

**“We must be responsible for our  
children”**

**The Makings of Motherhood in Ocean View**

**Shannon Laraine O’Rourke**  
ORRSHA006

A dissertation submitted in partial fulfillment of the requirements  
for the award of the degree of Master of Social Science in Social  
Anthropology

Faculty of the Humanities  
University of Cape Town

2016

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

## **PLAGIARISM DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Acknowledgements

First off, I would like to thank the UCT Knowledge Co-op for facilitating the project and the AW Mellon 1000 days project for funding my research. A huge thanks to my supervisor, Professor Fiona Ross: you have given me a great deal of support over the past year and I am truly grateful for your wisdom and guidance throughout my research and writing process. To all the Living Hope staff who supported me during my time in Ocean View: thank you for welcoming me with open arms and sharing stories about your lives that I will never forget. To Aunty Martha: thank you for letting me be your shadow and for teaching me what it means to do a job with a heart of love. I have the upmost respect for the support and care you provide to mothers and babies in the community. You are an inspiration to me and I will always remember the time we spent together. Last but not least, I am very grateful to all the mothers who participated in my research: thank you for opening your homes and sharing your experiences with me.

## Table of Contents

<b>Abstract.....</b>	<b>5</b>
<b>Chapter 1: Introduction.....</b>	<b>6</b>
<i>Research Question.....</i>	<i>6</i>
<i>Background.....</i>	<i>7</i>
<i>Research Setting.....</i>	<i>8</i>
<i>Research Participants.....</i>	<i>11</i>
<i>Methods.....</i>	<i>13</i>
<i>Ethics.....</i>	<i>17</i>
<i>Chapter Outline.....</i>	<i>19</i>
<b>Chapter 2: Constructions of Motherhood and Care in Literature.....</b>	<b>22</b>
<i>Family life in economically marginalized communities in South Africa.....</i>	<i>22</i>
<i>Feminization of poverty and its effects on the maternal/infant relationship.....</i>	<i>24</i>
<i>Responsibilization and Discourses of Motherhood.....</i>	<i>25</i>
<i>Framings of Care.....</i>	<i>29</i>
<i>Concluding Thoughts.....</i>	<i>31</i>
<b>Chapter 3: Addressing Lack: The Discourse of Deficiency in Ocean View.....</b>	<b>32</b>
<i>Dispossession and Sustaining Social Worlds.....</i>	<i>34</i>
<i>Emotional Responses to Power: Roles of religion and education in dealing with deficiency.....</i>	<i>37</i>
<i>Concluding Thoughts.....</i>	<i>41</i>
<b>Chapter 4: Risk and Responsibility.....</b>	<b>42</b>
<i>Inter-embodiment: mother and infant as “entwined presences”.....</i>	<i>42</i>
<i>Surveillance: the mother as risk-manager.....</i>	<i>47</i>
<i>"If a mother is HIV positive, she must make good choices": The construction of the responsible citizen.....</i>	<i>51</i>
<i>Concluding thoughts.....</i>	<i>53</i>
<b>Chapter 5: “I never knew that a little person like that could manipulate a big woman like me”: The Demands of Care.....</b>	<b>55</b>
<i>Proper Care Practices: The ideal MOTHER.....</i>	<i>56</i>
<i>Breast is Best: motherly love and nourishment.....</i>	<i>59</i>
<i>Giving Care, Taking Care: competing demands and the struggle for self-care.....</i>	<i>62</i>
<i>Networks of Care.....</i>	<i>64</i>
<i>Concluding Thoughts.....</i>	<i>68</i>
<b>Chapter 6: In Conclusion: Disrupting the discourse of deficiency.....</b>	<b>70</b>
<b>References.....</b>	<b>73</b>
<b>Appendices A-D.....</b>	<b>78-80</b>

## Abstract

This thesis explores conceptions and experiences of motherhood in Ocean View, South Africa through the investigation of a maternal and child health intervention. The Moms and Tots support programme seeks to provide mothers with health education and supportive social networks to improve maternal and child health in a resource-poor context. Based on data collected from participant observation and interviews, three major themes have emerged from the research: the framing of Ocean View and its residents within a discourse of deficiency, the responsabilization of the mother, and the demanding nature of care in the face of resource scarcity. Notions of the ideal mother represent a moral discourse around what it means to bring a new life into the world, and who is equipped to do so. I argue that positioning the mother as the site of intervention for improved well-being of future generations underplays the political-economic context that shapes physical, mental, and emotional health in Ocean View. Knowledge interventions that seek to produce behaviour change must focus on the mother's potential rather than risk and adequately acknowledge the constraints in social and material environments if they are to offer viable solutions for health improvement. The Moms and Tots programme plays a vital role in diffusing maternal responsibility through offering social and material networks of support to mothers in Ocean View.

## Chapter 1: Introduction

When I arrived in Ocean View for a site visit prior to beginning my research, a woman named Aunty Martha greeted me with a welcoming smile and a big hug. Aunty Martha is a community care worker at Living Hope and runs the Moms and Tots support programme in Ocean View. Upon our first meeting, Aunty Martha shared her thoughts on the importance of the support programmes in terms of mothers learning about self-care and baby care. As many of the women who take part in Aunty Martha's group are young, first-time moms, she feels a need to provide a "safe space" for them to talk about their struggles in caring for their babies and educate them on important topics such as breastfeeding. Throughout the course of my research, I gained a great deal of respect for the way in which Aunty Martha treated the moms and acted as a source of support, both within the group and outside of it. "You have to do your job with a heart of love", she told me, "it can't be something you do just for a little bit of money". Aunty Martha's labour was of the heart, and the way she cared for mothers and babies proved to be central to the success of the programme.

This depiction of Aunty Martha and her role in the Moms and Tots support programmes evokes central themes that have emerged from my research: the making of the responsible mother and the place of education in doing so, forms of care, and addressing lack in a resource poor community. When the built environment is seen as deficient, the individual who is responsible for sustaining a new life is faced with the challenge of care. Social programmes can offer support through education and the building of social and material networks, but it is vital to identify the structural constraints that impact care practices. The Moms and Tots support programme supplements maternal knowledge and facilitates networks of care that impact upon maternal and infant well-being.

### ***Research Question***

During my fieldwork in Ocean View, I often reflected upon the challenges that would arise when trying to raise a healthy baby in this community. I was struck by the ways in which caregivers must navigate constraints in infrastructure, health and safety,

access to resources, social networks, disease (HIV and TB, diarrhea), self-care, violence, poverty, theft, and more. In an attempt to evaluate the extent to which Living Hope support programmes are resulting in positive effects for the babies of the mothers who take part in these programmes, I developed the following research question:

*In what ways does the Living Hope Moms and Tots programme impact on maternal knowledge and support networks that affect infant health?*

The research explores how an NGO understands and enacts maternal support in the interests of child well-being in a resource-poor context. Working with mothers who had been through Living Hope's eight-week programme since 2013, the project aimed to give qualitative information to the NGO about the effect of their programme, the constraints of social and material environments and the well-being of mothers and children post-intervention.

### ***Background***

This research project is a UCT Knowledge Coop (<http://www.knowledgecoop.uct.ac.za>), AW Mellon 1000 Days (<http://www.thousanddays.uct.ac.za/>), and Living Hope (<http://www.livinghope.co.za>) collaboration to explore the effects of a caregiving programme on childcare practices. Living Hope, a Baptist faith-based organization and NGO based in Capri, conducts intervention programmes in communities in the Southern Cape Peninsula. While the goals of this organization have a religious component, there is a strong focus on the prevention, care, and treatment of people affected by chronic illnesses. Living Hope aims to undertake community development through education, social and health programmes.

The Moms and Tots group is an eight-week programme that has been running since September 2013. Living Hope is conducting this programme with the assumption that gaining knowledge about best practices for childcare will cause a change in behavior. The Moms and Tots programme is health focused and works to teach skills about basic motherhood, as Living Hope believes that many new moms have not had any instruction on basic things such as nursing/feeding, hygiene, safety, etc. Each of the eight weeks is themed, covering the following topics: Care of Baby, Care of Mom, Breast is Best, Why Babies Cry, Sick Children, Sexual Health and HIV, Nutrition, and Child Development.

The goal of the programme is to address the needs of new mothers and improve the health of the baby. There is a strong focus on keeping a baby HIV negative if the mother is positive. During the sessions, mothers are welcome to ask questions and seek guidance about their particular situation. Emphasizing a relationship with God is seen as a major aspect of the programme. During an interview about the planning of the programme, one programme developer stated, “ God helps us be the moms we want to be”. Although the programme operates in two areas – Ocean View and Masiphumelele – time constraints and social unrest disqualified Masiphumelele as a site. I concentrated on research in Ocean View.

### ***Research Setting***

As a result of the Group Areas Act, Ocean View was established in 1968 as an area of housing for coloured<sup>1</sup> people who were forcibly removed from their homes in surrounding areas that were re-zoned white (Moses, 2008: p.106). While the Group Areas Act was nullified with the end of Apartheid, Ocean View is still a predominantly coloured community (91%) with a small African presence (7%) (Statistics South Africa, 2011). Based on data from the 2011 census, the population of Ocean View is 13,569, and the average household size is 4.40 (See Appendix D for further details on demographic distribution of male: female headed households). The unemployment rate in this community is 20.8% among the labour force (ages 15-64), and 48% of households have a monthly income of R3,200 or less (Statistics South Africa, 2011). Moses (2008) states that Ocean View can be described as a community that is experiencing economic stagnation and deepening poverty (p.106). Based on social research among children in the community, Moses (2005) asserts that the children she consulted in Ocean View do not experience their community as safe (p.10). She states, “the danger and lack of security experienced by children and young people is connected to both the physical built environment (the presence of dark, open spaces) and more importantly to the social problems of alcohol and drug abuse and the associated violence in both public and private

---

<sup>1</sup> While this term no longer has legal currency, it is still commonly used and is a category employed in demographic analyses. Erasmus states, “coloured identities are not based on 'race mixture' but on cultural creativity, creolized formations shaped by South Africa's history of colonialism, slavery, segregation and apartheid (2001: 4). My use of the term 'coloured' does not imply acceptance of apartheid terms or ideologies.

spaces” (Moses, 2005: p.10). Moses also claims that as children get older, their concerns tend to shift from violence and physical danger to the social and emotional problems within the community, such as lack of support and unemployment (2005: p.11).

A lack of recreational services has proved to be a major concern for young people in Ocean View, and has been linked to high rates of substance abuse (Moses, 2005: p.121). While conducting a study on childhood in both Ocean View and Masiphumelele, researchers were struck by the greater number and range of clubs and social activities available in Masiphumelele compared to Ocean View (Bray et al., 2010: 114). Moses argues that this may be due to “current popular thinking which defines the previously ‘coloured’ township of Ocean View as less ‘needy’ than the predominantly black African township of Masiphumelele” (2005: p.122). This perception of Ocean View as having less need for services is challenged by statistics on violence and crime in the community in comparison to Masiphumelele. Police data from Ocean View police station (also serving Masiphumelele) reveals that about 70 percent of all assault cases occur in Ocean View, and the remaining 30 percent in Masiphumelele (Bray et al., 2010: p.121). Similarly, 80 percent of all cases of burglary, theft, and damage to property occur in Ocean View, and the remaining 20 percent in Masiphumelele (Bray et al., 2010: p.121).

A great deal of this crime is allegedly motivated by the need to fund a drug addiction, which is more prevalent in Ocean View than in Masiphumelele or Fish Hoek (Bray et al. 2010: p.125). Tik (crystal methamphetamine) is a major issue in Ocean View: in 2005, the head of Ocean View Secondary School reported to the *Cape Times* that about 60 percent of pupils (more than 700 young people) were tik addicts (Bray et al. 2010: p.126). Bray et al. state, “Many young residents of Ocean View struggle to form a positive notion of community because they perceive the social dynamics in their neighbourhood to be the antithesis of the social factors required to create a ‘community’” (2010: p.126). In local media, Ocean View is often portrayed as a community rife with substance abuse, violence, and crime. It is vital to consider how this portrayal creates stigmatizing effects for community residents and reinforces the idea of Ocean View as an inadequate social environment.

Struggles within the community have been linked to the traumatic experience of forced removals. Trotter (2009) asserts that coloured individuals displaced by the Group

Areas Act carry a unique historical and emotional burden, but these same individuals have also found built networks of trust and comfort with other removees who share similar narratives (p.73). He states, “The trauma of removals compelled victims to seek one another out for sharing, empathy, and solace” (Trotter, 2009: p.72). While in Ocean View, I spent a good amount of time with women in their 50’s and 60’s who worked for Living Hope. I found that when one person shared something about their experience of displacement, others would often speak about their own experiences, as if saying, “I share your pain”. A number of individuals shared stories about their lives before the Group Areas Act, and many identified attempts to seek restitution. One of the most common attempts was applying for land restitution claims to obtain payment for the property that was lost during the forced removals. While this payment can be seen as some form of reparation, the individuals that I spoke to received only a fraction of what the land is actually worth.

### Research Participants

Name	Age	Education completed	Number of people in household	Language	Relationship Status	Presence of Father	Sources of Income	Employment	Self-Ascribed Racial Identity
Tracy	25	Grade 12	5 (Herself, husband, 3 kids)	English/Afrikaans	Married	Live together	2: Her own, and husband's	Employed	Coloured
Nazia	24	Tertiary	4 (Herself, husband, 2 kids)	English/Afrikaans	Married	Live together	1: husband's	Unemployed	Coloured
Tasneem	17	Grade 8	10 (Parents, 6 siblings, 2 babies)	English/Afrikaans	Single	Involved, stays nearby	2: Baby's father, her parents	Unemployed	Coloured
Johanna	31	Grade 11	8 (Herself and her two children, Sister's family (5))	English/Afrikaans	Separated (still legally married)	Live separately, involved on weekends	1: Husband	Employed	Coloured
Hannah	24	Tertiary	5 (Herself, partner, partner's father, 2 kids)	English/Afrikaans	Partner (stay together)	Live together	2: Her own, and husband's	Employed	White
Sara	?	Grade 12	4 (Herself, husband, 2 kids)	English	Married	Live together	?	Unemployed	Coloured
Danielle	34	Grade 9	5 (Herself, boyfriend, 3 kids)	Afrikaans	Partner (stay together)	Live together	1: Boyfriend's	Unemployed	Coloured
Anya	30	Grade 9	7 (Herself, husband, husbands parents, 3 kids)	Afrikaans	Married	Live together	Child support grant money	Unemployed	Coloured
Melissa	?	Secondary	?	English	Single (in relationship with father of children)	?	?	Unemployed	Coloured

**Figure 1:** Demographic information of research participants (question marks indicate data that was not obtained)

The strength of Aunty Martha's community ties became clear when I was recruiting research participants for my study. Every mother that Aunty Martha contacted was happy to hear from her and willing to meet me for an interview. The only women that I was not able to interview were mothers who had full time jobs and could not meet me during daytime hours. My research sample consists of nine mothers who have completed the Moms and Tots support programme at some point since September 2013. Living Hope was able to provide me with the demographic information of some of the moms who participated in the support programme in 2015. Comparison between my demographic data and that of Living Hope reveals that the women I interviewed were more likely to be in relationships with the father of their children, have a higher level of education, and are more likely to be employed than other women who completed the

support programme in 2015. My sample was not selected at random, but rather on the basis of personal networks. This may explain some of the difference between my sample and other women who participated in Living Hope support programmes in 2015.

<b>Marital Status</b>	<b>Employment Status</b>	<b>Education</b>	<b>Language</b>	<b>Race</b>
Single	Unemployed	Secondary	Afrikaans	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Single	Unemployed	Secondary	English	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Single	Employed	Secondary	Afrikaans	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Married	Unemployed	Secondary	English	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Married	Unemployed	Secondary	Afrikaans/English	Coloured
Married	Unemployed	Secondary	Afrikaans	Coloured
Married	Unemployed	Primary	Afrikaans	Coloured
Single	Unemployed	Secondary	English	Coloured
Single	Unemployed	Secondary	Afrikaans	Coloured
Married	Unemployed	Secondary	Afrikaans/English	Coloured
Single	Employed	Secondary	English	Coloured
Married	Unemployed	Secondary	English	Coloured

**Figure 2:** Sample of 18 women who have participated in the Moms and Tots programme in 2015.

While Living Hope’s data is not as detailed as mine, it is still possible to make comparisons in certain categories. In terms of employment, three out of nine of my participants (33.3%) stated they were employed, while among the 2015 sample, only two out of eighteen (11.1%) reported being employed. Compared to the Ocean View statistic of a 20.8% unemployment rate, we can conclude that both my research participants (66.6%) and the 2015 sample (89.9%) experience a much higher rate of unemployment than the community average. In Ocean View 6.8% of the population has no schooling, 11.8 % has some primary, 7.6 % has completed primary, 48.1% has some secondary, 21.8% has completed grade 12, and 2.9% has higher education (Statistics South Africa 2011). Both my research sample and the 2015 sample have a higher education level than the community average. The fact that the moms who participate in the Living Hope support programmes have higher levels of education than the community average could

indicate that Living Hope is accessing a certain subset of the population. This could mean that the mothers who participate in the support programmes may not be the most “at risk” moms in the community. It is also important to consider that the average education levels in the community could have shifted in the past four years, as I am working with demographic data of the community from 2011 and Living Hope data from 2015.

In terms of relationship status, five of my participants reported being married, two are in ‘committed partnerships’ and live with the father of their baby, and two are single but have a relationship with the father of the baby. While I do not have detailed information about the nature of the relationship status of the 2015 participants (Living Hope only recorded marital status), six out of eighteen women (33.3%) of the 2015 reported being married, which is lower than the 55.5% of my research participants who are married. While being married does not necessarily equate to having a supportive partner, it is important to consider how this higher incidence of marriage among my research sample could have affected my findings on the well-being of the moms and babies who have completed the support programme. When asked about other forms of support, the mothers in my study often described the baby’s grandparents (maternal or paternal) as providing some sort of social or material support.

### ***Methods***

As I sat in on the Moms and Tots support programme during a site visit, I was taken by the way that Aunty Martha interacted with the mothers in the group. From reading the programme outline, I had expected the session to be structured in a way that the facilitator would speak about specific health topics and then take questions at the end. Yet Aunty Martha spoke casually with the women and allowed them to speak about their own experiences instead of giving a structured session in which she disseminated information. She seemed to know each mother on a personal level and was very encouraging when women shared the difficulties they were facing in their roles as caregivers.

I begin the discussion of my methods with a focus on Aunty Martha because my relationship with her had a significant influence on my methods of data collection. My association with Aunty Martha caused my research to be shaped by a politics of both inclusion and exclusion. In this section, I will outline the ways in which this association

impacted my fieldwork and my thoughts on how it affected the way I was perceived in the community.

The Living Hope community fieldworker, Aunty Martha, introduced me to the women who became my sample. Her sustained connections with these women made my task of finding research participants much easier than I had expected. I conducted formal interviews with nine mothers who had completed the programme and had informal conversations about the programme with a number of others and with Living Hope community workers and leaders. My relationship with Aunty Martha shaped the daily activities that became additional modes of data collection. As I had been advised not to walk around the community on my own, Aunty Martha allowed me to accompany her on her daily routines in the community, which were centered on health promotion for mothers and babies. This gave me a set routine during the days I spent in Ocean View (Tuesday-Friday), and also gave me the chance to develop a relationship with a woman who had spent the majority of her life in Ocean View and knew a great deal about raising babies in the community.

While my relationship with Aunty Martha gave me an immediate “in” with mothers who had participated in the support groups, it is also important to recognize how her presence may have impacted what was shared with me during interviews. As many of the questions that I asked were centered around the mother’s experience in the programme, it is possible that women may have been more hesitant to share critical thoughts with the programme facilitator present. In terms of questions around baby care, the mothers may have been wary of revealing care practices that were deemed wrong or undesirable in the support programme. For example, Aunty Martha is a very strong advocate of exclusive breastfeeding, and would discourage mix feeding regardless of a woman’s HIV status. While I never heard Aunty Martha reprimand a woman, it’s possible that women could have been reluctant to share their experiences of feeding practices deemed to be undesirable.

### Participant Observation

While there were certain days that I would attend activities at the Living Hope office in Capri, I established a schedule with Aunty Martha in Ocean View. I arrived to the office at 7:45 am and attended the daily devotion that began at 8am, which usually lasted between 45 minutes to an hour. After devotion, Aunty Martha and I often had tea with a few of the women who run other Living Hope support groups before the daily activities began. On Tuesdays, we ran a support group in the home of a woman who we met in the clinic. This group usually consisted of seven or eight mothers who lived relatively far from the Living Hope offices and found it easier to meet in the home of one of the women. Wednesday was clinic day—Aunty Martha gave health talks to mothers in the waiting room and I spoke to mothers about their experiences of baby care and told them about the support group that Living Hope has to offer. When in the clinic, we would check in with Sister Africa, who occasionally gave us referrals to go on home visits. Another support group took place every Thursday at Living Hope offices, beginning at 11am and would usually last around an hour and a half. On Friday, there were often events taking place at Living Hope offices in Capri, but when there was a free day, I accompanied Aunty Martha on home visits. We went to the homes of mothers who had recently given birth, or to homes where Aunty Martha wanted to follow up due to worries she had about the mother or baby.

It is vital to acknowledge how my personal identity affected my fieldwork experience. As an American in South Africa, many of the mothers I encountered wanted to know what I thought of the country and why I was here. As a white, middle class young woman, I feel that my identity as a foreigner may have allowed women to be more open with me than if I was a white South African. When women shared stories about their past and how their current situations have been shaped by it, I felt they were trying to educate me on the difficult history of Apartheid South Africa and its current manifestations in their social world. I believe that my age (24 years old) and status as an unmarried, childless woman also impacted on my interactions with research participants. Almost every woman that I interviewed or spoke to asked me if I had children of my own. After explaining that I would like to have children at some point, many of the moms, even ones that were five or six years younger than me, would share their

experiences in a way that gave me the sense that they were sharing information that I may use in the future.

My inquiry about experiences of motherhood in Ocean View was thus not informed by my own experience of motherhood. While this lack of experience made it difficult to relate to raising a baby, it also allowed me to inquire without judging mothers based on my own experience. Jacobson (1991) suggests that one's positionality shapes both observations and interpretations (p.7). The interests and activities among the people whom the anthropologist is doing research influence what the anthropologist is able to observe (Jacobson, 1991: p.7). Jacobson states that gender has a significant influence on access to people and events (1991: p.7). I feel that being a woman was key to my acceptance into certain environments, such as support groups and home visits, which were completely female. As the women I worked with were constantly breastfeeding and often speaking about intimate bodily or emotional experiences, I feel that a male ethnographer would have posed more of a disruption to this particular setting. In terms of limitations, I had almost no opportunity to interact with men in the community. As the majority of my time was spent among mothers or female staff (Living Hope), I did not get the chance to access men and inquire towards their experiences and perspectives on raising children in Ocean View.

### Interviews

The majority of interviews that I conducted took place in homes. I found the home environment best because it caused less of a disruption for the mother and baby and allowed me understand more about the social and material environment that impacted baby care. In total, I interviewed nine mothers: five interviews took place in home environments, three in the Living Hope offices, and one in the clinic. My interviews usually consisted of three parts: obtaining demographic information, asking a set of questions around the impact of the support programme, and finally inquiring into the relationship between the mom and the baby (see Appendix A, B, and C).

I found it necessary to alter my research methods throughout the course of my fieldwork. While I originally planned on conducting focus groups, after conducting my first interview with two mothers together, I realized that I would learn more if I

conducted in-depth, one-on-one interviews with mothers. As the support programme positions the mother as the site of intervention for infant health, I found that focusing on experiences of care articulated by the mother proved to be central to my understandings of infant well-being. Questions such as “How do you know how your baby is feeling?” or “Tell me about your baby’s personality” allowed mothers to speak about they learn about their babies and care for them. Out of the nine formal interviews, babies were present in six. When I asked questions about baby care, I found that the baby’s presence encouraged mothers to go into greater detail, and it also allowed me to witness the interactions between the two.

### *Language Barriers*

As someone who does not speak Afrikaans, I anticipated the need for a translator for interviews and other activities prior to beginning my research. Although Ocean View is primarily an Afrikaans speaking community, all of my research participants spoke English very well, and therefore all interviews were conducted in English. In the instance that any word or phrase was misunderstood, Auntie Martha would translate. Support groups were also conducted in English. I found this surprising, but Auntie Martha explained that sometimes women from outside Ocean View who do not speak Afrikaans attend. Daily devotions and Living Hope staff events were always conducted in English due to a mix of staff from Ocean View, Masiphumelele, and Capri.

### *Ethics*

As this project was born out of a partnership between Living Hope and the UCT Knowledge Co-op, I was required to sign a Memorandum of Understanding (MOU) prior to beginning my research. In this MOU, I agreed to share my research proposal with Living Hope, conduct fieldwork that would include feedback on the outcomes of the Moms and Tots programme, and share my findings with Living Hope upon completion of research. In the departmental ethical clearance session, one of the major concerns raised about my research was the issue of being “beholden” to an organization (Living Hope). Living Hope approached the UCT Knowledge Co-op with a request for a student to assess the impact of an eight-week support programme for mothers (especially HIV

positive ones) on the health of their newborn babies over time. It is important to note my positionality as a researcher in relation to the organization: I do not hold strong religious beliefs and identify as agnostic. Additionally, unlike my research participants, I do not have children and have never been pregnant. During an initial meeting about my participation in this research, one of the founding members of Living Hope stated that she knew that the support programmes were beneficial; she just needed more concrete evidence to be able to continue and receive funding. This statement illustrates an ethical dilemma of shaping research to fit the needs of the organization. In order to avoid this, I found it helpful to focus on imaginings around efficacy and beliefs held by the organization. The following research questions allowed me to interrogate held beliefs:

- What are the imagined care practices held by Living Hope and how do they materialize in the support programmes?
- In what ways does Living Hope work to shape parenthood, and how do their beliefs about parenthood translate into practice? Does the religious discourse shape ideas about what makes a good parent?
- Are there both intended and unintended outcomes of the support programme?

Looking at the ways in which Living Hope imagines their programmes and comparing these imaginings to the experiences of the mothers who had completed the programmes helped me transform an ethical dilemma into a point of inquiry. As one of the aims of my research was to feed qualitative information back to Living Hope about the effect of their programme, I found it useful to employ a recursive method. This method allowed me to feed findings back to Living Hope en route so that the critique could inform Living Hope's ideas, and through discussion, they modified my own understandings of the organization. At the end of the research period, I conducted a formal feedback session for the organization.

In addition to working around the idea of being "beholden" to an organization, I found it necessary to navigate sensitive relationships between Living Hope staff members. When staff members shared frustrations with me, I was careful to avoid sharing that information with the opposing party. In the case where I felt that sharing grievances about a certain procedure or structural issue would be beneficial, I would always ask the individual that voiced the complaint if they would like me to pass along the critique to the management staff that I met with each week. In this case, I would

maintain anonymity and frame the critique as an outcome of my observations and interactions when presenting it to management.

During the course of my research, I obtained informed consent both verbally and through the signing of a consent form. The American Anthropological Association states, “The informed consent process is necessarily dynamic, continuous, and reflexive. Informed consent does not necessarily imply or require a particular written or signed form. It is the quality of the consent, not its format, which is relevant” (AAA Ethics Blog, 2012). Recognizing consent as an ongoing process proved to be vital in circumstances in which I was meeting with mothers in the support groups week after week, and during each session, new information would be shared. At each session, I would remind mothers that I would like to include the conversations that took place during the sessions in my thesis, but if they did not want their opinions or experiences shared, I would gladly omit them. Every mother that I conducted a formal interview with signed a consent form and understood that I would include her demographic information as part of my research sample. In this thesis, I have changed the names of all research participants in order to maintain confidentiality. As the mothers who participated in formal interviews usually gave up an hour or more of their time to speak with me, I found it important to show my appreciation for their involvement. At the end of my research period in July, I invited all the mothers to a lunch that I hosted at Living Hope in Ocean View and gave them a few baby care items such as aqueous cream and diaper wipes.

### ***Chapter Outline***

Drawing upon a number of experiences and observations from my fieldwork in Ocean View, I aim to think critically about how Living Hope support programs work to address a perceived lack in the community through educating mothers on proper care practices. I explore framings of deficiency and identify how individuals respond to and cope with precarious life circumstances. Perceptions of lack do not always account for the ways in which structural inequality has produced instability within the community. The care that a baby receives is shaped by access to social and material resources, which have been greatly impacted by political-economic context and a history of oppression in Ocean View. The following chapters examine the different ways in which mothers are rendered responsible for infant well-being and expected to carry out certain forms of care

despite major structural constraints. The Moms and Tots support programme plays an essential role in augmenting maternal knowledge and engaging networks of support outside the domestic realm that empower women in caring for themselves and their children.

In Chapter Two, I position my argument within a broader body of literature on family life in economically marginalized communities in South Africa, responsabilization and discourses of motherhood, and framings of care. This literature explores how political-economic context influences well-being and the ways in which mothers are made responsible for providing certain forms of care to ensure the health of future generations.

In Chapter Three, I situate social life in Ocean View within a historical framework of dispossession and structural inequality. I articulate the ways in which both individuals and the community are constructed as deficient rather than the contexts and histories that have produced inequality and precarious living conditions. ‘Coping’ through religion and ‘improving oneself’ through education are routinely offered as modes through which individuals can address inadequacy. I argue that the normalization of structural violence produces the effect of making individuals accountable for their own well-being despite resource scarcity and structural constraints.

In Chapter Four, I draw upon the concept of responsabilization to think critically about notions of risk, surveillance, and culpability within the discourse of motherhood in Ocean View. I explore how the interconnected nature between mother and infant bodies often renders the mother responsible for her baby’s well-being, yet precludes the influence of the contexts and relationships that affect her ability to care. Surveillance is offered as a form of harm-reduction and evokes specific discourses around vulnerability and risk. Within the discourse of responsabilization, the mother is positioned as the source of both harm and well-being to the infant.

In Chapter Five, I explore how the assertion of proper care practices creates a specific discourse around the ideal mother and women are expected to achieve certain standards of care despite competing demands and constraints. I argue that infant well-being is determined by much more than the care practices of the mother and it is vital to acknowledge how networks of care and resource availability shape the well-being of the

infant. The Moms and Tots programme plays a vital role in emphasizing that women are not alone in raising children and facilitates networks of social and material support to empower mothers in the community.

## Chapter 2: Constructions of Motherhood and Care in Literature

### *Family life in economically marginalized communities in South Africa*

As Ocean View is a community that has been historically oppressed under the apartheid regime, it is vital to consider how this legacy plays affects family life and motherhood in the community. Budlender and Lund (2011) argue that the apartheid regime has led to the state-orchestrated destruction of family life for racial groups that were oppressed by the regime. The authors state, “the disruption of family life has resulted in a situation in which many women have to fulfill the role of both breadwinner and caregiver in challenging circumstances of high unemployment and very limited economic opportunities” (2011: p.926). This disruption of family life is illustrated in the fact that only 35 percent of children in South Africa live with both their mother and father (Budlender and Lund 2011: p.56). This statistic is different in the Western Cape, with 56% of children living with parents, but it is important to consider how this figure is altered in an economically marginalized community. In the poorest 20% of South African households, only 18% of children have both parents living with them (Hall and Meintjies, 2014). The data on co-residence are age-dependent: 37% of children age 0-2 live with both parents, 52 % live with only their mother, 2 % with only the father, and 10% live with neither biological parent (Berry et al., 2013: p.89). These statistics illustrate the importance of looking at the burden of care placed on women, as well as caregiving roles outside of the nuclear family model.

Bray et al. (2010) also explore the way in which the legacy of apartheid has led to fragmentation of families of children and adolescents, and assert “patterns of co-residence do not accord neatly with the racial divisions of apartheid” (p.94). In Ocean View, it is common for children and adolescents to seek care from family members and friends who do not live with them, as authors state “movement between extended family and neighbours’ homes is intrinsic to sociality among adults and children” (Bray et al., 2010: p.92). While children are able to seek support from caregivers outside the home, ethnographic research illustrates the stability and security of children is improved when living with both parents (Bray et al., 2010: p.57). This sentiment was also echoed in an

informal interview with Angela Nicks, a social worker in Ocean View, who asserts that in her experience, “the kids who do best have both parents involved in their lives” (Ms. Nicks 2015, pers. comm., 21 April). She states that even if the parents do not live together, children who have supportive relationships with both their mother and father are less likely to become involved in issues such as tik use and gang violence (Ms. Nicks 2015, pers. comm., 21 April).

Her perspective is backed by social research. In the article “Childcare and Poverty in South Africa”, Bray and Brandt (2007) look at the relationship between everyday dynamics of childcare and the greater social and economic circumstances that characterize poverty in Masiphumelele<sup>2</sup>. The authors argue that gaining insight into the interaction between poverty and childcare requires researchers to “look closely at the ways in which particular facets of poverty in a given place and time influence individuals and their intimate relationships involving the care of children” (Bray and Brandt, 2007: p.4). Through their close analysis of child care relationships in Masiphumelele, the authors find that while economic security has a significant influence on childcare, it is vital to focus on the emotional component of childcare relationships and how this has a strong influence on a child’s upbringing (Bray and Brandt, 2007: p.13). Focusing on this emotional component can also help to deconstruct some common assumptions such as the idea that living in a resource-poor environment will automatically lead to an unhappy or unstable childhood (Bray and Brandt, 2007:13). Through their ethnographic research, authors are able to conclude that quality of childcare depends on physical proximity (for example, co-residence) and relational proximity (close kinship ties, strong networks) (Bray and Brandt, 2007: p.15).

I shall be drawing on these arguments in exploring the ways that formations of care are generated around the infants whose mothers have been part of Living Hope’s intervention. Bray and Brandt’s research emphasizes the importance of the supportive social relationships that surround mothers and babies. As I discuss in Chapter 5, networks of care have a strong influence upon the well-being of both mother and baby in Ocean View. Bray and Brandt’s findings also draw attention to the way in which child rearing in an economically marginalized community is automatically viewed within a discourse of

---

<sup>2</sup> A township about 5 kilometers from Ocean View

deficiency. In Chapter 3, I explore the construction of Ocean View as a community that is lacking in multiple senses and assert that the political and historical contexts that have produced precarious living conditions are often ignored.

### ***Feminization of poverty and its effects on the maternal/infant relationship***

In the South African context, poverty and inequality are closely related to gender, race, and class, and poverty is strongly feminized (Kehler, 2001: p.42). In South Africa, women are much more likely to experience the struggles of raising a child without a partner, as 52 percent of children ages 0-2 are living with their mother only, versus only 2 percent living with father only (Berry et al., 2013: p.89). As Kehler (2001) notes, where women are primary income-earners, usually in low-paid jobs, the economic necessity of work may stand in the way of adequate care for themselves and their babies.

Increasing poverty among women has affected the emotional relationship between a mother and her baby. Drawing upon attachment theory, Cooper et al. (2009) state that the capacity of parents to provide the kind of care that creates a secure attachment during infancy is compromised in adverse situations such as poverty and maternal depression. Yet they also find that a large percentage of the children they observed are well-attached – which suggests the extraordinary effort people go to in providing childcare in difficult circumstances. In their explanation of attachment theory, Levine and Norman (2008) state:

All human infants become attached to the mother or another caregiver during the first year, but they become “securely” or “insecurely” attached according to the sensitivity of their caregivers. Sensitive response to infant signals leads to secure attachment, insensitive caregiving in this sense leads to two kinds of insecure attachment, “avoidant” and “resistant”. (p.130)

It is vital to consider how the mother/infant relationship is affected by resource scarcity, and work against the idea that insecure attachment is solely a result of poor mothering. Through their assessment of an intervention designed to improve the mother-infant relationship and security of attachment in Khayelitsha, a township with both high rates of poverty and maternal depression, Cooper et al. (2009) found that a home based intervention project led to improved outcomes for both mom and baby. This intervention consisted of training lay community workers, all women who were mothers themselves,

in basic parenting and counselling skills. The women in the intervention group were visited twice during their pregnancy, and a total of 14 times after giving birth, with the intervention ending at 5 months postpartum (Cooper et al., 2009). When assessed at 18 months, infants of mothers in the intervention group were rated as more securely attached to their mothers than infants in the control group (Cooper et al., 2009). This intervention draws on community resources and proves to be low cost and effective. In Chapter 5, I explore how the Moms and Tots facilitator, a community worker with strong social networks and a commitment to supporting mothers and babies in the community, shapes the success of the programme through her ability to establish emotional ties with the women who participate.

### ***Responsibilization and Discourses of Motherhood***

Broad social discourses around motherhood emphasize the influence of the mother upon infant well-being and often underplay the contexts and relationships that influence her ability to provide care. Within this framing, the mother is made accountable through a process of responsabilization. The concept of responsabilization is based in neoliberal discourses of self-regulation, and asserts the liability of the individual for his or her own health and safety, despite direct exposure to unsafe conditions (Gray, 2009). Discussing the assertion of individual responsibility in the workplace, Gray (2009) claims that the responsabilization strategy of health and safety “reconfigures employee individual responsibility for risk while neglecting the social and political culture in which individual responsibility is embedded and experienced” (Gray, 2009: p.328). Within this neo-liberal conception of responsibility, there is a strong focus on the actions, or lack of actions, of the individual (Gray, 2009). Framing individual actions as determining health and safety ignores the various power structures and particular circumstances that shape autonomous behaviour, and therefore places the individual at the center of blame (Gray, 2009). Robins (2006) examines the responsabilization model in HIV/AIDS activism in South Africa. He asserts that models of health promotion and rights-based mobilization demand responsible citizens, which are those who empowered, knowledgeable, and liable for their own health (Robins, 2006). These models do not adequately acknowledge the subjective experience of illness and how it is shaped by structural forces (Robins, 2006).

The responsabilization framework provides an analytical lens through which to view constructions of motherhood, particularly in resource-poor contexts. During my research in Ocean View, I found that mothers were viewed as responsible for ensuring the health of the future generation, despite significant structural constraints. This expectation is influenced by social and cultural underpinnings of the ideal mother, which shape women's subjective experiences of raising a baby. A review of the literature on conceptions of motherhood illustrates the ways in which the mother is produced as a responsible subject.

In the mid-1990s, Hays (1996) coined the term "intensive mothering" to describe the growing belief that the primary identity of the ideal mother should be a caregiver who dedicates a great deal of resources and energy to raising children. Since the creation of this term, a number of studies (see Blair-Loy 2003, Hays, 1996, McCormack, 2005) have revealed that the ideology of intensive mothering cuts across racial/ethnic and social lines (Elliott, Powell, and Brenton, 2015: p.352). Hays (1996) argues that intensive mothering is defined by three themes: the mother as the central caregiver, the mother devoting great amounts of time, energy and resources to her child, and finally regarding mothering as more important than her career or paid work (p.8). Reflecting on the standards of intensive mothering, O'Reilly (2004) claims, "this normative discourse of mothering polices all women's mothering and results in the pathologizing of those women who do not or can not practice intensive mothering" (p.7). These standards characterize certain mothers as being the ideal, and others as lacking in terms of their ability to adhere to a certain degree of care and devotion.

Based on their research in Canada, Romagnoli and Wall (2012) assert, "intensive mothering, which fits within neo-liberal notions of individual responsibility and risk management, and is based on middle-class ideals, is widely accepted as the 'proper' mode of child rearing" (p.273). In this sense, raising a child appropriately is dependant on the mother's ability to manage risk and take full responsibility for the child's well-being. The connection between the ideal mother and the responsabilized citizen has emerged as a major theme in my research. The assertion of the ideal mother as a responsible, educated, and empowered woman informs interventions that work to create better mothers. Romagnoli and Wall investigate how young, low-income mothers are

constructed as a group that is “at-risk” to both themselves and their children (2012: 273). They argue that, “a great deal of time and resources is being expended to mandate and regulate the mothering practices of young, low-income mothers” (Romagnoli and Wall, 2012: 288).

Investing time and resources into improving parenting practices reflects the notion that the health of the future generation can be addressed at the individual level. The Moms and Tots programme can be seen as one such intervention. As the programme equips mothers with knowledge on proper care, it aims to produce an educated subjectivity, which is viewed as key to the improvement of maternal and infant health. As I discuss in Chapter 5, the ideological framework of intensive mothering influences Living Hope’s archetype of the ideal mother and is also internalized by women who participate in the support programmes as they self-evaluate care behaviours. The issue at stake is that the influence of political economy and local context become less visible than the individual responsibility. While the Moms and Tots programme operates within this broader neo-liberal discourse that asserts the responsibility of the individual, it helps to diffuse some of the responsibility that is placed upon mothers by augmenting maternal knowledge and facilitating networks of support.

Hegemonic models of good mothering shape individual perceptions and experiences of motherhood. Miller (2005) claims, “when experiences do not match predicted expectations or marry with intentions, an individual’s ability to produce and sustain a coherent, culturally recognizable and socially acceptable narrative may be challenged” (p.10). Miller’s claim draws attention to the way in which women self-construct their experiences of motherhood, and the negative feelings that ensue when experiences do not meet ideals. I found that the Moms and Tots support groups acted as a place where women shared anxieties around failures to achieve certain standards of care.

Waltz’s (2014) study on breastfeeding among highly-educated, middle-class South African mothers provides an example of how women associate certain care practices with the ideal mother, and experience emotional difficulties when they feel that they do not match up to prescribed standards. For the women in her study, “breastfeeding signified a daily “sacrifice”, becoming symbolic of the fulfillment of particular notions of “good” motherhood”(Waltz, 2014: p.45). These notions of sacrifice and devotion align

with the discourse around intensive motherhood, which is tied to a middle-class identity, yet pervades notions of good mothering across class boundaries. Viewing breastfeeding as “a project to be managed” made it difficult for women to trust their own bodies, let go of the idea that breastfeeding requires a domain of expert knowledge, and accept that it is a learnt behaviour (Waltz, 2014).

It is important to note how conceptions of feeding practices and the ideal mother in South Africa have been influenced by state policy. In 2011, the Tshwane declaration affirmed South Africa as a country that actively promotes, supports, and protects exclusive breastfeeding (National Breastfeeding Consultative Meeting, 2011). Prior to 2011, the state promoted the use of formula milk and made it freely available at public health facilities (National Breastfeeding Consultative Meeting, 2011). This policy change was a direct result of the 2010 WHO guidelines on HIV and infant feeding, which asserted that all mothers, regardless of HIV status, should breastfeed exclusively for six months (Doherty et al., 2011). The state promotion of exclusive breastfeeding asserts that it is the ideal method of infant feeding and should be practiced by responsible mothers. In Chapter 5, I unpack the way in which the Moms and Tots programme associates breastfeeding with the reified status of the good mother.

The association between breastfeeding and the ideal mother is not unique to the South African context. Studies in a variety of settings (see Dykes 2005, Knaak 2010, Andrew and Harvey 2011) have asserted the link between breastfeeding and the good mother. Based on qualitative interviews with 33 Canadian mothers about their infant feeding experiences, Knaak claims that breastfeeding was an internalized ‘core belief’ about what it meant to be a good mother. As breastfeeding was seen as synonymous with good mothering, breastfeeding failure was the prevailing risk that these mothers worried about. Knaak states that mothers, “worried about this risk not because they felt strongly that their child would be unhealthy if fed formula, but because it would threaten their status and identities as good mothers” (2008: p.350). This finding illustrates how mothers construct their experiences of care around a dominant discourse that positions certain behaviors as ideal and others as sub-standard. Knaak (2010) argues that the pro-breastfeeding discourse has positioned alternative feeding choices as both morally and medically deviant.

Dykes' (2005) study on women's experiences of breastfeeding in the UK reflects the view of breastfeeding as a project and the female body in terms of production. Dykes claims that women in her study "conceptualised breastfeeding as a 'productive' project, yet expressed deep mistrust in the efficacy of their bodies" (2005: p. 2283). Women expressed concerns over their inability to visualize and measure how much milk the baby was getting, and tended to value breastfeeding for its nutritional components rather than an act of nurturing and intimacy (Dykes, 2005: p. 2287). A number of my participants shared this concern over nourishing one's baby solely with breast milk. Dykes' links anxieties around breastfeeding to the influence of the greater structural forces (health institutions, state policy, biomedical discourse) that shape women's perceptions of their bodies and identities. As I will show in Chapter 4, one way in which this happens in Ocean View is through the discursive production of the woman's body as risky to her child.

### ***Framings of Care***

The discourse around intensive mothering asserts that the care that mothers provide to their children is an act of love and devotion, not necessarily a form of intensive labour (O'Reilly, 2004). O'Reilly (2004) asserts that it is important to identify the historical and cultural underpinnings of motherhood to reveal how women are often denied the authority and agency to determine their own experiences of mothering. One such underpinning is the association between care work and feminine identity. In the introduction to their book *Care in Practice*, Mol, Moser, and Pols (2010) argue that the care of bodies is often seen as being confined to the domestic realm, and is often seen as private rather than public. Care is often represented as parental, or more specifically motherly, and is depicted as a matter of love (Mol, Moser, and Pols, 2010: p.8). In this sense, care is seen as intrinsic to the role of being a mother, and not necessarily considered to be a form of work. Gutierrez-Rodriguez (2013) looks at the ways in which domestic work is constructed as a feminized form of "informal" labour. She states, "despite women's increasing participation in the labour market and attempts to transform the traditional gendered division of work, domestic and care work is still perceived as women's terrain" (Gutierrez-Rodriguez, 2013: p.1). In addition to the conflation with the

feminine, these forms of labour are not acknowledged as making productive contributions to society (Gutierrez-Rodriguez, 2013: p.1).

The association between women and domestic work has roots in gender socialization. Feminist sociologist and psychoanalyst Nancy Chodorow argues that in any given society, feminine personality tends to be defined by a connection to other people more than masculine personality does (1974: 44). As a woman tends to see herself in connection to others, in particular her own family, she feels a strong responsibility for the welfare of her family and happiness and success of her children (Chodorow 1974: 59). Mol, Moser, and Pols assert the importance of rejecting the view of care as something that is innate to feminine nature and work to reveal how care is multifaceted set of practices that require continuous adaptation. Bringing attention to the complexities and demands of that arise in the practice of care can contribute to recasting motherly care as work (Mol, Moser, and Pols, 2010: 8). Positioning care as a form of work acknowledges the physical and emotional labour it entails. In Chapter 5, I explore how mothers experience the demands of care in the context of resource scarcity, and often find themselves in multiple caregiving roles. Women often become overwhelmed by care duties due to the fact that these responsibilities are often limitless and are seen as intrinsic to motherhood. Mothers are rendered responsible for infant well-being and expected to carry out care practices that are associated with the ideal mother, despite major constraints in social and economic resources.

Mol, Moser, and Pols assert the importance of revealing how care is a multifaceted set of practices that requires continuous adaptation (2010). They describe this constant modification of care as tinkering, and assert that tinkering is central to optimal care. Care is an embodied practice that does not always follow a specific set of protocols (Mol, Moser, and Pols, 2010). The authors argue that the ability to constantly adapt care is central to what constitutes good care: “persistent tinkering in a world full of complex ambivalence and shifting tensions” (Mol, Moser, and Pols, 2010: 14). Tinkering is a valuable lens through which to interpret care practices, as it recognizes how a distinctive set of circumstances will determine the necessary forms of care. It brings a new perspective to notions of what constitutes “proper care” and can therefore challenge

conceptions of the ideal mother as someone who carries out a specific set of care behaviours.

### ***Concluding Thoughts***

A review of the literature on the affects of resource scarcity on child-rearing, the discourse of responsabilization, and framings of care provide a theoretical basis for my exploration of motherhood in Ocean View. The legacy of apartheid led to the fragmentation of family life and sundered social networks in Ocean View and has significant affects upon the raising a child in the community. While poverty has a strong impact on child rearing, economic scarcity does not equate to an unhappy or unstable childhood; it is important to acknowledge the influence of social networks and the extraordinary efforts that people go to in providing childcare in difficult circumstances. Discourses surrounding the ideal mother have historical and cultural underpinnings that position care as intrinsic to one's role as a mother rather than a form of work. It is essential to position care as a form of work, recognize the physical and emotional labour it entails, and acknowledge how ideal care is context-specific and must be adapted in different circumstances.

## Chapter 3

### Addressing Lack: The Discourse of Deficiency in Ocean View

During my research, I spent a great deal of time with women in their 50's and 60's who worked for Living Hope, many of whom would tell me about how the experience of forced removals and being relocated to Ocean View has affected their lives. Elizabeth, a Living Hope community health worker in her late fifties, described how her older brother had recently visited the plot of land her family used to own in Red Hill, on the other side of the Peninsula, some ten kilometers away as the crow flies, before the Group Areas Act removals were implemented. She explained that during this visit, he found a collection of teaspoons that their family lost during the moving process. He wanted to put these teaspoons in a frame and display them in his home, but decided against it, as it would bring his parents too much grief. She said that she and her siblings had learned to cope with the pain of losing their old home, but if her parents saw these teaspoons displayed, "it would literally kill them". Small reminders – teaspoons – represent a pain too great to confront.

Ocean View was established in 1968 in terms of the Group Areas Act (1950) as an area of housing for coloured people who were forcibly removed from their homes in surrounding areas that became re-zoned as white (Moses, 2008: p.106). Henry Trotter (2009) explores the impact of the Group Areas evictions on present-day coloured identity. As 150,000 coloured people were forcibly removed from their homes between 1957 and 1985, Trotter asserts that coloured identity is often tied to the experience of loss (2009: p.50).<sup>3</sup> Coloured people responded to the pain of removal in a number of ways, and the vast majority of those who endured the evictions state that many older people died just before or just after being forced to move (Trotter, 2009: p.51). In this sense, people suffered the loss of place, loss of community, and even the loss of loved ones. Trotter states,

Residents who had identified with particular neighbourhoods were dispossessed of them, deprived of their patrimony, sundered from their

---

<sup>3</sup> The works of Zimitri Erasmus (2001) and Mohamed Adhikari (2005) also address the links between coloured identity and the experience of loss.

social networks, and forced to accommodate themselves to a new existence with strangers from other communities. In many ways, they had to recreate their sense of self and their social lives as their old networks were torn apart. (2009: p.55)

This pain associated with dispossession was evident in the narratives surrounding forced removals shared by Ocean View residents. Evalina, also a community health worker in her late fifties, described how forced removals created conflict and violence within the community. She told me how she and her family were forced to move from Capri to Ocean View when she was fourteen due to the Group Areas Act. She said that there “so many fights” when she came to Ocean View and felt that this was because so many different people had been put together in a new place and had been forced to leave their homes. Compared to the mothers that I interviewed and spent time with in the Moms and Tots support groups, I found that older women were much more specific about how the history of forced removals and the apartheid legacy manifests in contemporary social issues in Ocean View.<sup>4</sup>

How does one make meaning out of the experience of loss and feelings of lack? Ocean View is a product of forced removals in the late 1960’s. Fifty years later, the history and memory of forced removals still holds great influence upon people’s understandings of the suburb. The area is consistently described (in the media, by researchers, NGOs and the state, as well as in everyday interactions) in terms of lack. When deficiency is seen as commonplace, it becomes characteristic of the community and renders the violence embedded in social structure invisible.

In this chapter, I articulate the ways in which Ocean View residents identify aspects of their social world as inadequate and look at the roles of religion and education in responding to these feelings of lack. The Living Hope support programme addresses a perceived lack in both the individual (mother) and the community by providing education and networks of support to mothers of newborns in Ocean View. I show how the lived experiences of loss have contributed to the notion of an environment that is lacking in multiple ways. I explore responses to the experience of loss and work to identify how individuals foster feelings of strength in the face of insecurity. In a context of precarity,

---

<sup>4</sup> Most of the mothers that I worked with were between the ages of 17 and 35 and did not experience forced removals as the older generation did, but were rather born and grew up in Ocean View.

where traumas caused by political processes are reimagined as individual deficiencies, two core ideas have materialised. ‘Coping’ and ‘improving oneself’ are routinely offered as mechanisms for sustaining life.

### ***Dispossession and Sustaining Social Worlds***

Judith Butler and Athena Athanasiou (2013) discuss different conceptions of dispossession in their work “Dispossession: The Performative in the Political”. Athanasiou states that dispossession can have both positive and negative connotations: it can be a condition for autonomy, but can also be a mode of subjugation (p.2). Through dispossession, human bodies become materialized and de-materialized through forces such as slavery, colonization, apartheid, and immigration (Butler and Athanasiou, 2013: p.10). Butler and Athanasiou discuss the specific situation of territorial dispossession. Those who experience territorial dispossession are forced to leave their proper place, and the determination to remain in one’s proper place becomes an act of resistance (Butler and Athanasiou, 2013: p.21). Butler contends that thinking critically about dispossession can reveal how basic rights, such as shelter, food, and protection, are dependent upon a mode of governance that bestows and sustains those rights (2013: p.4).

South Africa’s forced removals created terrible precarity. Butler (2009) describes precarity as a “politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence and death” (p.2). The apartheid regime failed to promote the rights of coloured individuals and stripped them of their autonomy to choose their own living environments and communities. Discussing how the social environment affects the experience of precarity, Butler states, “We are interdependent beings whose pleasure and suffering depend from the start on a sustained social world, a sustaining environment. This does not mean that everyone is born into a sustaining world” (2013: p.4). The final sentence in this quotation is telling. While the mothers that I worked with in Ocean View may not have directly articulated the impact of forced removals and apartheid on their lives as the older women did, they clearly expressed ways in which they found their social world to be lacking in multiple senses. Mothers described how lack of access to health promoting resources such as nutritious and affordable food and reproductive health

services impacted on their own well-being, as well as that of their children. Others too saw Ocean View as an environment unable to sustain proper life. The intervention by Living Hope is directly shaped as a means to create a sustaining world for infants, by overcoming perceived lack – here, in maternal knowledge.

It is vital to think critically about the way in which historical context shapes notions of knowledge and deficiency. Reflecting on the resilience of colonial education in Africa, Francis Nyamnjoh (2012) argues that values developed during colonial times impart the superiority of the colonizer and continue to dominate education and life in post-colonial Africa (p. 130). Colonialism is a form of dispossession that devalues the subjectivity of the colonized, and education is put forth as an opportunity for social mobility and self-improvement. Within this discourse, the education is linked to progress and opportunity.

The Moms and Tots programme operates with the notion that imparting knowledge on proper care will lead to improved health and therefore works to educate mothers over the course of an eight-week intervention. When working to empower women with knowledge on infant care, it is vital to acknowledge how precarious living conditions impact a mother's ability to carry out ideal care practices and the effects of this on women's senses of self. A failure to acknowledge how structural constraints impact on health places the mother in a position of being fully responsible for her own health, as well as that of her infant. One of the prominent themes that arose in conversations about motherhood in Ocean View was the difficulty in accessing health-promoting resources. As I sat with six mothers in Mona's small living room, we spoke about the obstacles that these women face in seeking care services. There are no antenatal services in Ocean View. Women must travel to Fish Hoek for all of their health care needs while pregnant. While Fish Hoek is only about ten kilometres away, it is too far for women to walk there and back, and as very few have access to cars, they usually depend on an overcrowded minibus taxi for transport (paying seven rand each way). They explained that you have to go very early, get up at 5am to get ready, travel, and be at the clinic when it opens. "You wait your whole life there", Mona said, as you can arrive in the early hours of the morning but wait until the afternoon before a doctor will see you. Mona explained that during her third pregnancy, she only found out she was pregnant

when she was about three months along. She booked for an antenatal scan, but when the day of the scan arrived, she didn't have the fourteen rand for the public transport that she needed to travel to the clinic in Fish Hoek. As she couldn't find anyone to drive her, she was unable to go, and therefore she didn't have her first scan.<sup>5</sup>

Social barriers, such as costs of transport, to health-promoting resources create health risks. Mona's account illustrates how a lack of both material and social resources affected her ability to seek the necessary care services during her pregnancy. Identifying the ways in which mothers in Ocean View are affected by barriers to health-promoting resources is central to placing a greater emphasis on the structural inequalities that impact maternal and child health. Rather than viewing the mother as wholly responsible for her own health, as well as that of her child, it is critical to acknowledge how oppressive conditions have a major influence on health outcomes. It is vital to identify how violence is embedded in social structures and impacts upon individual agency and well-being. Kleinman's (1997) concept of everyday violence shows how hierarchy and inequality normalize violence as it becomes embedded in everyday life, rendering it visible yet unaccounted for. Echoing Kleinman's notion of everyday violence, Paul Farmer (2003) states that in cases of structural violence, human suffering is "structured by historically given (and often economically driven) processes and forces that conspire—whether through routine, ritual, or as is more commonly the case, the hard surfaces of life—to constrain agency" (p.40). As structural inequality is widespread in South African society, it becomes normalized, and leads to certain individuals and communities being characterized as deficient rather than the oppressive structures that reproduce violent living conditions.

---

<sup>5</sup> Apart from having difficulty in accessing antenatal care, women in Ocean View who rely on government-funded health care face restrictions on other reproductive health services. Despite recommendations that women receive pap smears every three years beginning at the age of 21, the South African Department of Health will only fund three pap smears throughout a woman's life, at the ages of 30, 40, and 50. Those who cannot afford to pay for the procedure more frequently face higher risks undetected HPV and cervical cancer. The Director of Living Hope told me about two mothers, both under the age of thirty, who died of cervical cancer last year. Both mothers had several young children. As an effort to combat cervical cancer, in 2014 the Department of Health introduced a free HPV vaccine to girls 9 years and older.

***Emotional Responses to Power: Roles of religion and education in dealing with deficiency***

When addressing individual and collective responses to social issues in Ocean View, it is critical to look at emotional responses to structures of power. In his book *Alter-politics*, Ghassan Hage (2014) asserts the importance of analyzing emotional responses to power, as well as emotional ties to nations and communities. He terms these responses “political emotions” and states that these kinds of emotions are “related to our sense of power over ourselves and our environment as we pursue the goals, ideals, and activities that give our life meaning” (Hage, 2014: p.4). Hage argues that an ethnographic exploration of emotional responses to structures of power can challenge the binary between the personal and the political. It can reveal how political environment deeply impacts an individual or group’s sense of decision-making power and social circumstance. This analysis of political emotions is central to my ethnographic exploration of social life in Ocean View. Living Hope community workers frequently described how their loss of decision-making power during apartheid era forced removals created emotional trauma. They linked this trauma to the current social ills in the community, such as substance abuse, theft, and other forms of violence. Analyzing political emotions inspires critical thought on how a history of structural inequality features in current imaginings of social and material environments in Ocean View.

Emotional responses to power can also reveal how individuals in Ocean View foster feelings of strength in the face of precarious living conditions. For Living Hope workers, belief in a higher power was a major source of strength when facing personal issues, as well as problems that were linked to social and material constraints in the community. Living Hope’s slogan, “Bringing Hope, Breaking Despair” illustrates the organization’s mandate of drawing upon faith in God to address deficiency in the communities they work in. The following story about the Ocean View Headquarters acts as a metaphor for the rhetoric of salvation held by the organization.

One morning during the early days of my fieldwork, Avril, the current manager of Living Hope in Ocean View, drove me from Capri to the Ocean View office. As she entered Ocean View, she began to tell me a story of how Living Hope began working in the community. The current Ocean View office used to be a house that was owned by a

drug lord and was a well-known site for the prostitution of young girls. Several community members were outraged, and one night, they decided to raid the house. One man was killed, and the owner of the house fled. Those involved in the raid continued to ransack the house until it was completely unlivable to ensure that the owner would not return. The house became available to Living Hope, and, with the help of volunteers, was rehabilitated into the current headquarters. The 'House of Sin' was transformed into a 'House of God'. Avril told me that she felt that this sequence of events was a sign from God that this community needed their services.

This rhetoric of salvation was often present in conversations I had with Living Hope staff. Individuals who worked with substance abuse support groups would tell stories about how addicts were only able to stop using once they had "found God". Discussing the role of Living Hope in Ocean View, Aunty Martha told me, "we walk down the streets, and it's like they see Jesus coming", as well as "even the Rastas take their hats off to greet us". Avril and Megan, the two women who spearheaded the support programmes for moms of newborns spoke about the importance of a relationship with God, as they believed that having faith in Jesus Christ was "the only way". Avril asserted that the Moms and Tots programme focuses on behavior change and emphasized the importance of promoting a Christian value system in the programme. She claimed, "When people come to know Jesus, behavior changes". Conversations such as these illustrate the way in which Living Hope staff adopt the motto of "Bringing Hope, Breaking Despair" and reveal the belief that faith is central in addressing deficiency and creating a sustaining environment. While Living Hope is a strongly Christian organization, they are tolerant of other religions and promote coexistence. This was illustrated in a situation when a Moms and Tots group formed in the home of a Muslim woman that Aunty Martha met at the clinic. As most of the group participants were also Muslim, Aunty Martha respectfully downplayed the religious component of the group and focused on conversations around health.

Daily devotions in Ocean View allowed the Living Hope staff to share their concerns about issues in the community, and also facilitated discussions around struggles they face in their work and personal lives. During devotion, the staff spoke about how to live in a Christ-like community in 'a place like Ocean View'. Andrea said that the

Christians in Ocean View must surround the drug addicts and the criminals, and that the Living Hope community workers<sup>6</sup> are the “lionesses” of the community. Andrea’s comment reveals an understanding of the community as a place of risk and danger, and asserts the role of the Living Hope in transforming this environment. Elizabeth closed this session with a prayer for unemployment in the community, stating, “We were not born and asked to be coloured, this is the way that you made us”. Elizabeth’s prayer reflects her understanding of the way in which coloured identity is linked to oppression. Her statement elucidates the experience of one’s place in the social order being defined by negative characteristics.

Hage argues that political emotions are affected by the perception of the ability to act upon what affects us, versus having to passively endure it (2014: p.113). While individuals may have felt a sense of powerlessness towards the injustices they endured during the apartheid era and continue to experience, believing in God’s plan helped them to transcend this injustice. Hage states, “to transcend means to be able to let go, and consequently ‘be able to live with’ more so than to ‘want to negate’, which signals the affective opposite: an inability to transcend” (2014: p.140). Transcendence through faith allows individuals to cope with struggles in both their own life and within their community. As a non-religious person, I was often astounded by the amount of faith and trust in the idea that God will provide. For Living Hope workers, Christianity had a strong role in what Hage refers to as “pulling oneself together”, which is creating the appearance of wholeness, coherence, and togetherness (2014: p.105). Faith in God proved to be major source of strength for the individuals who actively worked to improve social conditions in Ocean View. It also proved to have a unifying affect, as Living Hope staff would collectively discuss the role of faith in dealing with personal struggles and community issues.

While religion allowed people to cope with inequality and oppression, I found that education was envisaged as a mode through which individuals could improve themselves and their life circumstances. The education available to Ocean View residents was seen as lacking in two ways: too few schools; deficiencies in quality. The Moms and Tots support programme is structured around the idea that mothers are lacking knowledge

---

<sup>6</sup> All of the Living Hope community workers in Ocean View were women.

on proper care practices, and education will lead to behavior change and result in better health outcomes. Over the course of eight weeks, the support programme educates mothers on topics that are identified as key for improving both maternal and infant health. Information about breastfeeding, nutrition and infant illness were identified as the most valuable topics that women learned about in the group. I also encountered examples of how Living Hope sought to address a perceived lack in children's education. At a diarrhoea campaign held for preschoolers in the community, Living Hope community workers and a health inspector spoke to the children about how to prevent diarrhoea (wash hands, don't leave food sitting out) and also how to treat it (sugar-salt solution). As the health inspector taught the recipe for the rehydration solution, the children collectively echoed "eight teaspoons of sugar, half a teaspoon of salt, and one litre of clean water". A community health worker asserted that both kids and parents should be informed about health issues to increase the likelihood that good practices take place.

Ocean View is seen as lacking in terms of proper education and this inadequacy is addressed at the individual level. Understanding ideals of self-improvement through education provides important context for an analysis of the interventions offered by the Moms and Tots support programme. The programme acknowledges community issues such as lack of infrastructure, poor living conditions, and difficult social environments and works to supplement lack by augmenting maternal knowledge and engaging a set of social networks to support mothers. Within the support programme, the mother is the site of intervention for improving infant health and well-being. While it is important to empower mothers with the knowledge and resources that will help them to care for their children, we must consider how broader social discourses of responsibilization often underplay the impact of structural inequality on health outcomes. Within this neo-liberal discourse, individuals are made responsible for poor health outcomes, despite major constraints in social and material environments. The responsibilization framework is reflected in understandings of motherhood in Ocean View and will emerge as a key theme in later chapters on risk and the demands of care.

### ***Concluding Thoughts***

Understandings of Ocean View as a difficult social environment were articulated through multiple conversations and interactions with community residents. The ways in which deficiencies in Ocean View are encountered in religion and education reveals how ‘coping’ and ‘improving oneself’ are positioned as practical solutions for issues in a community that is lacking in terms of a sustaining social environment. Through faith, individuals can transcend social ills and structural constraints by believing in a higher power and becoming part of a moral community. Religion proves to be central to one’s ability to cope with difficult circumstances in Ocean View. When mobilized in a collective effort (Living Hope), religion is seen as having the potential to facilitate community transformation. Despite the historical production of social deficit, individuals are deemed responsible for achieving self-improvement through education. Education is anticipated to allow individual actors to better themselves and improve life circumstances.

While knowledge interventions that seek to produce behavior change can have positive effects, it is important to situate such approaches within a broader neoliberal framing of responsibility that asserts the importance of individual behavior. As broader structural issues that have produced instability are reimagined as individual deficiencies, structural inequality becomes normalized and individuals are made responsible for overcoming major constraints in social and material resources. Addressing structural issues that require a macro-level approach at the micro-level allows systems of inequality to perpetuate and contributes to the responsabilization of the individual.

## Chapter 4: Risk and Responsibility

In the corridor of the Ocean View clinic, Aunty Martha stands among a group of mothers with infants and gives one of her weekly health talks. Today the focus is on breastfeeding. Aunty Martha discusses how mixed feeding (formula and breast milk) is very risky for babies of HIV positive mothers, and even if the mom is not HIV positive, mixed feeding can lead to constipation. She emphasizes that breastfeeding is best for optimal nutrition, and also helps to create a bond between mom and baby as it shows the baby love. She says, “I feel so sorry for bottle fed babies”. As Aunty Martha concludes her talk, she strongly encourages the mothers to breastfeed, and welcomes questions about infant feeding practices.

Aunty Martha’s expression of best infant feeding practices and risky behaviour reflects specific ideas around risk and responsibility in motherhood. In this chapter, I look at how mothers are rendered responsible for preventing and managing threats to infant health in the face of resource scarcity. Employing a model of inter-embodiment, I explore notions of the interconnected nature between the mother and infant and look at how this connectivity is framed as having strong implications for infant well-being. Risk is linked to the maternal body, and surveillance of both the maternal and infant bodies emphasizes expectations of the mother as a responsible citizen. I explore how the discourse around responsibility and HIV positive motherhood maps risk onto individuals rather than behaviours. This chapter argues that responsabilization works to disguise the political-economic context that shapes health by making the maternal body the source of both harm and well-being. Although the Moms and Tots programme operates within this broader social discourse of responsabilization, it provides women with networks of support and resources that help diffuse some of the responsibility that is placed upon mothers.

### ***Inter-embodiment: mother and infant as “entwined presences”***

Inter-embodiment provides an important lens through which we can view the cultural meanings of infant’s bodies, as well as the relationship between the infant and

the caretaker. In her article on infant embodiment and inter-embodiment, Lupton (2012) states, “the body is not a constant or a given which exists prior to cultural meaning, and nor is childhood, and nor, therefore, are children’s (including infants’) bodies” (p.37). This suggests that the construction of the links between the maternal and infant bodies is influenced by cultural values. Based on my experience in Ocean View, notions of connectedness between the bodies of mother and baby and emphasizes the mother’s responsibility for the well-being of her child. This emphasis minimizes the influence of resource availability and other social relationships on childrearing and renders the maternal body both essential and risky to their children.

The notion of inter-embodiment is important for understanding the ways in which caretakers relate to and feel about the bodies of their infants, and also invokes the idea of interconnectedness between the vulnerable and the protective body (Lupton, 2012: p.46). Long (2009) asserts that “the practice of motherhood can mean having to make one’s body secondary, having it ‘owned’ by one’s baby” (p.148). Within the prevailing biomedical discourse, infant bodies are seen “unfinished” or “lacking”, meaning that they require a great deal of care through the constant monitoring of their bodily state, which frequently requires cleaning, feeding, and physical intimacy (Lupton, 2012: p.39). This perceived vulnerability has implications for the interconnected relationship between the maternal and infant bodies. Long claims,

Constructing oneself as a mother involves trying to know what one’s baby is and therefore what one is oneself. The baby’s body is a site where one’s greatest fears (about oneself and one’s baby) can be played out, but it also holds potential as a site of salvation. It is a site of multiple conflicts and surrenders in which anxiety hovers, never quite being able to hook onto discourse to explain, to resist, or to reassure. (2009: p.125)

Long asserts that the mother’s identity is constituted through her interactions, and these interactions establish her identity as a good mother or a bad mother: the former sustains life; the latter places the vulnerable infant in a state of precarity. In the Moms and Tots support programme, women often spoke about the demands that come along with this responsibility to sustain and protect their infants and how it creates emotional turmoil.

Simms (2008) states that the mother’s body is the “first house of being” for the unborn child, and after birth, the relationship to the maternal body conditions the infant’s

responses to the world (p.14). She claims, “We begin life not as separate monads but as entwined presences, as aspects of significant wholes where the newborn’s actions finds its complement and completion in the actions of the (m)other” (2008: p.15). Simms argues that the act of feeding reveals notions of the mother’s duty to nourish her infant in multiple senses. She suggests that breastfeeding allows the infant to be “well-housed” in the maternal world, which creates the security for the infant to be able to go and explore the outside world (2008: p.23). Discussing her own experience of breastfeeding her infant daughter, Simms reflects upon how she began to understand nourishment and connection to her baby through the act of breastfeeding. She claims, “Milk was the line that tied us together, the very special stuff that gave her life, growth, and contentment” (2008: p.12). As I discuss in the following chapter, the act of breastfeeding is linked to notions of the ideal mother and is constantly promoted in the Moms and Tots programme.

The concept of inter-embodiment emphasizes how caring for an infant requires intimate interactions and the ability to learn from physical cues. As infants cannot communicate needs and desires using words, it becomes necessary to focus on bodily forms of communication. Communication between mother and baby is sensory and physical (Long, 2009: p.127). The way in which mothers learned about their babies, as well how babies responded to their mothers, was a central focus of my interviews with mothers who had completed the Moms and Tots programme<sup>7</sup>. The goal of this inquiry was to understand the ways in which the mothers felt about their relationship to their baby and how they conceptualized the baby as an individual. All of the babies of the mothers that I interviewed were under 18 months and had limited language skills to express their needs and desires. Six out of nine mothers that I interviewed described how they learned to determine how the baby was feeling based on the type of cry that he/she made. Describing the cries of her four-month-old daughter Zara, Tasneem told me, “When my baby is thirsty, the cry is not so loud. When she is not feeling well, she shouts and cries like it’s sore.” Johanna said that the cries of her five-month-old son Andre were different when he was hungry versus tired, or if he was simply “cross”. The

---

<sup>7</sup> In my interviews, I asked questions such as “How do you know how your baby is feeling?” “What proportion of your day do you spend with your baby?” and “What are the things you find difficult about caring for your baby?” I also asked mothers to describe their baby’s personality and social world.

differentiation between cries reflects of a form of embodied knowledge that the mother has developed over time through interactions with her baby.

Mothers also described certain physical cues that would let them know how their baby was feeling. Tracy, the mother of 6-month-old twins, told me that when her son is feeling ill, his eyes become very red and teary. When her daughter is teething, she begins to play with her ears. Danielle, the mother of a 16-month-old girl, explained, “I can see in her eyes when she is sick or something is wrong with her.” Describing this bodily communication between mother and infant, Simms argues that the infant’s perception of the world as a stable and safe place is dependent upon the mother’s ability and willingness to interpret and respond to his or her needs (2008: p.16). As the infant relies on the mother for a sense of security in the world, the mother must learn how to understand the needs and desires of her baby so that she can respond appropriately. There is a great deal of debate about what an ‘appropriate response’ is, ranging from leaving babies to cry to constant carrying of the child. Mothers often depended on their ability to differentiate between cries to determine whether or not they must attend to the baby right away. Women often spoke about feeling overwhelmed by demands that result from the interconnected nature of the mother and infant bodies, particularly when breastfeeding exclusively for the first six months of life. Both Natalie and Nazia spoke about how being responsible for nourishing a vulnerable body greatly impacted on their independence, and often felt as if their bodies were tethered to that of the baby.

The Moms and Tots support group was identified as a space where mothers could discuss and learn more about their physical and emotional relationship with their baby. In terms of the physical connections, breastfeeding was identified as a clear link between the two bodies. During a discussion about breastfeeding and nutrition, Natalie described how she has come to learn that when she eats certain spicy foods, it affects her breast milk and makes her baby fussy. Tasneem spoke about how the group taught her the importance of her own nutrition while breastfeeding and how it affects her baby. She said, “everything I eat, she takes in”, and therefore, she has been trying to eat healthfully and avoid greasy foods. The way in which these mothers understand the effects of their own nutrition on their baby illustrates how inter-embodiment places further emphasis on the mother’s duty to care. As the mother and infant bodies are closely intertwined, the mother must

maintain her own physical health so that she can support the healthy growth of the infant body. This expectation places a great degree of responsibility on a mother who has limited access to health-promoting resources.

Just as the physical health of the maternal body impacts infant health, the mother's emotional state is perceived as having a strong influence upon the baby. During one support group session, Aunty Martha spoke about the importance of managing emotional health. She said, "when you are stressed, the baby will know", and "if you are unstable, the baby will be unstable for the rest of his/her life". These comments reveal how a mother is expected to have a healthy body and mind in order to provide a secure and nurturing environment for the baby. Given the extremely high rates of postpartum depression in working class communities in South Africa, it is important to understand how social and economic circumstances impact upon the mother's mental health. Cooper et al. (2009) found that post-partum depression rates in Khayelitsha, a peri-urban settlement on the outskirts of Cape Town with high rates of poverty and unemployment, were as high as 34.7%. Aunty Martha is able to refer women who are experiencing post-partum depression to a Living Hope social worker that provides free counseling. This illustrates one way in which the support programme provides networks and resources to support mothers in the community.

Julia, a seventeen-year-old first-time mom, told Aunty Martha that she felt often felt confused about how to care for her baby. She said that sometimes she would also cry when her baby cried because she felt so overwhelmed. Nazia and Natalie, the two other mothers who were present, both had two children, and told Julia that the first baby is often emotionally difficult, but it would get easier. Natalie said, "I stressed a lot with my first baby, and that stress affected the baby." Mothers' understandings of their emotional states in relation to the infant reveals another way the mother must manage her own health for the sake of her infant. The networks of support offered through Living Hope proved to be important for creating a supportive environment in which this responsibility could be discussed and handled.

Based on her research on the embodiment of social suffering in rural Bolivia, Tapias (2006) argues that, "mother's bodies and emotions are seen as the vectors through which gestating babies and breastfeeding infants develop transient and enduring ailments

and debility” (p.399). Tapias argues that Bolivian mothers believe that they pass their own social suffering and emotions to the bodies of their infants. Mothers felt that emotional distress brought on by domestic violence, economic hardship, and social conflicts affected the physical and nutritional qualities of their breast milk (Tapias, 2006: p.406). If the mother feels rage and sorrow, the baby will absorb those emotions through the breast milk and become ill (Tapias, 2006: p.406). In addition to having the ability to “infect” the baby with negative emotions, mothers also felt that they could pass positive emotions through milk, such as happiness and tranquility (Tapias, 2006: p.406). Tapias’ findings reveal how maternal emotions have the potential to produce positive or negative affects for the infant, demonstrating the influence of social suffering on emotional health. She argues, “to divorce an understanding of embodiment from the social and political contexts in which emotions are constituted presents a myopic understanding of distress and health” (Tapias, 2006: p. 410). This argument is central to working towards a greater emphasis on the way in which structures of power and oppression influence health and works against the notion that the mother is fully responsible for infant well-being. While a focus on inter-embodiment reveals the connected nature of the mother and infant bodies, a focus on the embodiment of social suffering brings attention to the social forces that affect the health of both mother and infant.

### ***Surveillance: the mother as risk-manager***

The view that infant health is dependent upon the mother’s proper decision-making and care practices suggests that the mother must constantly monitor her baby’s body to be aware of its needs. This surveillance can be viewed as form of risk-reduction. Discussing the intersections between motherhood and risk-consciousness, Knaak (2010) states,

Indeed, it is argued that the role of motherhood in contemporary society<sup>8</sup> is being redesigned in such a way that mothers are being increasingly positioned as veritable ‘risk managers’. Within this ideology, mothers are seen as having a moral and social responsibility to be risk conscious. (p. 345)

---

<sup>8</sup> Knaak’s study was carried out in Canada. Based on my experience in Ocean View, I argue that her ideological framing of the intersections between risk and mothering can be applied to a South African context.

In Ocean View, risk was often framed in terms of the mother's body or the living environment. The mother was expected to provide a secure environment and keep the vulnerable infant body safe from harm. During clinic talks and support group sessions, Aunty Martha would give advice on how to prevent and manage health risks. One of the most frequently addressed health topics was diarrhoea. Aunty Martha addressed prevention and treatment of diarrhoea in clinics, in the support groups, and during home visits. These talks focused on keeping a clean environment and being hyper-vigilant about food storage and hygiene<sup>9</sup>. Aunty Martha shared the recipe for a simple rehydration solution of salt-sugar-water, and also emphasized the serious nature of diarrhoea among infants<sup>10</sup>. While I was aware of one case of infant TB and an infant death due to malnutrition, when probed about childhood illness (coping strategies and care practices), the women in my sample answered in the negative. However, it is possible that mothers under-report illnesses that they do not consider to be serious. It is also important to note that my research was not conducted during diarrhoea season (November to May) and none of the children were sick at the time of my interviews.

The risk of infant diarrhoea demonstrates the risk the physical environment can pose to infant health. It becomes the duty of the mother to protect her baby from harm. Mothers are seen as having the responsibility to be "risk conscious" and be constantly aware of signs that the infant is in danger. In their paper on parenting programmes in South Africa, Ward and Wessels (2013) assert that positive parenting can buffer the effects of risk factors, such as poverty, on children (p. 62). They state, "good parenting is responsive", and argue that children need to be nurtured, stimulated, and kept safe by their caregivers (Ward and Wessels, 2013: p.62). Ward and Wessels assert the importance of supporting caregivers through parenting programmes to improve the health and well-being of the child. I found this approach to be prominent in the delivery of the Moms and Tots programme: although the programme positions mothers as responsible for managing risks that threaten infant health, it also equips mothers with the knowledge and resources to empower them to do so.

---

9 The Western Cape Department of Health Guidelines state that diarrhoea disease season is from November until May- this is due to warm summer months when the disease is more prevalent.

10 As infants can die from a bad case of diarrhoea in a matter of hours, Aunty Martha emphasized the importance of taking the baby to the clinic immediately and looking out for signs of fatal dehydration, such as lack of tears when the baby cries and lack of urine.

To create an understanding of how hegemonic notions of risk have been constructed, Knaak asserts the important of viewing risk as socially and ideologically mediated (2010: 346). She states,

Rather, the risk consciousness which conditions the choices and decisions of 'good' mothers is the risk framework constructed by broader agents and institutions of contemporary parenting culture (such as health ministries and 'expert' baby care manuals, for example), agents, and institutions which are, themselves, organised/mediated by broader ideological frameworks (such as the ideology of intensive mothering and contemporary public health ideology, for example). (p. 352)

Knaak's perspective on risk-consciousness asserts that institutions monitor and render individuals as responsible for health. Discussing the ways in which HIV positive individuals are positioned as liable for their health, Robins (2006) argues that health institutions demand responsabilized citizens, which are those who knowledgeable, empowered, and adhere to treatment plans. The responsible citizen avoids risk through understanding and adhering to specific guidelines that are deemed as best practices (Robins, 2006). Just as institutions influence perceptions of risk, they also construct ideal citizens.

I was able to witness the way in which health institutions shape notions of risk during my encounters with the referral process of the Ocean View clinic. Sister Africa, one of the head nurses at the clinic, gave Aunty Martha referrals for home visits of babies who are underweight or not growing properly. One such request was a home-visit for Nicola, a sixteen-day-old baby who had only gained two grams in the previous week. Sister Africa used the growth chart inside of the Road to Health booklet to judge whether a baby is growing and gaining weight properly. If the baby's weight gain is a matter of concern, Sister Africa would ask Aunty Martha to follow up with the case. Sister Africa told us that she was worried about Nicola and thought that there was a possibility the growth issues could be related to tik or alcohol use during the pregnancy.

When we arrived at Nicola's home and sat down with Isabel, the mother, Aunty Martha watched Nicola feed, commenting that it looked as if she was drinking well. In a post-visit discussion, Aunty Martha told me that she thought the baby looked fine to her, and that she wasn't too concerned about the low weight gain. She said that it is normal

for a baby to lose weight in the first week after birth, and Nicola's limited weight gain was probably not abnormal. Aunty Martha felt that Sister Africa should have considered this, and should not have been so alarmed by the low weight gain.

Nicola's referral illustrates different perceptions of risk. Sister Africa's use of the Road to Health growth chart demonstrates how the Department of Health guidelines act as a point of reference for determining at-risk infants. Sister Africa's response to Nicola's low weight gain reflects her duty as a health care professional to adhere to certain guidelines set force by the health ministry. The government-sanctioned health guidelines can be viewed as authoritative knowledge, which translates into practices and shapes expectations and ideas around health and illness (Miller, 2005: p.30). This authoritative knowledge asserts a distinction between those who are experts (medical professionals) and those who are not (mothers) (Miller, 2005: p.31). Aunty Martha's response reflects her extensive experience with babies in Ocean View; her local eye allows her to approach this situation with an understanding of the way babies gain weight in the community. She explores other factors that could have contributed to Nicola's low weight gain and does not assume that Isabel is morally culpable. Sister Africa's concern that the use of tik or alcohol during the pregnancy may have been a contributing factor to the low weight gain suggests how moral blame is attributed to the bad mother: as the maternal body itself is a site of harm, risk is mapped onto individual bodies. In this sense, surveillance of the infant body by an outside institution becomes a mechanism of salvation. If the mother fails to act as a risk-manager and keep the baby safe from harm, an outside force must assume this duty.

External intervention was sometimes critical. On such instance was the referral for a two-month old baby boy who wasn't growing properly. Again, Sister Africa believed that the mother's use of tik contributed to ill-growth, and requested that the baby see a dietician. The mother did bring her baby to the dietician and received free formula, but the baby passed away of malnutrition ten days after the referral letter was delivered. As Aunty Martha shared this information with me, she explained that the baby was not given the milk, but it was rather sold for money to purchase tik. While notions of risk defined by health institutions can lead to the devaluation of local understandings of health, this situation reveals how surveillance by an outside body is often crucial.

***"If a mother is HIV positive, she must make good choices": The construction of the responsible citizen***

During my time in Ocean View, I found that discussions about HIV positive motherhood focused on the mother's potential to cause harm to her baby. Examining the discourse of risk around HIV/AIDS can shed light on the ways in which the influence of structural violence and social relationships are seen as secondary to the duty to be a responsible citizen. One of the specific goals of the Moms and Tots programme was to educate HIV positive mothers on proper feeding and care practices. In discussion on HIV positive motherhood, Aunty Martha told me "If a mother is HIV positive, she must make good choices". She went on to describe some of the major risks that come along with being an HIV positive mother. If an HIV positive mother decides to breastfeed, the baby needs a daily injection of nevirapine for the first six weeks of life<sup>11</sup>. If the mother gets sore or raw nipples, she needs to be very careful to make sure the nipple doesn't crack and bleed, as blood would enter the breast milk and could infect the baby. One of the biggest issues Aunty Martha has encountered is when HIV positive mothers avoid disclosing their status to other people who care for the baby. This distribution of care often takes place when mothers return to work after the baby is 3 or 4 months old. If another caretaker is unaware of the mother's status and gives the baby something other than breast milk while the mother continues to breastfeed, the baby will be at a greater risk for contracting HIV<sup>12</sup>. HIV positive mothers are not simply seen as having the potential for risky behaviors, they are constructed as risky mothers.

It is vital to understand the infant feeding choices of HIV positive mothers within the context of resource availability and social relationships. This contextual analysis can help bring attention to the social and material circumstances that impact the mother's actions. It also reveals how mothers are often rendered ultimately responsible for infant health. Van Hollen (2013) argues that it is important to demonstrate the complexity of

---

11 The WHO recommends that HIV-exposed infants who breastfeed receive a daily injection of nevirapine (NVP) for the first six weeks of life. Those who replacement feed should also receive a daily dose of NVP from birth till four or six weeks.

12 Mixed feeding (breast milk and formula) is the most dangerous form of feeding for infants of HIV positive mothers because it puts babies in contact with HIV and also disturbs their digestive system, which makes them more susceptible to infection (Hausman: 2011: 138).

social relationships within which infant feeding practices are negotiated and determined in order to fully understand the decision-making processes and actions of the mother (p.193). Based on her study on infant feeding in the context of HIV in South Africa, Moses (2010) argues, “based on cultural, social, and emotional ties, others, besides the mother, have legitimate claims to decision-making and actual feeding” (p.2). Within the context of Ocean View, it is necessary to work against the idea that it is simply the HIV positive mother who is risky to her infant and bring attention to the fact that care practices are affected by a number of different circumstances and cannot be addressed as solely the “good” or “bad” choice of the mother. Rather than framing the individual HIV positive mother or the resource poor context as lacking, it is vital to emphasize the deficient nature of global and local structures of power that perpetuate inequality. This inequality leads to certain individuals and communities having greater access to resources that create the conditions for sustainable living, while others are situated in an environment of scarcity.

Robins (2006) explores how HIV/AIDS activism in South Africa has contributed towards new forms of “responsibilized citizenship”. Responsible citizens are knowledgeable and empowered HIV positive clients; these are the individuals required for safe and effective HIV treatment and drug adherence to take place (Robins, 2006: p.312). Robins argues that responsabilization approaches “do not adequately acknowledge the profoundly traumatic and transformative nature of illness and treatment experiences” (Robins, 2006: p.313). He draws on Victor Turner’s (1961,1969) analysis of ritual process to suggest that the experience of pain and suffering is fundamentally social, and sickness in the individual body can be seen as a sign of disease and disorder in the wider social body (2006: p.313). He argues that biomedicine “tends to depoliticize and individualize illness as well as contribute to the formation of modern citizen-subjects” (Robins, 2006: p.313).

Constructing HIV positive individuals as responsabilized subjects who can empower themselves through education and adherence to a proper treatment regime does not acknowledge the traumatic experience of illness, nor does it account for the structural inequality that has made certain individuals vulnerable to disease (Robins, 2006: p.321). It is vital to identify the ways in which forms of violence and inequality impact the ability

to make decisions about and assume responsibility for one's own health. Farmer (2004) uses the concept of structural violence to illustrate how poverty, gender inequality, and everyday violence constrain the choices of HIV positive women he encounters at his HIV/AIDS clinic in rural Haiti (Farmer, 2004 in Robins, 2006: p.313). Emphasizing the impact of structural violence reveals the shortfalls of responsabilization approaches to health. I argue that the responsabilization discourse is not constrained only to the sites of HIV/AIDS. The construction of the responsabilized citizen is present in the discourse around motherhood in Ocean View, revealing how motherhood is positioned as an individual matter rather than a social experience that is impacted by global and local structures of power and inequality.

### ***Concluding thoughts***

The concept of the responsabilized citizen offers a critical approach to notions of risk, surveillance, and culpability within the discourse of motherhood. Understanding the ways in which mothers are rendered responsible for infant health reveals how the impact of the political economy and structural violence become secondary to the mother's duty to provide care. This approach places the mother at the center of responsibility – and therefore blame, and depoliticizes and individualizes poor health outcomes. Within this discourse, the mother is expected to act as a risk-manager who is responsible for keeping the vulnerable infant body safe; she is constructed as the site of both harm and well-being. It is vital to acknowledge how the mother's care choices are not made in a vacuum; social relationships and contextual circumstances have a major influence upon the mother's degree of autonomy in decisions around how to care for the infant. A failure to acknowledge these relationships and contexts is oppressive in the sense that individual mothers become fully liable for infant health. As Moses (2010) asserts the influence of other relationships on infant health, and given the lack of infrastructure in Ocean View, placing the mother at the center of blame for infant health outcomes is highly problematic.

The Moms and Tots support programme plays an important role in diffusing the responsibility that is placed upon mothers through extending care networks outside of the domestic realm and beyond state infrastructure. It is important to identify fundamental

differences between framings of responsibility and responsabilization. While the support programme emphasizes the mother's role in caring for her infant, political processes of responsabilization assert that the mother is liable for the health of her baby, despite major structural constraints. The key difference is that the Moms and Tots programme supplements maternal responsibilities through offering support networks and resources that diffuse the burden of childcare. By taking part in the programme, women gain access to social and material networks that help them cope with struggles they encounter in motherhood.

## Chapter 5

### “I never knew that a little person like that could manipulate a big woman like me”: The Demands of Care

The experience of feeling overwhelmed by competing roles as a caretaker was elicited by a number of women who participated in my research. Women described feeling burdened by demands of physical and emotional energy, as well as a lack of social and material resources to provide care. Hannah, a 24-year-old mom with two sons under the age of 5, was pregnant with her third child and expressed worries about caring for another baby. Despite the fact that both she and her partner work, they are lucky if they make a combined total of 6,000 rand a month, and “money is very tight”. She constantly asks herself, “what are the kids that I have now going to have to sacrifice?” As I spoke to Nazia, also a 24-year-old mother, she cradled her newborn baby boy Amir, and Raeesa, her 16-month-old daughter, bounced around on the bed. Nazia explained that before Amir was born, she felt that caring for Raeesa was easy, as she could devote all her time and energy to her. Now that she has the demands of caring for a newborn, trying to care for Raeesa in the same way is difficult. Juggling the care of two babies means that Nazia is at home most of the time; she finds it difficult to be “cooped up” and often experiences feelings of isolation.

In this chapter, I argue that the demands of care place significant stress upon mothers with competing priorities and constraints in social and material resources. The assertion of proper care practices creates a discourse around the ideal mother as someone who takes responsibility for infant health by adhering to certain care behaviours. I show that many women self-evaluate their behaviours and internalize notions of the bad mother when infant health is compromised. Networks of care and support have a strong influence upon infant health and can also help to alleviate the mother’s burden of care and emotional struggles. The Moms and Tots programme is a place where women can seek support for the issues they encounter in their roles as mothers and facilitates social and material networks outside of the domestic realm.

### ***Proper Care Practices: The ideal MOTHER***

During my second week of fieldwork I attended the Moms and Tots graduation ceremony that celebrates mothers from Ocean View, Masiphumelele, and Red Hill who completed the support programme. Halfway through the graduation ceremony, Avril Thomas, cofounder of Living Hope, gave a speech on the vision of the Moms and Tots support programme. She explained that the main goal of the programme is to teach moms how they can best care for their babies, and illustrated her vision of the good mother using the following acronym:

**M:** Manager [“You have to manage your time, make sure the house is clean, and be organized.”]

**O:** Omnipresent [“You have to have eyes in the back of your head.”]

**T:** Teacher [“You need to teach them, these little precious children, they don’t know anything.”]

**H:** Helper [“I believe God is calling us as mothers to become our children’s helpers.”] *and* Healthy [“When we have children, we need to teach them about health, how to make good decisions. That’s why we have the group, to teach you what is healthy so that you can teach your children.”]

**E:** Enthusiastic *and* Energetic [“Our emotional health is very important. And that’s why we have Moms and Tots, to help us realize that we are not alone. We need to look after our emotional health so that we can be enthusiastic and energetic and give our children what they need.”]

**R:** Responsible. [We must be responsible for our children. What does it mean to be a responsible mommy? Do we take our babies to the clinic? Do we just have sex in the bed while the baby is there? No! We’ve got to be responsible.”]

Avril Thomas’ acronym and her descriptions of the significance behind each letter illustrate a clear vision of the traits of a good mother, which are wrapped up in a set of care practices and relationships. As I sat among the mothers at the ceremony, I became curious about their thoughts around this discourse of what constitutes a good mother. Not only was Avril advocating a certain set of traits that a good mother should embody, she also emphasized the importance of the mother’s relationship with God. Avril elucidates the importance of this relationship as she concludes her speech, stating,

So it’s important to have a relationship with God. And that’s what our moms group is all about. Yes, it’s helping you with all the practical things, breastfeeding, immunizations, sexual health, but also, giving you the opportunity to make Jesus your savior. It’s about mind, body, spirit— we can’t just live life

without thinking about the spiritual side. And we believe that Jesus is the answer. He is the one that will be able to help you to be the mother that your children need. (June 19<sup>th</sup>, 2015)

Avril's statement asserts that idea that a good mother is not simply someone who can carry out a set of proper care practices: she is a moral and spiritual woman, more particularly, a Christian. This connection between good mother and good Christian illustrates the presence of a specific moral discourse around mothering<sup>13</sup>.

It is essential to understand Living Hope's portrayal of the proper mother within the context of the religious mandate of the organization. As I have illustrated in Chapter 3, religion is routinely offered as a mode through which individuals can address deficiency in their lives. Avril's assertion of what it means to be a good mother is built upon a discourse of Christianity and also reflects an ideal of intensive mothering (see Hayes 1996, Romagnoli and Wall 2012, O'Reilly 2004). The Moms and Tots programme operates with the perception that educating mothers about proper care practices will lead to a change in behaviour; this known as a Knowledge-to-Action (KTA) framework. Within this framework, the mother is identified as the agent that has the potential to enact change. Viewing the mother's care as central to the health outcomes of the infant places women in a position of potential empowerment, but also moral blame. Based on her research on motherhood in South Africa, Long (2009) asserts that motherhood is a "primary social site for the construction of divisions between 'good' and 'bad' women" (p.55).

The mothers who participated in my research shared feelings about their experience of motherhood and how they felt that they compared to certain ideas and expectations of the good mother. During one of the support group sessions, Aunty Martha asked the women, "How do you feel as moms?" I was taken aback by the outpouring of emotion that was sparked by this inquiry. Crystal, a 24-year-old mother, began by talking about the guilt she felt about her thirteen-month-old son Michael's health. When Michael

---

13 Reflecting on notions of motherhood in South Africa, Guy (1990) argues that cultural practices and beliefs in relation to motherhood have been transformed by colonialism, where Christian and traditional belief systems began to interact. Walker (1990) claims that colonialism and Westernization have had a strong influence upon African conceptions of motherhood, and Christian notions of motherhood have been dominant since the mid-twentieth century. While these notions have continued to change and adapt over time, it is important to acknowledge the influence of this historical context.

was diagnosed with tuberculosis (TB) last February, Crystal felt that God was punishing her for not finishing her schooling and giving up everything to have a baby. After his diagnosis, she stopped doing things for herself, such as taking pride in her appearance, and felt that she needed to devote all her energy to her son. Originally from Durban, Crystal said that she felt that her son's illness also resulted from living on a place like Ocean View, and that she is "not so accustomed to living this way". Crystal's interpretation of her son's illness is framed by local discourses of risk and responsibility. It is also embedded in religious narratives, as she asserts that her son's illness is a result of her own moral wrongdoing. Sameera, a 21-year-old mother, became very emotional when she spoke about her experience of being a mother. She said that whenever her two-year-old son got a fever or any sort of illness, her own father would blame her, and would tell her that it was her fault for not caring for him properly. She started to cry as she told the group that these accusations made her feel useless.

The responses of these mothers illustrate a deep sense of responsibility for their child's well-being, and internalized guilt when well-being is compromised. While Crystal was able to identify how she felt that aspects of living in relative poverty (compared to her previous environment) contributed to her son's illness, she still felt that his TB was a result of her moral wrongdoing. Crystal did not describe this moral wrongdoing as a specific failure in caring for her son, but rather a failure to achieve a certain social status (finishing school) before becoming a mother. Reflecting upon the intersections between social status and the good mother, Romagnoli and Wall (2012) state, "It is, of course, those who fall outside of middle-class social values and norms that become identified as risky" (p.275). Crystal's view of her son's illness being linked to her failure to achieve the position of a middle-class, educated mother reflects this notion of good mothering being tied to social status. As I have noted in the Chapter 4, the shift from identifying certain behaviours as risky (those that endanger the child or self) to individuals as risky (those that endanger a moral universe) leads to stigma and moral blame. Sameera links her emotional pain over her experience of mothering to harsh judgments by her own father. She explains how his view of her as failing to keep her son healthy causes her to feel like an inadequate mother. Despite being a young, unemployed, single mother, Sameera does not describe her struggles in motherhood as being due to her life

circumstances, but rather as an outcome of feeling incompetent, which has resulted from internalized judgment. Both mothers reveal emotional distress over an inability to achieve the status of good mother, and link deficiency to their personal actions rather than to the inadequacies of their support systems and living circumstances.

***Breast is Best: motherly love and nourishment***

A mother's adherence to a set of ideal care practices has a major influence upon her ability to achieve the reified status of good mother. In South Africa, exclusive breastfeeding is state-sanctioned and is widely promoted as the ideal infant feeding method. The emphasis on the importance of breastfeeding was a recurring topic in Aunty Martha's health talks at the clinic, during the Moms and Tots support group, and was often discussed during home visits with new mothers. Breastfeeding was consistently put forth as the ideal infant feeding method, both in terms of its nutritional benefits and its role in facilitating the mother/infant bond. This emphasis on breastfeeding as the optimal choice for infant feeding reflects a wider social discourse which links breastfeeding with intimacy and nourishment. Since the Tshwane Declaration of 2011, exclusive breastfeeding is state policy in South Africa (National Breastfeeding Consultative Meeting, 2011). Simms (2008) asserts that breast milk has significance beyond its nutritional value: it can be seen as a metaphor for motherly love and protection (p.19). She states,

Nourishment goes beyond food. Happiness comes from the gestures surrounding the giving and receiving of milk. Milk, the original nourishment, is not merely a food for the stomach. It feeds the child's senses: the perfume of the (m)other's skin, the gaze of her eyes, the rhythms of the soothing voice all invite the infant to enter a world that is new but safe. (2008: p.19)

This depiction illustrates how the act of breastfeeding is conceptualized as a more than good nutrition for the baby; it is seen as an act of love that provides the infant with holistic nourishment. Aunty Martha articulated the association between breastfeeding and motherly love and nourishment in a number of support group sessions. Studies on breastfeeding in a variety of different contexts (see Andrew and Harvey 2011, Waltz 2014, Dykes 2005, Knaak 2010) have illustrated how breastfeeding is tied up with the identity of being a good mother.

Mothers who participated in the support programme identified breastfeeding as one of the most important topics addressed in the group. They felt that discussions around the importance of exclusive breastfeeding, the issues with mixed feeding, and effects of maternal nutrition on the infant informed their feeding practices. During the group sessions, mothers also shared anxiety around sustaining the baby with their breast milk, and often expressed a certain degree of distress over the demanding nature of breastfeeding. During one session, Charlotte told the group how she felt that she wasn't producing enough milk and ended up giving her baby formula<sup>14</sup>. Aunty Martha asserted that lack of milk is not a common issue, but rather an issue of the infant latching properly. She asked Charlotte to squeeze her nipple to see the milk and concluded that it looked good, not watery. Conceptions of a mother's breast milk can be linked to broader notions of deficiency. In her study on maternal beliefs and child survival in a shantytown in Northeast Brazil, Nancy Scheper-Hughes (1985) explores how maternal perceptions of breast milk illustrate conceptions of their bodies as weak (p. 303). She found that when women refer to their breast milk as watery, bitter, or sour, they were simultaneously speaking metaphorically to the scarcity and bitterness of their lives in an economically marginalized community (Scheper-Hughes, 1985: p.304). This reveals a direct link between political economy and intimacy- breast milk of poor quality becomes a symbol of the resource scarcity that inhibits a mother's inability to nourish her baby.

During a discussion about the superiority of breastfeeding, Aunty Martha asserted, "You can love your child more than a bottle-fed baby" and explained that breastfeeding creates a strong bond between the mother and baby. It is important to note how this conception of the mother/infant bond created through the act of nourishment disavows the influence of other caregiving figures. Research participants consistently spoke about the important role that family members and partners play in loving and caring for their babies; the care relationships that surround the mother have a significant influence upon infant well-being. Additionally, mothers do not always see this strong mother/infant bond as positive: many women in the support group shared feelings of

---

<sup>14</sup> UNICEF states, "If a mother is moderately malnourished, she will continue to make milk of good quality, better than infant formula. If she is severely malnourished, the quantity of breast milk produced for each feeding may be diminished."

being overwhelmed by the physical and emotional demands of breastfeeding. The strong emphasis upon the bond created through breastfeeding positions the mother as primarily responsible for providing the infant with love and nourishment, which precipitates certain consequences for the mother. Based upon their study on infant feeding choices in the UK, Andrew and Harvey (2011) found that the demanding nature of breastfeeding led to women feeling a loss of independence in their lives (p.55). Andrew and Harvey claim that women in their study felt that breastfeeding tied them to their baby because they had to be with him/her at all times in case of feeding (2011: p.57).

Many women with whom I spoke echoed this sentiment. During one of the support group sessions, Natalie shared her feelings of exhaustion over the demands of caring for her infant daughter Maya, who wakes up to five times a night to feed. The demands required of a mother who wishes to breastfeed but cannot be physically present for her infant was illustrated during a home visit with Candice, a sixteen-year-old mom. Candice spoke about how she balances her responsibilities as a mom while she is still in school (Grade 11). She explained that she wakes up every day at 6am to express breast milk for her daughter to drink while she is away during the day. Her gran and cousin share the duty of caring for her baby while she is at school, and then she comes home at 3pm to take over. While the production of milk is located in one body, the work of nourishment and care is spread across three women of two different generations. Women also drew upon support outside the family when facing difficulties with breastfeeding. A Living Hope community worker told me that when her daughter was having a difficult time breastfeeding her first baby, Aunty Martha would come over late at night to provide help. She would bring warm cloths to place on the mother's breasts to stimulate milk flow and would speak to the mother about the stress and anxiety she was experiencing. These examples of care distribution illustrate the importance of the social relationships that influence infant well-being.

The strong focus on the mother's duty to nourish her infant deemphasizes the relations that surround mothers and infants, particularly relationships that ensure that mothers get enough food, have places to stay, and a secure living environment. A lack of acknowledgment of these social relationships positions the mother as the primary influence upon infant well-being. Based upon her study of infant feeding practices among

HIV positive mothers in Gugulethu<sup>15</sup>, Moses (2010) argues that maternal practices are often powerfully shaped by senior female relatives (mother's own mother, mother in law, aunts). For mothers living in extended family households, the wishes of these older women sometimes need to be followed (Moses, 2010: 19). Moses' argument challenges the notion that mother's make autonomous decisions about how to care for their infant, and are therefore solely responsible for health outcomes. Understanding the interactions between mother and baby requires an analysis of the social relationships that impact these interactions.

### ***Giving Care, Taking Care: competing demands and the struggle for self-care***

As I sat among a group of moms in the support programme, I listened to Mona speak about the difficulty of raising three young children along with caring for her mentally ill aunt and elderly father. She explained how her own mother's death significantly impacted her care duties. Because her own mother helped her tremendously with caring for her first two children as infants, the arrival of her third baby made her feel 'like a first-time mom'. With her mother gone, she has had to learn how to do everything on her own. While her husband does help, he works in the daytime and goes to Mosque in the evening, so most of the care work is left to her. While caring for three children under the age of six can be demanding enough, Mona also has to juggle care duties for her father and aunt. She spoke about how the care of her aunt fell to her after her mother passed away, as her aunt's other sisters refused to help. She broke down crying as she spoke about this and said that she doesn't feel she is able to provide her children with the life she wants to give them.

Mona's experience as a caretaker illustrates how her ability to provide her children with care in the way she desires becomes compromised with competing duties, all care related. Mona's experience of multiple care duties reveals how women must prioritize care; while the ideal mother is one who devotes all her time and energy to her child, in this context, the mother cannot selectively choose who to care for. On the day of my last attendance of the support group, Mona shared worries that she may be pregnant again and had a difficult time coping with the idea of having a fourth child, especially as

---

15 A township in Cape Town, South Africa

her youngest son is still in his infancy. When I met Mona at the Moms and Tots graduation ceremony two months later, she confirmed that she was pregnant, and will have to find a way to stretch her care a bit further.

Discussing her duties as a mother and a caregiver, Mona told me “a woman’s work never stops”. This statement illustrates a strong gender ideology around child rearing and care: while Mona acknowledges the demanding nature of this work, she accepts that this labour is part of her role as a mother, daughter, and niece. When asked about the role of her husband in helping with care duties, Mona told me he does provide some help, but when he comes home from work, he goes to the Mosque in the evenings and is not around that much. Based on a number of other interviews and informal conversations I had with women in Ocean View, it became clear that care most often fell into the mother’s lap. Few women described their husbands or partners as having a significant role in providing childcare.

Many mothers who came to the support group shared struggles with feelings of isolation, as most were at home during the day with only their children. Based upon their study on the challenges of new mothers in the USA, Paris and Dubus (2005) claim that being isolated can contribute to feelings of postpartum “blues” (p.73). New mothers may feel particularly lonely because of the difficulty of sharing these unpleasant feelings (Paris and Dubus, 2005: p.73). Women who nurture newborns may also experience a disconnection from their primary sources of support as a result of the amount of time and energy that goes into care (Paris and Dubus, 2005: p.73). Paris and Dubus identify a number of factors that contribute to feelings of isolation and loneliness: the physical and emotional demands of nurturing an infant, not having their own mothers around, and being unable to share their experiences with someone who can relate and understand the frustrations (2005: p.77). The level of devotion that is expected from mothers of newborns places a huge emphasis on the vulnerable infant body, and can cause the needs of the mother (emotional, spiritual, and physical) to become secondary to the infant. In an interview with Melissa, a mother of two, she spoke about her surprise over how demanding caring for infants can be. Reflecting upon these demands, she claimed, “I never knew that a little person like that could manipulate a big woman like me.”

Five out of the nine mothers that I interviewed felt that participating in the support

group improved their ability to care for themselves, and also gave them more confidence in asking for help when they needed it. During group sessions, Aunty Martha made it a point to emphasize how self-care is central to being able to care for a baby. She told me that mothers often become so overwhelmed with caring for their babies that they don't care for themselves. She encourages them to take the time to do certain things like brushing their hair and getting dressed properly to "make themselves beautiful", which will help them feel better about themselves and increase self-esteem. Asserting the importance of making mothers feel warranted to focus on their own needs works against the pervasive idea that the total sum of the mother's energy needs to be devoted to the baby. Reflecting on the discourse of the ideal mother in South Africa, Long (2009) asserts, "the good mother happily indulges in her labours of love, expecting no rewards, but basking in maternal bliss." This framing reflects the notion of care as intrinsic to motherhood (see Mol, Moser and Pols 2010, Chodorow 1974). Mothers felt the emphasis on self-care was a valuable aspect of the support programme. Danielle, a 34-year-old mother of three, said that after she completed the support group, she learned to ask people in her life for more social support in caring for her children. Anya, a 30-year-old mother of three, said that the group gave her confidence to ask for more help from her husband, and that it also caused her to become more proactive about seeking other support services in the community.

### *Networks of Care*

My research participants consistently identified the support programme as a source of social and material support. The support group facilitated the exchange of both material items (baby clothes, household items that they are no longer using and that other mothers may need) and experiences of mothering. Many women felt comforted in knowing that they were not alone in their struggles and found it helpful to hear about those of the other mothers. In addition to sharing within the group, Tasneem said that she shared what she learned in the group with friends that did not get to participate and it made her feel good to be able to spread this knowledge. When presented with the question, "Did you find it helpful to connect with moms dealing with similar issues?" all nine mothers that I interviewed answered yes.

The importance of the group as a social support network was highlighted in a situation that I witnessed at the end of my research. Nazia had completed the group about a year ago with Raeesa (now 16 months old), but returned to the group after she gave birth to her second child. Although she already knew that health education content that was being taught in the group, she found it useful to return for the social aspect and to share new concerns about caring for two babies. She also felt the group helped her deal with the sense of isolation and loneliness that she was experiencing as a stay at home mom. Other mothers reiterated how the social time that they got in the group was very important, and they liked having a reason to get out of the house. Mothers, particularly first-time ones, found the group helpful in dealing with their anxieties around caring for their babies, which were strongly focused on health concerns such as nutrition (feeding practices) and illnesses.

Schrag and Schmidt-Tieszen (2014) define social support as “a network in which the individual perceives love and care from others, such as family, relatives, and friends, and can receive guidance for help with daily tasks” (p.316). Support networks are significant in reducing stress and can help ease the adjustment after childbirth (Schrag and Schmidt-Tieszen, 2014: p.316). In their study on the nature of social support networks of young, single mothers in the USA, Schrag and Schmidt-Tieszen found that family proved to be the greatest source of social support in young mothers’ lives. Participants identified mother figures (either birth mother or the woman who raised them, such as a grandmother) as the most supportive family members, and sisters and aunts came second (Schrag and Schmidt-Tieszen, 2014: p.316). Conducting home visits with Aunty Martha, I witnessed the influence of family support in the lives of two mothers we visited. On the first home visit, we met with a seventeen-year-old mom named Erica, who had a three-month-old baby girl. Erica is from Retreat, but was living with her boyfriend, the father of her baby, in his mother’s disorderly home. She started coming to Ocean View a few years ago with her brother and ended up living there, but the rest of her family remains in Retreat. When Aunty Martha asked Erica about how she was coping with being a mom, she was withdrawn and gave short responses. After leaving, Aunty Martha commented on the young man who was sleeping on the couch during the interview, saying that he was one of the sons who lived there, and was a tik addict who

would sell anything he could find in the house to feed his habit. She also commented on the unwashed clothes of both Erica and her baby girl, as well as the packets of chips that she saw in her pocket, assuming that this was her main source of sustenance. Aunty Martha was quite concerned about this situation and put in a good deal of effort trying to get Erica to join the support group, to no avail. Erica's situation illustrates the way in which existing networks of care often facilitate further connections that contribute to social support. Those who fall outside networks of care are more likely to be vulnerable to precarious living conditions.

The situation I witnessed at Erica's home environment was in contrast to that of the next mother we visited, Natalie, a 30-year-old mother of two. Natalie lived a five-minute walk down the road, yet her home environment felt significantly different to that of Erica. She welcomed us into her home with a big smile guided us into her living room, which was very well kept and filled with family photos. She beamed as she spoke about her three-week-old baby girl, and told us that she is getting lots of support from her parents and sisters, all of whom she lives with. While she does not live with the father of her baby, they are "in a relationship" and see each other as often as they can. While she felt the need to be around her newborn baby almost all the time, she could count on her mom or sisters for help. We invited Natalie to join the support group, and she did so the next week. While the contrast between these two situations can be attributed to aspects such as age difference, previous experience as a mother, and greater economic stability, it was clear that the support of family was great source of strength in Natalie's life. Many of the mothers I met during my research identified family members as significant sources of support, especially when not living with or in a relationship with the father of the baby.

The nine women that I interviewed all had some involvement with the father of their baby, and most were in a committed relationship<sup>16</sup>. Of the nine women, five of my participants reported being married, two were in committed partnerships and living with the father, and two were single but had a relationship with the father. Most of these mothers described positive relationships with the father, but two women experienced

---

16 Schrag and Schmidt-Tieszen identify four different ways that the women in their study describe paternal presence: fathers who were completely absent, fathers who offered minimal support, those who were involved in a very positive way, and those involved in a negative way (2014: 322).

negative relationships. Johanna, a mother of two, was still married to her husband but had recently moved into her sister's house with her two children due to conflict with him. Her husband would see the children on weekends, but was not involved in daily life. At the time of our interview, Anya was living with her husband. During a visit to Living Hope four months later, Aunty Martha informed me that Anya had taken her children and gone to a safe house due to her husband's abusive behaviour. While my research focus was more upon experiences of mothering and the relationship between the mother and baby, I found it vital to gain an understanding of how the supportive or unsupportive personal relationships in a mother's life affect her network of care, as well as that of the baby.

While family and partners play an important role in a network of care, I found that an individual with a passion for helping mothers and babies could make a significant contribution to the mother's care network. Acting as Aunty Martha's "shadow" as she went about her daily duties in Ocean View, I realized the central role she played in offering support to mothers in the community. A great deal of the programme's success was based upon the facilitator's community ties, ability to activate networks, commitment to follow up, as well as the emotional labour involved in caring for mothers who are struggling. Every few weeks, Aunty Martha receives referrals for mothers from Ocean View who have given birth at False Bay Hospital and makes arrangements to visit them in their homes. These home visits are a major way that Aunty Martha meets mothers who later become part of the support programme. Paris and Dubus (2005) assert that home-visitor interventions prove to be a successful way of providing support to new mothers, especially those suffering from feelings of isolation or depression. They argue that the connection developed with the home-visitor determines the support that mothers gain from the intervention (2005: p.79).

Aunty Martha does not restrict her home visits to women who have been referred to her by False Bay hospital, but takes an active interest in any mother or baby she meets in streets or clinics. One day in the clinic Aunty Martha met Mona, a mother who was interested in participating in the Moms and Tots programme, but lived far from Living Hope. As Mona had a number of interested neighbours, Aunty Martha decided to run a group out of her home. This group proved to be very successful: it consistently had better attendance than the group held at Living Hope headquarters, and once the Moms and

Tots programme finished, all the mothers in this group completed another Living Hope parenting programme. This illustrates how Aunty Martha's willingness to alter the group to fit the needs of mothers produces positive outcomes and leads to participation in other Living Hope programmes.

Research participants described Aunty Martha's dedication and support as central to their positive experience in the programme. I found that Aunty Martha's community ties and local understanding of child-rearing had a significant influence upon the delivery of the Moms and Tots programme. The discursive structure of the programme operates on a model of deficiency that assumes mothers in the community need to be educated on proper care. In practice, the programme is more nuanced; Aunty Martha acknowledges that women have some knowledge and capacity and works to augment maternal care practices through providing further information and support. Although the programme has been designed to remedy a social ill, it becomes a resource rather than a teaching environment and is central in facilitating networks of support for women in the community.

### ***Concluding Thoughts***

Living Hope's archetype of the ideal mother intersects with Christian morals and notions of intensive mothering. Intensive mothering reflects neo-liberal values of individual responsibility and positions the mother as accountable for her own well-being, as well as that of the infant. Within this model, a woman can achieve the reified status of "ideal mother" through the achievement of proper care practices. Breastfeeding serves as an example of responsible practice, and also reveals how the assertion of the mother/infant bond often disavows the importance of other caretakers.

Although mothers must navigate the demands of multiple caretaker roles and constraints in social and material resources, notions of deficiency are often linked to the inadequacy of the mother rather than the difficult circumstances. Mothers experience emotional struggles as they internalize these judgements and self-evaluate care behaviours. The issue at stake is that the contexts and relationships that influence maternal and infant health are ignored when the mother is seen as having the primary responsibility to provide care. Although the Moms and Tots programme reflects a

broader social discourse of responsabilization, it equips mothers with knowledge and facilitates social networks to support them in caring for babies. The supportive relationships and resource availability that surround the mother and baby have a significant influence upon well-being and must be viewed as central to the mother's ability to provide care.

## Chapter 6: In Conclusion: Disrupting the discourse of deficiency

The historical context of apartheid and the persistence of inequality in contemporary South African society are central to understanding individual and collective perceptions of lack in Ocean View. In circumstances where deficiency is seen as commonplace, it becomes characteristic of the social environment and is also mapped onto individual bodies. Acknowledging the influence of historical and political-economic context is crucial to disrupting a discourse of deficiency that positions individuals and communities as deficient rather than oppressive social structures.

The aim of my research was to understand how the Moms and Tots programme impacts on maternal knowledge and support networks that affect infant health. While my research enabled me to pinpoint certain effects of the support programme, I found that a great deal of my data spoke to both individual and collective identifications of factors that affect well-being in Ocean View. Through my interactions with mothers, Living Hope employees, and Ocean View residents, I encountered a variety of different framings of the issues that threaten new life in the community. I found that these framings tended to fall into three categories: broad structural issues, social ills within the community, and concerns over the mother's delivery of care.

Structural issues were linked to the apartheid legacy that led to the Group Areas Act and forced relocation of people classified coloured to Ocean View. Fifty years later, the memory of forced removals still features strongly in people's understandings of the suburb. Ocean View residents elicited specific ideas around the way in which their livelihoods were affected by inequality. This is exemplified in Elizabeth's prayer, as she claimed, "we were not born and asked to be coloured, this is the way you made us." While individuals linked this history of oppression to current social ills in the community, I found that framings of Ocean View tended to emphasize the ways in which the community was deficient rather than the structures of inequality that have produced violence and instability.

Within this exploration, it is vital to consider how notions of inadequacy operate within a discourse that asserts there are certain social worlds that are sustaining, and

others that are not. Butler and Athanasiou's (2013) speculations on the experience of dispossession analyse the presence of the normative social world in the construction of deficiency. Butler contemplates how the vulnerability of certain dispossessed subjects figures in definitions of what it means to be human. She questions,

Who and what is excluded from the "human", and how has the category of the human come to be formed against the background of the abject or the disavowed? In other words, how has the human been formed and maintained on the condition of a set of dispossessions? (2013: p. 36)

Butler's inquiry inspires critical thought upon the way in which the definition of human subjectivity is based upon the experience of subjugation. Rather than viewing the hegemonic social realm as the benchmark that serves as the base for determining subjectivity, Butler asserts that the experience of the dispossessed creates the conditions for the experience of being accepted into or acknowledged by the social order. In this sense, the existence of deficient social worlds is central to the construction of sustaining social worlds. Identifying the ways in which sustaining social worlds can be seen as lacking in terms of social justice and equality contributes to the disruption of the dominant discourse on deficiency.

Butler's theoretical framing of the sustaining realm as dependant upon the persistence of the deficient can be applied to framings of motherhood in Ocean View. Through my experience with the support programme, I found that Living Hope promoted a specific archetype of the ideal mother, which was based on the adherence to certain care practices and behaviours and the disavowal of others. This binaried approach to motherhood frames the good mother, the responsible, empowered, and knowledgeable subject, against the backdrop of the bad mother. Framings of the bad mother emphasized how the lack of adherence to proper care practices placed the infant in precarious circumstances that could result in poor health, or even death. In this sense, the mother becomes as a potential threat to infant health; risk is mapped on to persons rather than behaviours.

As greater structural issues become normalized in Ocean View, individual mothers are made responsible for ensuring the health of the future generation despite major social and material constraints. As this process of responsabilization places mothers at the center of blame for poor infant health, mothers internalize this liability and self-

evaluate their behaviours. This was exemplified in a support group session already described in which Aunty Martha posed a simple question: “How do you feel as moms?” The outpouring of emotion that this question brought forth remains strong in my memory. Tears flowed as women shared feelings of being overwhelmed by the duty of care for their children in the face of scarcity, and the guilt that ensued when they could not provide in all the ways they wanted to. The Moms and Tots programme proved a strong source of support for women experiencing struggles within motherhood. As women in Ocean View are often raising children in a materially poor context, a social support network that allows women to discuss their struggles and diffuses some of the maternal responsibility was central in offsetting the burden of childcare. Although the Moms and Tots programme is operating within a broader social discourse that asserts the liability of the mother for infant health, it works against the idea that women are alone in their responsibility to provide care.

The theoretical implications of this work emphasize the importance of shifting away from explanatory models that assert the individual responsibility of the mother for infant well-being. While it is important to empower mothers with the knowledge and resources that will contribute to positive health outcomes, it is vital to address the greater structural issues that have produced instability and inhibit access to social and material resources. Motherhood is both an individual and a social experience. Discourses surrounding the ideal mother and proper care practices must account for the contexts and circumstances that shape the experience of motherhood. As Mol, Moser, and Pols (2010) argue, this involves contemplation of the ways in which different ideas of the good reflect different values and ways of ordering reality. The discourse of deficiency surrounding motherhood in Ocean View reflects an ordering of reality that characterizes individuals, rather than structures, as lacking. The Moms and Tots programme plays an important role in framing childcare as beyond the individual responsibility of the mother. Through augmenting maternal knowledge and creating supportive networks, the programme supplements the lack that mothers encounter and emphasizes how care relationships that surround the mother impact on infant health.

## References

American Anthropological Association, 2012. Principles of Professional Responsibility. Found at: <http://ethics.aaanet.org/category/statement/>

Andrew, N. and Harvey, K. 2011. Infant feeding choices: experience, self-identity, and lifestyle. *Maternal and Child Nutrition* 7: 48-60.

Berry, L, Biersteker, L, Dawes, A, Lake, L, and Smith, C. 2013. South African Child Gauge 2013. Available: <http://www.ci.org.za/depts/ci/pubs/pdf/general/gauge2013/SouthAfricanChildGauge2013.pdf>

Blair-Loy, M. (2003). *Competing devotions: Career and family among women executives*. Cambridge, MA: Harvard University Press.

Bray, R and Brandt, R. 2007. Child Care and Poverty in South Africa. *Journal of Children and Poverty*, 13(1): 1-19.

Bray, R, Gooskens, I, Kahn, L, Moses, S, Seekings, J. 2010. *Growing up in the New South Africa: Childhood and Adolescence in Post-Apartheid Cape Town*. Cape Town: HSRC Press

Budlender, D, and Lund, F. 2011. South Africa: A Legacy of Family Disruption. *Development and Change*. 42 (4): 925-946.

Butler, J. 2009. Performativity, Precarity, and Sexual Politics. *Revista de Antropologia Iberoamericana* 4(3): i-xiii.

Butler, J. and Athanasiou, A. 2013. *Dispossession: The performative in the political*. Cambridge MA: Polity Press.

Chodorow, N. 1974. Family Structure and Feminine Personality. In *Women, Culture & Society*. Rosaldo, M.Z. and Lamphere, L, eds. Stanford: Stanford University Press. 43-66.

Cooper, P, Tomlinson, M, Swartz, L., Woolgar, M, Murray, L., and Molteno, C. 1999. Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry* 1999, 175: 554-558.

Cooper, PJ, Tomlinson, M, Swartz, L, Landman, M, Stein, A, McPherson, K, Murray, L. 2009. Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial. *British Medical Journal* 338:b974.

- Doherty, T. Sanders, D. Goga, A. and Jackson, D. 2011. Implications of the new WHO guidelines on HIV and infant feeding for child survival in South Africa. *Bull World Health Organ* (89) 62-67.
- Dykes, F. 2005. 'Supply' and 'demand': breastfeeding as labour. *Social Science & Medicine* 60(10): 2283-2293.
- Elliott, S., Powell, R., Brenton, J. 2015. Being a Good Mom: Low-Income, Black Single Mothers Negotiate Intensive Mothering. *Journal of Family Issues* 36(3): 351- 370.
- Erasmus, Z (ed.). 2001. *Coloured by History, Shaped by Place: New Perspectives on Coloured Identities in Cape Town*. Kwela Books: Cape Town.
- Farmer, P. 2003. *On suffering and structural Violence: Social and economic rights in the global era. In Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press. 29-50.
- Farmer, P. 2004. An Anthropology of Structural Violence. *Current Anthropology* 45(3):305.
- Gray, C. 2009. The Responsibilization Strategy of Health and Safety: Neoliberalism and the Reconfiguration of Individual Responsibility for Risk. *British Journal of Criminology* 49(3): 326-342.
- Gutierrez-Rodriguez, E. 2013. The precarity of feminization: on domestic work, heteronormativity and the coloniality of labour. *International Journal of Politics, Culture, and Society*. 27(2): 191 – 202.
- Guy, J. 1990. Gender oppression in Southern Africa's precapitalist societies. In Walker, C (ed.). *Women and Gender in Southern African to 1945*, pp. 33-47. Cape Town: David Philip.
- Hage, Ghassan, 2014. *Alter-politics: Critical anthropology and the radical imagination*. Melbourne University Press.
- Hall, K & Meintjies, H. 2014. *Demography-Children Living with Parents*. Available: <http://www.childrencount.ci.org.za/indicator.php?id=1&indicator=2>
- Hausman, B. 2011. *Viral Mothers*. Ann Arbor: University of Michigan Press.
- Hays, S. 1996. *The Cultural Contradictions of Motherhood*. New Haven: Yale University Press.
- Hofer, M. 2006. Psychobiological Roots of Early Attachment. *Current Directions in Psychological Science* 15(2): 84-89.

- Jacobson, D. 1991. *Reading Ethnography*. SUNY Press: Albany.
- Kehler, Johanna. 2001. Women and Poverty: The South African Experience. *Journal of International Women's Studies*, 3(1): 41-53.
- Kleinman, A. 1997. The violence of everyday life: The multiple forms and dynamics of social violence. In *Violence and Subjectivity*. Das, V, Kleinman, A, Ramphela, M, & Reynolds, P. Eds. Berkeley: University of California Press. 226-241.
- Knaak, S.J. 2010. Contextualising risk, constructing choice: Breastfeeding and good mothering in risk society. *Health, Risk, & Society* 12(4): 345-355.
- LeVine, R. and Norman, K. 2008. Attachment in Anthropological Perspective. In *Anthropology and child development: a cross-cultural reader*. R. LeVine & R New, Eds. Wiley Blackwell: London. 127-142.
- Long, C. 2009. *Contradicting Maternity: HIV-positive motherhood in South Africa*. Wits University Press: Johannesburg.
- Lupton, D. 2012. Infant embodiment and interembodiment: A review of sociocultural perspectives. *Childhood* 20(1): 37-50.
- McCormack, K. (2005). Stratified reproduction and poor women's resistance. *Gender & Society*, 19, 660-679.
- Miller, T. 2005. *Making Sense of Motherhood: A Narrative Approach*. Cambridge University Press.
- Mol, A., Moser, I., and Pols, J. (eds.). 2010. *Care in Practice: On Tinkering in Clinics, Homes, and Farms*. Transcript Verlag.
- Moses, S. 2005. Does space and place matter? Perspectives from girls growing up in a Cape Town neighbourhood created under apartheid. CSSR Working Paper No. 136.
- Moses, S. 2006. The Impact of Neighbourhood-Level Factors on Children's Everyday Lives, Well-Being and Identity: A Qualitative Study of Children Living in Ocean View, Cape Town. *Social Dynamics: A Journal of African studies*, 32(1): 102-134.
- Moses, S. 2008. The Impact of Neighbourhood-Level Factors on Children's Everyday Lives, Well-Being and Identity: A Qualitative Study of Children Living in Ocean View, Cape Town. *Social Dynamics: A Journal of African studies*, 32(1): 102-134.
- Moses, S. 2010. Infant Feeding in the Context of HIV: Exploring Practice and Decision-making. Unpublished Honours Thesis, Department of Psychology, University of Cape Town, South Africa.

National Breastfeeding Consultative Meeting. 2011. Tshwane declaration of support for breastfeeding in South Africa. *South Africa Journal of Clinical Nutrition*. 24(4): 214.

Nyamnjoh, F.B. 2012. Potted Plants in Greenhouses: A Critical Reflection on the Resilience of Colonial Education in Africa. *Journal of Asian and African Studies*, 47(2):129-154

O'Reilly, A. 2004. *From Motherhood to Mothering: The Legacy of Adrienne Rich's Of Woman Born*. Albany: SUNY press.

Paris, R. and Dubus, N. 2005. Staying Connected While Nurturing an Infant: A Challenge of New Motherhood. *Family Relations*, 54: 72-83.

Robins, S. 2006. From "Rights" to "Ritual": AIDS Activism in South Africa. *American Anthropologist*, 108(2): 312-323.

Romagnoli, A. and Wall, G. 2012. 'I know I'm a good mom': Young, low-income mothers' experiences with risk perception, intensive parenting ideology and parenting education programmes. *Health, Risk & Society*, 14 (3): 273-289.

Scheper-Hughes, N. 1985. Culture, Scarcity, and Maternal Thinking: Maternal Detachment and Infant Survival in a Brazilian Shantytown. *Ethos* 13 (4): 291-317.

Schrag, A. and Schmidt-Tieszen, A. 2014. Social Support Networks of Single Young Mothers. *Child Adolesc Soc Work J*, 31: 315-327.

Simms, E. 2008. *The Child in the World: Embodiment, Time, and Language in Early Childhood*. Detroit: Wayne State University Press.

Statistics South Africa. 2010. *Population group of head of household for household weighted, Ocean View*. Available: [www.statssa.gov.za](http://www.statssa.gov.za).

Statistics South Africa. 2011. *2011 Census Suburb Ocean View*. Available: [https://www.capetown.gov.za/en/stats/2011CensusSuburbs/2011\\_Census\\_CT\\_Suburb\\_Ocean\\_View\\_Profile.pdf](https://www.capetown.gov.za/en/stats/2011CensusSuburbs/2011_Census_CT_Suburb_Ocean_View_Profile.pdf).

Tapias, M. Emotions and the Intergenerational Embodiment of Social Suffering in Rural Bolivia. *Medical Anthropology Quarterly* 20(3): 399-415.

Trotter, H. 2009. Trauma and Memory: The Impact of Apartheid-Era Forced Removals on Coloured Identity in Cape Town. In Adhikari, M. (Ed.), *Burdened by Race: Coloured Identities in Southern Africa*. Cape Town: UCT Press.

Turner, V. 1961. Ndembu Divination: Its Symbolism and Techniques. Manchester: Manchester University Press. In Robins, S. 2006. From "Rights" to "Ritual": AIDS Activism in South Africa. *American Anthropologist*, 108(2): 312-323.

Turner, V. 1969. The Ritual Process: Structure and Anti-Structure. Chicago: Aldine. In Robins, S. 2006. From “Rights” to “Ritual”: AIDS Activism in South Africa. *American Anthropologist*, 108(2): 312-323.

Van Hollen, C. 2013. *Birth in the Age of AIDS: Women, Reproduction, and HIV/AIDS in India*. Palo Alto: Stanford University Press.

Walker, C. 1990. Women and gender in Southern Africa to 1945: An overview. In Walker, C (ed.). *Women and Gender in Southern African to 1945*, pp. 33-47. Cape Town: David Philip

Waltz, M.H.A. 2014. Milk and Management: breastfeeding as a project. *Anthropology of Southern Africa* 37(1-2): 42-49.

Ward, C. and Wessels, I. 2013. Rising to the Challenge: Towards effective parenting programmes. South African Child Gauge 2013: Part 2: Essential Services for Young Children.

World Health Organization 1987. Breastfeeding, breast milk and human immunodeficiency virus (HIV). Statement from the Consultation held in Geneva, 23-25 June 1987.

Websites consulted:

- <http://www.avert.org/professionals/hiv-prevention-programming/prevention-mother-child/guidelines>
- <http://www.unicef.org/programme/breastfeeding/related.htm>
- <https://www.westerncape.gov.za/news/diarrhoea-disease-season>

**Appendix A: Demographic information requested from mothers**

Name	
Age/DOB	
Education Completed	
Number of people in household and their relation to you	
Language spoken at Home	
Baby's name, age, gender	
Sources of Income	
Support Networks: Social and Material	
Involvement of Father	
Any sicknesses the baby has experienced?	

## Appendix B: Moms and Tots Questionnaire

-When did you complete the support group?

-Do you feel that the programme has helped you to deal with challenges you face in being a mom?

YES  NO

Comment:

-Was there anything about the support group you would change?

YES  NO

Comment:

-Was there anything that you would have liked to speak about but didn't?

YES  NO

Comment:

-How did you feel about meeting other moms with newborns? Did you find it helpful to connect with moms dealing with similar issues?

YES  NO

Comment:

-For moms with older children: Were there things that you learned in the group that you wished you had known when your other children were small babies?

YES  NO

Comment:

-Is your child up to date with his/her immunizations?

YES  NO

Comment:

-Do you plan to participate in other Living Hope support programmes or activities?

YES  NO

Comment:

### Appendix C: Interview Questions

1. Tell me about the most important things you learned in the support group.
2. What would you say to new moms who are thinking of joining the group?
3. How is your own health? Have you been to the clinic recently?
4. Tell me about your baby. What kind of baby is he/she?
5. What are the things you find difficult about caring for your baby? The things you find easy?
6. What portion of your day do you spend with your baby? Who looks after the baby when you are busy (day vs. night)?
7. Who does your baby know? Who is involved in his/her life?
8. How do you know how your baby is feeling?
9. Do you plan to have more children? Why/Why not?

### Appendix D: Distribution of Male:Female Headed Households in Ocean View

Population group of head of household by Gender of head of household				
for Household weighted, Ocean View				
	Male	Female	Unspecified	Total
Black African	144	69	-	213
Coloured	1724	1103	-	2826
Indian or Asian	12	6	-	18
White	5	-	-	5
Other	14	7	-	21
Unspecified	-	-	-	-
Total	1898	1185	-	3083

Source: Statistics South Africa