This process ensured that my research was not harmful to anyone, did not interfere with the medical care that patients received at the hospital, and that participation was voluntary and anonymous. The permission process took eight months and included many layers of administration to pass through.

Nonetheless, ethical dilemmas emerged. Firstly, due to the hierarchies in place within the hospital the participation of medical professionals was at times tricky to negotiate. Since my research was supported and approved by the higher layers of management, lower-ranking workers sometimes seemed reluctant to engage with me yet unsure of whether they could refuse because I was 'sent' by their superiors. Even doctors seemed compelled to agree to interviews when my requests were made in the presence of their superiors. I dealt with this by only inviting people for interviews after establishing sufficient rapport, and never applying pressure to comply with my requests, but rather always stressing that there would be no consequences if they declined.

This points to a lacuna in the ethical clearance process, which is geared towards receiving permission from those in positions of power, at the top of the hierarchy in the context in which the research took place. The consent process is not adequate in solving this tension: since potential participants among hospital staff are presented with an official-looking consent form, which stressed the permission obtained from their superiors, the 'informed consent' procedure only cemented the pressure on potential participants to engage. Moreover, the practice of signing a consent form immediately instantiates a hierarchy (Ross 2005).

The primary focus of ethical clearance procedures, the patients, appeared less vulnerable than I had assumed. Since the hospital serves a generally materially impoverished clientele, and the mothers of recipients are there only because their babies are critically ill, I was worried about the potential intrusion the interviews with the mothers of milk recipients could form to an already over-burdened group. What I encountered was quite different: the interviews seemed appropriate; I spoke to women the day of or close to discharge, and the women I spoke to seemed happy to reflect on their time here, now with this positive outcome and the reward of a healthy baby and home-going so near. These women were not necessarily

representative of the hospital's average recipient mother, but, as described above, there was a larger degree of pre-selection than I had anticipated.

Many people I came across during my fieldwork seemed to assume that I was working in the hospital as a doctor, or at least as a researcher with medical training. I was regularly approached by students, nurses, radiologists, and sometimes even doctors with all kinds of requests involving medical expertise, such as 'are you drawing blood today?' or 'which baby needs the X-ray?' While mostly humorous, these situations did alert me to the fact that most people who could see me and worked alongside me in this space assumed me to have a type of knowledge or expertise that I did not possess. On the basis of that assumed expertise I was put in a particular position within the existing hierarchies, awarding me access to people and resources in this strictly ordered space that the people I was working with often did not. Being a young white woman (the majority of especially younger doctors were women) and casual dress, as well as the position and activities I normally occupied (standing and writing in the middle of the rooms) served as indicators of status corresponding to doctors'. To offset these assumptions, I regularly reminded people I was a researcher.

On several occasions I was invited to look at patients' folders, and I was assured that this was part of the permission I had been granted, although I do not know what procedures for parent/guardian consent had been undertaken.

### **Introducing the Participants**

During the donor interviews, I was usually greeted by a woman with a baby on her hip. Maureen<sup>9</sup>, an accountant, was the first I interviewed at her home high up the mountain in Oranjezicht, her daughter playing in the next room and her three month-old baby asleep upstairs (see table 1). Next I spoke to Tania, who ran a play school and received me in an equally impressive home in Gardens, scattered with toys. She proudly showed me her blue-eyed baby of almost a year at the end of our conversation. I drove out in the opposite direction to meet Salma in Rylands, where I was so enthusiastically greeted by her three children that it was hard to turn away from playtime to talk to their mother. She was a chartered accountant. Lara, a postdoctoral fellow at Stellenbosch University, was pregnant with her second child when I met her in her home in Claremont. Summer, a speech and swallowing therapist, moved to Cape Town from the United States a few years ago, and I met her at their farm in Wetton, their living room lined with miniature John Deere models.

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<sup>9</sup> All donor names are pseudonyms.

Precious, from Botswana, and her German partner welcomed me into their flat in Kenilworth. She was a neonatal nurse and a research coordinator. I talked to Stella, a dietician, in her beautifully colour-coordinated home in Tamboerskloof, she nursing her son while her daughter did a puzzle on the coffee table and their dog lay at our feet. Tina, from the UK and herself involved in research on breastfeeding, talked to me in her house in Rondebosch, her son of nine months playing on the floor. Naomi, an energetic redhead, met me in her Kenilworth home on a sweltering December day. My final interview was with grade five teacher Amelie in Tokai, the ‘newest’ donor of all with her first child only three months old at the time.

<b>Name</b>	<b>Occupation</b>	<b>Number of children</b>	<b>Age of children</b>	<b>Length of donation</b>
Maureen	Accountant	2	2.5 years 3 months	8 months 3 months
Tania	Leading play group	2	3 years 11 months	4 months 8 months
Salma	Chartered accountant	3	7 years 3 years 11 months	15 months 11 months
Lara	Post-doc fellow and lecturer	1	3.5 years	2 years 3 months
Summer	Speech and swallowing specialist	3	4 years 2 years 7 months	15 months 11 months 7 months
Precious	Midwife, NICU nurse and research coordinator	1	8 months	4 months
Stella	Dietician	2	2 years 4 months	3.5 months
Tina	Nurse and researcher	1	9 months	Unknown
Naomi	Unknown	1	7 months	Unknown
Amelie	Grade 5 teacher	1	4.5 months	1 month
Nuraan	No formal occupation	1	3 weeks	1 week

*Table 1: Breast milk donors interviewed between November and December 2014. All except Lara were breastfeeding at the time. Number of children, age and length of donation at the time of interview. All names are pseudonyms.*

The milk bank staff played an important role in my research from the start. They welcomed my supervisor and me a year before fieldwork would start to talk about the project, and their enthusiasm from the very beginning was invaluable, as was their support

throughout. The milk bank’s current director is Lisa Derman, who is from the UK and has a MA in paediatric nursing as well as in Public Health (see table 2). She is supported by Kelly Anderson, a dietician, who also functions as a manager and treasurer, and Poppy Ncawbe, who carries out daily tasks ensuring the smooth running of the milk bank. The three of them run the milk bank on a day-to-day basis. The staff operated from a cosy office in the hospital amidst breast pumps and promotional materials. There were desks with computers against the wall where Lisa, Kelly and Poppy sat most of the time, sending emails and making phone calls at high speed to oversee the process of delivering milk to about forty premature infants every day, and at the same time keeping track of donations.

<b>name</b>	<b>position</b>	<b>education</b>
Lisa	Director	Paediatric nurse, lactation consultant, MA public health
Kelly	Office manager	Dietetics
Barbara	Public relations	Nurse, midwife and lactation consultant
Poppy	Administrative officer	Student
Ulrike	Processing officer	General Assistant

Table 2: The milk bank Staff featured in fieldwork. All pseudonyms.

The milk kitchen was my first port of call during fieldwork. There was Lea, the supervisor, with her round, friendly face (see table 3). Doris was the eldest there and just a few months shy of her retirement. In the last weeks of my research she was transferred to the neonatal unit, because she was trained as a nurse. The other women working in the milk kitchen were ‘general assistants’. Ulrike was employed by the milk bank, but spent almost all her time in the milk kitchen, pasteurising diligently for both the milk bank and the hospital. The milk kitchen consisted of a small office, a room with two industrial size freezers and one industrial size fridge, and a room with work surfaces along each side where the feeds were mixed, measured and labelled. This room also contained the pasteuriser and the autoclave<sup>10</sup>, and is where the work of the milk kitchen took place. The whole room was kept sterile, requiring everyone inside to wear sterilised gowns, hairnets, masks and gloves.

The next group of participants is harder to define. The neonatal unit in the hospital was full of people who moved in and out. Doctors and nurses rotated according to different schedules, patients came and went, and after two months I still did not fully understand the

<sup>10</sup> A machine used for sterilising medical equipment by treating it with very high temperatures through steam



rhythms of this space. The neonatal unit consisted of a long corridor, with a small reception area followed by the three crucial ‘units’: the Intensive Care Unit 1 and 2 (ICU) first, followed by High Care Unit 1 and 2 (HCU) and finally the Special Care Unit (SPCU). The SPCU and HCU had 24 beds each, in groups of three placed back to back, while the ICU only had fourteen.

Hygiene, order and hierarchy were embodied in the hospitals very architecture, making these ideals tangible and their logic effective past the medical space alone. The neonatal unit and KMC unit<sup>11</sup> were on the top floor of the hospital, and represented the most advanced part of it. The milk kitchen and maternity wards were referred to with a generic ‘downstairs’. The milk kitchen was on the ground floor, edged between administration and the ‘food kitchen’, an indicator of its relatively low status compared to the vital neonatal unit. The tearooms – separate for doctors (overlooking the ICU) and nurses - were also clearly demarcated as private spaces away from most work activities, and not accessible to patients – or researchers. Surveillance and monitoring structured the neonatal unit. All the units had glass walls on at least two sides, the view only interrupted by various medical devices, a visual cacophony of wires and monitors. Each unit had a central ‘counter’ (the ICU had two) used for storage and where nurses and doctors converged to talk, use the computer, make phone calls and write things down on forms or in folders. Often the radio was playing: station Heart FM. Due to the open layout anyone in that room or the adjacent room(s) was always aware of who was there and what they were doing. In a way this was modelled on the panopticon, prioritising surveillance (Foucault 1997: 195).

Each unit had their own nursing staff, although exchanges happened frequently. I will introduce the people who I interacted with and who feature in this thesis, but there were many more who were present during this time. I loosely follow the hierarchical structure in presenting these people<sup>12</sup>. There were a few doctors that acted as informants. While there were many more around, it was often difficult to approach them, because they would primarily visit the units during their ‘rounds’, when they were hard at work and very

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<sup>11</sup> The KMCU was based on the principle of Kangaroo Mother Care, a practice of maintaining skin-to-skin contact with premature or low birth weight infants on the mother’s chest as much as possible, which also includes frequent breastfeeding (see Doyle 1997).

<sup>12</sup> At first I was surprised by the clear display of hierarchies between doctors, between nurses, and within both groups. Nurses’ status was conveyed through their uniforms, and was evident in how they treated one another and what tasks they performed. Ironically, doctors’ higher status was indicated by their lack of a uniform. They usually wore their everyday casual clothes. Another important marker of their status was the stethoscope, hung around each doctor’s neck.

focussed. The most important sources of support were Dr Wilson<sup>13</sup>, head of the neonatal unit and one of the four consultants, and Dr Muller, a paediatrician and consultant. They were both involved in this research from its conception and their enthusiasm for the research was crucial in navigating the hospital space. Dr Taylor and Dr Jansen were the other two consultants. Dr Glover was a senior medical officer whom I interviewed. Dr Taylor and Dr Glover both had young children and tried to donate and donated breastmilk respectively.

<b>Name</b>	<b>Unit</b>	<b>Occupation</b>
Lea	Feedprep	Supervisor
Doris	Feedprep	Nurse
Ulrike	Feedprep	Processing Officer
Dr Wilson	Neonatal Unit	Head Neonatal Unit
Dr Muller	Neonatal Unit	Paediatrician
Dr Jansen	Neonatal Unit	Paediatrician
Dr Taylor	Neonatal Unit	Paediatrician
Dr Glover	Neonatal Unit	Senior Medical Officer
Dr Davies	Neonatal Unit	Medical Officer
Dr Wright	Neonatal Unit	Medical Officer
Sister Thelele	High Care	Nurse
Sister Makhubela	Intensive Care	Nurse
Sister Williams	Intensive Care	Nurse
Sister Locke	High Care	Nurse
Sister Adams	Special Care	Nurse
Sister Abrahams	Intensive Care	Nurse
Sister Annika	Kangaroo Mother Care	Nurse

*Table 3: the hospital Staff featured in fieldwork. All pseudonyms.*

I interacted with many nurses and conducted seven formal, semi-structured interviews. The first was with Sister Thelele<sup>14</sup>, who took me under her wing from the start, letting me follow her as she fed donor milk to the recipient babies present at the time. A week later I managed to sit down with two nurses working in the ICU that day: Sister Makhubela, a young nurse full of energy and smiles, and Sister Williams, a wizened but humourous woman, in charge of the ICU. After a few weeks I befriended Sister Locke, who had always greeted me in a friendly fashion. I also spoke regularly with Sister Annika, who led the Kangaroo Mother Care Unit (KMCU). My last two interviews took place within my final week of fieldwork,

<sup>13</sup> Doctors were typically referred to by hospital staff and patients with their title and last name, but introduced themselves to me with their first names, which is also how they referred to each other. I use the formal mode of address in this thesis.

<sup>14</sup> I use the formal title ‘Sister’ and last names, because this how nurses were referred to and referred to each other consistently (Annika and the Feedprep staff were an exception to this rule).

and were with Sister Adams and Sister Abrahams, both older nurses with many years of experience.

The recipient mothers I interviewed were Beatrice, Petra and Zimasa<sup>15</sup>. These interviews were arranged with the help of sister Annika, who was in charge of the KMCU. This unit occupied a whole corridor on the same floor as the neonatal unit, but was worlds apart from it. It contained the mothers' room, which could house eight mothers who had babies in the neonatal unit, and two KMC rooms, each occupied by eight mothers and their babies who were almost ready to go home. These mothers' stay in the KMC was either because they were waiting for the baby to reach the discharge weight of 1720 grams, or because they were receiving assistance in establishing breastfeeding and caring for their baby.

The first two interviews took place on the day that both Beatrice and Petra were discharged. Beatrice was a mother of four, her other children were eighteen, sixteen, and six, and her youngest had spent 86 days at the hospital, because she was born prematurely. She was a crèche teacher, and she and her husband, a machine operator, lived in Hout Bay. Petra had three girls, the youngest born at Retreat 68 days before the interview after six months of gestation, and the older ones were nine and eighteen years old. She worked at Woolworths and received much support from her husband, while her eldest daughter was attending grade 12 in the Eastern Cape. I talked with Zimasa in the mothers' room, where she was staying. She was from Gugulethu. Zimasa's baby was born about four weeks earlier and had received donor milk for three days just after that, when she was waiting for her milk to come in.

The people I have introduced here feature throughout the thesis and move in and out of the chapters, although the third chapter focuses mainly on the donating women, while chapter four and five look more closely at the hospital staff and the recipient mothers.

## **Outline of the Thesis**

Breast milk is produced in the context of a particular mother and a particular child, and is impacted by the environment<sup>16</sup> – there is a direct relation between outside and inside.

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<sup>15</sup> All recipient mothers opted for pseudonyms. I use informal first names, because this is how they introduced themselves to me.

<sup>16</sup> “Infants receive ‘personalised’ milk from their mother” (Hinde and German 2012: 92). What a mother eats and drinks, as well as how much she sleeps, exercises or how she feels all impact on the constitution of the milk she produces. Additionally, an individual mother's milk changes from feed to feed to address the particular needs of her baby. During breastfeeding there is a vacuum between the baby's mouth and the mother's nipple, resulting in some of the baby's saliva being sucked into the breast, allowing the mammary glands to react and adapt the composition of the milk (see Garbes 2015).

Through the process of donation it is exteriorised and leaves the closed circuit between mouth and breast. The milk moves into a different circuit, a more clinical and technical setting, where it is tested and pasteurised, and eventually it enters new circuit of care. At each nodal point in the trajectory a different set of discourses and practices materialises around the object and change it, in some ways literally and figuratively in others. In the chapters that follow I trace these discourses and practices around saving, securing and sustaining life.

I argue that when breast milk is donated a rhetoric of ‘saving babies’ is employed to obscure reciprocal relations established between donor and milk bank and to deny the establishment of a social tie between donor and recipient. Technologies play a crucial role in aiding the milk’s transformation as it follows its trajectory from donors’ homes into the clinical setting, where it is framed in terms of safety and risk. Care enters into the constellation of relations that the milk ensures in unexpected ways and figures into the ways the milk is distributed in the hospital. Thus, donated breast milk shifts back and forth between being seen as a bodily fluid, food, and medicine as its trajectory takes it through different constellations of saving, motherhood, technologies, care, safety, risk and medical authority. Ultimately, a set of moral decisions converges around donated breast milk and materialises relationships in different ways. The three dimensions of these moral decisions are saving, sustaining and securing, and these are covered in chapter three, four and five.

In chapter two I offer an overview of the literature investigating the theoretical considerations in which this research is anchored. Chapter three focuses on the experience, feelings and attitudes around breast milk donation from donors. The fourth chapter follows the milk into the hospital, and considers how the substance becomes framed in terms of safety and risk as it moves through a series of technological interventions. In chapter five I turn to the donor milk prescription process and discuss how care and particular notions of motherhood influence the medical decision-making around this. The research demonstrates that the milk’s status as a product and potential commodity is always in question as it moves in and out of the moral discourse that surrounds and saturates it.

## Chapter 2

### ‘The Fluid of which Bodies are Composed’: Consubstantiation and the Gift

There is currently a strong international movement promoting breastfeeding worldwide. This position is reflected in South African state policy and official declarations of the World Health Organisation (WHO) and UNICEF. After a decade of promoting the use of formula milk rather than breastmilk, a decision made in the light of the risks of vertical (i.e. mother-to-child) HIV transmission, the South African government re-committed to facilitating breastfeeding in the Tshwane declaration of August 2011 (National Breastfeeding Consultative Meeting, 2011). This was a direct result of the revised guidelines on breastfeeding published by the WHO in 2010 (Doherty et al., 2011), themselves informed by South African research. The hospital is part of the Baby Friendly Hospital Initiative, as implemented by the WHO and Unicef based on the Innocenti Declaration first launched in 1990 (Unicef: 2005). This underpins their commitment to the promotion of breastfeeding through a ten-step plan, including not offering any artificial teats or dummies, or free breast milk alternatives (Unicef: 2005). The recent emergence of several milk banks in South Africa also attests to these developments.

However, the problems surrounding effective distribution of state resources and the public-private distinction in healthcare complicate the picture. South Africa has a highly unequal wealth distribution, limiting access to healthcare for a significant proportion of the population. The public sector faces a lack of resources and overburdened facilities, but nevertheless is in some cases at the forefront of new developments (including the Baby Friendly Hospital Initiative and Kangaroo Mother Care). It is against this backdrop that the entanglement of scientific recommendations, economic calculations and moral imperatives finds its way into the trajectory of the donated breast milk.

## **Breastfeeding and Breast Milk**

My previous research examined breastfeeding among middle-class mothers in Cape Town, and the ways in which women's identities shifted and were reconfigured through a process of embodied learning<sup>17</sup> (Waltz 2013; Waltz 2014). This work has given me an insight in the current debates around breastfeeding (for a comprehensive review of earlier research see also Van Esterik 2002). There has been a steady attention from a feminist angle, posing breastfeeding at the centre of dilemmas around the relation of motherhood and 'formal' labour and self-identity (Bartlett 2002; Bartlett and Giles 2004; Blum 1993; Dykes 2005; Galtry 2003; Hausman 2004). Many others have dealt with moral constructions of motherhood (Crossley 2009; Kukla 2006; Lupton 2000; Marshall, Godfrey and Renfrew 2007; Murphy 1999; Stearns 1999; Taylor and Wallace 2012; Wall 2001) and the place of breastfeeding within this. A few works adopt a historical focus, showing the pendulum-like motions of normative discourse from promoting breastfeeding to formula and back (Baumslag and Michels 1995; Blum 1999; Bryant-Merrill 1987). Some authors have shifted the focus to women's embodied experiences of breastfeeding and subjectivity (Schmied and Lupton 2001; Sutherland 1999). Authors drawing on this line have also related experience to the negotiation of the body, space, identity and self-expression of breastfeeding women (Andrew and Harvey 2011; Avishai 2007; Mahon-Daly and Andrews 2002). Additionally, there is some work on breastfeeding, maternity and sexuality, which argues that the breast's dual potential to be a sexualised object and a symbol of maternity gives rise to public anxieties around breastfeeding and a moralising discourse trying to separate the two (Avery, Duckett, Frantzich 2000; Bartlett 2005; Giles 2002).

While within the domestic context and within the mother-child dyad breastmilk is a complex substance with varying meanings, when removed from that context certain properties become more prominent. Carroll recently found that especially connected to a hospital setting, "the absence of pathogens and the work of the HMB [Human milk bank] had transformed the milk into a highly medicalised, industrial and somewhat uniform product" (2014: 477). This happened through processing of the milk, and allows it to become a legitimised medical object in the neonatal unit (Carroll 2014). In the United States (and in South Africa), it is necessary to obtain informed consent from the parents before administering donated breastmilk, because it is not only administration of food but also of a

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<sup>17</sup> It is important to note that some women do not like breastfeeding – yet there is a moral discourse telling them to. Paradoxically breastfeeding in public is still not widely accepted, leaving many mothers feeling uncomfortable and thereby restricted in their movement while breastfeeding (see Waltz 2013).

bodily fluid of another person (Carroll 2014: 478). She argues that milk donation could be compared to the donation of blood (ibid.). But it is also more than that: neonatologists reposition breastmilk as akin to medicine (Carroll 2014: 479). This is based on symbolic and actual properties, as I will show in chapters four and five.

Despite the normative assumption of a direct and intimate relation between a mother/milk-producer and the infant that consumes breast milk, there are other histories, which include wet-nursing, cross-feeding and surrogacy practices. Wet-nursing historically implied breastfeeding a baby that biogenetically/gestationally belonged to another woman on a contractual and often paid basis (Shaw 2004: 287; Shaw 2007: 442, Thorley 2008: 26). The relation between wet-nurse and the infant's mother was thus usually stratified by class. Cross-nursing refers to feeding another's baby occasionally, and presumes a relationship of equality between the mothers (ibid.). Adoptive or surrogate nursing takes place when a woman feeds an adoptive infant, on a long-term and exclusive basis (ibid.). While all three of these practices challenge the dominant conception of the breastfeeding relationship as an intimate, dyadic practice<sup>18</sup>, donation differs because it removes the physical aspect of nursing from administering milk. The donating mother expresses her milk at home (or in the hospital), has it collected or carries it over to a milk bank and the infant receives it by spoon, cup, syringe or bottle. While the breast milk donor may not be present, this does not automatically mean that she does not experience a sense of relatedness to this person. Carroll found that for many mothers the 'imagined' presence of the donor is keenly felt and that some mothers perceive this to disrupt the 'sanctity' of the normative mother-child dyad (Carroll 2014: 477).

### **The 'Yuk-factor' and Substance**

Addressing literature about the 'yuk-factor' can help in gaining insight in the milk as a bodily fluid and associated ideas of revulsion and the abject. Many people across the western(ised) world express an intuitive repulsion for the idea of cross-nursing or feeding donated breastmilk (Shaw 2004; Thorley 2008). Even breastfeeding one's own infant (especially in public) can be subjected to a strong condemning moral discourse (Mahon-Daley and Andrews 2002). Breast milk as a substance is highly valued but also seen as contaminating, transgressive, 'dirty', especially in a medical context, where it is a potential bearer of pathogens (Carroll 2014), but also in a social context, particularly among women and men

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<sup>18</sup> While this can be seen as the normative or favoured conception of breastfeeding, it mostly speaks to middle and upper-class practices and excludes many other breastfeeding arrangements from view.

upholding a western, middle-class model of parenting privileging biogenetic parenthood (Shaw 2004). The normative direction for breastmilk is perceived to be from the mother to her 'own' baby, and concerns arise when this direction changes (Carroll 2014: 468; Shaw 2007: 440). Rhonda Shaw has captured an important aspect of this repulsion in her work on cross-nursing:

Because cross-nursing arrangements challenge the limits of the private mother/child bond or relationship, and the corresponding moral requirement that a mother's work be done in isolation from other women, they expose – among other things - the ethos of motherhood that underpins dominant (racialised and class-based) ideologies of the family in Western culture (2004: 288).

This can be traced back to more fundamental theoretical statements on 'dirt' and 'the abject.' Elizabeth Grosz draws on Julia Kristeva's work when defining the abject: "The abject is what of the body falls away from it while remaining irreducible to the subject/object and inside/outside oppositions" (1994: 192). Drawing on Mary Douglas, bodily fluids can be seen as 'dangerous', marginal stuff that crosses the boundaries of the body, and upsets order or categories (Douglas 1970: 145). Associated are fears of infection and contamination. Yet nothing in itself is dirty – it is only regarded as disrupting or disturbing depending on the context (Grosz 1994: 192). Grosz extends these notions by inquiring the hierarchy or order of propriety in these bodily fluids and their different indices of control, disgust, and revulsion, as culture intervenes in the constitution of the value of the body (1994: 195). She argues that especially women's bodies in contemporary Western discourse are inscribed as a mode of seepage – leaking, uncontrollable and lacking self-containment (Grosz 1994: 203).

Breastmilk seems to be ambiguous, as it can be constructed both as 'sacred' or as contaminating/contaminated. An example can be found in the debate around breastfeeding and HIV transmission. Until recently, HIV positive mothers were discouraged from breastfeeding because the HI virus can be transmitted through breastmilk. That is, breastmilk was seen as contaminating. Now research has shown that it is safer for HIV positive women to breastfeed than mix-feed or bottle feed babies, and so they are encouraged to breastfeed exclusively; their milk is now seen as 'clean' and even as capable of preventing HIV transmission (Doherty et al. 2011; Stromberg 2013). In the space of less than a decade, milk has moved, conceptually, from being a contaminant to being clean and even a protective agent.



Breastmilk as a bodily fluid that crosses and blurs the boundaries between mother and child thus has the potential to challenge these categories and the fundamental ideas around an individual in a bounded body. Yet this ‘danger’ is relatively contained in the sanctified mother-child dyad. When breastmilk moves beyond this private relationship the factor of repulsion can be enhanced. Class is a factor in how milk is thought of, as this depends on a particular constitution of the body, where the milk outside of the body becomes a generic entity.

In South Africa, the flow of milk across social categories could prove an especially salient aspect, since research has shown that donors are mainly from the middle and upper classes, relatively wealthy, married and highly educated women (Bolton 2012). (However, this is not always the case: part of Milk Matter’s supply comes from women in the hospital who are nursing). In the context of the hospital, recipients are typically from a lower socioeconomic background. Taking into account the divisions in South African society with class and race often intersecting, breastmilk crosses a range of socially constructed categories, race and social class among them. Taking Douglas’ (1970) work into account, the milk’s crossing of such categories could contribute to its status as abject or repulsive. The fact that there is no conscious body-to-body contact between the donating mother and the receiving baby seems to allow space for a process of sanitisation and medicalisation that neutralises the perceived polluting qualities of breastmilk.

### **Donation**

Theory around ‘the gift’ can be used to analyse themes like alienation, reciprocity, altruism, benevolence and reception. Theoretical work around the gift originates in Mauss’ famous essay (Mauss 2011: vi). Mauss suggests that contrary to the idea that a gift has no entailments, it carries a strong moral/ethical charge – the obligation to return a gift (at some point). So, far from being disinterested, gifts are the foundation of the social because they weld people together in webs of reciprocal relations. According to an extensive review by David Graeber, Mauss defined giving a gift as transferring something without any immediate return, or guarantee that there will ever be one – and this is where morality enters (2001: 225). In some cases the gift can be seen as to partake something of the personality of the giver (Graeber 2001: 154).

When thinking about breast milk donation in relation to the gift, recognising it as a substance is critical. Carsten’s discussion of the term is useful as she argues that the promise

of substance as an analytic term in kinship studies lies in its flexibility and its capacity to express ‘transformability’ (Carsten 2004: 116, 149):

Substance, as we saw, can denote a separate thing (such as a person or body part); it can denote a vital part or essence of that thing or person; and it can also denote corporeal matter more generally, the tissue or fluid of which bodies are composed. This conflation becomes particularly critical when it is precisely the relation between persons – the discreteness or relative permeability of persons, the flows of bodily fluids, the exchanges of corporeal matter – that is at issue. (Carsten 2004:120-121)

The transformability that invoking substance opens up space for is precisely what makes it a useful concept in the study of the donation trajectory. In the case of a gift we see the conflation between ‘thing’ and ‘essence’ or ‘personhood’ regardless of the definition of this particular term, indicating that the gifting of a bodily substance has a double potential of transferring something of the giver (and upsetting bounded categories).

The gift enters medical anthropology in the literature around organ donation. Rhonda Shaw has noted that in the case of organ donation invoking the ‘gift relation’ is part of a positivist discourse based on a moral model that frames donation as noble and a morally worthy act, and distances it from commercial interests and commodification (2010). The other side of this is that it can be considered morally ‘wrong’ to capitalise on a ‘sacred’ bodily fluid like breastmilk (Shaw 2007: 444). Framing donation in terms of altruism or charity is also a way of depoliticising the exchange relation (ibid.).

Yet when milk banks started to emerge in the United States the milk was regarded as ‘merchandise’ and women were paid for supplying their milk (Golden 1996: 79). The milk was distributed for free, and the milk banks usually subsided on donations of charitable organisations (ibid.). The question of ‘charity’ slips in in a different form here: it was considered an act of altruism to pay lower class women for their milk (ibid.). It was by the 1950s that breast milk’s position in the US shifted from a commodity to a ‘sacred’ substance, as the focus shifted from mothers’ needs to those of babies during the recasting of motherhood in the baby-boom era<sup>19</sup> (Golden 1996: 81-83). During this time well-off mothers became the regular suppliers of milk banks (Golden 1996: 85).

Presently, this is a site of contestation, as the sale of breast milk appears to be on the rise (Steele et al. 2015). Recently websites such as the UK-based ‘onlythebreast.com’ have

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<sup>19</sup> After World War II in the US the educated woman who made motherhood a career, professionalizing homemaking, was increasingly celebrated (Golden 1996: 84).

attracted attention from academics and the public, with health care experts issuing warnings against the ‘risk’ of buying unscreened breast milk from private sellers (Weaver 2015; Steele et al. 2015). This raises the question to what extent breast milk can be seen as a commodity and how donation influences that. Appadurai (1986) comprehensively touches on the ambiguous status of commodities. According to a strict, Marxist definition, a commodity is “a product intended principally for exchange, and such products emerge, by definition, in the institutional, psychological and economic conditions of capitalism” (Appadurai, 1986: 6). However, he contends that many less ‘purist’ definitions regard commodities as “goods intended for exchange, regardless of the form of exchange” (ibid.). This renders unclear the distinction between commodity and gift. Appadurai concludes that commodities do have a particular type of social potential that makes them distinguishable from products, objects, goods, and artefacts, but only in certain respects and from a particular perspective (ibid.).

Breast milk can be considered *more or less* commoditised in light of this definition. Looking more closely at its ‘social potential’ may offer more clarity. Anna Tsing (2013) has provided an interesting take on the commodity-gift dilemma by arguing that even within a capitalist system these are never separate, and that the creation of value in capitalist systems relies on gifts. Tsing (2013) argues that the commodity form is never fully settled – or at least not right until the end of the commodity chain, so that its status as gift/commodity/thing/something else is dependent on the context and not on the object per se. She shows that objects in a commodity chain can move in and out of being commodity or gift.

While Tsing uses mushrooms in her example, similarly donated milk’s status as an object is always in need of stabilisation, and this includes stabilising against the possibilities of it becoming a fully capitalist commodity – which would be immoral and illegal. Discourses stabilised the object – the language of ‘saving babies’ stabilised a bodily fluid with potential yuk-factor into a positive entity, and materialised the object as something not disgusting. In the hospital the revulsion factor returned, but again there was a set of practices that stabilised and literally changed its composition, but also produced a language that secured it as a medical object. This also happened in relations of care: the milk was simply administered in a way, but there was an implicit moral discourse. The intrinsically ambiguous status of the milk was always in question. Concrete sets of discourse and practices served to stabilise the milk as a particular kind of thing and not another with moral underpinnings.

## Chapter 3

# ‘My baby comes first’: Breast Milk Donation, Saving Babies, and the Good Mother

“It is a bit of a schlep!” Stella exclaimed after describing her breast milk expressing and storing routine for me. Yet, like other donors, she was deeply committed to donating breast milk and ‘saving lives’. One of my most burning questions when starting this research was why donors donate. While lacking personal experience with infant nursing, I had done my honours research on experiences of breastfeeding among middle-class women in Cape Town, and it was clear that breastfeeding was decidedly not as easy as it seemed. Taking the time to express and donate while also feeding and caring for a baby seemed like a lot to take on. Why go to that trouble?

Here, I turn to the donors of the milk and look more closely at their motivations for providing milk to the milk bank, which is one of the nexus points of this research. I argue that breast milk donation in the South African context rests on notions of ‘saving babies,’ and that this generated an affective economy that in turn both generates and obscures the exchange that the act of donating milk is imbued with. While donation seems like a completely altruistic act – there is no compensation and no relation – many donors actually experienced a reciprocal relationship with the milk bank, the first of a circuit of exchanges that the milk was part of. This is followed by a discussion of how the milk recipients are imagined by these donating women, which leads to a discussion notions of ‘saving’ and their role in affective economies. Finally, I turn to a paradox between saving babies and notions of what it means to be a ‘good’ mother. The chapter argues that there is a tension between ‘saving babies’ and a model of parenthood expecting mothers to ‘put their own baby first’.

### **What Motivates Breast Milk Donors?**

Not surprisingly, I received a range of answers to this question, and not without contradictions. Some seemed simple: as Maureen illustrated, many donors had excess milk that they were reluctant to throw away. Precious told me: “There was a surplus, it was always

full in the freezer. And then one day, it just clicked in my mind that I could donate”. Maureen heard a story about a breastfeeding woman who expressed in the shower so that her excess milk would be washed away and go straight down the drain. It baffled her how someone could do that: “it only takes five minutes to express and it doesn’t cost anything!” Summer would agree. She started donating after filling up a chest freezer full of milk while her premature son was in the hospital, leaving no space for her husband to freeze the meat. When I asked her if she had considered disposing of the milk in another way, she exclaimed “of course not! It’s liquid gold! There is no way I am going to throw it away!”

These anecdotes echoed the perceived value of expressed milk. Similar statements can be found in a range of testimonies published on the milk bank’s website. This substance was seen as precious, extremely valuable, almost sacred, and a range of properties was attributed to it. A doctor in the ICU explained: “where I come from, milk is gold”. As Stella put it: “to me breastmilk is a miracle, food that the Lord made, and I know that the babies basically die if they don’t get it”. None of these women thought of formula as an alternative for breastmilk, as Lara illustrated: “In terms of nutrition, the milk will change according to what the baby needs. What formula can do that?” referring to the milk’s capacity to change in relation to demand<sup>20</sup>. Yet, as I show in chapter four, the milk is represented in the hospital as a uniform entity. As discussed in chapter two, when it comes to value anthropology usually distinguishes between a gift or commodity exchange in this regard. As Anna Tsing explains “they thus animate different systems of value: Value in a commodity system is in things for use and exchange. Value in a gift system is in social obligations, connections, and gaps” (2013: 22). How does donation fit into this?

When expressed milk was attributed such value, this had a profound impact on what it meant to donate. As Stella said: “I can save a lot of babies through donating milk.” Many women seemed to feel motivated to donate through these notions of ‘saving’ –saving it from being wasted and saving a life. What motivated Maureen to keep donating was “the knowledge that you are helping”. She figured that if she had enough milk, why would she not give some away? “It is something I can give back”. She started donating right after her milk came in. Stella said: “I just feel like I am so privileged to have this [milk], I give other children a second chance to live, I give them a good start”. Salma said that “there is great reward in doing something selflessly”. She felt motivated by religious ideas: “There is something very beautiful in religion: If you save one life, you save humanity”.

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<sup>20</sup> Nevertheless doctors commented that any donated breast milk was better than formula.

Some women had a different take on this. Summer downplayed her role as a donor: “I never sit and dream about these wonderful deeds I’m doing. I don’t sit here and think I’m a hero”. Salma also mitigated her statement somewhat: “When I say ‘saving lives’ I am kind of overdramatising. But it is significant, nutrition is a very important contribution if not saving lives directly”. By saying “it is like with old clothes, when you are in position to help someone who needs something,” Maureen stressed that excess breastmilk is something she did not need, that had no value for her and can therefore easily be passed. In her opinion, donation did not ‘take anything’ from the donor. This gives rise to the puzzling situation of giving back without being taken from. It also shows how the value of breast milk is minimised in one context while highlighted in others.

Maureen’s comparison between breastmilk and ‘old clothes’ draws on an especially salient trope in the South African context. It is an ubiquitous experience of the mainly white upper and middle classes to have people of less financial means ask for ‘old clothes’, a strong reminder of the gaping inequalities in South Africa that exposes in many instances the racialised dimension of said inequalities. By likening breastmilk to this, Maureen is making a statement of the perceived socioeconomic and racial difference between her and the milk recipients.

The milk is seen as excess here – a product that is considered surplus to need. As milk production increases with stimulation (i.e. ‘need’), the women were actively creating an alienable surplus. This surplus is simultaneously abject and valuable. It is a waste product, yet it has value; it is abject, yet it has potential. As an object it is ambiguous and semiotically unstable. The work that happens around it when it is donated is not only about removing pathogens and ensuring hygiene, but also about stabilising the object.

Precious’s response stood out, as she was the only one who directly tied donating to notions of care. To her this was something she had taken with her from her home country Botswana: “At home we have this thing that ‘sharing is caring’, so the fact that you care for someone is what keeps me donating, because life is all about caring and sharing love”. There is a subtle difference in the implications of sharing compared to ‘giving back’. Sharing invokes a collectivity based on mutuality, as it implies that you keep something for yourself too. Through this logic the value of what is shared is acknowledged. In both instances a power structure is at play between excess, distribution and need, but the notion of sharing seems to restore a degree of balance, while the colloquial expression of ‘giving back’ has a particular association of privilege and hierarchy.

For some women, concrete reminders of their donations seemed an important aspect of its continuation. When Maureen stopped breastfeeding her first baby she received a card from the milk bank saying how many litres she had donated: “It was very nice to get a result back”. As I show in chapter five this part of circuit of exchange. There is a process that links anonymised donors to a product that is produced so specifically, yet given to a baby they never see, resulting in a peculiar intimacy that is also anonymous. A particular substance that is intimate and specific moves through a generalisable circuit, yet in the imagination remains a relation between one mother and a child. Lara commented on this: “I think the fact that they can actually trace your donations was really special”. She enjoyed hearing more about the receiving babies through the milk bank: “They wrote a little story and that really made a personal impact. It definitely helped to make it more real, put a face to a number”.

Many women, including Lara, cherished the connection with the milk bank staff and relied on them for support and advice:

What really made me think it is the right thing to do was the people at the milk bank. They were just so caring and so nurturing, the one girl would actually come past my house and catch up and have her cooler bag and off she would go. They are passionate about milk and if I had any questions, like if I had problems with my breast pump, they would give me great advice.

These stories seem to illustrate Stella’s contradictory claim that “the more you give the more you receive back. I just love being able to give something that nobody actually can repay you for”. These ideas of ‘getting back’ point to a model of reciprocity that may not be the same as Precious’ notion of sharing, in which the milk bank’ exchange of ‘results’ and support for milk is important in continuing the donating relationship.

Many women in my sample also reported that their personal experience with premature babies, whether professionally or their own, strongly influenced their decision to donate. As Precious put it: “As a neonatal nurse I have given donor milk to the prematures and the sick babies and those that had lost their mothers, so it seemed a natural thing, because I know the benefits of breastmilk”. Her discourse of donation shifts here from sharing to a more medical interpretation, where value is invested scientifically. Stella had a similar motivation: “I’m passionate about babies, I really love infants, being a dietician, working with HIV, to me it’s just such a privilege for my children to be able to have my breast milk, and donating is an important thing to do”. Summer had experience with the importance of breast milk both as a speech and swallowing therapist and as the mother of a baby born at 25 weeks:

My profession made a big difference in my decision to donate, because I was well aware of the importance of breastmilk, I know what NEC<sup>21</sup> is ... And having a premie... when I was in ICU with him all the moms were able to express for their own babies. I knew the importance of it and I knew what would happen if they didn't get that, so that's one of the reasons why I continued to donate, because I knew it would make a difference.

Lara, who experienced complications with the birth of her son, added: "It definitely has to do with having had a baby in the ICU, seeing those tiny little prems".

Eight out of eleven women I interviewed had either professional experience with donor milk or a baby that had been in the ICU, an indication that women with such experiences may be more inclined to donate. A more systematic analysis is needed to fully substantiate this claim. Another point it raises is the methods of selection that occurred. The milk bank' staff did report they especially selected 'better donors' for interviews. These better donors seemed to be women who not only donated plenty of milk, but who also expressed their dedication to donating to the milk bank. The claim made here may be merely based on a bias on the sample, because women with previous experience with donor milk may be more articulate about their dedication to donor milk and thus more likely to be selected for interviews. Given that the focus is on meaning-making, the potential skewing of the sample does not negatively affect findings; in fact it illuminates more strongly a set of patterns that others have found to hold in different contexts.

Donating women did not meet the recipients of their milk, but nevertheless they pictured a direct relationship between their specific milk and a receiving infant, rather than the generalised product their milk would become. Given that donating women felt motivated to do so because they felt they are 'making a difference' or 'saving lives', I explored how they imagine the recipients.

### **'State Babies': Imagining the Milk Recipients**

Like their motivation to donate, many donors' understanding of the milk recipients was grounded in their professional experience. Stella said: "Because I worked with the premies I know exactly what they look like". Summer: "I don't actually ever think about where the milk goes. I worked at Groote Schuur and Red Cross, so I was familiar with state hospitals and state babies and a lot of the milk I donate will obviously go to state hospitals". Some donors seemed vaguely aware that the milk bank also supplied private hospitals, yet the general assumption seemed to be that the milk was given to 'poor' babies. Like many donors,

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<sup>21</sup> Necrotising enterocolitis: A lethal digestion problem in infants (see Neu and Walker 2011)



Summer claimed that she never thought about where her milk is going, yet she described a specific scenario, coining the term ‘state babies’. Invoking this category was a nod towards the public-private health care divide in South Africa, where public hospitals cater predominantly to a financially impoverished population.

Precious touched on another aspect: “You don’t want to think about some babies lying there and you know their mom is no more”. The notions of death and abandonment was a strongly emerging theme in my conversations with donating moms. Many of them made reference to the recipient babies as motherless, having absent mothers for mostly unspecified reasons. For example, Lara explained: “I had a little hospital tour, where you could see where the milk was going. Seeing these tiny little things, and abandoned babies as well took away all my doubt about donating”.

For some donors images of death and abandonment seemed to be an allusion to class and race. Maureen pictured a premature baby who needs milk to grow and survive. She added: “It doesn’t matter what race. Just a tiny little baby who for some reason doesn’t have access to breastmilk and who needs me to survive”. She commented: “It doesn’t matter what baby the milk goes to, regardless of the circumstances or the situation, like when babies are found in dumpsters. I am not judging whoever these babies belong to”. Her tone was full of pity, and she implied a connection between babies’ unfavourable circumstances and racialised categories.

Maureen returned to this matter, saying that the quality of the milk does not depend on race, and when the milk bank is happy to give the milk to someone she is happy, thus seemingly indicating her initial doubts around her ‘white’ milk potentially going to black babies. She stated: “I don’t think that a black lady would necessarily be better at providing milk, but I don’t think that my milk is better either”, making a complicated statement in which her unprovoked denial of race seems to indicate the ambiguity of substance in relation to racialised categories.

The mothers of recipient babies were consistently imagined as insufficient and incompetent. Lara made a link between abandonment and ‘issues’ the mothers might have faced:

Having seen some abandoned babies, which I found so, so sad, and also the whole government lack of education around HIV, like moms must feed or mustn’t feed, or exclusively, and all of those dramas, I think that has also done a lot of damage to the benefits of breastmilk.

She also stated that: “It [donated breastmilk] is not going to the private people with money, it is going to anyone who needs it”, extending the public/private health care distinction to define socioeconomic standing, in which the milk recipients are labelled as ‘needing’. Stella invoked similar notions of lack, here in relation to education and material and social resources:

As a dietician I’ve worked with the mothers as well, usually it’s just the mothers. They need to express, and it’s difficult and they don’t have proper breast pumps, and they all sip the cold drink, Stoney, because they believe it makes more milk. They’re usually very poor, and they usually don’t have a lot of support from other members of the family with them or supporting them.

Summer’s reply stood out for the nuanced perception of recipient babies and their families:

There are a lot of babies in the ICUs in state hospitals, and the family can care, but they have a hard life, they live in a township, they don’t have electricity or running water, they have other kids, they can’t just quickly go to the hospital and feed their babies, express for their babies, and they don’t have the means to store their milk.

She also addressed the gap between this point of view and the most commonly expressed ‘abandoned babies’ theme:

A lot of people visit there and say ‘oh shame these poor children’ and they’re all like ‘ag’ and I *know* the mom of that baby and she can’t come because she has no money to get here until payday comes at the end of the month! It is not that she doesn’t *want* to be here, it’s that she *cannot* be here.

This leads her to a crucial insight: “So I kind of think of it that way, you are helping a baby in need, and hopefully you’re helping the parents as well, just to get by until they can do it themselves”.

In later stages of my research, I found that this is exactly what the staff of the milk bank and the doctors working in the neonatal unit envision donation ideally to entail: to provide support to the *parents* of premature, sick or low birth weight babies. Donated breastmilk was often seen as a means to bridge the period that the babies’ mother may need to start expressing or breastfeeding herself, or as a temporary solution when the mother did not have the means to travel to the hospital regularly enough to provide breastmilk when there was no in-house bed available for her. It can take some time before a mother is able to breastfeed or express breastmilk, especially when babies are too sick or too young to suck or

after a Caesarian-section birth<sup>22</sup>. Another complication affecting HIV positive mothers is that they needed to have at least 50 ml of breastmilk before nurses at the hospital could pasteurise it and feed it to their babies<sup>23</sup>. To get to this quantity might take some time, especially in the aforementioned circumstances. This support to parents stood in contrast to most donors, who seemed to focus almost exclusively on helping *babies*. This focus was so strong that it often eclipsed the existence of the mothers entirely. It generated an affective economy that turned on the figure of the abandoned baby.

### **Affective Economies: Saving Abandoned Babies**

Statements that donation ‘makes a difference’ or ‘saves lives’ had a common rhetoric of salvation, mostly grounded in notions of hierarchy and difference. Euphemisms were employed to obscure the difference between the donating mothers and the receiving, yet most donors were aware of this gap. For example, by referring to the mothers of recipients as ‘not average income mothers’, as Salma did, a normalisation process took place in which relative wealth is made the norm, and poverty the deviation. This is a reversal of the actual situation in South Africa<sup>24</sup>. In fact, it is the donating mothers who generally are ‘not average income’.

Compared to wider trends of the donation of bodily substances, most notably organs, breastmilk followed an inverse trajectory. Instead of the usual poor-to-rich and south-to-north ‘flows’, it is mainly affluent women donating and babies born in impoverished conditions receiving. Not only is this the opposite of the dominant trend (see Scheper-Hughes 2003: 1645), it is also a marked deviation from histories of milk sharing such as wet nursing (Shaw 2007). In many Western countries breastfeeding is now most prevalent among the middle classes (Golden 1996); a sign of privilege rather than vulnerability. Here, breast milk donation takes on new dimensions.

To some extent the images of the recipient babies in need of saving were provided by the milk bank. Lisa told me that they are looking for an ‘emotional response’ through their

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<sup>22</sup> After birth by Caesarean section breastfeeding can be more difficult, because of the scar and trauma (see Rowe-Murray and Fisher 2002).

<sup>23</sup> HIV+ mothers were encouraged to breastfeed their babies and to ‘flash’-pasteurise their milk to kill the HI virus. This form of pasteurization happened by briefly inserting jars of milk in boiling water in the kitchen in the KMC unit. The HIV+ milk was not pasteurised in the milk kitchen to avoid contamination of the other milk.

<sup>24</sup> In South Africa a very small percentage of the population lives in affluence, while the vast majority faces much more impoverished circumstances. With a Gini-coefficient (measurement of deviation from equal distribution of wealth) of 65 South Africa is the most unequal society in the world, in spite of being relatively wealthy (World Bank).

marketing<sup>25</sup>, because they believe that to be the most effective strategy to attract new donors. For example, their Facebook page is a conscious mix of breastfeeding tips, news items and research relating to breast milk, and a platform to encourage donation, interspersed with tags like #breastfeedingtips and #wonderfulbreastmilk. They aimed for this emotional response through what they described as ‘emotive pictures’, by showing very small, premature babies. Sometimes this included captions mentioning abandonment, and vulnerability was usually stressed. They further used their newsletter and their website to share information on breastfeeding and provide support to breastfeeding mothers. Research indicates that milk bank’s promotional materials can be quite effective in influencing donor’s motivations (Brierley 2014).

Dr Muller, a paediatrician at the hospital and serving as a medical adviser on the milk bank’s board, referred to these strategies as aiming for a ‘womb quiver’ or a ‘let-down reflex’. This spoke to the gendered assumptions behind them. To make an emotional appeal to women to convince them to donate was first of all an indicator that rationalising donation is not a productive strategy; that donation fell outside a utilitarian, economic form of reasoning for donors. What was left was an appeal to an embodied response, drawing on a strongly emotional identification, itself produced through birthing experiences. Yet the milk bank may see a sense of charity, which is somehow more likely to succeed by drawing on a moral discourse that presents those ‘in need’ with emphasised neediness – infantilising the infant. Most donors referred to the recipients of their milk as ‘tiny little babies’, the double diminutive strongly indicating helplessness, dependency and vulnerability.

Of course, premature and low birth weight babies (indeed, all newborns) *are* helpless, dependent and vulnerable. It seems hard to look at a baby of 0.6 kg and expect not to feel an emotional response. Yet after spending some time in the neonatal unit I began to see that those are not the only characteristics of these admittedly tiny humans. Many of them display great determination, force, and strength considering the circumstances, and many continued to grow and get better in spite of all kinds of adversity. Watching a baby of less than 2 kg, eyes barely open, clasp both its hands around a cup of milk and gulping it down was not an image of helplessness to me. That these babies’ behaviour and appearance is so regularly ‘read’ as helpless in order to invite help is part of a particular approach to what donation might mean, and a broader conception of the infant as powerless (see Lancy 2008).

This emotive strategy employed by the milk bank situated their donation campaigns

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<sup>25</sup> The main marketing strategies made use of the milk bank’s Facebook page, their newsletter and their website. Additionally they organised several events throughout the year to raise awareness and/or funds.

in an affective economy. Buchbinder and Timmermans (2013) have described how affect can be deployed toward political ends, particularly around ‘saving babies’. They define affective economies as “*systems of exchange in which people enact and elicit emotional responses for social and political ends, such that affect comes to serve as its own currency and yield its own profits and costs*” (Buchbinder & Timmermans 2013: 104, italics in original). Affective economies draw on widely shared sentiments, create specific, agentive audiences and creatively deploy cultural authority (ibid.: 107). The milk bank did this through drawing on widely held anxieties around ‘saving babies’ (i.e. babies in dumpster, abandonment, illness), by creating a particular audience of breastfeeding mother that has a capacity to act, and by drawing on scientific studies and news articles based on these shared through their Facebook page to demonstrate the authority and legitimacy of their claims. Science is used to elicit a rationalist response, but an affective one. Emotive responses are not only produced and given meaning through emotive institutions, but also generate a type of currency that is transferable to a wide range of contexts (ibid: 105). In this case, the emotive response to the idea of abandoned, vulnerable babies led to an exchange of breast milk through donation.

The effect draws on ‘tiny little babies’ as a ‘safe’ trope to ‘save’. Denied, obscured, and ignored is the connection between these tiny little babies, inequality and an ongoing history of structural violence and exclusionary political economy. Babies are seen as innocent and free from blame, unlike their mothers (see Caplan and Hall-McCorquodale 1985 and Jackson and Mannix 2004). This runs counter to the milk bank’ and medical professionals’ ideas that you are actually helping the mother by donating. Both ‘saving’ and ‘salvation’ as well as ‘innocence’ have strong Christian and colonial connotations and draw on stereotypes of the ‘needy’. Thus there is a double symbolism at work that grounds donation in both of these practices.

Lila Abu-Lughod critically interrogates issues of women, cultural relativism and difference (2002: 787). She argues that a culturalist approach to difference obscures the political and historical factors at work in its establishment (ibid.). She also points out the patronising quality of the rhetoric of saving (Abu-Lughod 2002: 789). It shows how certain categories of people are regarded as points of intervention in this liberal constitution of the subject. The infantilisation of infants is an expression of this, as are the images/imaginings of abandonment. Abu-Lughod points out that ‘saving’ implies not only saving from, but also saving *to*<sup>26</sup>, and the

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<sup>26</sup> In the case of Abu-Lughod’s article this is saving Muslim women *from* Islamic patriarchal oppression *to*

assumed superiority of the latter (2002: 788-789). In the context of breast milk donation, the ‘saving to’ is not simply assumed – it takes the form of a health outcome that has been scientifically documented (Hinde and German 2012). Breast milk as a bodily fluid has associations with imparting essence or personhood (Carsten 2004) or ‘making a person’ (Waltz 2013). ‘Saving’ in this particular context is not only about a discourse that re-instates hierarchies in a highly unequal society: the consubstantiation that the sharing of breast milk could potentially imply is denied through negating the mutuality in the act of donation, by making it one-way, by erasing the direct social tie that results from the gift between donor and baby. This way ‘saving’ functions to counter-balance the subversive or repulsive associations with sharing milk outside the mother-child dyad, because these potentially abject qualities are encompassed in the sacred.

### **Good/bad mother: does doing a ‘good thing’ make a ‘good mother’?**

Breastmilk donation was constructed as a charitable act, a selfless activity to help others (in spite of the fact that donors in this sample seem to have a sense of ‘getting back’ as well). I suggest that this activity was imagined as directed at a baby, but included a circuit of exchanges. However, there is a paradox between this discourse and local idealised models of motherhood, in which being a ‘good’ mother meant an exclusive, private breastfeeding relationship and a form of devotion to the child that borders on self-sacrifice (Marshall, Godfrey & Renfrew 2007; Murphy 1999; see also Waltz 2013). Therefore there was a tension between ‘saving lives’ versus ‘doing the best for your baby’. While donating milk and helping babies in need was thought admirable, donors seemed to feel the need to assure me, those around them, and perhaps themselves, that this did not mean that they lost sight of the needs of their own children. For example, Summer told me she had to cut her donations for the sake of her son:

I ended up having issues with over-supply, and my son got too much foremilk and not enough hindmilk, because he was so small. And that would upset his tummy and he got really uncomfortable so I had to actually slow down on my expressing to reduce my supply a bit so that he could get the proper feed.

Stella worried that interfering with her milk production would make her breasts ‘go *deurmekaar*’ (Afrikaans: confused): “That was my worry. That it’s going to mess up the biological production of making enough milk for him”. Lara regretted that some of her friends were critical of donating: “They need to know about where it goes and what

difference it can make. Of course your own baby comes first but they give up so easily and it's just sad". Even her own mother questioned her decision to donate:

I lost a lot of weight after [giving birth], and I think it was from breastfeeding and expressing. My mom said 'make sure you keep up your strength in order to make sure that your baby is ok'. We went away on holiday and there was no electricity, and so I had to manually express, and she said 'why are you wasting so much time on that, rather focus on your baby and being selfish for your baby'.

Here, being 'selfish' for your own baby takes moral precedence over providing for another child, complicating the picture of altruism.

Lara, eight months pregnant at the time of the interview, described her strategy to donate milk after the birth: "What I'm planning on doing is exclusively breastfeed on the one breast and express on the other, but I'll obviously have to see what the baby needs, and my baby will come first obviously". Several women reported that they stopped donating milk before their own babies were weaned, because their milk 'supply' 'dropped' and they prioritised the continuation of their children's feeds. As Maureen put it: "I did what I could, but I wanted to give my daughter the best possible". Milk bank staff advocate this, so that mothers would not 'do their own baby short.' The staff feared that donation might interfere with the mother's baby receiving enough milk, which they stressed was always the priority.

## **Conclusion**

Gifts without repayment, giving back without being taken from. The contradictions in donating women's statements around what it means to give away their milk may be attributable to the moral discourse governing human tissue donation (bodily fluids – disgusting in themselves), rendering donation 'noble and morally worthy' (Shaw 2010). Accomplished through the production and donation of a surplus (waste) in a process that transforms waste into a 'sacred' substance, the value of donated milk in the context of deprived infants is valorised and highlighted, but downplayed in the context of the donor. The concept of sharing could bridge this gap, as it allows the substance to remain valuable both before and after the act. It also has the potential to displace the model of scarcity underpinning much of the popular and scientific ideas around breastfeeding, something I address in chapter five.

The 'saving babies' trope drew on Christian and colonial notions that had strong resonances with the current class and racial distinctions in South Africa, aligned with privilege and shaped who donated and who received. The veiling of the return in donation

maintained the moral discourse surrounding donation as a selfless act, which stabilised the milk's sacred qualities and denied its potential to be abject (by blurring boundaries through sharing substantiation or personhood through sharing milk). As I have shown, this moving in and out of a relation of reciprocity marks a substance or object that is simultaneously the source of an intimate relation and generalisable.



## Chapter 4

# The Little Sentry: Safety, Hygiene, and Technologies in the Donation Trajectory

The first few days I spent in the neonatal unit at the hospital were quite overwhelming. To my (medically) untrained eyes and ears the criss-cross of tubes and monitors, the cacophony of beeps and alarms was never-ending. The incubators, the blue lights, and the traced heartbeats all spelt death and disease to me. It was surprising then to spot, on one of those intimidating monitors, a small cartoon of an English Palace Guard, complete with the traditional bearskin high furry hat. The brand or model name next to it: ‘little sentry’. The connection between this benevolent little guard and the monitor – both a screen and a monitoring device – offers a symbolic representation of the core concerns of the chapter: security and surveillance.

In the setting of the hospital, donor milk took on new properties, its status more ambiguous than it was to the donating mothers<sup>27</sup>. The focus shifted from ‘saving babies’ to ‘safety’, and the risks that recipients should be safeguarded from. The donor milk was no longer just ‘a miracle’ or ‘liquid gold’. It was also a potential site of contamination, a transmitter of viruses, bacteria, other micro-organisms. In the neonatal unit (consisting of intensive care, high care and special care) and the feed preparation area staff weighed risks continuously – the risk of formula, the risk of contamination. These risks were assessed *and* kept at bay through a variety of technologies.

This range of technologies, from routines such as washing hands, to everyday domestic appliances and high-end medical equipment, were indispensable to the donation process and shaped its trajectory. The technologies aided the professionals and the donors involved in obtaining hygiene – the solution for keeping risk at bay. Thus technologies were

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<sup>27</sup> Donating mothers dealt with ‘safety issues’ as well. They were taught how to express and store the milk with minimal opportunity for contamination, by using only the sterilised bottles the milk bank provided, only using certain kinds of breast pumps and sterilising them in between pumping, and by freezing the milk soon after expressing. Every time they donated a sample of their milk went to a laboratory for testing, and if their milk was contaminated repeatedly the milk bank would visit them to find out what had gone wrong and solve the issue.

part of the configuration of care that recipient babies received in the hospital. This logic impacted on how donation was framed in the clinical settings, by the mothers of recipient babies and by the health care professional prescribing and administering it.

I first describe the four nodal points involved in the re-scaling of donor milk, and how they aided in the transformations it underwent. These four nodal points signal the milk's altering of meaning, and sometimes the transformation of the actual entity. During breastfeeding there is a closed circuit between baby and mother. Expressing and storage form the first nexus producing something else, alienating the milk from the dyad. The next are pasteurisation and testing, technical interventions producing something devoid of risk. Packaging is homogenising intervention – although the milk itself is not homogenised, it is produced as a homogenous or uniform product. Prescription is a technique that legitimises the dispensation of donated milk in the clinical setting. Prescription is not tailored to a specific child, but based on an aggregate, a prediction of what a child in general needs. It stabilises the discourse of absenting risk, and ensures a delicate balance, producing milk as food that is also medicine. Until this point the milk was a product, alienated and standardised, but through prescription its medical valence and properties are emphasised. Prescription is a technique that reframes the milk's value, foregrounding food as medicine, and medicine as food. From there I zoom in on the act of administering the milk, followed by a discussion of how safety, hygiene and risk feature in the process that brings the milk to the babies. Finally, I show how these notions impact on the way the milk donors are imagined by recipient mothers and nurses and doctors in the neonatal unit.

I argue that four nodal points of technological interventions described in this chapter facilitate the re-scaling of donated milk from bodily fluid (that is food), to a substance akin to medicine that can legitimately be prescribed and fed within a medical context. Through these interventions the milk is scaled up by being made generalisable through techniques that work by taking the intimate and opening it to the broad - from something produced from the particular dyadic relation and its social formations through these interventions, into a substance that is made less particular, intimate and dyadic, and more of a commodity, generic and available. Prescription in particular stabilises the milk in a discourse of security, of absenting risk.

## **Administering Milk**

When the milk was taken from the mother-child dyad in which it was produced, the abstraction was strangely mirrored in the administration of the donated milk in the neonatal unit. The term ‘administered’ signals the transformation that the milk has undergone from intimate bodily fluid that is food to a combination of food and medicine, and the method of administration further solidified this.

One Tuesday in April I watched as a baby was being fed. This was done through a tube going from his nose into his stomach, connected to a machine that slowly pushed the milk out of a syringe. The changing of the feed was done in less than a minute, almost the blink of an eye. Baby H probably did not notice anything. The nurse who did the changing called over another nurse to sign – every time donor milk was dispensed two signatures were required, signing off the amount, donor number, date and time. She told the other nurse “I’ve done all the milks” and they left. I checked the baby’s file, and saw his father called a week before (or was called) to say the mother would be there more. But the mom still had not been since.

The breastfeeding relationship was idealised as close, intimate, and often closed, private, and the administration of milk in the neonatal unit sometimes stood in sharp contrast to this. There is more to breastfeeding than just breast milk. Part of its benefits could be attributed to the nurturing and bonding practice of having a baby on the breast, in one’s arms. This was central in Kangaroo Mother Care, a set of ideas around caring for infants that focus on skin-to-skin contact, which has been shown to have lasting benefits particularly for preterm and low birth weight babies (Doyle 1997). These were factors that donor milk could not compensate for.

The contrast between a mother breastfeeding and a nurse changing a syringe in a machine next to an incubator was remarkable. On the one end, the quantity of milk changing bodies often remained a mystery (see Waltz 2013), while the other is characterised by precise measurement through a highly technical intervention. In case of the latter, premature babies who were often unable to suck and feed were literally kept alive by the tubes and machines dispensing milk to them. That donor milk was considered beneficial even in such an abstracted form indicates there was something to it that went beyond the nurturing relationship, that it had measureable (and yet to be measured – new research finding new things that breastmilk does comes out all the time) properties that are considered beneficial on their own based on scientific evidence (Bai et al. 2009; Hinde and German 2012).

## Four Nodes of Technologies

Before the milk was administered, it went through several nodes that scaled it up from a particular bodily fluid to a legitimated substance in the medical setting. This begins with the extraction of milk from the dyad through milk expression. While the in-house donors at the hospital were taught and encouraged to express with their hands, private donors mostly used electric pumps. Almost all donors I interviewed had a particular story behind their breast pump. Tania told me she expressed a few times in the car with her double hands-free pump while driving. Salma's sister in Australia sent Salma her breast pumps, and many others were handed down through sisters and friends and returned again<sup>28</sup>. Some women cut holes in their bras to make expressing easier, or tied together two single pumps to 'speed things up'. On one afternoon I watched Kelly and Barbara sort through an entire box of pumps and pump parts that the milk bank acquired over the years, seeing what can still be used and what should be discarded, commenting on how 'cute' some were and how 'complex' others. Technologies were not only part of caring practices and networks of care, but also cared for.

The milk bank discouraged people from using second hand or sharing breast pumps, because they formed a potential source of contamination. They told the donors that 'you wouldn't share your sister's toothbrush', drawing on breast milk as a bodily fluid (like saliva) and explicitly invoking its 'yuk-factor'. The message was clear: expressed milk, before freezing or pasteurisation, is risky and must be contained. The milk bank did encourage people be 'creative', recognising that special equipment was expensive and that improvisation can make expressing 'more efficient'. They rented out Medela Lactina pumps (which had completely exchangeable tubing, minimising the risk of contamination)<sup>29</sup>, and also encouraged hand expressing, which if taught right can be 'very efficient and hygienic', as long as the woman washes her hands.

The next technology that played an important role in the donation process is an unassuming domestic appliance: the freezer. Donors kept expressed milk in their own freezer while accumulating enough to donate<sup>30</sup>, and the milk bank staff kept it in theirs before taking it to work, where it was kept in one of two chest freezers in their office or, after pasteurisation, in the industrial freezers in the milk kitchen. The freezers offered a site where

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<sup>28</sup> This kind of circulation can be found in all classes (Ross, personal communication), and signals an economy of exchange in a gendered circuit of very intimate close friends or relatives.

<sup>29</sup> The milk bank rented out pump motors for R180 per week and sold the tubes (double tubing costs R860 and single R625).

<sup>30</sup> Expressed breast milk could be safely kept at room temperature for up to 24 hours. Since it took most donors a few weeks to fill up the standard 'batch' of 2 Litres the milk was usually frozen.

the everyday domestic habits of food preparation threatened to mix with the unusual practice of milk donation. Dr Muller told me: “I pick up the milk after work, because I have a spare big freezer now where I can store the milk overnight. I don’t really want to store it in my kitchen freezer and have the milk mix with food”. Here, it was unclear for whose sake the food and milk should not mix, or which was considered ‘at risk’ of contamination (perhaps both). In other cases, it was unambiguous: both Lisa and Kelly told me their partners had initially been ‘grossed out’ by having their freezers double as milk storage facilities. To them the donated milk was primarily a bodily fluid – something that they were not keen to keep close to their steaks. Abstracted from the intimacy of breastfeeding, the milk becomes a repulsive other.

From the freezer the milk went to the pasteuriser to effectively kill bacteria and viruses (including HIV) present in the milk, while preserving its vital nutrients (Ewaschuk et al. 2011). Before the pasteurisation the milk was decanted from the donor’s containers and poured into uniform bottles. The bottles were labelled with the date, donor number and batch number, and sealed like milk sold in the supermarket. The pasteurisation machine was located in the milk kitchen, a large square silver box about the size of a washing machine, with a ‘bath’ inside in which the milk bottles were placed in a wire basket. The machine heated the milk to a temperature of exactly 63.5 C. For every donated ‘batch’ a small sample of the milk was sent to a laboratory for testing after pasteurisation. The milk was distributed only after the results came back as ‘clean’. Milk kept in the milk kitchen freezer was labelled green if the results had come back, and yellow if they were still awaited – a way of demarcating milk that was ‘unsafe’ or ‘safe’. The milk bank’s website contains a description of why the milk is pasteurised, part of the process of reassuring donors. Some, especially Lara and Salma, expressed their concerns that their milk might contain ‘bugs’ that could be harmful to recipient babies, due to not freezing in time or not cleaning the breast pump correctly. Pasteurisation was a way of removing this ‘yuk’ from the milk – literally and figuratively.

After these technological interventions, milk could be administered – if a doctor prescribed it. This final step was crucial to the milk’s reception in the neonatal unit, a technique that stabilised the donor milk as a beneficial substance akin to medicine, as the rest of this chapter shows. The prescription process will be described in more detail in chapter five.

## Hygiene, Safety and Risk

Expressing and storing, pasteurisation and testing, packaging and prescription were permeated by discourses and practices pertaining to hygiene, safety and risk. In line with this, doctors related their prescription of donor milk not only to the benefits prescribed to breast milk, but even more to the risks of formula. Commenting on the widespread use of formula in hospitals and clinics Dr Muller said:

What people don't appreciate is the risk of formula. Formula can be given at any time. This is wrong, because systematic review shows that pre-term babies are more likely to get sick or die when given formula, so in terms of risk parents should sign consent for formula. There is a miniscule risk of infection through donor milk, but there is more risk with formula because it is not sterile. The powder contains organisms that can grow because it is not mixed at boiling temperatures.

At the time of writing, state hospitals were transitioning from providing free formula to implementing the new Exclusive Breastfeeding Policy, which took full effect on 1 April 2015. Dr Taylor told me about the consideration for prescribing donor milk: "A major thing is the risk of the baby getting formula. The younger they are in terms of gestational age and days of life, and the smaller, the higher the risk". She continued: "another factor is HIV infection if the mom is high risk, so we might give donor [milk] in the early days when there is not enough to pasteurise". Donor milk was framed as a substance that could help avoid the various consequences of the ingestion of formula or unpasteurised breastmilk of an HIV positive mother.

But donor milk is not without potential 'risks', too, as Dr Muller illustrated with the following anecdote:

In the last 24 months there was a woman with twins who didn't have a lot of milk, so another woman in the room offered her milk. She had tested [HIV] negative before birth, but tested positive after, and after she had given the milk. So milk-sharing<sup>31</sup> is risky.

He further commented that 'it is always a big exercise when milk sharing happens', referring to the testing and admonishments milk sharing caused in the hospital. When an infant was fed by someone else than his or her mother, the woman who fed the baby and the baby itself would have to undergo HIV and Hepatitis B tests, and the thought of such an event upset

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<sup>31</sup> Milk-sharing refers to the informal administration of breast milk that is not the biogenetical mother's to a baby. In this particular context it also means that the milk is not pasteurised.

members of staff. Milk-sharing in this particular environment was such a dramatic event, because of the underlying premise that breastmilk is inherently ‘dangerous’<sup>32</sup>.

There were several sites in which these ‘risks’ of donor milk were actively addressed. This happens mostly in the space of the hospital, but started before. Donors were screened through a ‘lifestyle questionnaire’ (see appendix) including questions on sexual activity and substance use such as alcohol, nicotine and antidepressants. They also had to undergo an HIV and Hepatitis B test before their milk could enter the distribution network. Lisa told me that the milk bank was more careful in this regard with in-house donors, because they were more ‘at risk’. This points to assumptions about the hospital patients, who were generally understood to be likely to be substance-dependent by hospital staff<sup>33</sup>. Donors had to express into sterilised bottles provided by the milk bank and freeze the milk at home to manage the risk of bacterial growth taking place in the milk.

After the milk was carefully transported to the hospital in cooler bags by either the donor or the milk bank staff, the milk went the space in which the feeds for the babies in the neonatal unit were prepared. Two interchangeably used names circulated, the more recently assigned and clinically sounding ‘feedprep’, and the persistent previous term ‘milk kitchen’, which had a more domestic ring to it. The changing of this term points to the issues around the symbolic separation of donated milk and food that were also apparent in the freezers of the milk collectors. The whole milk kitchen was a sterile space, and before entering I had to be dressed in sterile clothes and put on a hair net, mask, gown, and gloves. Three to four women worked in the milk kitchen every day from seven to seven, to prepare formula feeds, and to pasteurise and prepare breastmilk. Frozen donated milk was thawed, packaged, pasteurised and then frozen again to be distributed.

The testing continued after the milk is donated, as a small sample of every pasteurised batch (milk donated at one time, usually around 2 litres) was sent to a laboratory for analysis. During my research the milk bank’ testing had just moved from Somerset Hospital to Groote Schuur Hospital. Since then they had seen a marked increase in the amount of bacterial growth found in the milk samples<sup>34</sup>. The tests also took much longer to get back, four days

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<sup>32</sup> One could argue that this assumption is an ethical one; practitioners have to assume the worst in the best interests of the patient.

<sup>33</sup> The hospital is a second tier referral hospital; many of the women who deliver there who do not fall into its catchment area (i.e. after assessment at a different MOU) are medically defined as more at risk. There is a medical assessment which makes a clinical finding, but in this case Lisa was also referring to something else – a social understanding of risk.

<sup>34</sup> Subsequently they found out that when the milk was picked up in the morning the drivers went on to collect from Red Cross and other hospitals, and the milk only reached Groote Schuur’s laboratory at around four in the

instead of two. This was a problem as milk was distributed day by day, so they did not have a lot of ‘breathing space’, and they could not give out milk until the tests come back. This pointed toward a different kind of risk that the milk bank had to balance – time was always pressing, as there were always babies who needed milk and never enough of it, yet it also took time to process the milk in a way that minimised the forms of risk discussed above. There is the tensions of risks – one set, related to minimising risk has the effect of increasing the time it takes to ensure safety, and thus increased a different kind of risk: that a baby might not get the milk on time.

Ulrike did all the pasteurising. She was employed by the milk bank and did this labour intensive work, because as Lisa stressed “it all needs to happen very sterile and precise”. The unpasteurised milk was kept strictly separately in a freezer in Milk Matter’s office. HIV positive mothers expressed into ‘Black cat’ peanut butter jars ‘to discriminate’ and make sure their milk did not end up being pasteurised with the other milk, as Dr Muller told me. There was a distinction made here; and careful, categorical, symbolic work as well as actual effort went into differentiating the milk as ‘safe’ or not.

In the neonatal unit different hygiene measures were in place. Hand-washing was encouraged through signs and spoken reminders<sup>35</sup>. Every incubator had a bottle of disinfectant on it, and nurses and doctors were constantly rubbing their hands to sanitise. Nurses were encouraging mothers to express into sterilised cups so that their milk could be fed directly to their babies and no additional pasteurisation was needed. These practices became part of stabilising the milk as ‘safe’ and foregrounded its medical valence. Here the entity was in a context where its medical properties were valued – the production of hygiene is in excess of what is required for the object to do its work, and this excess is what was creating the conceptually stable object. This does not mean that this was not necessary; it was critical to what product had to do. It was securing the value of the object, and was also securing life.

Nurses who dealt with the milk did not always seem to have very precise understanding of what processes the milk had gone through, nor did the parents of recipient babies. Yet they all firmly believed that it was ‘safe’. For example, Sister Abrahams, a nurse

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afternoon. This impacted on the tests, because they could not be sure whether the contamination happened at the hospital, at the donor or during this trip, when it was sitting in a hot car.

<sup>35</sup> One afternoon a group of students came in and they were told to ‘wash up everyone’ and ‘take off watches and roll up sleeves’. They dropped all their backpacks and coats around the doorway. A few days later, as I left the ICU two moms came in talking to each other, and I heard the nurse ask sharply if they have washed their hands.



working in the ICU told me: “All we know is that it is tested, it is legitimate, it is safe”.

Another nurse, working in the SPCU said:

I’m fine with working with donor milk. It is always pasteurised. We work with gloves and the moms are screened against any illnesses before, so the milk comes from a sterile, clean, safe and healthy environment. So it is safe, and we just continue it being safe by using gloves and sterile cups and syringes.

The emphasis on the milk’s safety, and the fact that it should come from a verified source and handled in a particular way (avoiding direct contact) underline the awareness of the milk’s potential to bring risk.

There were many different ideas around what actually happened to the milk before it was delivered, ready-to-go, to the neonatal unit. Sister Abrahams thought the milk was autoclaved (a machine that is used to sterilise equipment and bottles). Khanyisa, one of the recipient mothers, thought it was boiled. Nuraal, an in-house donor, thought it went through ‘some kind of purification process’. All of these share the idea of eliminating ‘pollutants’. However, there were different ways of understanding potential risk in breast milk donation: doctors understood it to be medical complications in recipient babies, the milk bank saw it primarily as the threat of bacterial growth, and also as drugs passing through, while nurses seemed mainly concerned about viral transmission. Depending on each person’s place in the donor milk’s trajectory, and their relation to the milk, particular ‘risky’ aspects of processing, prescribing, distributing and receiving donated milk stood out. It was widely accepted that breast milk donation could ‘bring risk’ with it – but behaving in risky ways was not. There were elaborate measures differentiating between those two states of being risky and bearing risk. Bearing risk was removed as far as possible through a set of techniques, but the possibility of being risky could never be fully eliminated.

### **Imagining the Donors**

In these considerations of the riskiness surrounding donor milk, the donor was often framed as being responsible for imparting the risk. This was not always true – sometimes contamination happened after donation, but it does pertain to aspects such as the transmission of viruses or other substances. Yet when I asked how the milk donors are imagined, most nurses and recipient mothers told me they never think about the donor<sup>36</sup>. Sister Williams said:

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<sup>36</sup> By contrast, the doctors did not imagine the donors. Dr Glover had been a donor herself, and told me she sometimes wondered if it was her own milk that she was prescribing. Dr Taylor had a friend who donated, so she had been looking out for her friend’s milk. Dr Muller was actively involved with the milk bank and ran the Hout Bay depot, so he was involved with picking up milk from donors’ houses and storing it in his own freezer

“It is like with adoption, you don’t want to know too much”. Most people indicated that they did not find it necessary to know about the donors, because they trusted the procedure, like Sister Abrahams: “I strongly believe it is from a good source. I know they are very careful”. Khanyisa, whose child was receiving donated milk, told me:

They said they check the person’s milk, see if it was healthy. Maybe they will boil it, so I don’t have to worry about disease, because the person is healthy. I would have been worried about disease if they didn’t check, but at least I know that it is good. My child is a prem so he is very sensitive.

She further explained that she never wondered who the donors were: “I don’t think it really matters, what is important is the baby’s health, and that the person is healthy. Maybe the person will look decent but is not healthy, so it’s not important to know who the person is”.

Before her own milk came in, Petra only accepted donor milk for her baby after a doctor explained that the milk is checked first “or else there can be something that can make my baby sick”. She added: “They never told me who the milk was from, I never knew it, even today. I know only that it’s safe”. Patricia was told that donor milk comes from ‘moms who have a lot of milk and are very clean’, and they ‘make sure there are no germs’. When I asked if she ever wondered who the donors were, she said:

No, I don’t actually... When you have enough milk, [like] moms of babies who passed away, anyone can donate, as long as it is clean. My baby never got a sickness, I would be worried if he was sick or infected. You can’t be choosy about who or why, or about colour or race. It would be wrong to say ‘I don’t want milk from so and so’. If your child needs it, even if I know the donor and don’t like her face, if I don’t want the milk my child is going to suffer”.

In these cases safety seemed to rest on notions of either health or cleanliness. The donating mother is excluded much in the same way as recipient mothers were left out of donors’ imaginations. As Petra put it: “I don’t want to picture the donor, as long as there is milk to help my child and the doctors say it’s safe”.

It raises the question of who is considered risky, and who has to accept risk, like Petra saying that a recipient cannot be ‘choosy’. Questions of risk and safety permeated in different ways along the process. They were constellated differently - for the donors the risk was over-expressing and creating milk less-suitable to their own babies. Other risks could be managed by adhering to the precautions the milk bank set out: washing hands and implements, using sterilised bottles and pumps, freezing the milk immediately after

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before bringing it with him to the hospital. They all seemed to have a clear idea of what donating entailed and who the private donors were, and what happened to the milk before reaching the babies.

expressing. For others, such as the recipient mothers, risk was something assigned to them, and safety something in which they had to trust.

The act of prescription was an important part of the process by which an intimate bodily fluid became in effect both food and medicine. While much of the process of making the milk safe for consumption by preterm babies happened before it was prescribed, this really affirmed its properties that set it apart from ‘just food’, such as formula. It was the fact that doctors prescribed it that assured both recipient mothers and nurses that the milk was indeed safe, and beyond – part of a medical treatment that certain babies need.

## **Conclusion**

Technologies are implicated in the donation process from the start and feature in unexpected ways, aiding in abstracting the milk and thereby its transformation. The milk shifted between bodily fluid, food, and medicine, through technological and medical interventions of expressing and storing, pasteurising and testing, packaging and prescribing – the nodal points I have identified. As the milk shifted in status, meanings attached around it in different ways. In some ways, as the meanings of the milk shifted in and out of commodity form, the milk also shifted in ontological status. Here, languages and practices worked to stabilise particular objects as a different kind of object, causing difference to emerge at other points than pasteurisation alone. These processes are shaped by a larger discourse of safety and risk, which takes a particular form in the space of the hospital that comes to frame donation as well. ‘Risk’ is understood in specific ways according to an individuals’ relation to the milk.

The links between safe and safety, babies, donated breast milk and the technologies involved become apparent when considering how exceptional it is that babies get the donated breast milk in the neonatal unit at all. Receiving milk in that particular space would not be accepted if it were not for the technological interventions that the milk passed through before being administered. Without those it would simply be milk-sharing, which, in this medicalised context, is fraught with notions of risk that permeate the whole logic of infant feeding and care. The milk needed to undergo certain transformations through these technologies to become legitimised. Expressing and storing allowed the transformation from intimate substance to bodily fluid, a repulsive other. With pasteurisation and testing the milk became a valuable food item. The next point was the prescription, which legitimised the milk not only as a suitable, ‘safe’ food, but added the dimension of it functioning as a medicine. Up until then donated milk was a product – alienated and standardised. After prescription by

a doctor it became a particular substance selectively given for medical reasons to infants who need not only food but also its healing properties, a compound for prevention or treatment of disease. These processes rendered a particular substance as generalisable.

The milk had a double potential – it could be a compound for treatment and prevention of disease, but also a bearer of disease, both bacterial and viral. Technologies work to manage this risk and guard against it; thus to bring out the breast milk's positive potential. The doctor's authority bestows legitimacy so that nurses and carers of recipient babies state that even if they did not know exactly where the milk comes from, they trust it is healthy, disease-free, safe. In short, something you would give your baby.

## Chapter 5

### D1 of Life: Affect, Attachment and Modalities of Care in the Neonatal Unit

The folders in which a continuous ‘management progress report’ was kept for every baby described them and their parents in a set of numbers and abbreviations, hashtags and statistics. When Sister Williams was explaining how to read the folders to a paramedic in training, she commented dryly that ‘they make a lot of abbreviations, these doctors’. One of the most striking featured at the start of most babies’ progress reports: ‘D1 of life’. Day one of life, the first day of a baby’s life. A life, short as it may be, held in this one phrase, captured with one letter and one number. In this setting Day 1 is recorded as post-natal, contrary to the 1,000 days argument<sup>37</sup>, where a critical developmental period starts at conception. The phrase points to paradoxes in the clinical setting. Patients are rendered as abstract entities, numbers, treated according to protocols and bureaucratic procedures. At the same time, care and affect play a crucial yet not always acknowledged role in these processes. Medical practitioners seem to move in and out of relationships of objectification and subjectification with their patients. How is the logic of care explained in this setting where it does not officially figure?

Byron Good argues that:

The write-up [of progress or case notes] is not a mere record of a verbal exchange. It is itself a formative practice, a practice that shapes talk as much as it reflects it, a means of constructing a person as a patient a document, and a project (Good 1994: 77).

The role of the patient has been an important topic in Medical Anthropology, which has long provided a critique of biomedicine and its founding assumptions – situating it as a particular type of knowledge with a particular history, presenting itself as universal (Gordon 1998; Lock and Nguyen, 2010) – and thereby objectifying and reifying the patient (Taussig 1980). The links between biomedicine and ‘science’ have become particularly important since the 1980s, when ‘best practice’ in medicine became ‘evidence-based’ (Lambert 2006; Good

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<sup>37</sup> A prevailing argument in the biomedical context in which the period from conception to roughly two years of age is seen as a critical window for human development.

1994). Good has further studied how ‘the medical world and its objects’ are built up for doctors-in-training in medical school, teaching them to see, write and speak in particular ways to continue to construct *medical objects* in medical practice through systemised and regulated interactions with patients (Good 1994: 65-87; emphasis mine).

Here, I take issue with this argument, showing that despite the reification implicit in case notes and medical procedures, there is care. I build on a growing body of work in medical anthropology that shows that in various contexts that there is more to medical practice than adherence to standardised protocols suggest. Oliver Human illustrates “the limits of the cognitivist model upon which protocols are based”, by showing how doctors deal contextually with medical protocols (2012: 15). According to him, protocols are important in standardising decision-making, increasing efficiency and providing a way to measure performance (Human 2012: 17). However, he found that some doctors defy the protocol based on a type of ‘excess’ of knowledge (Human 2012: 16). This is gained ‘through practical experience in a contingent world’ and cannot be easily defined in the abstract (Human 2012 20-12). He concludes that while protocols are necessary for the efficient treatment of large populations, the experiential knowledge, including intuition, affect and experience, expressed in medical practice remains crucial in the ethical decision-making regarding exceptional cases (Human 2012: 29-30). In the context of clinical trials, Justin Dixon (2012) argues that affective relationships develop between clinical research organisations and their participants that went beyond and sometimes ran into conflict with the protocol. Through practices of care ‘extra-protocol’ day-to-day demands emerged (Dixon 2012: 47). As Human (2012) showed as well, ‘extra-protocol’ affect, care and knowledge can clash with the protocol, but are also necessary to implement medical care effectively and ethically, something I show in this chapter. Annemarie Mol has written extensively about care, arguing that:

Care practices move us away from rationalist versions of the human being. For rather than insisting on cognitive operations, they involve embodied practices. Rather than requiring impartial judgements and firm decisions, they demand attuned attentiveness and adaptive tinkering (Mol et al. 2010: 15).

Lock and Nguyen add that in the practice of biomedicine ‘culturally informed values’ are combined with professional choices (2010: 5). Those culturally informed values play into the focus of this chapter. I argue that there is even more ‘beyond the protocol’ than Human and Dixon contend. Attachment and care are part of the everyday medical practice in the

neonatal unit, despite processes of objectification. I nuance this claim by showing there are caring practices that assist<sup>38</sup> and infantilise; there are real modes of care, yet the outcomes often lie outside biomedical practitioners' hands; and that sometimes affect and attachment also find their way into medical decision-making: in this case strong social and cultural models of mothering played a role in the ways that mothers were assessed and medical facts were construed.

### **Names and Numbers: Biomedical Bureaucratisation in the Neonatal Unit**

On the surface, impersonal modes of identification were extensive in the neonatal unit. The Sisters quite strictly referred to one another by their last names, and when I first introduced myself with only my first name this was met with confusion. Most babies were referred to by nurses and doctors either by their bed number, or by the last name of one of their parents. Often babies were referred to as 'he' or 'it', even when 'he' or 'it' was female. This struck me as an expression of expertise and professionalism in the clinical setting, and aided in establishing the hierarchies that play out both between medical professionals and patients, and among themselves, in order to maintain efficiency and standardised treatment.

The depersonalisation became apparent early on in fieldwork as I was preparing a feed for 'baby 2' on the feed list with Doris. This list is made by the Sisters in the neonatal unit, who note what feed the doctors have prescribed for each baby. For every feed a 4 ml syringe was prepared for 'baby 2'. Since this was so little I asked Doris if she knew who this baby was. Her face seemed to have a wistful look when she told me that in the milk kitchen they did not know 'how much the baby weighs or anything'. Only if there was a 'donor order form' on which it was mentioned did the milk kitchen staff know anything about the situation of the babies for whom they were preparing feeds. Doris' comment also implied that a baby's condition could be summed up by its weight, or that weight was somehow the most important indicator of its state of being<sup>39</sup>. From babies' names to their condition, a range of things was reduced to numbers and acronyms. The same applied to the milk: called either EBM (expressed breast milk), DEBM (donated expressed breast milk) or P/EBM (HIV+ expressed breast milk), these acronyms were a way of categorising and stabilising the milk, and patients.

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<sup>38</sup> In the cases discussed here, assistance with breastfeeding and infant care.

<sup>39</sup> As noted in chapter one, weight was also an important factor in discharging babies from the hospital.

At first the depersonalisation, objectification and bureaucratisation seemed very pervasive to me, something much of the literature on medicalization notes. But soon I also started noticing the myriad ways in which these processes were subverted. On one of my last days in the hospital I noticed a sign on ‘Baby Sandberg’s’ incubator: ‘My name is Liam’. A few weeks before I had noticed a similar sign on Zimasa’s baby’s incubator. Zimasa was not sure who had put the sign up, but the nurse in charge told me it had been her. She explained to me that she felt it was ‘more personal’ this way, and that she did not like referring to the babies by their parents’ names. She used to get stickers and craft material to stick on the name signs, but she was not allowed to do that anymore because it might cause infections, as the materials were not sterile. She believed it helped parents’ bonding with the babies to name them, and for the same reason she encouraged them to bring a blanket from home, so they had something of their own for their baby<sup>40</sup>.

The donors of the milk were subjected to its own paradoxical instances of abstracting and identification in the hospital: “the donor is only a number” Sister Abrahams told me, and in the neonatal unit in a way, it was. Sister Abrahams told me that she thought it was strange that for months all the donor milk they received was from donor 800. She and other nurses were puzzled how one woman could have so much milk, and why it was only her milk that they were receiving. They did not know that 800 was the number given to the entire batch of the (neatly labelled) imported milk from the United States, given to the hospital by the milk bank in lieu of rent, a topic I explore further below. The milk’s trajectory was obscured by the single number by which it was known in this context. In the milk kitchen it was very different: when Ulrike and I were preparing milk for the pasteuriser I saw ‘Salma’ on a label and realised I was actually handling the milk of someone I had interviewed<sup>41</sup>.

### **‘As a Mother’: Medical Practitioners, Care, and Donor Milk Prescription**

Especially in the beginning of my fieldwork I focussed on how professionals and patients became objectified in a process of medical bureaucratisation as described above, but more

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<sup>40</sup> Another effort to make babies more recognisable was by giving them knitted caps and booties. Since all the babies were only wearing the same oversized nappies, this minimal clothing did not only serve to keep them warm, but also to make them look a little more familiar. When she heard she would be discharged that afternoon, a mother in the KMC said to her baby: “now I can dress you properly”, implying the regret she may have felt at being unable to engage with her baby in certain ways during the hospital stay. When Sister Annika gave her talk on how to resuscitate your baby, the only question that she got afterwards was one of the moms asking if she could have the cap that the demonstration baby doll was wearing.

<sup>41</sup> the milk bank did not pool their milk to be able to trace donors and the names of donors were used alongside the donor numbers, leaving the donated milk not yet nameless at this point.



and more often I actually saw the opposite. Every day there were many mothers in the neonatal unit, nursing, talking, and laughing. At no point during my fieldwork were there less than four in any of the units, and most of the time there were many more, plus fathers, grandparents, or other children. All the mothers were engaging with their babies in various ways, practicing Kangaroo Mother Care, breastfeeding, expressing, or playing with their babies. Often I could hear the nurses and doctors talking to the babies as they were treating them, cooing, smiling. I began to notice how they usually apologised to the babies before doing something that seemed to be uncomfortable for them, such as drawing blood or turning them around into a different position.

Towards the end of my research Doris had been re-assigned from the milk kitchen to the high care unit. She was changing a baby's nappy, and the little girl just kept crying. "She wants to be cuddled", Doris commented. Sister Adams told me about her 'observation' routine:

Then I wrap them down nicely, I cuddle them in a blanket and I send them off nicely, I mean I don't put them down rudely or abruptly, because I want them to sleep nicely. I think of it as if this was my child, how would I want it to be treated, and that is how I treat them.

When I asked her how this thinking of the babies as 'like her own' influenced how she cared for them, she told me:

I give quality care. My way of thinking is, if this was my child or grandchild, how would I treat it, however deformed or sick a baby is. When I think of it as my child I know I'm going to give the best care. I don't even think of it as my neighbour's child, because then already it wouldn't matter as much".

Dr Glover told me that when she went away on holidays she always missed 'her' babies in the neonatal unit. "Shame for my own babies!" she said, referring to her own two children. They shared their mother's love and affection with countless others.

The use of language of appropriation used by the people working in the hospital, from the milk kitchen to the doctors, was widespread. Doris told me: "The milk in the pasteuriser is 'my milk' for 'our babies'". Sister Williams complained one day to me: "My babies are hungry, where is the milk?". On another, particularly rough day, she sighed: "The things I do for my babies..." One doctor told another that 'her TB baby' had died (and that she hoped she would not get another case of those). There were many other examples, and this even continued in front of babies' mothers. Dr Glover was interacting with a mother and baby in the KMC, and when moving to the next bed said: "How is my other child doing?". In spite of this persistent use of these terms, the mothers present did not forget their role - when Sister

Annika asked the women in the mothers' room if their babies received donor milk, many who answered no said 'only my milk' and put their hands on their chests, a moving gesture that reminded me of where both babies and milk also belong. But Dr Glover's reference to her own children made me realise that the appropriation of babies, in language at least, is itself a form of care. By making a baby one's own, greater attachment and greater care were implied, as Sister Adams had explained.

Still, there were limits to what nurses (and doctors) could do. On my first day in the neonatal unit I noticed how a baby had actually not stopped crying since his feed. Sister Thelele heard it and thought he was still hungry, but knew that he would have to wait two hours, because she could not do anything different than the prescribed routine. Due to the generalisability of the prescribed milk, feeding could not be particular to this baby. These medical decisions were important, as the feeds for a premature babies needed to be carefully balanced, but in effect prescription stabilised a particular form of care - biomedical care rather than affective care, setting the ground for the way these intersected despite technologies, as described in chapter four. Thus, while prescription offered an intervention and had a positive event horizon, it at the same time posed a limit to what caring could be done.

Here, affect was curtailed, and changing nappies was technicalised. Medicine tries to stay objective, stabilising objects as objects, and stabilising care as an object as well, that is taught and follows a routine, resulting in not naming babies, and not feeding according to hunger but to prescription. The practical dimensions of 'care', - changing nappies, rearranging babies, making sure they are comfortable, changing their bedding, etc. - falls under the rubric of 'observations', drawing everyday, domestic practices into medicalised language. Many of these everyday clinical practices nonetheless had a semblance of domesticity and intimacy. The neonatal unit was largely run by women. There were some male doctors and sometimes the babies' fathers were there, but the mothers, the nurses, and the majority of doctors are women. This figured into the everyday medical practices, because as both doctors and nurses explained, in spite of these limits it was 'as a mother' that they cared.

### **Assessing Mothers in Donor Milk Prescription**

The particular model of motherhood that played a role in caring also found its way into the prescription process of the donor milk. Officially this is done according to a standardised

protocol, an exact set of measurable criteria: the baby had to weigh less than 1.5 kg<sup>42</sup>, be premature or have an otherwise compromised digestive system, and the mother needed to be absent or unable to provide milk herself. In practice, the process was far more nuanced than this and drew on different factors. I offer a detailed case to illustrate.

One Friday morning, while I was sitting by a baby's incubator and reading his folder, I was surprised when suddenly four doctors - Dr Davies, Dr Wright, Dr Harris, and Dr Jansen - were standing in front of me. They had reached this baby on their rounds. Dr Davies referred to the baby as 'this little baba' and explained the case to the others: "Baby is 33 weeks gestational age and one week old". After going over some medical facts, they discussed the mother. Dr Davies told them she was in isolation in a ward downstairs, but that 'they' are not communicating. Only because Sister Williams went downstairs to help her express they knew anything about her.

They discussed whether the baby should still be prescribed donor milk. "If mom isn't going to give a drop of milk..." Dr Davies started. Dr Jansen agreed: "We can't give donor indefinitely, it is not an unlimited supply, that isn't fair to others'. Dr Wright weighed in, noting that there were two new microprems in HC. Dr Davies said that there is another baby that she wanted to go off donor milk. Dr Jansen then made the decision to cease giving donor milk. She apologised to the baby, but justified her decision: "There is also the mixed feeding issue, and if mom isn't going to breastfeed it is better to go on formula now".

Because the mother was HIV seropositive, once they gave the baby formula he could not have breastmilk anymore; mixed feeding is implicated in vertical transmission (Coutsoudis et al. 2001). The doctors agreed that it looked like the mother would have to be admitted to another hospital to be treated for tuberculosis, and Sister Williams confirmed they were waiting for a place. Dr Jansen decided they would give donor milk for one more day, so Sister Williams could still go back and express more to supplement the donor milk with expressed milk - then 'at least he had a full week'. She went on to say that the baby did not really 'qualify' anyway, because he 'doesn't meet the criteria': The baby weighed more than the maximum weight for donor milk prescription, and the mother did not intend to breastfeed once the donor milk ceased. She seemed to be implying he should not have

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<sup>42</sup> According to the the milk bank 'donor order form' that is used to prescribe donor milk, the recipient baby must weigh less than 1.5 kg. However, this was not always the case, because (as discussed) different criteria could factor into this decision. Some doctors also cited different cut-off points when discussing donor milk prescription with me.

received donor milk in the first place. They then discussed what to give instead, and settled on a formula feed for premature babies.

They moved over to the next bed where Dr Davies introduced the baby as a ‘beautiful, growing prem’. It was noted that there was no bed for the mother who had arrived the previous night. There had been no bed for her even though one was promised, so she slept in someone else bed. “With that person?” Dr Wright asked. But the person who was supposed to be in the bed apparently was not there. Indignation ensued: “We don’t keep beds!” Dr Jansen mentioned how some mothers were also smoking too much: “There is a mom in KMC who goes out to smoke every two hours and leaves the baby on the bed! And she is only nineteen...” Dr Davies went on to say how ‘dedicated’ the mom of the baby at hand was: “She is really, really dedicated, she is here every day, she is expressing and breastfeeding, she is so dedicated”. They agreed that if she was so dedicated she should get a bed. Dr Wright said she is on top of her list, and they agreed that she should get the bed of the woman who left.

After witnessing this I recalled asking Dr Davies a few weeks earlier about one of the first babies I came across in my research. Just after a few days the baby was suddenly not on donor milk anymore. Since I had not been there for long this very much puzzled me at the time, especially since the baby only weighed just over 1.2 kg, well below the 1.5 kg cut-off point. I asked her why this was. She told me: “The mom hasn’t given us anything. She has substance issues, uses ‘tik’<sup>43</sup>, she has not made any effort, so they took the baby off donor milk”. Before that she explained what had initially confused me, the fact that the baby was far below the 1.5 kg criterion for donor milk: “He has been here for a month so he’s getting old, too old. Not too big, but they can’t keep giving donor milk forever, then they would run out”. She added that ‘they’ are happy to give donor milk when the mom is ‘really trying’ to breastfeed, but that was not the case here.

It seemed that whether or not a baby was prescribed donor milk by doctors did not solely depend on what you could call ‘medical facts’ or measurements alone, such as weight and the patient’s medical or physical condition. The perception of the baby’s future, of its potential, and most critically, the mother’s ‘dedication’ and ‘effort’ seemed crucial factors – the mother’s status became part of the medical facts in question. Whether the mother is judged to be a ‘good mother’ influences the forms of food that were made available to the baby. Many loosely defined criteria were drawn upon here, but generally in the context of the

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<sup>43</sup> Local term for methamphetamine.

hospital a ‘good mother’ was deemed a woman of appropriate age, especially not too young, who did not smoke, drink or use drugs, who went through every possible effort to breastfeed or express, and who visited regularly, and could be contacted when she was not there – drawing on similar normative ideas around devotion as mentioned in chapter three. Other factors played in here too; for example, the presence of the father of the baby or not having too many other children could make the mother appear as more responsible.

Later that week I interviewed two of the doctors working in the neonatal unit, curious to find out more about the prescription process. The first doctor, Dr Glover, initially told me this:

There is a protocol, so it goes according to that. When a baby is less than 1.3 kg and is exposed or there is a clinical indication for exclusive breastfeeding. Sometimes a baby is big but there is another reason. Sometimes it is to help mommy establish milk.

Dr Taylor, a paediatrician told me: “When the baby is older and ‘on donor’ there are sometimes major issues with the social circumstances. When the mom is trying to give milk but is far away and has no transport we are a bit more generous”. In saying this she confirmed what I had observed, that the mothers’ effort, or ‘trying’ was an important factor in the continued prescription of donor milk. Dr Taylor elaborated:

It’s not the baby’s fault if a mom is not helpful, but for babies where the mom is making no effort I am more strict, I’m more strict in putting my foot down. When the mom is really trying but has hard social circumstances I am more lenient. I know it’s not the baby’s fault, but it is an emotional reaction.

The judgements of a mother’s capacities do play in, and mothers’ status features in how medical facts are construed.

### **Donor Milk Prescription: Scarcity and Informed Compliance**

While affect and mother’s assessment figured in donor milk prescription, they were outside of the prescription protocol. Notions of hierarchy and medical expertise shaped the process of prescription and administration of donor milk, in theory. Dr Muller explained the prescription procedure to me as follows:

There are forms that need to be signed, like consent forms, but we don’t want the availability of donor [milk] to undermine breastfeeding. Some women say they don’t have to express because they got donor. But donor milk is prescribed to babies who are less than 1500 grams whose moms can’t supply for whatever reason. It can be transient so for three to four days while the mother build up supply, or when the baby has low blood sugars and needs top up feeds. HIV positive moms often do not have a lot of milk. The benefits of exclusive

breastfeeding are great, but term babies<sup>44</sup> erode the stock quicker. There is a very limited set of criteria. I would like to expand those but the supply is limited.

The prescription process is thus marked by two inherent tensions: the fear that the availability of donor milk is going to have an adverse effect on establishing maternal breastfeeding, and the economic logic of supply and demand based on a model of scarcity<sup>45</sup>. This led to particular kinds of economic calculations involving breast milk, such as when Dr Jansen explained that sending a driver to retrieve milk from a mother in Groote Schuur: “It is a resource that we’re using, but milk is the sustenance of life”. Dr Taylor, another paediatrician, confirmed this:

I work with donor milk primarily in the management of our prems, as to who we feel benefits from milk, bearing in mind that it is a limited resource. We have to make hard decisions. There are babies who we don’t give it to. I’m part of who decides who gets it. It also involves counselling the parents a lot, because when we start a baby on donor often the mom feels off the hook. The moms need to be motivated to produce milk.

Both she and Dr Muller stressed that they were lucky to have the connection with the milk bank, given the scarcity of donor milk. Dr Taylor said: “we are fortunate at the hospital because we have easy access to donor milk, so we can be a little more liberal. There are very few small babies here to whom no donor is offered in the first days”. Dr Muller highlighted the business arrangement that lay at the basis of this:

We can be a bit more free with the donor milk, because the milk bank supplies it free of charge. They normally charge a processing fee, because they are not allowed to trade it. They get rent-free accommodation and we get rent-free milk.

The arrangement between the milk bank and the hospital highlights the ways in which donor milk had become an entity that is both personal and impersonal. The milk itself at this stage has become a relatively standardised ‘product’, and the donors have retreated from consideration. At the same time, the milk had become personal in a different way, as it now signals a relationship between the milk bank and the hospital, and specific individuals within each organisation. The donation of the milk to the hospital is part of an exchange of milk for space. As part of the exchange social ties are made and re-made.

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<sup>44</sup> Babies born at ‘full term’ or 40 weeks of gestation

<sup>45</sup> Fiona Giles has proposed to operate from a ‘model of plentitude’ instead, which could be used as a way to disrupt order and subvert scientific policing of women’s bodies (Giles 2008: 33). By this logic, providing donor milk should encourage instead of undermine a mother’s own breastfeeding, and this was precisely my experience with the three recipient women I interviewed (although as noted in the introduction, this sample may not be representative of the hospital’s patient population).

It became clear that when it came to donor milk prescriptions, the mothers' wishes were not necessarily the final word. Especially the cases of HIV positive women were cited in this regard. As Sister Abrahams explained:

A lot of times when a mom is exposed she doesn't have enough milk, so she will say formula. We tell the doctor that that's what the mom wants, it is the mom's choice, but if it's premature we encourage breastfeeding. We do encourage donor milk first. Some moms stress a lot and to take some pressure of the mom we may offer donor. We tell her it's temporary, but you can see the relief on her face<sup>46</sup>. For premature babies we try our best to get colostrum, but we have to express it ourselves, because mom doesn't know how.

This was exemplified by a conversation between Dr Davies and Sister Williams, which suggested firstly that there are gaps in the protocol that can only be filled by care/caring and rely on the affect of medical practitioners for their patients and care as a moral imperative. The mother of the baby whose donor milk was discontinued (as described above) was staying in the hospital's labour ward, but she was too sick or exhausted to breastfeed. Before the decision to cease donor milk was reached, Sister Williams was in a difficult position because there was no milk from the mother for this baby, but without a prescription she also could not give either formula or donor milk. She asked one of the doctors what she should do, and was told that the doctors had talked to the mother. She had wanted formula for her baby, but they explained to her that 'that's not good for the baby' so that they 'can't give that'.

This left the nurse trapped between doctor's prescriptions and patient's wishes. The mother had not expressed since then. A doctor told Sister Williams that the mother *had to* express and the nurse conceded. Sister Williams was reluctant to help the woman express, but she did go downstairs. Dr Davies heard her complaints and asked why the nurses downstairs could not express her, but Sister Williams said: "This is my job and I'll go". Sister Williams expressed the mother the whole weekend, three or four times a day. She told me this almost reluctantly, but it sounded very intensive (expressing and pasteurising took around 45 minutes). She even brought the baby down to the mother for Kangaroo Mother Care.

Secondly, this shows how mothers' feeding 'choices' are directed by doctors and nursing staff. When mothers opted for a feeding choice that is not considered 'right' (because of the associated 'risk') there are various ways of settling for a different form. Medical practitioners grounded their preferences for certain feeding options in scientific research (see Gordon and Lambert 2006) and their contingent experiences with neonates (see Human 2012). Part of the 'conflict of interests' arose because medical practioners in this case acted

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<sup>46</sup> Some recipient mothers expressed their relief at their babies' receiving donor milk, because it alleviated their anxiety around their babies' nourishment.

in the best interests of the child – even if that meant reshaping mother’s wishes. Consent was obtained, but sometimes resembled ‘informed compliance’ (see Schwennesen et al. 2010: 211)

I came across this many times in babies’ folders, where there were often ongoing and urgent instructions to ‘counsel’ mothers for feeding choice, or ‘counsel’ mothers about expressing and breastfeeding. In this case the baby was only four days when Sister Williams went to express his mother, which led to the following comment in his folder: ‘no EBM available – mom reportedly wants to formula feed. Counsel mom ie breastfeeding choice + initiate feeds after’. So the ‘counselling’ seems to be imagined more persuasively than just counselling and the ‘choice’ less than choosing, as the instruction implies. As in this example that could mean overriding the mother’s perspective until she was persuaded to be milked. The following example came from a fragment from another baby’s management progress report:

1. ALL Donor EBM – mom not sent any EBM.
2. find out what is happening to mom! Does she want to breastfeed? – has to be exclusive

The ‘all’ was in capital and underlined forcefully. The question ‘does she want to breastfeed?’ is not simply a question, that could have ‘yes’ or ‘no’ as equally acceptable answers. In the context of the neonatal unit this question is imbued with moral imperative, scientific recommendations and economic calculations.

## **Conclusion**

Medical professionals moved in and out of relations or terms with regard to the babies in the neonatal unit. There was a subtle sense of temporality and duration to this moving in and out of different kinds of relationships, from the objective relationship that is demanded by protocol to a mode of personal engagement. This was primarily reflected in the language people used<sup>47</sup>. Language was critical in how relationships were materialising, dematerialising and rematerialising into something else. ‘What’s best for this baby’ was the underlying motive for hospital staff, but the outcome, if good, remained largely unknown. These modes of objectification and subjectification are framed by the intervention that the state is making in securing breast milk production and consumption for those most vulnerable.

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<sup>47</sup> While it might be reflected in the way people handle babies, that kind of contact was minimal in the neonatal unit with its incubators.



Medical practitioners' care and affect were not accounted for in the protocols that are observed in the neonatal unit, but they were crucial for the everyday functioning. Expressed through a language of appropriation, medical practitioners cared for patients in ways that blurred what should be expected of them. Often this was necessary to resolve tensions between the protocol and patients' ability or wish to comply – informed compliance became a process of aligning patients' behaviour with medical practitioners' ideas of 'what's best', grounded in scientific recommendations and a model of scarcity pertaining to breastmilk. Economic calculations around production of milk and 'effort' put into it were implicated in who 'deserved' donor milk and who did not. For some women working in the neonatal unit in different capacities, caring for patients and their understanding of care was tied to notions of motherhood, and ideas around a model of what constitutes a 'good mother' found their way into the decision-making process around donor milk prescription.

## Chapter 6

# Between Sacred and Abject: Transformations through Moral Processes

Donated breast milk undergoes a series of transformations as it shifts from its space of production to its site of ingestion, from a particular mother-child relationship to a baby in the neonatal unit. I have characterised this as a process of making the particular generalisable. When the milk becomes generalisable, its generalisability is managed through specific techniques. It is widely represented as sacred until it exits the dyadic relation of its production and its abject qualities become apparent. These abject qualities need to be carefully managed. One way of doing this is technically, through pasteurisation and testing. Another way is symbolically, through language and practices stabilising the milk as certain kind of object.

As it moves along the donation trajectory and through the four nodal points identified in chapter four, the milk undergoes a series of transformations that ultimately leads to the foregrounding of its medical value for babies in a neonatal unit. The transformations are material and symbolic, as the meanings around the milk change, and yet also the actual entity.

The milk is offered as a gift. It receives its return (Mauss 2011) in the ways that it is conceptualised as a direct intervention to ‘saving a life’; that is, the gift recirculates on the imaginative horizon, and receives concrete form in the letter each donor receives. Meanwhile, it enters a circuit that was practically invisible to the donating mothers, who imagined their gifts as made directly to a baby. The milk circulates through a series of exchanges – between the milk bank and donating mothers, hospitals and babies, establishing an affective economy. In turn the milk bank exchanges rent-free milk for rent-free space with the hospital. In the neonatal unit, milk is made available as a gift to selected babies. In some instances, the milk is imagined as a means to bridge the gap where a mother may yet produce her own milk; in others it is a ‘good start’, however short that may be. In the former instance, giving donated milk to a baby is part of hope it will lead to an increased production of milk there.

As an alienable product, breastmilk has commodity potential in a capitalist market (see Steele et al. 2015). However, it is legally not permitted to do so, and part of the symbolic work that is happening at every stage I have identified is to ensure that it does not enter into a system of currency exchange. There are strong moral injunctions against commodification too, and the medical intervention is to try and stabilise the object as unsafe or safe.

At each point different sets of discursive structures constellate around the ideas of saving, securing and sustaining life and the values that go into that. At the same time the object is constantly secured against its own instability by these meaning-making systems. Its ontological status is stabilised by the operations that are happening around it at any given time.

Aiming to secure life, medical professionals make sets of decisions about who should receive milk. Biomedical knowledge and state policy around exclusive breastfeeding (see Tshwane Declaration 2011) shape the terms of this decision, but as I show, it is also impacted on by sets of moral ideas around the processes in which a gift is made available. The moral issues that people were navigating centre around the question of the allocation of resources, including the decision about who is worthy of receiving certain gifts. This decision was partly medical and partly grounded in affect, attachment and modalities of care.

As I have shown, milk donation and receipt rest partly on the moral forces that are at play in rendering this one or other kind of object as it moves through the process of donation and receipt. For donors it was about 'saving'. To the milk bank the imperative was securing the milk through technical procedures of expressing and storing, pasteurising and testing, packaging, and prescribing. To medical professionals at the hospital it became about not only the well-being of the baby but also the mother, whether the mother would be able to sustain the child, and what kind of help and resources they could put towards the mother while also sustaining others.

This suggests that breast milk is an unstable entity whose status is secured in different ways. Drawing on Tsing's argument (2013) that value in a capitalist system depends on gifts, a commodity is never purely a commodity, I have shown, the milk is never purely one kind of milk. It moves between different properties and is different things to different people in different contexts. Breast milk appears on the surface to be a standard human product: given that it is an innate capacity of women to produce milk, it appears to be universal, and yet the meanings even in a small sample are very differentiated. As I've shown, as milk moves from the intimate dyad in which it is produced and is made generalisable through a variety of

techniques and moral processes (both symbolic and material), its properties as food, medicine and bodily fluid are differently emphasised. Its ontological status simultaneously stands for - and stands in for - relationships of different kinds.

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# Information Sheet

Researcher: Miriam Waltz  
Social Anthropology, University of Cape Town

Project title: Breastmilk Donation: Tracing a Transforming Substance from Donor to Baby and in between

Hello! My name is Miriam Waltz, and I am a Master's student in Social Anthropology at the University of Cape Town. I am currently conducting research on breastmilk donation and receipt. This information sheet will explain more about this project and what it means to participate.

## **The Research Project**

I am following networks of milk distribution from donating mothers to recipient babies. I aim to understand people's ideas about donation and receipt of breastmilk.

## **Outline of the Research**

I will trace the path that milk follows from breast to baby. The project focuses on links between people of varying backgrounds and geographical locations. Three main groups will be included: mothers who have breastfed or are breastfeeding and have either donated or decided against it, staff and volunteers of the milk bank and the hospital who are involved in the distribution of donated milk, and caregivers of babies who are receiving milk.

## **Methods**

My research will consist of observations, informal conversation, and semi-structured interviews.

## **Ethics**

As a researcher it is my primary concern to make sure my research does not harm anyone. Anyone who participates in this research has the option to remain anonymous if they wish, and all communication with me is confidential.

Any information that I obtain will only be used with express permission of the people involved, and will not be shared with others.

If you agree to be part of this research, you can withdraw at any time, or retract any information you have previously given.

If you do not want to be part of this research, there will be no negative consequences.

If I become aware of any harm to or neglect of a child I am legally obliged to report this.

This research has been approved by the Department of Anthropology at UCT and the Human Research Ethical Committee (HREC) of the Faculty of Health Science at UCT.

## **Participation**

If you agree to be part of this research, it means giving some of your time and sharing some of your experiences. I may ask you to let me interview you for a one-on-one interview that can last between twenty minutes to 1.5 hours.

No one but me will have access to any notes or recordings I take, although I may share some with my supervisor.

I will share notes and interview transcriptions in which you feature with you to make sure you are comfortable with the information I obtained and that I understood you well. The information will become part of a Master's thesis and a journal article.

There will be no direct benefit to you in participating, but I hope that my research will contribute to the availability of donated breastmilk by getting a better idea of how donors, recipients and milk bank and hospital staff experience the process.

It is entirely your choice whether you want to participate in this research. Taking part will pose no risk for you, because the research is based exclusively on observation and interviewing. If you want to participate I will ask you to sign a consent form, which gives me permission to use the information you provide. However, you can still decide to withdraw from the research at any stage.

## **Queries**

If you have any questions or concerns about this research, you can contact me, my supervisor, or the HREC (details below). I would be happy to explain my research in person to you and answer any questions you may have. If you feel uncomfortable with anything in relation to this research, please do not hesitate to raise the issue with any of us.

### **Miriam Waltz**

Researcher

Cell:

[mhawaltz@gmail.com](mailto:mhawaltz@gmail.com)

### **Professor Fiona Ross**

Supervisor

Tel:

[Fiona.Ross@uct.ac.za](mailto:Fiona.Ross@uct.ac.za)

### **Human Research Ethics Committee**

Contact person: Prof Marc Blockman

Tel:

Ref no.: 705/2014

## Consent Form – Interview

Researcher: Miriam Waltz  
Social Anthropology, University of Cape Town

Project title: Breastmilk Donation: Tracing a Transforming Substance from Donor to Baby  
and in between

I, ....., resident at .....

agree to participate in a research project on the process of breastmilk donation and reception run by Miriam Waltz (MA student in social anthropology, University of Cape Town), under supervision of Prof Fiona Ross (anthropology, University of Cape Town).

I agree to be interviewed at a location of my choice.

I agree / disagree to an audio recording of the interview being made (please circle your choice)

I understand the objectives of the research.

I have read the information sheet, understand its contents and have had the opportunity to ask questions about it.

I understand that I am under no obligation to participate in this research.

I understand that I can withdraw from the research at any time or retract any information I have given without penalty.

I agree to information obtained being used in a MA thesis and a journal article.

I understand that information is confidential and that I can select a pseudonym if I wish.

I understand that if the researcher becomes aware of any harm to or neglect of a child she will be legally obliged to report this.

Signed .....

On .....

At .....

Researcher's signature .....

**If you would like to raise concerns, ask questions or clarify or discuss your welfare as a research participant, please contact:**

**Miriam Waltz**  
Researcher  
Cell:

**Professor Fiona Ross**  
Supervisor  
Tel:

**Human Research Ethics Committee**  
Contact person: Prof Marc Blockman  
Tel: