

An Investigation of Socioeconomic Status (SES) as a Variable Affecting the Nature of Mother-Infant Interaction

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Language Pathology)

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Abstract

Previous literature state that mother-infant interaction is influenced by the mother's socioeconomic background and that there are correlations between low SES conditions and inadequate mother-infant interaction thereby acting as a risk factor for later communication development. This mixed method study investigated how socioeconomic status (SES) affected the nature of mother-infant interaction, following the priority sequence model. In this approach, quantitative results were supplemented by extensive qualitative results. In order to control for the variable of culture, mother-infant interaction of ten mother-infant dyads (0-3 months) from the homogenous Cape Malay Muslim cultural group, were observed in a daily routine activity, namely bathing. Behaviours were recorded with a checklist. All the participant mothers participated in semi-structured interviews regarding their beliefs and practices about infants. Participants were categorized into Low and High SES groups according to information regarding household income, employment, education and living conditions indicators. Results of this group of participants showed uniformity of mother-infant interaction behaviours and beliefs and practices surrounding infants. The main finding of this study is that SES is a complex variable that has many dimensions and is difficult to describe. It cannot be easily isolated, and it appears that culture is a more influential variable affecting mother-infant interaction during the zero to three month period.

Keywords: Socioeconomic status (SES), mother-infant interaction, Cape Malay Muslim, culture

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Chapter One

Introduction

It is well known that good, early mother-infant interaction is essential for healthy child development (Kelly & Barnard, 2000; Owens, 2005; Popich, 2003; Rossetti, 2001). Mother-infant interaction, a known predictor of later communication development, has been the focus of early communication intervention for some time (Kelly & Barnard, 2000; Rossetti, 2001). In the literature, it has been established that while infants are biologically designed to interact and learn, diverse environmental factors including cultural variables and socio-economic standards (SES) also influence child development (Bradley & Corwyn, 2002; Garbarino & Ganzel, 2000; Hoff, 2003; Lagerberg, Magnusson & Sundelin, 2005; Popich, 2003; Rossetti, 2001; Sameroff & Fiese, 2000).

Recent literature recognises that knowledge of language development and its precursors, such as the nature of mother-infant interaction, has been based predominantly on research on the white, middle class, First World cultures (Garcia Coll & Magnuson, 2000; Louw & Avenant, 2002; Owens, 2005; Simmons & Johnston, 2007). Thus, conclusions have been drawn from small nuclear family contexts and from predominantly white, low-context cultures (Hall, 1990). Historically, behaviours uncharacteristic of the white, middle class, First World cultures were deemed as *risk factors*, for example, minority groups were encouraged to adopt the child rearing beliefs and practices of white, middle

class, First World cultures (Garcia Coll & Magnuson, 2000). Due to this belief, programs to enhance child development and improve parenting had been developed in countries such as the United States and Europe, and directed to minority populations living in low socioeconomic conditions (Garcia Coll & Magnuson, 2000). Owens (2005) emphasizes that SES and cultural *variances* to white, middle class, First World cultures, should not be viewed as negative, but rather as an insight into the belief system of a *different* population. Garcia Coll and Magnuson (2000, p. 107) present culture as a "resource" implying that different cultures should be seen as "assets" in the sum of influences upon a child's early development. Studies in Africa, Asia, Canada, Central and South America furthermore highlight this (Garcia Coll & Magnuson, 2000; Geiger & Alant, 2005; Simmons & Johnston, 2007). Garcia Coll and Magnuson (2000) explain that the positive aspects of individual cultures which encourage child development must be assessed and utilized appropriately. Geiger and Alant (2005) also mention the importance of identifying and understanding the assets and disadvantages of *various* cultures.

Poverty is viewed as a risk factor for communication delay (Rossetti, 2001) and it has been emphasised that early interventionists must consider the major social support systems for families living in poverty for appropriate management (Halpern, 2000). On the other hand, poverty may not always result in an infant developing communication delay or culminate in maladaptive parenting (Tomlinson, Cooper & Murray, 2005). Despite living in extreme conditions, mothers in poor communities may have strong social networks that nullify or

reduce the impact of the economic hardships (Tomlinson et al., 2005). There appears to be a general consensus that SES affects aspects of child development, including mother-infant interaction (Garbarino & Ganzel, 2000; Hoff, 2003; Owens, 2005; Rossetti, 2001; Tomlinson et al., 2005). However, there appears to be limited research regarding the effects of SES on mother-infant interaction during the zero to three month period.

Literature Review

Literature regarding SES and child development, parenting, interaction style and culture is reviewed below. The measurement of SES is also discussed. The importance of mother-infant interaction and early intervention within a Primary Health Care framework (PHC) is highlighted, and the ecological model of human development serves as the theoretical paradigm of this study.

1.1 Ecological model of human development

Human Ecology refers to how the environment affects and shapes human development (Garbarino & Ganzel, 2000; Sameroff & Fiese, 2000). Children do not develop in isolation, but rather in interaction with their specific environment and vice versa (Garbarino & Ganzel, 2000; Sameroff & Fiese, 2000). Garbarino and Ganzel (2000) have described the environment affecting the development of humans in terms of microsystems, mesosystems, exosystems and macrosystems. Concerning management, it is possible to identify various influences on child development in terms of these constructs (Sameroff & Fiese,

2000); for example, microsystems refer to the immediate environment such as the infant's home. Mesosystems explore how microsystems are connected; for example, the involvement of health professionals at the infant's home; and exosystems are exterior settings which indirectly affect the infant's development; for example, the hospital administration's protocol on home visits for health professionals. Finally macrosystems refer to the larger community or culture which governs society, an example of which is religion (Garbarino & Ganzel, 2000). This *systems approach* illustrates "the individual's experiences as subsystems within systems within larger systems" (Garbarino & Fiese, 2000; p. 78). The systems approach is illustrated in Figure 1.

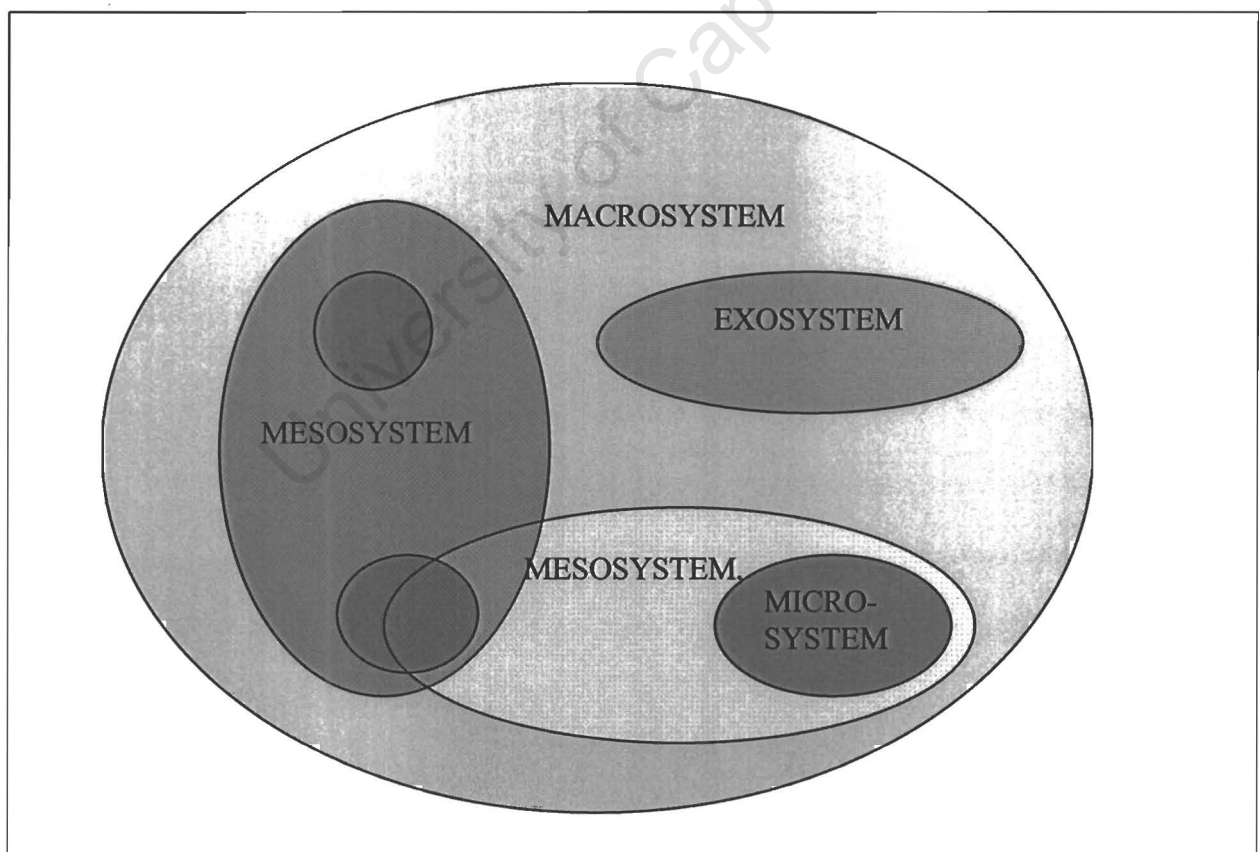


Figure 1: The Ecological Model

1.2 The importance of mother-infant interaction

Interaction between a mother and an infant is the central or pivotal 'microsystem' and begins from the first day of life, and the neonate is an active participant in this interaction (Gardner & Goldson, 2006; McCormick, 1990). Mother-infant interaction is reciprocal in nature as the infant responds to the mother's cues and vice versa (Gardner & Goldson, 2006; Klaus & Kennel, 1982; McCormick, 1990; Osofsky & Thompson, 2000). Communication interaction, including play and daily routines, develops the infant's sense of self or identity and allows the infant to acquire the social norms of his or her culture (Gardner & Goldson, 2006; McCormick, 1990). McCormick (1990) states that cultural norms for social interaction relate to language and communicative proficiency. Primary caregivers are the earliest source of communication stimulation to which the infant is exposed (McCormick, 1990). Mother-infant interaction allows the infant to develop socially appropriate communication skills (Owens, 2005).

Brazelton and Cramer (1990) define six characteristics of healthy interaction, namely; synchrony, symmetry, contingency, entrainment, play, autonomy and flexibility. Synchrony refers to the mother's tendency to react to the infant's behaviour. In this way, the infant learns the routines of the mother and consequently the mother becomes more secure about herself as a nurturer (Brazelton & Cramer, 1990). Symmetry refers to the infant's ability and capacity to engage in interaction and the mother's ability to recognise this. The infant displays specific behaviour which the mother responds to contingently.

Entrainment refers to the rhythmical pattern of behaviour between mother and infant. During interaction, mother and infant predict each other's responses (Brazelton & Cramer, 1990). Play sequences involve repetition of behaviour in interaction and is expanding on their entrainment. The infant begins to learn that interaction can be controlled and so begins to become more independent or autonomous (Brazelton & Cramer, 1990). The interaction between mother and infant, although made up of predictable behaviour, also allows for more flexible behaviour (Brazelton & Cramer, 1990).

Research indicates that the quality of mother-infant interaction affects the security of attachment and is indicative of later communication development (Kelly & Barnard, 2000; McInroy & Kritzinger, 2005; Owens, 2005; Pennacchia, 1998; Rossetti, 2001; Wendland-Carro, Piccinini & Millar, 1999). Attachment is defined as the feelings of bonding and closeness which are facilitated and maintained by behaviours evident in mother-infant interaction (Bowlby, 1969; Lamb, Thompson, Gardner & Charnov, 1985). According to Bowlby (1969), the mother's sensitivity and responsiveness to the infant's signals which allow them to remain within close proximity of each other is central for secure attachment to occur. Attachment is achieved by, for example, eye contact between mother and infant, touching the infant, breastfeeding and opportunities for developing the infant's ability to imitate facial expressions (Klaus & Kennell, 1982; Pennacchia, 1998; Rossetti, 2001; Valman, 1995).

Bowlby's (1969) theory of attachment explains how children relate to people. He further explains that infants are biologically designed to be social in nature and that attachment may occur with individuals other than the primary caregiver. Attachment behaviour is more prominent after the first year (Bowlby, 1969). As the infant reaches twelve months of age, attachment to new individuals become increasingly difficult and continues at a slower pace until adulthood (Bowlby, 1969).

Previous researchers focussed on mother-infant attachment for populations at-risk for developmental delays, focussing on the importance of adequate and early opportunity for attachment (Rossetti, 2001). A crucial period for the development of attachment is the first hour after birth (Klaus & Kennell, 1982; Pennacchia, 1998; Siegel et al., 2006). The normal, well infant is alert, makes eye-contact with the mother and searches for the mother's breast to feed (Siegel et al., 2006). Equally, the mother is anxious to meet her new infant, and although the birth process is tiring, many mothers report that they feel energised after birth (Siegel et al., 2006).

Rossetti (2001) stresses that there are two significant factors of post-natal attachment; that is, the alertness of the newborn during the first 60 – 90 minutes and the mother's response. According to Rossetti (2001), mothers' initial responses are generally universal across all cultures and ages. If there is a lack of opportunity for the mother to have contact with her baby immediately following the birth, the attachment process may be *disrupted*, but does not necessarily

develop into insecure attachment later in life (Rossetti, 2001; Siegel et al., 2006; Valman, 1995). Early caregiving is important in establishing secure attachment as it provides the mother and infant with the opportunity to recognise and identify each other's patterns of behaviour (Rossetti, 2001).

Ainsworth (1969, cited in Lamb et al., 1985, pp. 31) developed the Strange Situation Procedure to measure the infant's quality of attachment. It aimed to assess how infants respond to strangers, separation from the caregiver and how the caregiver is used for the purposes of exploration (Lamb et al., 1985). The assessment is structured so that the infant is exposed to three situations which increase in stress for the infant. The researcher would then be able to observe the infant's behaviour toward the caregiver (Lamb et al., 1985).

Tools for the assessment of attachment, such the Strange Situation Procedure, are intended to be administered on infants who are at least 10 months old (Rossetti, 2001). Rossetti (2001) notes that for healthy infants, early caregiving provides a natural platform for the development of attachment. For the purposes of the current study, early mother-infant interaction as a precursor of attachment, and not attachment itself, is the focus, as the participant infants were between zero and three months old.

1.3 Early Intervention

Early intervention focuses on primary and secondary prevention for communication delay (Fair & Louw, 1999; Paul, 2001; Popich, Louw & Eloff,

2006; Sameroff & Fiese, 2000). Primary prevention involves reducing the occurrence of disorders, whereas secondary prevention involves early intervention strategies to minimize the possible effects of risk factors on development – particularly also communication development (Fair & Louw, 1999; Paul, 2001). Vaccines and inoculations and access to adequate health care are examples of primary prevention (Paul, 2001). An example of secondary prevention, where Speech-Language Pathologists are involved, is the assessment and management of infants at-risk for communication delay (Fair & Louw, 1999; Paul, 2001).

The primary health care (PHC) system, which was adopted and implemented in South Africa, regards prevention of illness and promotion of health as highly as the management of existing conditions (Dennill, 1999; Fair & Louw, 1999; Swanepoel, 1999). PHC aims to provide access to basic health for all and its success is heavily dependant on the communities which it serves (Dennill, 1999). The development of a PHC system is based on the needs of the communities and the socioeconomic, cultural and political characteristics of the communities (Dennill, 1999). Communities are therefore empowered by effective application of PHC principles (Swanepoel, 1999). PHC emphasizes prevention of illness, promotion of health and accessibility to basic health care services for all (Dennill, 1999). It seeks to provide basic health care which is affordable and appropriate for the community it serves (Dennill, 1999). Early Communication Intervention (ECI) complies with a PHC philosophy, as services focus on primary and

secondary prevention (Fair & Louw, 1999; South African Speech-Language and Hearing Association [SASLHA], 1997; Ziev, 1999).

Parent-centred intervention is emphasized in early childhood intervention (Anderson & Battle, 1993; Louw & Avenant, 2002; Maura, Shimmel, Ciacera & Prabhakar, 2003; McDaniel, Campbell, Hepworth & Lorenz, 2005; Paul, 2001; Popich et al., 2006; Rossetti, 2001; Ziev, 1999). The needs and assets of the family are considered and assessed (Anderson & Battle, 1993). When the family and their surroundings are taken into account when assessing an infant, intervention may be adapted to accommodate individual differences (Maura et al., 2003; Rossetti, 2001; Sameroff & Fiese, 2000). Paul (2001) explains the need to identify the family's needs as well as their assets. Families are active participants in decision-making processes, thus health professionals must respect and consider the family's background (Louw & Avenant, 2002; Maura et al., 2003; McDaniel et al., 2005).

The focus of intervention has moved from an individualistic medical model approach, focussing on the individual child and its disorder or delay, to providing assistance to families with children with developmental delays (Carpenter, 2005). This includes infants who are identified early in life with factors that place them at risk for developmental difficulties later in life (Carpenter, 2005). Carpenter (2005) also points out that intervention with at-risk populations should commence as early as possible. The medical model is concerned with the identification and treatment of disease, while social models take into account the social and

environmental aspects that may have affected the condition of the client (McDaniel et al., 2005; Ross & Deverell, 2004). Literature suggests that when embarking on family-centred intervention, the incorporation of aspects of both medical and social models is most effective (McDaniel et al., 2005; Ross & Deverell, 2004). Ross and Deverell (2004, p. 13) describe a combination of the medical and social models as the “biopsychosocial” model. This model therefore promotes the assessment and intervention of not only communication disorders or delays, but also taking into consideration the social and environmental resources affecting the infant (Ross & Deverell, 2004).

Speech-Language Pathologists have an important role to play in the NICU (American Speech-Language-Hearing Association [ASHA], 2004a, 2004b; Dunn, van Kleeck & Rossetti, 1993; Ziev, 1999). Services provided include feeding evaluation and intervention and parent education regarding mother-infant interaction (ASHA, 2004a, 2004b; Dunn, et al., 1993; SASLHA, 1997; Ziev, 1999).

Current practice to improve attachment and interaction involves Kangaroo Mother Care (KMC), for both pre-term and term babies (Feldman, 2004; Paul, 2001; Rossetti, 2001). In the Neonatal Intensive Care Unit (NICU), while the infant is still in the incubator, mothers and fathers are encouraged to talk to and touch their infant, which are achieved with KMC (Feldman, 2004). KMC includes placing the baby, wearing only a diaper and occasionally a cap, between the mother's breasts (Feldman, 2004). Benefits of KMC are numerous. For instance,

biologically, the mother's body heat, smell, touch and voice, provides a "central regulatory framework" facilitating the infant's development (Feldman, 2004, p. 146). Skin-to-skin contact aids the infant in coping with environmental stimuli which may be overwhelming in a NICU, and lowers infant stress (Feldman, 2004). Mothers also benefit from KMC as skin-to-skin contact stimulates lactation and also releases a hormone which reduces stress and depression (Feldman, 2004).

KMC also promotes mother-infant interaction and attachment with premature infants (Feldman, 2004). It provides the mother and infant with opportunities to become familiar, and interact with each other, especially if the infant first had to spend some time in an incubator (Feldman, 2004). It is beneficial to teach parents how to identify infant states as it is important to recognise the best time to interact with the infant (Paul, 2001; Rossetti, 2001). A normal, healthy infant usually moves between a sleep and an awake state (Rossetti, 2001). Furthermore, in the awake state, the infant may be drowsy, alert and attentive, has its eyes open and is active, or crying (Rossetti, 2001). Therefore, the best time to interact with the infant is during the quiet alert state (as opposed to the active alert state), when the infant is alert and attentive (Klaus & Kennell, 1982; Rossetti, 2001). Parent education – including information such as this – is an aspect of health promotion, one of the main activities of PHC (Swanepoel, 1999).

Wendland-Carro et al. (1999) investigated the efficacy of a video presentation and discussion of infant cues in order to promote the mother's ability to identify

her infant's behaviour to enhance mother-infant interaction. Mothers and their healthy, newborn infants were recruited and included in either a control or an experimental group. The control group received an intervention aimed at improving basic caregiving skills such as hygiene issues and immunizations. The mother-infant dyads were observed at their homes a month later and two periods of mother-infant interaction were observed for synchronised interactions. Synchronised interactions were defined as behaviour where the infant or mother initiated interaction and the other responded appropriately, for example, the infant vocalized and the mother vocalized in reaction (Wendland-Carro et al., 1999). Results indicated that the experimental intervention was successful in increasing the amount of synchronised interactions. The researchers concluded that this intervention was appropriate for mothers from disadvantaged backgrounds and in cases where dysfunctional mother-infant interaction was suspected as it improved the quality of mother-infant interaction (Wendland-Carro et al, 1999). This study highlights the effectiveness of early intervention within the first month of life. Wendland-Carro et al. (1999) noted that *any* video focussing on enhancing mothers' awareness of infant cues may be valuable.

1.4 Socio-Economic Status (SES)

Bradley and Corwyn (2002) define SES as a description of financial, non-material resources such as education, and social resources translating to wellbeing. Similarly, Leatt (2006a) describes poverty for children as situations where children are depleted of the necessary resources with which to be healthy,

educated and safe in order to flourish. Financial resources are most commonly indicated by income or value of assets (Bradley & Corwyn, 2002). Asset value refers to the value of not only income, but includes property and motor vehicles for example. (Thiede & Chuma, 2006). Additionally, access to finance assists in obtaining access to services such as educational and health services, which in turn decrease many of the dimensions that lead to poverty (Leatt, 2006b). Social resources on the other hand refer to the individual's social network and may include the number of residents in the home or presence of a babysitter or helper. (Bradley & Corwyn, 2002).

Researchers investigating SES and child development have stressed the need for a sound measurement of SES (Hauser, 1994). The measurement of SES is complex. Bradley and Corwyn (2002) note that there appears to be no consensus amongst researchers on how variables of SES should be measured and that the variables of SES may operate differently in various cultures and for different purposes.

SES may be measured along three variables, namely, household income, education and occupational status (Bradley & Corwyn, 2002; Hauser, 1994). Bradley and Corwyn (2002) argue that information regarding education and occupational status may be considered as indicators of social resources. Leatt (2006a) mentions that there is no standard measure for SES and poverty in South Africa, particularly for children, but that indicators of SES may be used in order to gain an understanding of individuals' SES.

Socioeconomic status may also be measured along direct and proxy measures on income, consumption and wealth (Thiede & Chuma, 2006). Direct measures involve detailed questionnaires while proxy measures involve more complex mathematical procedures (Thiede & Chuma, 2006). Direct measures are expensive as well as complex, whereas proxy measures employ variables of SES that are more easily accessible, for example, assets and specific household characteristics (Thiede & Chuma, 2006). Proxy measures may be calculated according to three approaches, namely predicting consumption, calculating the sum of assets and finally, factor analysis (Thiede & Chuma, 2006). There are many variables to consider when constructing an asset index, but the most common variables used are durable goods, such as television sets, type of car, and household characteristics, such as drinking water, type of tiling (Thiede & Chuma, 2006). Considerations regarding which variables to include in the asset index are dependant on the research question and the study population (M. Thiede, personal communication, April 24, 2007).

Income and expenditure measurements of SES are not sufficient to gain an understanding of poverty (Leatt, 2006a). As poverty has many dimensions, measurement includes not only income measures, but material, environmental aspects and access to services. (Leatt, 2006a). It is possible to identify the extent to which resources including health, education and safety, may be accessed, across these dimensions (Leatt, 2006a). Noble, Wright and Cluver (2006) suggest that the effects of the dimensions of SES be defined by experts together

with the general population. However, income is the easiest variable to obtain as other variables, such as quality of education, are more subjective (Leatt, 2006b).

Bradley and Corwyn (2002) point out that culture and ethnicity may affect how SES affects phenomena. For this reason, the current study embarked on recruiting participants from the same ethnic and cultural background.

A general consensus is that SES is a highly subjective measure, depending on context and purpose, and that it is up to the discretion of the researcher to describe SES accordingly, in order to answer the research question (Bradley & Corwyn, 2002). Bradley and Corwyn (2002) further mention that the practicality of data collection may also affect the researcher's decision on how to estimate SES. Due to the nature of this research project and the researcher's lack of expertise in the field of economics, and the advice of an expert in the field of health economics (M. Thiede, personal communication, April 24, 2007), a more *descriptive* approach to the depiction of SES was adopted. Thiede and Chuma (2006) warn that collecting data on SES may be difficult due to participants' lack of responsiveness or providing inaccurate information. Since the observations in this study were home-based and the researcher gained insight into the participants' homes and assets, this was largely prevented.

1.5 SES and Parenting

Recent literature views poverty as an environmental risk factor for developmental delay especially when it co-occurs with other risk factors such as adolescent

mothers, lack of education of the parents or single parents, lack of stable residence and inadequate health care, among others (Bradley & Corwyn, 2002; Garbarino & Ganzel, 2000; Halpern, 2000; Kritzinger & Louw, 2003; Rossetti, 2001; Sameroff & Fiese, 2000). Poverty in itself is not a direct cause of developmental delay in children, but it coincides or leads to multi-risk factors which then negatively affect child development (Sameroff & Fiese, 2000). In light of the ecological theory, these factors may influence parental behaviour (Osofsky & Thompson, 2000). Parenting behaviour may be influenced by the transactional relationships between parent and environmental characteristics (mesosystems), community factors, for example, availability of resources; (exosystems); and cultural factors (macrosystems) (Osofsky & Thompson, 2000). For example, a low SES mother who is unemployed may be frustrated and neglect to spend time interacting with her infant. However, a low SES mother may also have access to services such as mother-child groups which provides her with support in coping and caring for her infant.

One of the important elements of parenting is the role of “social networks” (Osofsky & Thompson, 2000: p, 58). Social networks include those members in the family or community who generally offer support to the parents in some way. Regardless of SES, the support may be useful to primary caregivers as they are able to receive advice, emotional support and assistance with the infant (Osofsky & Thompson, 2000). Osofsky and Thompson (2000) describe further that the support offered may not always culminate positively if the primary caregiver has conflicting ideas to those of a supporting individual, and may in fact, add

stressors for the parents. Osofsky and Thompson (2000) also explain that the size of the social network is not as important as the strength of the relationships between the primary caregiver and the individuals within her social network in terms of promoting positive parenting.

In a study conducted by Halpern (2000), it was found that approximately 40% of American families with very young children live in poverty stricken areas. The results of this study indicated that these parents were viewed as immature and were often accused of negligence by their wealthier counterparts (Halpern, 2000). International and local literature indicates that difficult circumstances may negatively affect parenting skills and the caregiver's ability to stimulate their infant's development which increases the likelihood of maladaptive parenting (Garbarino and Ganzel, 2000; Halpern, 2000; Kritzinger & Louw, 2003). Bradley and Corwyn (2002) explain that parents with low SES often have more stressors than their high SES counterparts. This may relate to low self-esteem and negative beliefs about themselves and their abilities as parents, which may in turn have a negative impact on family relationships, especially parent-child relationships which include attachment and interaction. However, parents may be able to develop favourable parenting behaviours within challenging social environments if they have a sound social support system and if both parents are involved (Osofsky & Thompson, 2000).

Tomlinson et al. (2005) investigated the status of mother-infant attachment in Khayelitsha, a peri-urban settlement characterised by poverty, situated near

Cape Town, South Africa. Their longitudinal study involved measuring and observing mother-infant interaction at 2 and 18 months, as well as measuring attachment at 18 months. The observations were conducted at a clinic in Khayalitsha in a room with a one-way mirror. Most of the mothers were living in extreme poverty and the researchers hypothesized that there would be a high incidence of insecure attachment. Instead, only about a third of the mother-infant dyads were found to display deficient attachment. They attributed this statistic to the ¹high context of the isiXhosa culture, where mothers have support not only from family members, but the community as well (Tomlinson et al., 2005). In the isiXhosa culture, children are the joint responsibility of the entire community (Tomlinson et al., 2005). Tomlinson et al. (2005) further mention that the negative effects of poverty may be suppressed in high context communities due to the natural community support networks and relationships.

1.6 SES and Child Development

Research on how SES influences early vocabulary development, has given rise to questions regarding how the environment affects child development (Hoff, 2003). Hoff and Tian (2005) reported that SES affects the nature of mothers' speech towards children that is; high SES mothers use language that promotes language development more often than low SES mothers.

Hoff (2003), working with toddlers, aimed to investigate how specific aspects of the environment affected specific characteristics of behaviour. Following the

¹ High and low context cultures are explained in greater detail in section 1.7: SES and Culture

theory of environmental specificity, Hoff (2003, pp. 1396) embarked on a study to explain how maternal speech acts as a “mediator” between SES and vocabulary development. Hoff (2003) aimed to explore the hypothesis that children’s language develops as a result of SES-related differences in the learning environment. Participant dyads were video recorded where mothers interacted with their children during set activities of daily living, such as dressing and mealtimes. Recordings were then transcribed and analysed using computer software. Results indicated that the high SES mothers used longer mean length utterances (MLU) than lower SES mothers, as well as more variety in the type of words used (Hoff, 2003). This study incorporated education as well as occupational status in the measurement of SES (Hoff, 2003). To reduce or minimize extraneous variables, the inclusion criteria for the mothers were very specific and the children were selected according to similar levels of language development. Participant parents were classified as High or Mid SES. For High SES, both parents had to have a university degree and worked in professional or highly regarded positions. For Mid SES, both parents had to have completed high school, but have had no further training, and worked in unskilled or semi-trained positions (Hoff, 2003). The results identified that differences in maternal speech accounted for the differences in the children’s vocabularies (Hoff, 2003). The researcher noted that the content and structure of mothers’ speech directed towards their children was consistent with that directed to the researcher, which could be as a result of SES (Hoff, 2003). Thus, the mothers’ communication behaviour may have been as a result of their social status (Hoff, 2003). Hoff

(2003) pointed out that SES-related differences in child rearing beliefs may also affect the nature of speech towards children. Although this study did not assess the value that other environmental aspects had on the child's language, this was acknowledged as a limitation of the study. It also appears that culture was not considered as a variable which could have affected the nature of the results. The cultural and ethnic details of the participants were not reported. Hoff's (2003) measurement of SES did not include income. It appears that this dimension of SES was assumed according to the occupational status of the participant parents. The study did not include a Low SES group.

Lagerberg, Magnusson and Sundelin (2005) studied mothers' perceptions of mother-infant interaction and child *difficultness* of their 18 month old children. They considered the variables of SES and other subjective factors including postnatal depression. SES was measured by parental education and occupation, but not income as the researchers stated that this information was not available (Lagerberg et al., 2005). For High SES, both parents must have had a university degree and work in professional positions, including teaching, researcher, lawyer, etc.). For Low SES, both parents were not tertiary educated and not employed in professional positions. Finally, all other participants were classified as Mid SES (Lagerberg et al., 2005). Data was collected using questionnaires only and the researchers acknowledge that observing the interaction between mother and child from an external perspective may have affected the outcomes of the study (Lagerberg et al., 2005). The results indicated that no association between high SES, positive mother-child interaction and low child difficultness

was found (Lagerberg et al., 2005). Culture does not appear to be considered as a variable, which also may have affected the nature of the results. They acknowledge that environmental and social factors were not considered which, was a limitation of the study.

Bakerman-Kranenburg, van Ijzendoorn and Kroonenberg (2004) studied whether differences in attachment were due to ethnicity or SES. They compared African-American mothers with White-American mothers, and found that low SES mothers were less sensitive to the needs of their infants which affected the nature of mother-child interaction. Although they concluded SES as a reasonable explanation of the differences found between these groups, no inter-group correlations were made and therefore not adequately substantiated. They also did not control for culture. Furthermore, in the sample population, high SES was restricted to White-American mothers, and the majority of the African-American mothers were classified as low SES. The results, however, indicated that SES may have been a factor in determining childrearing practices including mother-child interaction, which affects child development.

1.7 SES and Interaction style

Research investigating how SES affects mother's interaction style with their infants is limited. Leyendecker, Lamb, Scholmerich and Fricke (1997) aimed to determine how context in which interaction occurs and the length of observation affected measures of mother-infant interaction as well as comparing differences in mother-infant interaction between low and middle SES groups. They found that

the quality of mother-infant interaction certainly was context-dependant, especially with regard to functional contexts such as feeding and play settings. Importantly, their findings suggest that SES effects on this interaction were also context-dependant (Levendecker et al., 1997).

Hammer and Weiss (1999) investigated how play interactions were structured in African American mothers and their toddlers. SES was measured using a published index, the Two-Factor Index of Social Position (Hollingshead & Redlich, 1958, cited in Hammer & Weiss, 1999, p. 1221). The index incorporated income, education as well as occupation. Participants were categorized into a Low SES and Mid SES group. They found that play was structured similarly across the SES groups, but that SES accounted for some differences in language behaviours of mothers and toddlers (Hammer & Weiss, 1999). Their study was based on older children that is, between 12 and 18 months old. However, their study highlights that differences in mother-infant interaction exist along SES lines.

1.8 SES and Culture

Culture refers to behaviour that is depicted as normal in a specific social group (Ross & Deverell, 2004). Culture affects the beliefs, practices attitudes towards services, amongst other behaviour, of people (Anderson & Battle, 1993; Ross & Deverell, 2004). Beliefs in child rearing, family communication style and parental perceptions of infants across various South African cultures have been found to

be important factors affecting caregivers' level of participation in early intervention services (Louw & Avenant, 2002).

Culture influences mother-infant attachment as well as interaction (Anderson & Battle, 1993; Kolobe, 2005; Siegel et al., 2006; Simmons & Johnston, 2007). There is an abundance of literature discussing the effects of culture on child development as well as mother-child interaction (Garcia Coll & Magnuson, 2000; Geiger & Alant, 2005; Kolobe, 2005; Levine et al., 1996; Popich, 2003; Siegel et al., 2006; Simmons & Johnston, 2007).

Literature has noted that SES may also determine attitudes, values and beliefs including child rearing and the behaviour of parents toward infants and children, gender and discipline (Hoff, 2003; Horn, Cheng & Joseph, 2004; Owens, 2005; Popich, 2003; Ross & Deverell, 2004). Literature indicates that very low household income and maternal education, which are variables of SES, is strongly related to child rearing practices (Hoff, 2003). SES differences in beliefs regarding child rearing may influence the nature of speech toward children (Hoff, 2003). SES may also influence the time available for mother-infant interaction thereby affecting the nature of this interaction (Hoff, 2003). However, none of the literature found regarding this, had controlled for *culture* as an extraneous variable. This inevitably would have affected the nature of their results.

In a study by Horn et al. (2004), the effects of SES on the beliefs and practices of child discipline in African-American parents were investigated. They concluded that there were no consistent differences between the SES groups, but

acknowledged that the small sample size provided a limitation. In addition, they highlighted the importance of a better definition of SES as income was used as an only measure for SES in the study (Horn et al., 2004). They measured SES by calculating the median income of the sample. The researchers believe that a more comprehensive definition of SES may yield more sound results (Horn et al., 2004). Horn et al. (2004) identified that SES encompasses a variety of factors which need to be taken into account. A major limitation of Horn et al.'s (2004) study is the reliability of the participants' information regarding their disciplinary beliefs and practices. There was a concern that the participants may have imparted information that is more socially acceptable due to the sensitivity of the topic (Horn et al., 2004). This will have influenced the nature of the results.

In a similar study, Kolobe (2004) investigated whether a relationship existed between child rearing beliefs and practices of Mexican-American mothers, and infants' developmental status with regard to motor development. One of the questions addressed was whether mothers differed in child rearing beliefs and practices based on their SES. Kolobe (2004) does not explain details on how SES was measured and which criteria were used to categorize participants. Kolobe (2004) found differences in child rearing beliefs and practices between mothers who were acculturated (influenced by the First World, White American culture) and newly immigrant mothers. Immigrant mothers scored less on mother-infant interaction scales. Kolobe (2004) attributed this finding to low SES, particularly, level of education. The quality of the home environment as measured by the HOME Inventory proved to be more influential (Kolobe, 2004).

The HOME Inventory consists of a set of subscales containing semi-structured interviews and observations of mother-infant interaction (Kolobe, 2004). It must be noted though that most of the participants in this study were considered low SES (Kolobe, 2004). Kolobe (2004) did not account for the fact that many of the children had been diagnosed with and treated for developmental delay which may have bearing on the nature of the results. Kolobe (2004) highlights that within-group differences in child rearing beliefs and practices exist along maternal and environmental variables.

Many of the research studies mentioned are criticized for poorly controlled, diverse variables which affect the nature of the results. There is thus a need for controlling variables, such as culture, in order to describe SES more clearly. This is difficult as culture is a complex phenomenon. In view of this, the current research aimed to determine what effect, if any, SES has on the nature of interaction with infants.

Attempting to keep the variable of culture constant, the homogenous Muslim Cape Malay cultural group was studied. The Muslim Cape Malay cultural group is an example of a high-context culture (Hall, 1976). High-context cultures encourage unity and members know what is expected of them in various situations (Hall, 1976; Harwood et al. 1999). In low-context cultures, members are more independent and do not have or form many strong relationships (Hall, 1976). Hall (1976) notes that both high and low-context cultures have strengths and weaknesses, and that one is not superior to the other.

This uniquely uniform cultural grouping, the Cape Malay Muslims, reside in the Western Cape, particularly in the Cape Town metropolis, in South Africa. The ancestral heritage of the majority of the Muslims in the Cape, is in the slaves; political exiles and convicts from East Africa and South East Asia (India, Indonesia and Sri Lanka) who were brought to the Cape from 1658 onwards (Ganjoo, 2004). The majority of Cape Malay Muslims are bilingual in Afrikaans and English (Ganjoo, 2004), adhere to the religion of Islam and have developed clearly defined traditions specific to this community in the Cape.

Box 1: Islamic Laws and Customs Concerning Newborns

The religion of the Muslim people is Islam. Islam is a religion which prescribes laws for most aspects of life. Islam teaches that children are gifts and blessings from Allah (God) and parents will be rewarded in the Hereafter for taking care of their offspring (Bari, n.d.; Husain, 1982). Thus, caring for children accordingly is a manner of glorifying God (Bari, n.d.; Husain, 1982). According to Islamic Law, children have the right to develop in a safe, caring environment which promotes positive learning experiences as education is strongly emphasized in Islam (Husain, 1982; Sallie, 2001). Learning and caring should therefore be a happy experience (Sallie, 2001). Parents thus have a responsibility to teach the faith to their offspring (Bari, n.d.). Islamic Law also states that fathers have superior rights over mothers to children, although important decisions are made collaboratively by both parents (Sallie, 2001). Although parenting is the duty of both parents, fathers are solely responsible for the material

sustenance of the family, leaving the mother as the primary carer of the children (Sallie, 2001). Discipline and obedience are important in Islam and parents are encouraged to instil these values from birth. All children should be treated equally regardless of their gender. Children should always be treated with kindness, thus cursing and swearing at a child is strongly disliked (Sallie, 2001).

There are also Islamic customs regarding the birth of children (Bari, n.d.). These include cleansing and dressing the baby, reciting the Athaan (call to prayer) in the right ear and the Iqamah (announcement of the commencement of prayer) in the left ear, rubbing a bit of date or sugar on the baby's palate, sacrificing a sheep, shaving the baby's hair, circumcising male babies on the seventh day, and naming the baby on the seventh day after birth (Bari, n.d.).

There appears to be little research focussing on the Muslim cultural group and their beliefs and practices regarding child rearing in South Africa. Dangor and Ross (2006) investigated the cultural beliefs of South African Muslims regarding Down Syndrome. They mention that rules of religion and culture are entwined within this group (Dangor & Ross, 2006). They highlight the importance of knowledge regarding various cultures by speech pathologists and audiologists in order to provide culturally sensitive practise (Dangor & Ross, 2006).

1.9 Rationale for Current Study

Halpern (2000) noted that the majority of studies in child development do not view poverty as a significant single variable which influences the child's life. Research on SES and child development seems to focus on toddlers and older children (Bradley & Corwyn, 2002; Hammer & Weiss, 1999; Lagerberg, Magnusson & Sundelin, 2005).

Rossetti (2001) also notes that there is a need to identify risk for communication delay and intervene as early as possible. Early intervention should thus commence as soon as possible to prevent or reduce the effects of developmental delays or disorders (Carpenter, 2005).

In a culturally diverse country such as South Africa, it is vital to understand and be aware of the differences between and within various cultures in order to achieve effective service delivery (Dangor & Ross, 2006; Louw & Avenant, 2002). Geiger and Alant (2005) also emphasize the importance of investigating and understanding the communicative interactions between caregivers and children in various cultures.

This study aimed to explore SES as a variable and describe how the dimensions of SES affect the nature of mother-infant interaction during the zero to three month period, within a controlled, high context cultural group, namely Cape Malay Muslims. The purpose of this research was not to render one SES group

as superior to the other, but to identify and describe the natural differences in behaviour.

University of Cape Town

Chapter Two

Method(ology)

2.1 Research Question

Does socio-economic status (SES) influence the nature of mother-infant interaction?

2.2 Aims of the Study

2.2.1 Primary Objective

The main objective was to describe how SES affects the nature of early mother-infant interaction.

2.2.2 Secondary Objectives

The objectives of this study were:

- 1) To explore SES as a variable affecting the nature of mother-infant interaction.
- 2) To explore and describe the nature of mother-infant interaction in mothers from high and low SES contexts.
- 3) To describe mothers' beliefs regarding infants.

2.3 Research Design

A descriptive, mixed method research design utilizing both quantitative and qualitative methods was followed in this study.

The research design was descriptive, which was best suited for this study as it allowed the researcher to describe detailed aspects of the nature of mother-infant interaction with regard to SES (Durrheim, 1999; McMillan & Schumacher, 2001). There was no manipulation of independent variables, as there would be in an experimental study (McMillan & Schumacher, 2001). Descriptive designs are also useful for both quantitative and qualitative methods, which were both utilized in this study (Babbie & Mouton, 2005).

A mixed method approach, incorporating both quantitative and qualitative methods of data collection and analysis, was utilized in this study (Creswell & Plano Clark, 2007; Vos, et al., 2005). Mixed method designs allow the researcher to integrate findings and interpret them from different angles (Creswell & Plano Clark, 2007; Ulin, Robinson & Tolley, 2005). Historically, there has been a debate between quantitative and qualitative researchers, about which paradigm may be superior to the other (Vos et al., 2005). Vos et al. (2005) explain that the conventional thought that paradigms and methods should be related resulted in researchers tending to choose between either quantitative or qualitative methods. Paradigms explain a researcher's stance in terms of ontology, epistemology and methodology (Terre Blanche & Durrheim, 1999). Ontology refers to how reality is perceived, for example positivists view reality to be

constant and measurable (Terre Blanche & Durrheim, 1999). Epistemology refers to how knowledge about phenomena can be gained, for example positivists believe that knowledge can be gained through neutral observations (Terre Blanche & Durrheim, 1999). Finally, methodology refers to the practicalities of how the researcher studies phenomena, for example positivists may employ experimental research designs (Terre Blanche & Durrheim, 1999). Other paradigms include the interpretive, constructionist and pragmatic paradigms (Terre Blanche & Durrheim, 1999). The researcher followed a pragmatic paradigm.

The rise of pragmatism brought a new dimension to the way research is conducted, as pragmatists believe that both quantitative and qualitative methods are useful in different contexts and for different purposes (Vos et al., 2005). A pragmatist focuses on the research problem and therefore decides which aspects can be described better by quantitative means and which need to be qualitative in order to gain better insight (Creswell, 2007).

Quantitative research makes use of numerical data and sometimes statistics to help the researcher describe and make inferences about populations (Durrheim, 1999).

Qualitative methods are naturalistic permitting the study of phenomena in realistic situations through observation and interviewing (Creswell, 2007; Durrheim, 1999; Ulin et al., 2005). In most instances, the researcher is responsible for the interpretation of raw data, focussing on the underlying

meaning; and often employs multiple data collection strategies (Creswell, 2007). This method is employed when researchers intend to develop an indepth understanding of phenomena (Creswell, 2007).

This study followed the 'principal method' as stipulated in the Priority-Sequence Model (Morgan, 1998) (cited in Ulin, et al., 2005, p. 52). The model illustrates how complementary qualitative and quantitative methods may be used in a single study. The researcher decides on the primary or main method, and supplements it with either a preliminary or a follow-up study using a complementary method (Ulin, et al., 2005). There are thus four different options described in this model as illustrated in the table below:

Table 1: The Priority-Sequence Model. *Adapted from:* Ulin, et al., 2005, p. 48.

Priority-Sequence Model	
(1) Preliminary qualitative study ↓ Quantitative Main Method	(2) Preliminary quantitative study ↓ Qualitative Main Method
(3) Quantitative Main Method ↓ Follow-up qualitative study	(4) Qualitative Main Method ↓ Follow-up quantitative study

This study followed the second option. The researcher collected the quantitative and qualitative data during the same sessions. However, the quantitative portion

of the study led the researcher to explore phenomena more qualitatively. The results of the quantitative portion were used to complement the results of the qualitative portion. Utilizing both methods extends insight into the interpretation of the results (Ulin, et al., 2005).

Creswell and Plano Clark (2007) describe a similar approach for mixed method studies. In an *embedded* design, both quantitative and qualitative types of data are collected, where one set of data is used to complement the other (Creswell & Plano Clark, 2007).

A qualitative method was appropriate for this study as it aided the researcher in understanding how SES affects mother-infant interaction, as well as to determine the dimensions of SES. Visual data analysis was used to complement qualitative findings (Lindegger, 1999).

2.4 Participants

2.4.1 Population

The Cape Malay Muslim cultural group was the sample population in this study. For logistical reasons, this was further confined to the Cape Metropolitan area situated in the Western Province, South Africa. Census data do not distinguish between various cultures in South Africa, but rather the Cape Malay Muslim cultural group is presented as part of the “coloured” ethnic group (Statistics South Africa [StatsSA], 2003). The coloured ethnic group comprises 53.9% of the population in the Western Cape Province (StatsSA, 2003). 18.9% of the coloured

population in South Africa are first-language speakers of English while 79.5% are first language speakers of Afrikaans (StatsSA, 2003). The Cape Malay cultural group are a unique group of people who are descendants of East African and South East Asian slaves, political exiles and convicts brought to the Cape from 1658 onwards (Ganjoo, 2004). They brought with them the religion, Islam and constructed the first mosques around the areas where they lived (Ganjoo, 2004). Due to *apartheid* laws, they were settled together in specific areas, forming the basis of the homogeneity of the culture (Ganjoo, 2004).

2.4.2 Selection Criteria of Participants

Dyads of mothers and infants were selected to participate in this study.

(a) Selection Criteria for Mothers

- **Inclusion criteria:** The biological mothers of the infants had to be of the Cape Malay Muslim cultural group. In this study it was important that the mothers be of the same cultural background. It was important to keep this variable constant as culture has been identified to affect child-rearing practices (Dangor and Ross 2006; Levine et al., 1996; Rossetti, 2001).

For the purposes of this study, the following combinations of guidelines were applied. Fees for a government institution in the Western Cape in South Africa are charged and subsidized rates are applied according to individual or household income. For a considerable subsidy, a maximum household income of R50 000 and less is considered. Government

subsidies are provided to those who are unable to bear the costs of health care. This may indicate *low* SES.

However, the nature of the billing system does not necessarily assist with indicating a high income bracket. Following the population census in 2001, the Western Cape Provincial Economic Review and Outlook [WCPERO] (2006) concluded that the majority of households within the Cape Metropolitan area earn between R4 800 and R76 800 per year. The researcher then deduced that households earning more than R76 800 constituted High SES. The distribution of wealth in the Cape Metropolitan area appears to be skewed with the majority of households earning low incomes. WCPERO (2006) explain that this is due to the availability and quality of employment. Only approximately 5% of the city's population earn in excess of R307 201 (WCPERO, 2006).

According to this distribution and the government subsidy guidelines, the researcher concluded that a household income of less than R50 000 per year constituted low SES, as these households were eligible for government subsidy, and R76 800 per year and more constituted high SES. Therefore, according to the literature found, these criteria may be used in categorizing high versus low SES (Brazelton & Cramer, 2002; Hauser, 1994).

Initially, the researcher used household income in order to describe SES. The following guidelines were used:

- **For high SES group;** Mothers with a stated household income of at least R76 800 per year.
- **For low SES group;** Mothers with a stated household income of R50 400 or less.

The unemployment rate in Cape Town is highest for people younger than 34 years of age (WCPERO, 2006). Unemployment amongst this generation may be due to a lack of jobs available, even though the education and skills among younger people may be higher than among older people who occupy these jobs (WCPERO, 2006). This posed an added difficulty in determining how unemployment and education could have been described in relation to SES. For this reason, the researcher had chosen not to include these variables-although valuable- as criteria for *inclusion* in this study.

Exclusion criteria: Mothers under the legal age for consent that is, 21¹, were excluded which ensured the exclusion of adolescent mothers, with all the previously identified variables and risks that adolescent motherhood contributes to early mother-infant bonding and interaction (Levine et al. 1996; Osofsky & Thompson, 2000; Rossetti, 2001). Finally, mothers without a fixed address were excluded as compounding issues of homelessness were beyond the scope of this study (Osofsky & Thompson, 2000).

¹ Post script; the legal age of consent as per South African law, was lowered to 18 years in July 2007 during the course of data collection (Blockman, 2007).

(b) Selection Criteria for Infants

- **Inclusion criteria:** Healthy infants (0-3 months) born at full term to mothers as per above selection criteria.
- **Exclusion criteria:** Infants who had been diagnosed with medical conditions were excluded. These infants would have presented with other extraneous variables that may affect patterns of mother-infant interaction (Rossetti, 2001).

2.4.3 Sampling Method

This study employed non-probability, purposive/judgmental, convenience and snowball sampling.

Non-probability sampling was employed as a sampling frame of all Muslim Cape Malay mothers with newborn babies in the Cape Metropolitan area was not feasible (McMillan & Schumacher, 2001).

Sampling was purposive/judgmental (Maxwell & Satake, 2006; Ulin, et al., 2005, van Vuuren & Maree, 1999). This entailed a list of criteria, namely rigid inclusion and exclusion criteria to target a group of participants who presented with similar traits in order to isolate the variable in question, in this case SES (Maxwell & Satake, 2006; Ulin, et al., 2005).

Convenience sampling was utilized as participants were approached as they became available during the time of data collection (Babbie & Mouton, 2005;

Maxwell & Satake, 2006; McMillan & Schumacher, 2001). Mothers who met the inclusion criteria were approached and invited to participate in the study.

Snowball sampling was also employed; and participants were asked whether they knew any other mothers who may be able to participate in the study. Snowball sampling is appropriate when participants are difficult to locate and when community networks encompassing the selection criteria are known (Babbie & Mouton, 2005).

2.4.4 Sample Size

The aim was to recruit at least 6-8 participants across the SES groups for the qualitative part and 15-18 participant dyads per SES group for the quantitative part of the study.

A sample of 6-8 participants is considered adequate for a qualitative study as detail of experience rather than generalisability is sought (Kelly, 1999). A small sample was ideal as the purpose was to derive information regarding the beliefs, practices and experiences of mothers (Ulin, et al., 2005). The depicted sample size served as a guide, since sample size is usually determined in qualitative research when saturation has been reached (Ulin, et al., 2005). For quantitative research, the sample size has to be large enough to provide plausible results (McMillan & Schumacher, 2001). In quantitative studies, the sampling size is dependant on a number of issues (McMillan & Schumacher, 2001). These issues include the nature of the research design and hypothesis (McMillan &

Schumacher, 2001). When studying many variables, a larger sample size is necessary (McMillan & Schumacher, 2001). This study set out to investigate one independent variable (SES) and one clearly defined dependant variable (mother-infant interaction) and thus did not require a particularly large sample. McMillan and Schumacher (2001) also highlight that inconsistent processes of collecting data require larger samples, while this study maintained as consistent procedure for data collection as possible.

The final sample consisted of 10 participant dyads across SES group. The decrease in number from the original aim was due to difficulties in locating and obtaining consent from mothers, as well as time constraints. All participants participated in both the quantitative and the qualitative parts of the study.

2.4.5 Recruitment Procedure

- Following University of Cape Town, Faculty of Health Sciences, Human Research Ethics Committee approval, permission was requested from the relevant managers/heads of one government hospital and several private hospitals to approach potential participants at their institutions (Appendix B). Hospitals known to be frequented by high numbers of the Cape Malay Muslim population were chosen.
- The researcher was then guided by the hospital managers to approach private and public baby clinics where mothers with babies 0-3 months were readily available when they attended clinics for general follow-ups and immunisations. A private baby clinic, two private midwifery clinics and

two government clinics were approached for permission to approach potential participants in their waiting areas.

- Upon *verbal* response to request for permission (Appendix B) from these institutions, the researcher gained access to potential participants in the following manner :
 - The researcher sat in the waiting areas of the clinics. Contact with potential participants was made as they waited to be seen by the clinic staff. The clinic sister introduced the researcher and her aims to those in the waiting room. Once this initial contact was made, the researcher collected the personal details of those interested and contacted them telephonically to arrange a date and time for data collection. The researcher encountered at least six mothers who refused to participate in the study.
 - The clinic sister at the private baby clinic allowed the researcher access to the list of patient names in order to identify Muslim mothers by their names. These mothers were then contacted telephonically with verbal permission from the clinic sister. The clinic sister also informed these mothers when they arrived at the clinic that they might be contacted by the researcher.
 - Additionally, the researcher sought to recruit participants by distributing flyers at the clinics, and speaking on air over a community radio station.

- Furthermore, participants were asked whether they knew of anyone else who would be interested in participating in the study. The researcher then approached those identified telephonically to invite them to participate in the study. The mothers were given time to decide on participation. The researcher contacted them again to confirm whether they wanted to participate and arrange a date and time for the home visit.
- In view of the positioning of the researcher as a Cape Malay Muslim herself, Muslim mothers were identified by a three step process: by scanning through names on a clinic's patient list and identifying those who may be Muslim; those who responded appropriately to the Islamic greeting; and those who verbally identified with and were part of the Muslim Cape Malay cultural group.

2.4.6 Ethical Considerations

Following University of Cape Town, Faculty of Health Sciences, Human Research Ethics Committee approval, the above recruitments followed the following ethical principles.

Verbal permission was obtained from:

- Relevant managers/heads of both the public and private baby clinics,
- Head sisters of the baby clinics.

Informed consent was obtained from mothers meeting the inclusion criteria who were willing to participate in this study.

The principles of autonomy, beneficence, non-maleficence and justice were adhered to (Medical Research Council [MRC], 2000). Participants were informed that they reserved the right to autonomy and may refuse participation as well as withdraw from the study at any time without explanation, or obligation, and were given time to decide on participation (Holloway & Wheeler, 1996; MRC, 2000; Orb, Eisenhauer & Wynaden, 2001). In addition, the possible benefits and risks were explained in order to empower their autonomous decision regarding participation. Consent was free, voluntary and revocable (MRC, 2000). Mothers who agreed to participate were asked to sign an informed consent form (Appendix C) which explained the purpose and nature of the study. A verbal explanation was added for clarification. The researcher confirmed that the mothers understood what they were consenting to prior to signing the consent form. Furthermore, all tape and video recordings will be safely stored by the researcher for two years post data analysis and then destroyed to ensure anonymity. The names of the participants were kept confidential at all times (Orb et al., 2001). Privacy of the participants was ensured by conducting all data collection in their homes.

Beneficence refers to acting in the interest of the participant (Holloway & Wheeler, 1996; MRC, 2000). The researcher adhered to this principle by explaining the emotional risks as well as benefits to the participants. Every participant received a DVD of their bathing session with their infants on completion of participation.

Non-maleficence refers to preventing harm, emotional or physical harm and benefiting for the participants (MRC, 2000). The researcher informed participants regarding the possible emotional risks and warned that some questions may be construed as intrusive or offensive. The participants may have felt that their security were at risk since data collection took place in their own homes. For this reason, some mothers refused to participate.

The ethical principle of justice refers to fairness in research (Holloway & Wheeler, 1996; MRC, 2000). Participants must be protected from exploitation and harm at all times (MRC, 2000). Holloway and Wheeler (1996) mention that the setting where interviews take place, falls under the principle of justice. They suggest that interviews be set in an environment where the participants feel comfortable in (Holloway & Wheeler, 1996). This was adhered to as the researcher conducted all interviews in the participants' own homes.

2.4.7 Participant Description

Following all of the above, the finally participating dyads were made up of mothers and their infants. All mothers were married to the infant's biological father. All mothers reported that they identified with the Cape Malay Muslim cultural group. The biographical details of the mothers are tabulated below:

Table 2: Biographical details of participants

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Mother's age	24	37	33	28	28	38	24	30	32	36
Infant's age	3wks	6wks	2.3mnths	3wks	2mnths	3mnths	2mnths	3wks	2.2mnths	7wks
Employed	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes
Income bracket p/a	R1-R4800	R38 401- R50 400	R307 200 +	R307 401 +	R76 801- R153 600	R76 801- R153 600	R153 601- R307 200	R76 801- R153 600	R1-R4800	R9 601- R38 400
No. of children including infant	2	3	1	1	1	5	1	4	3	2

Categorizing mothers into high and low SES groups proved to be very complex. The original description of SES as determined by the researcher was not adequate. The original measurement of SES involved purely household income. SES may be measured along income, education and occupational status (Bradley & Corwyn, 2002). However, this was not sufficient for this study.

Table 3: Participant details regarding three variables of SES

Participant	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Highest Education Achieved	Fashion Certificate	High School certificate	BA degree	Diploma in Business Admin	Diploma in Information Technology	High School certificate	University incomplete	High School certificate	Grade 9	High School certificate
Occupation	Unemployed	Unemployed	Service Delivery Manager	HR Consultant	Unemployed	Unemployed	Unemployed	Small business owner	Cleaner	Sales Associate
Household Income Bracket (pa)	R1-R4 800	R38 401- R50 400	R307 200+	R307 200+	R76 801- R153 600	R76 801 - R153 600	R153 601- R307 200	R76 801- R153 600	R1-R4800	R9 601- R36 400
High/Low SES using household income only	Low	Low	High	High	High	High	High	High	Low	Low

The literature suggests gaining an understanding of how SES is *experienced* by individuals (Leatt, 2006a; Noble et al., 2006). Thus, further factors influencing SES had to be considered. The SES circumstances are tabulated below:

Table 4: Living conditions

Participant	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	Total Yes	Total No
Own house	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	7	3
Family Transport (car)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	8	2
Satellite TV	No	No	Yes	Yes	No	Yes	Yes	Yes	No	No	5	5
House/mobile phone	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	9	1
Easy access to clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10	-
Living with Family	Yes				Yes					yes	3	7

2.5 Data Collection

This section involves the steps taken and procedures used to collect data, and describes the materials and apparatus used and the pilot study is discussed (Vos et al., 2005).

2.5.1 Description of materials

- Two subsections of the Clinic for High Risk Babies [CHRIB] protocol were used (Appendix F) in order to observe and record an infant's and mother's

pattern of interaction as depicted in the figure below (Kritzinger & Louw, 2002).

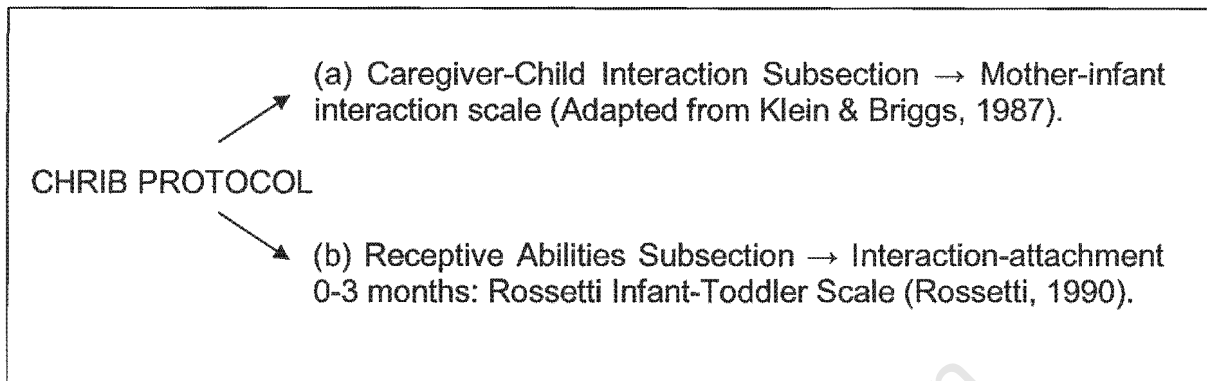


Figure 2: Subsections of the CHRIB protocol used in this study

The CHRIB protocol was developed over a decade, between the 1990's and 2002, in South Africa and serves as a comprehensive and in depth assessment tool of child development (Kritzinger & Louw, 2002). The protocol addresses all developmental areas, such as behaviour, hearing and middle ear functioning, listening skills, general development, play, communication skills, receptive and receptive language skills oral motor and feeding skills, genetic abnormalities, and finally parent-infant interaction (Kritzinger & Louw, 2002). Each developmental area is assessed with specific well established assessment tools which are relevant to the South African context as they are, or have been adapted slightly (Kritzinger & Louw, 2002). The protocol is conducted by a team of Early Interventionists including a speech pathologist, occupational therapist, audiologist and nurse. The protocol does not make use of norms, but rather developmental expectations as measures of an infant's performance and is thus criterion-based (Kritzinger & Louw, 2002). The CHRIB protocol

allows for the observation of behaviour in various settings (Kritzinger & Louw, 2002).

This study made use of the Caregiver-Child Interaction subsection of the CHRIB protocol, with those items not relevant to this study omitted. The Observation of Communicative Interaction Scale, originally developed by Klein and Briggs (1987) is used in the protocol to assess parent-infant interaction. The CHRIB adapted the original scale and added a fourth rating (optimally) on the Likert-type scale. The researcher deemed 'optimally' to indicate *appropriateness* of behaviour in response to the infant's behaviour. The original scale made use of the observation of the frequency of behaviours only, namely whether behaviour was observed rarely, sometimes, or often.

The Rossetti Infant-Toddler Language Scale is used as an assessment of infant-toddler communication and appears in the CHRIB in four developmental areas, namely, play, communication skills, expressive and receptive language (Kritzinger & Louw, 2002). The Rossetti Infant-Toddler scale is used for the assessment of communication skills under 3 years of age. The scale focuses on pre-verbal parameters (play, interaction/attachment, pragmatics and gestural development) as well as expressive and receptive language (Rossetti, 1990). For the purposes of this study, the Interaction-Attachment 0-3 months subsection of the

Rossetti Infant-Toddler Language Scale was utilized, omitting items inappropriate for this study (Rossetti, 1990).

- Semi-structured interviews with the mothers were conducted using a topic guide to gather qualitative data (Table 5). Interviews provided the researcher with valuable information with which to understand phenomena (Maxwell & Satake, 2006). Although the topic guide allowed the researcher to keep the interview focussed on main interest areas in line with the study objectives, it also allowed for flexibility (Ulin, et al., 2002). Table 5 shows the rationale for the questions in the topic guide which had been composed before the pilot study was conducted.

Table 5: Rationale for topic guide questions

Question	Rationale
1. What are your expectations about your new baby?	1. The researcher was interested in finding whether mothers from different SES backgrounds had different expectations regarding having a new baby.
2. What were your initial feelings or reactions about your baby?	2. The researcher was interested to find whether mothers experienced the same feelings and reactions immediately following the birth of the baby (Rossetti, 2001).
3. What do you think are the general traditions regarding newborn babies in your community?	3. It was hypothesized that the different SES groups had differing beliefs regarding traditions, particularly surrounding newborns (Hoff 2003, Hoff et al., 2004, Owens, 2005)..

4. What do you feel is the most important thing to consider when rearing a child?	4. Literature noted that childrearing beliefs differ due to SES related differences (Hoff 2003, Hoff et al., 2004, Owens, 2005).
5. Do you think boys and girls are treated differently in your community? Why/why not?	5. The researcher hypothesized that mothers from differing SES backgrounds would have different experiences regarding issues around sex (Hoff 2003, Hoff et al., 2004, Owens, 2005)..

2.5.2 Description of apparatus

- A video camera (Samsung Digital Camcorder: VP-D371i): This allowed the researcher to complete, re-check/ and transcribe checklists in their own time.
- A Dictaphone (Sansui micro cassette recorder: SD-100Z): This allowed the researcher to record verbal interaction during interviews verbatim and to cross-check transcripts for further analysis.

2.5.3 Procedures

- Following recruitment of participants and adhering to ethical principles as described in the participants section above, the researcher requested permission from the managers/heads of the institutions and the sisters or midwives to approach prospective participants (Appendix B) and informed consent from the mothers who were willing to be included in the study (Appendix C).

- Initially, verbal consent was obtained either when the researcher had contacted the mothers in the waiting rooms of the clinics or telephonically. A date and time was agreed upon by the participant and the researcher for data collection to commence at their homes at a time that was most convenient to the participant. Mothers were asked to sign consent forms prior to the commencement of data collection.
- Mothers who signed an informed consent form were also asked to complete a form enquiring about their biographical and income details (Appendix D).
- A pilot study was conducted with two mothers.
- The researcher experienced at least eight mothers choosing to withdraw from the study when the researcher called to confirm dates for the home visit, or who cancelled appointments and chose not to rearrange for another time.
- During home visits, a daily, routine activity was recorded with the video camera. For consistency an entire bathing activity was recorded, which included undressing before and dressing after bathing. The video recordings were used to record the observations and therefore aided in the analysis and interpretation of the data (Babbie & Mouton, 2005).
- The video recordings were interpreted making use of the checklist which was made up of the aforementioned subsections of the CHRIB protocol (Appendix E). The checklist aimed to record the patterns of mother-infant interaction. In addition, detailed descriptions were made of observations.

- Semi-structured interviews with mothers were conducted. The researcher spent time building rapport with each participant. Open ended questions were asked, and these were guided by a topic guideline (Table 5). The researcher also kept detailed field notes to record relevant events not evident in the recordings of the interviews, such as the nature of the environment and relevant moments (Ulin, et al., 2002).
- The researcher kept a detailed record of all events leading up to the findings in an audit trail. Audit trails should enable other researchers to follow the exact procedure of the study so that the results can be verified (Ulin, et al., 2002).

2.5.4 Pilot Study

A pilot study was conducted with two participants to identify logistical issues that needed adaptation in the data collection procedure. The researcher thus had the opportunity to assess whether the questions of the semi-structured interview were appropriate and allowed for finding rich data. Logistical issues regarding video observations such as positioning of equipment, length of observation and feedback regarding the pilot participants on the proposed methodology could also be assessed.

Both participants fitted the low SES measures as depicted for the original purposes of this study. They both also had other children and were not first-time mothers. The participants were fully informed regarding the nature of their participation and provided consent for both the video observation as well as the

semi-structured interview. Both mothers were filmed bathing their infants, this included undressing the infant before bathing, as well as dressing the infant after bathing.

The outcomes of the pilot study and the changes made included the following:

- The researcher found that the interviews widely digressed from the topic. Questions therefore had to be formulated which would assist the interviewees to focus on specific topic areas. The researcher also made use of prompting questions in order to further explore areas of specific focus. The following questions were formulated as adaptations to the original topic guide previously depicted in Table 5:

1. What did you expect regarding the baby while you were pregnant?
2. What were your initial feelings or reactions about your baby?
3. What are the traditions practiced in your community regarding newborns?
 - a) Which of the traditions do you practice?
 - b) Which of the traditions do you disagree with?
 - c) How does the family get involved with the newborn?
4. What do you feel is the most important thing to consider when rearing a child?
5. Do you think boys and girls are treated differently in your community?
Why/why not?

- Bathing was the best activity for observing mother-infant interaction, as the mothers were preoccupied with the activity and less anxious about being video recorded. In addition to the bathing activity, the researcher recorded interaction, such as dressing the baby before and after bathing, to ensure that a wider array of behaviours was captured.
- The video camera was better than the Dictaphone in sound quality for the interviews. The Dictaphone picked up too many environmental noises making it difficult to hear what the participant was saying. Therefore all interviews were recorded with the video camera rather than the Dictaphone for optimal sound quality.
- The data collected from the pilot study participants were included in the main study. According to Kanjee (1999), pilot studies may be made up of a sub sample of the main sample pool.

2.6 Data Analysis

The researcher stored all data in computer files, as well as organised the handwritten data in a file. Data from the video were analysed quantitatively as well as qualitatively, and the interviews were transcribed and analyzed qualitatively as per the priority sequence model applied here.

2.6.2 Quantitative Data Analysis

Visual data analysis was used in order to graphically depict data making use of graphs and tables (Lindegger, 1999).

The researcher made use of a second expert observer who viewed all the video recordings of the bathing sessions. The second observer was given the same checklist, but was provided with no information regarding the findings of the researcher. The data collected by the second observer was compared to the data found by the researcher.

2.6.1 Qualitative Data Analysis

Transcriptions began soon after the completion of every interview. Researchers who transcribe as early as possible have the opportunity to add meaning to non-verbal information such as emotion displayed in voice (Ulin, et al., 2002). Furthermore, early transcribing allows the researcher to identify areas which may need clarification (Ulin, et al., 2002).

The data analysis involved detailed descriptions and identification of trends of the information gained from interviews with mothers. Interviews were transcribed and analyzed using thematic content analysis (Babbie & Mouton, 2005; Maxwell & Satake, 2006). The researcher followed the processes of familiarization with the data that is, immersion, generating themes with categories, coding the data under meaningful headings of emerging themes, elaborating on the coded data, and finally interpreting the phenomena and re-checking for a thorough analysis (Babbie & Mouton, 2005; Terre Blanche & Kelly, 1999; Ulin, et al., 2002).

When first approaching the data, the researcher noted the following: the main idea of the text, the speaker's attitude regarding the message, whether

participants were verbalizing their individual beliefs or that of the group of participants, and finally evaluating whether the speaker was relating personal accounts or hypothetical situations (Ulin, et al., 2002). The process of immersion enables the researcher to identify problems affecting credibility of the results and to adjust accordingly (Babbie & Mouton, 2005; Kelly, 1999; Terre Blanche & Kelly, 1999; Ulin, et al., 2002). The researcher may also begin identifying themes and highlight areas that need to be expanded upon (Babbie & Mouton, 2005; Kelly, 1999; Terre Blanche & Kelly, 1999; Ulin, et al., 2002). After studying a number of transcriptions, the researcher began to identify the recurring themes and evaluated how themes were linked (Terre Blanche, 1999; Ulin, et al., 2002).

Themes were then organised into codes (Babbie & Mouton, 2005; Terre Blanche & Kelly, 1999; Ulin, et al., 2002). According to Ulin et al. (2002), there are no specific guidelines regarding this process. The researcher coded the data using words used by the participants, or synonyms thereof. Codes may be words or phrases taken from the data or that appear in the literature (Babbie & Mouton, 2005; Ulin, et al., 2002). Importantly, codes may change over time according to the content of the data (Ulin, et al., 2002). Coding sorts were then formulated, which is to group similar codes into themes and copy them in a separate file (Ulin, et al., 2002). The researcher then determined the main and sub themes. The main and sub themes may be identified from the coding sorts which is substantiated by quantitative and qualitative characteristics of the data (Kelly, 1999; Ulin, et al., 2002). Ulin et al. (2002) classify quantitative characteristics as for example, the amount of participants who provide similar information; and

qualitative characteristics as analysing the vocabulary used by interviewees, emotion, tone, etc.

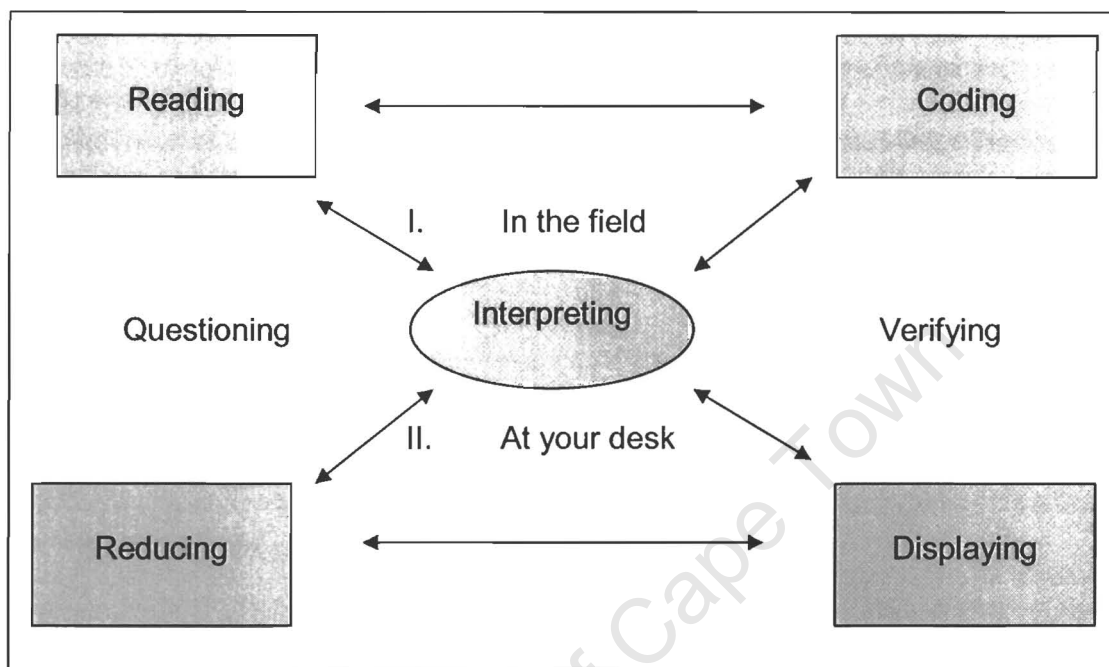


Figure 3: Qualitative data analysis, adapted from Ulin et al., 2002, p.144.

Conclusions drawn may be verified by the interviewees, by presenting them with summaries of what they have said thereby adding to the credibility of the results (Ulin, et al., 2002).

Finally, the findings were interpreted and relationships between themes were inferred (Babbie & Mouton, 2005; Ulin, et al., 2002).

2.7 Validity, Reliability And Trustworthiness

The assessment of the quality of the research findings differ for quantitative and qualitative data (Ulin, et al., 2002). Validity and reliability refers to quantitative research, while trustworthiness refers to qualitative research (Ulin, et al., 2002).

Validity, reliability and trustworthiness are explained in more detail below:

2.7.1 Validity

In quantitative research, validity refers to "the degree to which scientific explanations of phenomena match the realities of the world", (McMillan & Schumacher, 2001, p. 167). Internal validity refers to what extent extraneous variables affect the nature of the results, while external validity refers to what extend results may be generalised to the larger population (McMillan & Schumacher, 2001)

In order to establish validity, the researcher must ensure that content, face, criterion and construct validity is adhered to (Vos et al., 2005). Content validity refers to whether the instrument used, in this study, the checklist (Appendix E) , measures what it claims to measure, and whether the items on the instrument are sufficient (Durrheim, 1999b; Vos et al., 2005). The instrument must therefore be representative of the construct (Durrheim, 1999b). Face validity refers to whether the instrument appears at a glance to measure what it claims to measure (Vos et al., 2005). While content and face validity remain largely subjective, criterion validity is more objective as the researcher measures and

compares scores with an external source measuring the same construct (Durrheim, 1999b; Vos et al., 2005). Construct validity is different to criterion validity as it involves the underlying theory of the construct, and how it is related to other constructs within the same theoretical framework (Durrheim, 1999b; Vos et al., 2005). In this study, validity was achieved by the following:

Sample characteristics: The participant dyads in the sample were from the same cultural group. This was to ensure that culture in terms of ethnicity and religion could be controlled in order to isolate SES. Only healthy infants were included as ill and premature infants present different and complex problems that may impact mother-infant interaction (Rossetti, 2001). Again, this was to isolate SES as the variable under consideration and thus a measure of validity.

Materials: The CHRIB Assessment Protocol had been devised and researched in South Africa, therefore adding to its validity for use in the current study (Kritzinger & Louw, 2002; Kritzinger & Louw, 2003). The measurement materials used in the protocol have been proven to assess behaviour they state to measure and are based on developmental expectations rather than norm-referenced (Kritzinger & Louw, 2003).

Pilot study: A pilot study was conducted which assisted the researcher to refine the interview guide where necessary and to practice logistics (best use of recording equipment, estimated duration of interview, applicability of topic guide etc), thereby additionally aiding to increase the validity of this study.

Triangulation: Data was collected using two different methods, adding to the validity of the study (Vos et al., 2005).

2.7.2 Reliability

Reliability, on the other hand, refers to the accuracy of results, that is, that the scores are consistent (McMillan & Schumacher, 2001). Reliability refers to the extent to which a measure is able to produce the same or similar results when used under the same conditions at different time periods (Vos et al., 2005).

There are different methods to test for reliability. Test-retest reliability refers to the consistency of results across different trials. A correlation coefficient can be calculated in order to determine whether the measures correlate (Durrheim, 1999b). Where test-retest is inappropriate, the researcher may employ parallel forms where two instruments are administered on one occasion and the results correlated to determine reliability (Durrheim, 1999b). This method may prove to be expensive and unfeasible in which case the researcher may employ a split-halves method. This method entails randomly dividing items into halves. The correlation may be determined by a statistical calculation, the Spearman-Brown formula (Durrheim, 1999b). The most common method to test reliability is internal consistency. This entails measuring the correlation between individual items on the instrument which can be determined statistically, most commonly, Cronbach's coefficient alpha is used (Durrheim, 1999b). For this study, reliability was ensured by the following:

Pilot Study: The researcher was able to determine the effectiveness of the data collection process which allows the study to be replicable.

Materials: The CHRIB assessment protocol has been adapted in South Africa and has been proven to be a reliable tool to measure infant development (Kritzinger & Louw, 2003).

Inter-judge reliability: A second rater was asked to review the video-recordings. This ensured reliability across evaluations, recordings and analysis of results (Kelly, 1999).

2.7.3 Trustworthiness

In qualitative research trustworthiness involves four concepts, namely credibility, dependability, confirmability and transferability (Ulin, et al., 2002).

Credibility was achieved through saturation of data, interpreting findings in multiple ways and searching for all possible explanations for phenomena, making use of multiple data collection strategies and analyzing through various viewpoints, allowing peers not involved in the research to assist in problem solving and decision making, and finally "member checking" where the researcher returned to the participants to verify information and the interpretation of the data (Babbie & Mouton, 2001, p. 277). Credibility was also achieved by controlling for culture, however, the possibility of other explanations for the findings are not discredited, but rather explored (Durrheim & Wassenaar, 1999; Kelly, 1999).

Dependability is achieved when the same study is administered to a similar group of participants in a similar context bearing similar findings as the original study (Babbie & Mouton, 2001). An audit trail is useful in establishing dependability as well as credibility. Credibility is achieved when findings are not as a result of researcher bias. The audit trail used to aid dependability and credibility includes the raw data, all field notes and summaries, emerging themes, personal notes of research journey, pilot studies, amongst others (Babbie & Mouton, 2001). The researcher kept an audit trail which added to the dependability of the study (Ulin, et al., 2002).

As qualitative research does not focus on generalizing results to the broader population, transferability of results becomes important (Babbie & Mouton, 2001). The researcher demonstrated transferability for the discretion of the reader to apply in different contexts appropriately. It is achieved by thick, detailed descriptions of phenomena, as well as purposeful sampling in order to obtain rich data (Babbie & Mouton, 2001). Confirmability was achieved due to observations happening in a natural setting, namely the participants' homes. The researcher aimed to achieve transferability where the information gathered in this study may be applied in other studies within different contexts (Durrheim & Wassenaar, 1999; Kelly, 1999).

Method triangulation as adopted in this study is seen to improve the trustworthiness of the researcher's interpretation of the data (Babbie & Mouton, 2001; Kelly, 1999; Maxwell & Satake, 2006; Terre Blanche & Kelly, 1999; Ulin, et

al., 2002). This entailed the use of two methods of data collection which aided in gaining a more comprehensive, integrated interpretation of the data, namely observation of mother-infant interaction and semi-structured interviews (Terre Blanche & Kelly, 1999; Ulin, et al., 2005, Vos et al., 2005). The researcher continually evaluated reliability and validity, as well as trustworthiness focussing on credibility, generalisability and transferability, during the course of the study, (Durrheim & Wassenaar, 1999; Kelly, 1999).

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Chapter Three

Results & Discussion

Data were collected and analyzed according to the priority sequence model. The model stipulates how quantitative and qualitative methods may be used to complement each other in a single study (Ulin, et al., 2005). In this study, the quantitative portion preceded the primarily qualitative portion. Quantitative data was collected from observations of mother-infant interaction from a video recorded session of a routine daily activity. This was followed by semi-structured interviews with all ten participants. Qualitative and quantitative data were analyzed separately. Quantitative data are represented by visual data analysis (Lindegger, 1999). Qualitative data were described in terms of thematic content analysis. The quantitative results were complemented by the qualitative results in addressing the aims of the study. The challenges that arose necessitated another analysis of the biographical and demographic data gathered. This was then tallied quantitatively and visually represented, which supplemented and added richness to the descriptive data. Moreover, this raised new questions.

The ten participants are marked with the abbreviations P1 to P10 for the purposes of maintaining autonomy. Quotes are reported verbatim and therefore have not been edited for grammar.

The results are presented and discussed according to the following themes which emerged from the data:

- Socioeconomic Status (SES) as a variable: the need to look deeper
- Results from the videos depicting mother-infant interaction
- Results from the semi-structured interviews
- Integration of results

3.1 Socioeconomic Status (SES) as a variable

In spite of the difficulties in recruiting participants, the ten participants represented the original criteria of half categorized as High SES and half categorized as Low SES. As data collection was conducted in the participants' homes, the researcher had the opportunity to gain some insights into the living conditions of the participants. These differed markedly and therefore the proposed description of SES for this study, that is, using household income as a concrete measurement, was not an adequate reflection of SES. Household income is most commonly used to measure SES in South Africa as it is the easiest variable to obtain (Leatt, 2006a, b; Thiede & Chuma, 2006). However, financial indicators of SES alone, such as household income are not sufficient, although information regarding education and occupational status are subjective and difficult to quantify (Leatt, 2006a). Following the advice of an expert in the field of health economics (M. Thiede, personal communication, April 24, 2007), the researcher had gathered information regarding the occupational status, education and living conditions of each participant (Table 3) and this was used in order to broaden the *description* of SES. The indicators of SES used had been

identified in the literature (Bradley & Corwyn, 2002; Hauser, 1994; Thieda & Chuma, 2006).

Table 3: Participant details regarding three variables of SES

<i>Participant</i>	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Highest Education Achieved	Fashion Certificate	High School certificate	BA degree	Diploma in Business Admin	Diploma in Information Technology	High School certificate	University incomplete	High School certificate	Grade 9	High School certificate
Occupation	Unemployed	Unemployed	Service Delivery Manager	HR Consultant	Unemployed	Unemployed	Unemployed	Small business owner	Cleaner	Sales Associate
Household Income Bracket (pa)	R1-R4 800	R38 401- R50 400	R307 200+	R307 200+	R76 801- R153 600	R76 801 – R153 600	R153 601- R307 200	R76 801- R153 600	R1-R4800	R9 601- R36 400
High/Low SES using household income only	Low	Low	High	High	High	High	High	High	Low	Low

These three indicators were still insufficient to adequately categorize the participants into High and Low SES groups. For example, five out of ten participants were unemployed and five out of ten participants never pursued tertiary education of any form. However, participants who did not pursue tertiary education were not necessarily unemployed and three of the five unemployed participants had pursued tertiary education and were unemployed as they had husbands who were employed and enabled them to stay at home. Three out of the five participants who were high-school educated were employed, one of whom was managing her own small business from home. According to the initial measurement of SES for this study, three out of the five participants who were

unemployed would have been classified as High SES as their stated household income was more than R76 801 pa.

The living conditions of the participants were then examined (Table 4). All participants reported that they had easy access to clinics. This meant that even if participants did not have their own car or easy access to transport, they would be able to rely on a family member to take them. One participant (P9) who did not have easy access to transport lived within walking distance of the clinic. Participants who were reported as not living in their own house, indicated that they were boarding with their parents or in-laws. Situations where participants were boarding with their parents or in-laws and who received assistance with transport were taken to indicate that they received family or social *support* within low economic conditions. These indicators of living conditions allowed the researcher insight into the *experiences* of SES for every participant.

Table 4: Living conditions

Participant	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	Total Yes	Total No
Own house	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	7	3
Family Transport (car)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	8	2
Satellite TV	No	No	Yes	Yes	No	Yes	Yes	Yes	No	No	5	5
House/mobile phone	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	9	1
Easy access to clinic	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10	-
Living with Family	Yes				Yes					yes	3	7

From this additional information, the participants were reclassified into High and Low SES. Table 6 shows the indicators used to describe SES for the purposes of this study. The researcher took into account the household income bracket, education, employment status and living conditions indicators, namely whether the participant lived in her own house, and whether they had satellite TV, and whether they owned a car, which are construed as assets based on the examples provided by Thiede and Chuma (2006).

Table 6: Indicators contributing to describe SES in this study

Participant	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Household Income Bracket (pa)	R1-R4 800	R38 401- R50 400	R307 200+	R307 200+	R76 801- R153 600	R76 801 – R153 600	R153 601- R307 200	R76 801- R153 600	R1-R4800	R9 601- R36 400
Highest education achieved	Fashion Certificate	Matric	BA degree	ND: Business Admin	ND: Information Technology	Matric	University incomplete	Matric	Grade 9	Matric
Employment	Unemployed	Unemployed	Service Delivery Manager	HR Consultant	Unemployed	Unemployed	Unemployed	Small business owner	Cleaner	Sales Associate
Own house	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
Satellite TV	No	No	Yes	Yes	No	Yes	Yes	Yes	No	No
Family Transport (car)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
SES GROUP	Low	Low	High	High	Low	High	High	High	Low	Low

The *living conditions of the participants* largely affected if the participants were categorized as Low or High SES. A participant was categorized as Low SES if their household income stated below R50 400, if they were unemployed, and did

not pursue tertiary education. Additionally, participants were considered Low SES if they were living in a single room with their in-laws or parents and not in their own house, and who did not possess assets such as a family car and a satellite TV.

The re-consideration of the variables contributing to SES meant that half the participants were considered Low SES and half High SES (Figure 4).

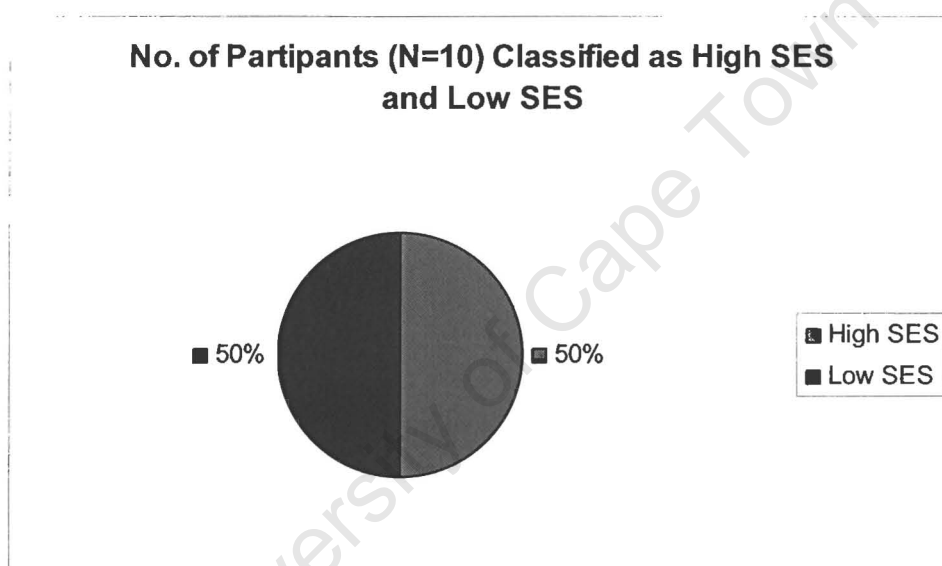


Figure 4: Number of participants (N=10) classified as High and Low SES

P5 and P8 were categorized as Low and High SES in this study respectively. On the original description of SES in this study, they both would have been considered High SES by virtue of their stated household income.

P5 had a National Diploma in Information Technology, was unemployed and a first time mother. She lived with her in-laws in a single room with no bathroom, or other living space of her own. Even though P5 stated her household income as

being R76 801- R153 600, which would have been considered High SES following the original description of SES, however, taking into consideration her living conditions, this indicated Low SES.

P8 on the other hand, did not pursue tertiary education, but was managing a small business from home. She had four children, including the participant infant. She also stated a household income of R76 801- R153 600. Indicators of her living conditions suggest that she was living comfortably and was able to afford her own house, family car and a satellite TV.

This illustrates the different living conditions of the participants and highlights the importance of gaining an understanding into *how* indicators of SES affect the *experiences* of individuals (Leatt, 2006a; Noble et al. 2006). It can be seen by the example provided that while P5 had a tertiary education and P8 did not, it had no bearing on their employment status. This raises the question of whether the descriptions of SES in studies where SES was measured by education and employment status alone, were adequate (Hoff, 2003; Lagerberg et al., 2005). Additionally, although these two participants reported the same household income bracket, they lived in vastly different conditions, indicating the need for a *thick* description of SES. Literature shows that SES is multidimensional and therefore cannot easily be defined, but rather described along the various dimensions of SES, including financial (income, assets, expenditure, etc.), human (access to education) and social (family support, etc.) resources (Bradley & Corwyn, 2002; Leatt, 2006a; Noble et al. 2006).

It must be noted that participants who did not have the means to live in their own houses, were supported by family members, or by the community. For example, P9 did not own a mobile phone nor had a house phone. She relied on neighbours who lived across from her in a separate flat to use their house phone in order to be contacted. In this way, members who lived in her block of flats supported each other. P9 therefore benefits in accessibility to such resources, without owning them herself. At the time of recruitment, P9 was also accompanied to the clinic by her neighbour as she had walked to the clinic. Such support of family and friends allow mothers to gain access to necessary resources, such as access to clinics as well as improving the effects of low financial conditions, thereby neutralizing many negative effects of low SES conditions (Tomlinson et al., 2005).

SES appears to be a continuous variable that may be described along indicators. This is consistent with the findings of Horn et al. (2004) who stress the importance of taking into consideration a variety of factors in order to describe SES. Ross and Devereil (2004) also mention that determining SES is complex. The indicators alone are not sufficient in gaining a clear understanding of SES, as the *experiences* of people and the extent to which the indicators of SES prevent them from social inclusion, are also important (Leatt, 2006a; Noble et al. 2006; Ross & Devereil, 2004).

3.2 Results from the videos depicting mother-infant interaction

Analysis of the data from the checklist recording mother-infant interaction and additional qualitative observations of the video recorded sessions are presented. The Mother-Infant Interaction Scale (originally from Klein & Briggs, 1987) was utilized as it appeared in the CHRIB protocol, which was developed in South Africa (Kritzinger & Louw, 2002). The original tool employed a frequency rating scale (rarely, sometimes, often) which was adapted in the CHRIB by adding a fourth rating, that is 'optimally'. The researcher deemed 'optimally' to indicate *appropriateness* of behaviour in response to the infant's behaviour. Therefore, the researcher did not assess the frequency of behaviour as the original rating scale suggests, as the video ranged between 10-15 minutes in length.

Apart from a very few individual differences, it was noted that the participants displayed very similar behaviours. Some participant mothers were quiet as their infants were quiet and there seemed to be no need to respond. Some participants who were quiet were shy in nature and therefore may have felt uncomfortable and intimidated by the presence of the video camera.

The checklists completed by the second observer were compared to the checklists completed by the researcher. The second observer confirmed most of the behaviours noted by the researcher. Discrepancies were discussed between the researcher and second observer.

The second observer noted that none of the participants imitated their infants' vocalizations as a communication act. This was in line with the researcher's observations (Table 6). The second observer also confirmed the researcher's finding that some of the participant mothers and some of the infants were quiet during the session. The second observer felt that in these circumstances, discrepancies arose with the researcher in terms of the quality of the interactions. Where mothers were particularly quiet, the second observer did not record the behaviour as 'optimally' whereas the researcher had, focusing on the frequency of the behaviour, rather than on whether the behaviour was appropriate or not in response to the infant's behaviour.

One participant (P9) displayed the same behaviour as the other participants, but with a lower frequency. She hurried through the bathing session. This was understandably due to her older son being ill and being watched by his grandmother in the next room. The checklists of this participant indicated discrepancy between the second observer and the researcher. Following discussion, the second observer agreed that the participant could be awarded the checklist point for *displaying* the behaviours and that her interaction with her infant was *appropriate*. Therefore, her behaviour was recorded as 'optimal', which indicates that the behaviour was appropriate in response to her infant's behaviour in the given context.

Table 7: Number of participant mothers displaying specific behaviour (N=10)

Behaviours Observed	Yes	No
Provides tactile and kinesthetic stimulation	10	
Mother displays pleasure while interacting with infant	10	
Changes verbalization in respond to infant's stress	10	
Changes infant's position, attempts to distract	9	1
Provides positive physical stimuli, e.g. rocking, patting	7	3
Avoids negative physical or verbal response	8	2
Attempts to make eye contact	10	
Reciprocates eye gaze.	10	
Consistently returns infant's smile	10	
Smiles in response to infant vocalization	10	
Uses higher pitch	10	
Talks more slowly	10	
Exaggerates intonation	10	
Uses rising intonation patterns.	10	
Waits after vocalizing and looks expectantly, providing infant turn	10	
Imitates child's vocalizations		10
Repeats own sounds, words or phrases	10	
Answers when infant vocalizes	10	
Touches or responds with facial expression within 2 seconds after infant vocalizes	10	
Vocalizes within 2 seconds after infant moves arms, head, etc	8	2
Stops own activity or verbalization in response to interruption by infant's vocalization or movement	10	
Responds to infant from a distance of more than 2 feet	5	5
Changes activity due to negative cues from infant	7	3
Reduces intensity of	10	

Interaction		
Terminate attempts at interaction	5	5

Table 7 shows that 18 out of 25 behaviours observed were displayed by *all* of the participants. Some behaviours were not noted for all the participants, particularly behaviours which respond to infant distress and negative cues, the reason being that some infants were quiet and did not present with distress or negative cues. However, Table 7 illustrates the *uniformity of behaviours* displayed by the participants across SES groups.

Figure 5 below illustrates three distinct behaviours that did not appear on the checklist, but that were repeatedly observed by the researcher. Exactly half (50%) of the participants kissed their infants. Seven out of the ten participants (70%), while talking to the infant, would verbalize utterances 'for' the infant that is, talked on the infant's behalf. Finally, six out of the ten participants (60%) verbalized all of their actions.

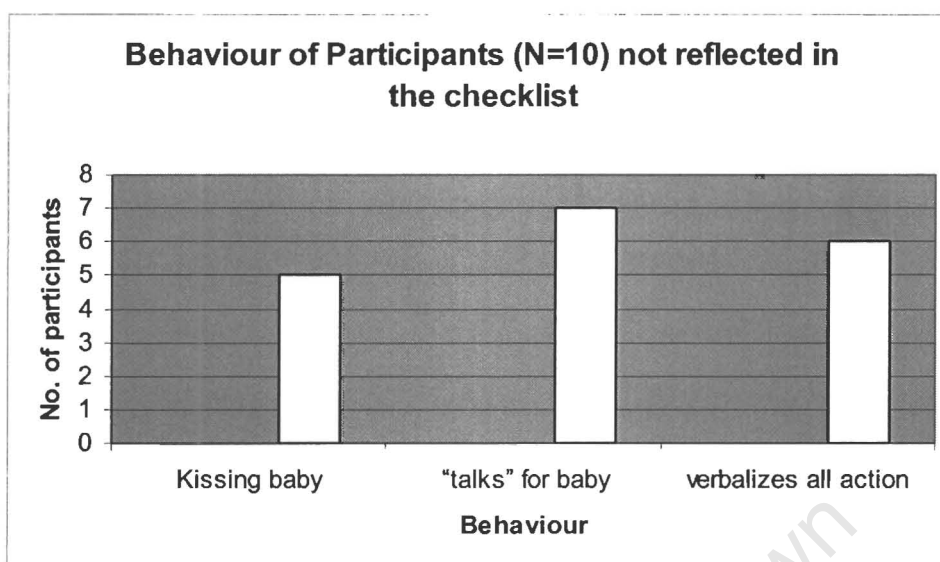


Figure 5: Behaviour of Participants (N=10) not reflected in the checklist

These three behaviours were observed across SES groups. The behaviours noted were not restricted to variables such as the mother's age, or first-time mothers, which is in contrast to Owens's (2005) statement that mother-infant interaction may be influenced by the number of pregnancies and especially whether she is a first-time mother or not.

Recognising the limitations of the small sample size here, the uniformity of behaviours observed in the participants in this study suggests that SES has little, if any effect on the nature of mother-infant interaction in the Cape Malay Muslim cultural group in the zero to three month period. This is in contrast to literature that state that mother-infant interaction is influenced by the mother's socioeconomic background (Bakerman et al., 2004; Hammer & Weiss, 1999; Hoff, 2003; Kolobe, 2004; Lagerberg et al., 2005; Owens, 2005).

	Hammer & Weiss (1999)	Hoff (2003)	Bakerman et al. (2004)	Kolobe (2004)	Tomlinson et al. (2005)	Lagerberg et al. (2005)
Aim(s)	Investigated how African American mothers and their infants structure play interactions and whether play interactions differed due to SES.	Investigated how SES affected early vocabulary development via maternal speech.	Investigated whether differences in attachment were due to ethnicity or SES by comparing White-American mothers to African-American mothers.	Investigated whether a relationship existed between child rearing beliefs and practices of Mexican-American mothers, and infant's developmental status regarding motor development, affected by mother's SES and acculturation.	Investigated the mother-infant relationship and attachment in a peri-urban settlement.	Investigated mothers' perceptions of mother-infant interaction and child difficultness of their 18 month old children with regard to SES and other subjective factors such as postnatal depression.
Finding(s)	SES accounted for some differences in language behaviour of the mothers of toddlers. However, play was structured similarly across SES groups.	Children's vocabularies differed as a result of SES, via maternal speech	Differences in attachment between groups were attributed to SES.	Differences between mothers were found to be due to SES.	Higher incidences of secure attachment than hypothesized.	High SES does not necessarily translate to positive mother-infant interaction and low child difficultness.
SES indicators used	Two-Factor Index of Social Position, making use of information regarding income, education and occupation	Employment and education	Education and income	The Hollingshead scale was used, but no details provided on which indicators of SES were used.	Information regarding education and type of housing was collected, but no indicators of SES are evident.	Employment and education
Sampling description	12 mother-infant dyads recruited from clinics, day care centers and a pediatrician's office.	63 mother-toddler dyads were drawn from two socioeconomic groups, mid SES and High SES.	1364 participants were recruited from 10 sites around the USA.	62 mother-infant dyads participated through snowball and convenience sampling. Prospective participants were interviewed regarding demographic details before selected to participate in the study.	147 mother-infant dyads from an informal settlement characterized by poverty. Participants were recruited by the researchers identifying them door-to-door.	1039 mother-toddler dyads
			78			

Data collection strategy	Observations of mother-child play were held in a structured setting. Information regarding employment and education was gathered by asking participants to fill out a questionnaire.	Observations of mother-infant interaction were recorded in the participants' homes during activities of daily living, dressing their children, feeding breakfast, and playing with toys.	Observations were conducted in structured settings as well as the participants' homes.	Standardized measures were used to measure behaviour. This was administered in structured settings, as well as in the home environment.	Observations of mother-infant interaction and attachment occurred at 2 months and 18 months postpartum in a structured setting.	Data was collected in the form of questionnaires only.
Acknowledged limitations	- Small sample size - Data collected from structured settings, and not in natural settings	- Did not consider other environmental aspects which could influence the development of the child's language. - No Low SES group.	High SES was restricted to White-American mothers	Data obtained were cross-sectional and therefore could not address causality.		- Did not include income in the description of SES as the information was not available. - Data was collected using questionnaires only, therefore no observation of mother-infant interaction - Did not acknowledge environmental and social factors regarding mothers' perceptions.
Additional limitations	Structured settings do not allow the researchers to observe mother-infant interaction within their natural SES environment.	- Did not control for culture. - Did not include income in the description of SES.	No within-group differences were made in order to control for culture.	- Did not account for children who were diagnosed and treated for developmental delays - Most of the participants were considered Low SES.	SES not clearly defined.	Did not control for culture.

The descriptions of SES in the studies above are not well defined. Four of the studies did not identify the multidimensional nature of SES, and did not incorporate all the main indicators of SES, namely, finance, education and occupation in their description of the variable. In the current study, SES is considered to be made up of multiple variables, which are reflected in the description of SES.

Most of the studies mentioned had large sample sizes and went through extensive recruitment procedures. The scope and financing of these studies is on a much larger scale than the present study, as this study was conducted by a single postgraduate student researcher.

Although this study employed a small sample size of only ten participants, the researcher gained access into the participants' homes which added richness to the data and provided the researcher with insight to the living conditions of the participants. Three of the studies reviewed collected data in structured settings only, or handed out questionnaires.

Finally, culture was not always controlled for in the studies reviewed, which could have affected the nature of their results, thereby masking SES as a variable. In this study, culture was controlled for by all the participants being part of a homogenous cultural group, the Cape Malay Muslim culture.

3.3 Results from the semi-structured interviews

Following the video recorded observations of an extended bathing activity, semi-structured interviews with all the participants were conducted. Five themes emerged by using thematic content analysis on the transcripts of the interviews.

The five themes were:

- Mothers' social networks
- Mother's experiences surrounding the birth
- Traditions surrounding newborns
- Childrearing beliefs
- Issues surrounding the gender of the infant

3.3.1 Mothers' Social Networks

The most frequently recurring theme from the interview transcripts was the social networks of the participant mothers, particularly the role of the grandmothers. Social networks are highlighted by Osofsky and Thompson (2000) as one of the most important elements of parenting. They emphasize that the strength of the relationships between other individuals and the primary caregiver, in this case, the mother, is more important than the size of the social network (Osofsky & Thompson, 2000).

All the participant mothers mentioned that the grandmothers helped them in the first few days with household duties, babysitting other children, or taking care of the newborn infant themselves to relieve the mother for a short time.

P1.: "In my community the mothers play a big role, the mothers of the new mothers, you heard in the bath session the mother had to come in because the mothers are very involved..."

P4: "To a large extent during the day, my mommy plays quite a big role but more supporting me with other responsibilities like cooking, that my mommy will do so that I can take care of him, she will wash his clothes, those types of things my mommy will do for me so that I have more time with him."

"When she sees that I am tired she will take him and feed him, she'll burp him, she'll put him to sleep."

P5: "The day I came back from hospital I was very emotional because I suddenly realized I had no idea what to do, coz you come home and you think you really don't know what to do. There's all these things coz I had problems with my breastmilk and that was straining on me and the formula, what formula do I take, so you really rely on your mommy."

P8:" ...my mommy usually come make food for me for the first couple of days or if she can't then my mother in-law for the first week and then after that I'm, my sisters, they phone and ask, but mostly I rely on my mother in-law and my mommy."

*P9: "Yes, she's (mother) help me a lot. I'm working and she's looking after the one (child). I can't give all to her because she's also sieklik [sickly] and that, I can't do that. I give *** (baby) to my mummy and I give the other one (son) to her."*

In light of the ecological theory, the distinct roles of the grandmother described above, illustrates an important mesosystem (Garbarino & Ganzel, 2000; Sameroff & Fiese, 2000). Mesosystems refer to the interaction of microsystems, which refer to the infant's immediate environment, in this case, the relationship with its mother (Garbarino & Ganzel, 2000; Sameroff & Fiese, 2000). The mesosystem in play here illustrates how the involvement of the grandmother affects the ability of the mother to take care of the infant. The grandmother's involvement relieves pressure on the mother and therefore strengthens the environment for the infant.

Apart from the major role of the grandmothers, other family members also assisted in forming strong social networks for the mothers, and therefore illustrating other mesosystems. Participants reported that family members provided positive support. One participant (P3) mentioned that without the help of her sister-in-law, she would not have been able to cope with her new infant. At times, family members take over some of the roles of the grandmothers, as illustrated by the quotes below.

P7: "Well, they visit often, they take him off your hands for an hour or so and it helps. Makes you feel also when you have visitors that you have people to speak to, besides your husband, you see your husband everyday, you need other people since, even though I wasn't forced to stay at home everyday, you don't want to take the child out if the weather's bad, so having family around really helps."

P9: "It was my sister. Every child I have my sister is bathing them because I don't know how to bath the baby with this-needle [referring to navel clip]. And after that I was with him I bath him because I must learn so next time if I have another baby I will know how to deal with tings like that."

P10: "They (family) are very much involved like babysitting, especially like here, with my first baby I was very like don't touch my baby, don't sneeze, I was very paranoid, but with this one, oh please take her, let me get some sleep, so they like to take her and hold her and walk up and down with her....I've got lots of brothers and sisters and they always here, lots of children always here, lots of people."

Family members, including the grandmothers also give the mother advice about how to take care of her infant, for example:

P3: "The advice I was given from every possible cousin, aunt, uncle, everyone has something to say. As time goes by you learn that people want to help and you take what you can from that advice, what works for you and if it doesn't work for you then (Shrugs) but everyone gets involved."

P10: "The old aunties like to give you advice, don't put them off and listen to them coz sometimes they do have sound advice."

It was observed that *all* participants had a supportive social support system that provided them with support in caregiving, as well as emotional support, which is in line with the view of Osofsky and Thompson (2000). Osofsky and Thompson (2000) explain that primary caregivers receive advice, emotional support and assistance with the infant from the members of the social support network, which facilitates adaptive parenting.

3.3.2 Mothers' experiences surrounding the birth

Rossetti (2001) mentions that mothers' responses immediately following birth, are universal. This is supported by the interview transcripts, six of the ten participants described feelings of being in awe, relieved and feeling overwhelmed immediately following the birth of the infant. While four of the ten participants explained that they were "emotional" and "cried". Some of the participants mentioned that during pregnancy they felt excited, and first time mothers mentioned that they felt anxious and scared regarding their abilities to take care of the infant.

Seven of the ten participants mentioned that their primary concern was to give birth to a healthy infant.

P2: "I think the main thing was I was just hoping that he was going to be a healthy baby."

P4: "Expectations around the baby itself was for me, he needs to be healthy and that was it."

P6: "The most important thing that you expect is for her to be healthy. That's the first thing that goes through your mind. I suppose for me as a mother that is the main thing, with all my pregnancies."

P10: "That she's healthy and that especially when I was pregnant I just wanted it to be, towards the end, I wanted it to be over and done with, but she's a healthy little girl, she's got no rubles, she's got all her fingers and her toes, she can see and hear you know all those things."

Six of the ten participants reported that their initial bonding moment was immediately following the birth where the infant is placed on the mother's stomach, and the infant breastfeeds. This highlights the importance of early opportunity for attachment (Klaus & Kennel, 1982; Rossetti, 2001; Siegel et al., 2006)

P1: "After you wake, then you start feeling close to the baby, especially once they let him latch onto you or the first time and the baby is suckling, it makes you feel like this is my baby and I gave birth to this baby and now this baby needs me and I must feed it, you know you basically feel responsible for it, you know and then all that emotions just comes basically for me when he as breastfeeding was when I felt this baby is my baby."

P4: "The first bonding moment is immediately in the first two minutes when you put him on your chest and you look into his eyes and you see his face I think there is an immediate bonding that takes place.... I think more so when you put him on your breast and you try to feed him, but it doesn't work the first time round so it becomes a frustrating experience for the mother because you really want it to work, but it definitely is a bonding between mother and child."

P6: "Well he breastfed a few minutes after he was born so from then already. You just went through all of that and you feel emotional and you crying so you do start bonding almost immediately when you start breastfeeding so that's how I felt."

P9: "The first time the baby is coming out. 'Cos you're waiting for 9 months..."

Therefore, it appears that the participants experienced very similar expectations and feelings following the birthing process which is in line with Rossetti's (2001) claim that mothers' responses are universal.

One first time mother recalled her experiences, which she had not expected, in the quote below:

P3: "I have to be honest in terms of what went through my mind. I thought it was going to be a much easier process. Basically, that you wouldn't have so many sleepless nights, that you would have a colic baby for instance, those are the things that you didn't expect."

3.3.3 Traditions concerning newborns

(a) Traditions Practiced

The only tradition mentioned, practiced by all the participants, was the *doopmal* (namegiving ceremony). All the participants were aware of the traditions around the *doopmal*, but not all participants mentioned that they hosted traditional ceremonies. The *doopmal* is a social event where family and friends are all invited to witness the ceremony and treated to a spread of traditional foods following the ceremony. Family and friends often bring gifts along for the infant. Some of the customs regarding the *doopmal* is that the infant, regardless of gender, is dressed in a special white dress, placed on a cushion surrounded by red roses, and is named by a Islamic leader, an *Imam*. The name of the infant is usually only known by its parents until it is announced by the *Imam*. There appears to be a lot of pressure from the community on mothers to host a traditional ceremony as indicated by the quotes below:

P3: *"The day I got home from hospital there was about without lying to you 80 people, it wasn't at my home, it was at my mother-in-law's, we had the namegiving there and obviously the whole world and their sisters and uncles were there from both sides of the family..."*

P4: *"...will be the doopmal, and in our case it was a big doopmal and I think there's a lot of pressure on the community that you have to have this big traditional doopmal and that it has to be with a doopmal rokkie [dress]."*

P5: *"The doopmal itself was very traditional with the big pillow and the roses around and he had to have a specific outfit on and then not traditional in the sense that my husband gave his name."*

P8: *"We had the doopmal. I didn't want to have one initially coz I said I'm gona come from hospital, I'm gona be bored, I'm gona be sore, I don't know what I'm gona be feeling like...so I said to my husband, you and my mother can organize it...the same day I came home from hospital I had it, so the sooner the better then it's over and done with, coz they wanted to have it. They invited everybody, a couple of hours and it was all over. They borrowed someone's midorah [referring to a traditional scarf], the neighbour's opposite, coz they had to have one of those and put flowers on and take photos."*

These customs are not equivalent to general *Islamic* customs surrounding new infants and namegiving (Bari, n.d.), but rather the customs mentioned here seem to be practiced specifically by Cape Malay Muslims.

One "Low SES" participant (P9) mentioned that it was not necessary to have the big traditional namegiving if people were unable to afford the expenses. The researcher interpreted this to mean that there is a lot of pressure from the community to host a big traditional ceremony. This was confirmed by other participants, for example:

P4: *"...will be the doopmal, and in our case it was a big doopmal and I think there's a lot of pressure on the community that you have to have this big traditional doopmal and that it has to be with a doopmal rokkie [dress]."*

P5: "The doopmal has to be really big. The entire world needs to know about the doopmal, the preparation!

P8: "Well the doopmal that's for sure, that's what I had a big one with coz I didn't give a big doopmal for her and then it was a 'big' thing. That in Cape Town is something that you must have."

P10: "I didn't initially want one [namegiving ceremony] coz to me it doesn't matter either way it's not too important, but no, you must have one and it's important. So I was kinda bulldozed into it."

Similarly, P6 thought that the namegiving ceremony was not such a significant event that needed to be celebrated in such a manner.

P6: "I'm not too keen on the whole doopmal story reason being it's not such a big issue the namegiving for me it hasn't been. If there's one thing that could maybe be done away with is the namegiving. Look, it's only a tradition like you said, the 40 days and things coz it'd not a must."

(b) Traditions considered unrealistic and not practiced

All of the participant mothers mentioned that traditions regarding staying in bed for seven days following the birth and staying at home with the infant for the first 40 days are unrealistic. Participant mothers felt that if they were well and healthy and if the infant was healthy, there is no reason to stay at home, especially not for the mother to stay in bed.

P1: "You can't lie in bed with a newborn, it's just impossible."

P3: "I don't see why I should stay at home with a baby for 40 days coz if I'm able to be out and she's ok, she's well, what is the reason behind the 40 days? I know that a lot of people place a lot of emphasis on the 40 days and they say that you need to heal and that's the reasoning behind it and the baby needs to-but I mean, I didn't stay in 40 days and we're here and there's nothing wrong with us. I absolutely disagree with the 40 days."

P6: "After the first 5 or 6 days if you had a normal delivery you fine then you can walk around. I mean even if it's your first born and you're a strong mommy and then you can walk immediately after your baby has been born. It's really not necessary, you're not ill, it's just a condition."

P8: "...my mother in-law was here and my husband was here but I think after the 2nd or 3rd day I was out already. I think its all about how you feel coz why must you restrict yourself if you can move around why must you, you don't have to lie in bed, I mean ok if u not feeling well, but I was fine."

P9: "No! With her (points to eldest daughter) I give birth Wednesday, Thursday she must go see clinic. Otherwise I walk with them; you must just close their heads in, then. With him I was, with the other one (son) I was everyday on the street with him..."

P10: "The whole 40 days thing I don't take much notice of, I just stayed at home coz it was quite cold....so I didn't really go out, but I think I went out after 3 weeks and I went to work and I showed her off to all my colleagues....she was 2 or 3 weeks old and we were out shopping so that 40 days thing.... I don't pay much attention to that staying at home coz you get claustrophobic. You feel like the walls are closing down on you and you looking at the same 4 walls. No, you need to get out and life revolves around the baby so you need to see other people, I needed to see other people other than the people who I normally see, so I just needed to even if it were strangers, I just needed to get out of the house so I took her with."

This view was held by participants across SES groups.

Exactly half of the participants (5) felt that there were negative aspects to the tradition of family and friends visiting the mother and new infant. They found it disruptive to routines, and physically tiring for both mother and infant, for example:

P6: "You can't have too many visitors because I think it's bad for the child and you don't know what germs are around and obviously you're scared of that. Also the child sleeps most of the time when they're just born so they need some time to rest without being bothered. So at the beginning I think it's a bit much when people want to spend the whole day everyday with you."

However, they mentioned that the positive aspects of having many visitors outweigh the negatives, for example:

P6: "But it could be a help if one of the people pop by and they just give you a breather and with conversation they make you relax".

This again emphasizes the importance of a strong social support system as described by Osofsky and Thompson (2000) earlier.

3.3.4 Childrearing Beliefs

Seven of the ten participants highlighted morals, values and respect as fundamental qualities they wanted to instill in their children, for example:

P2: "The main thing is the respect that they must have."

P6: "Yes, education is important but foundation starts at home, it's respect, it's the goals and the morals and the child knowing right from wrong."

P8: "Manners definitely. That is something that I'm very I mean I know some children are rude, but you get rude and you get (waves hand) you know? The children nowadays I mean (shakes head) it's downright disgusting".

Teaching religion to children was highlighted by half of the participants as core to childrearing. Participant mothers mentioned that if children have religion as their basic set of principles that "everything else" will follow.

P2: "You obviously have to from at an early age that Islamic foundation, because that if that is not there then you can forget. And that is where with our Islamic foundation the respect for elders and begin obedient as well not only to the parent, but also reminding them that at the end of the day, Allah comes first. So when they're obedient to Allah and Allah's rules then everything else will fall into place."

P5: "So the most important thing is faith coz everything really stems from there."

P6: "Most importantly when it comes to Islam it's to do with the laws of the Qur'an and they say the shariyah [Islamic law] which we have to abide by."

Four participants noted parent-infant bonding as a childrearing belief. Participants believed that establishing the initial bond with the infant was of vital importance. P5 specifically mentioned that she was also concerned about the father bonding with the infant.

P3: "You need to show the child the love by touching and feeling and also communicating with them and I think telling the child all the time that you love them."

P5: "Establishing that bond firstly. To me it seems easier for the baby to bond with the mother coz you know the mother is always there and responsible for the feeds and stuff, but to establish the bond with the father to me was very important."

Three participants mentioned that they wanted their children to grow up to be independent individuals who will not need to rely on others for their own success, for example:

P10: "That they'll be independent, that they wont need anything from anybody or anyone, that they can see to themselves and stand on their own two feet. That they can have that independence and not forget where they come from, not forget their religion."

Three of the participants believed that parents model the behaviour of their children, for example:

P1: "The most important thing to me is that I believe the way you behave is the way your child is going to behave."

The child rearing beliefs are consistent across SES groups as illustrated by these selected examples. This is in contrast to research findings that differences in

child rearing beliefs exist in different SES groups (Hoff, 2003; Kolobe, 2004). However, their descriptions of SES were superficial and did not take into account the living conditions of participants, or how SES was *experienced*.

3.3.5 Issues surrounding the gender of the infant

Seven of the ten participants felt that boys and girls were treated differently in their community. Owens (2005) states that in different cultures, gender differences may exist. Boys were seen to be reared to be physically stronger, while girls were treated gentler and softer. Boys were seen to have more freedom than girls.

P1: "Boys are different they grow up and do their own thing and move around more they've got much more freedom. Also in my religion boys have more freedom and they're allowed to do a little more than girls, coz girls need to have a male family member with them if they want to do anything they need someone who can take care of them."

P5: "In any community I suppose they see the boy that needs to grow up to be strong, independent and can handle things. Just strong male, get through anything, whereas a girl, she can be mothered. If she cries you can hug her if a boy cry you just tell him to stop."

P6: "Girls get reared more gentler, boys get reared more harsh."

P10: "When they older they tend to place more restrictions on the girls than the boys. They boys, you can do whatever you want to do and it'll be ok, but if a girl does it then it's not ok."

Three participants felt that the reason for this was influenced by the laws of Islam and the roles of men and women in Islam, as the participant below stated:

P8: "Girls as they grow older, there's more restrictions on them compared to boys. Sometimes you look at it and think it's just not right, but that's just how it is, that's how our religion is. Sometimes you think it's just not right but when you read on it, you understand why."

Two participants mentioned a personal preference towards the gender of infants. One participant mentioned that she felt that men were keener to have sons and would therefore initially bond more with them.

P7: "I think it's not a general thing, it's personal to every person and each person has their own preference, how they feel at that point."

Therefore, it is evident that participants from across SES groups have similar beliefs and practices surrounding infants and child rearing. This is in contrast to the claim that attitudes and beliefs may differ according to SES (Ross & Devereil, 2004). It may be, however, that these differences may affect the beliefs and attitudes of mothers later in the child's life.

Culture appears to be a more valuable variable with regard to influencing the nature of mother-infant interaction during the zero to three month period. This is in line with literature that explains how culture influences the beliefs and practices of people (Anderson & Battle, 1993; Ross & Devereil, 2004).

3.4 Integration of results

The findings of this study indicate that for the Cape Malay Muslim cultural group it appears that SES *does not* affect the nature of mother-infant interaction during the zero to three month period.

Literature indicates that poverty or low SES conditions are synonymous with low mother-infant interaction and parenting skills placing infants at risk for later communication delays (Bradley & Corwyn, 2002; Garbarino & Ganzel, 2000; Halpern, 2000; Kritzinger & Louw, 2003; Rossetti, 2001; Sameroff & Fiese, 2000). In contrast to this, Lagerberg et al.'s (2005) study investigating mothers' perceptions of mother-infant interaction and child difficultness of their 18 month old children, found no correlation between high SES and positive mother-infant interaction. In this study, it was found that mothers displayed similar mother-infant interaction behaviours, and similar beliefs and practices regarding infants, regardless of SES.

The findings that the child rearing beliefs, and mother-infant interaction behaviours were uniform across SES groups, may be explained by the Cape Malay Muslim culture being a high-context culture (Hall, 1976). Previously, Tomlinson et al. (2005) found that the negative effects of low SES conditions may be suppressed in high-context communities and this may have been the reason for the findings in this study, where additional variables of social support affected or even cancelled SES criteria.

Social support networks also present as a resource for mothers, therefore negating the possible negative effects on Low SES in particular (Osofsky & Thompson, 2000). Support networks aid the mother in caregiving, advice, and household duties. In circumstances where mothers lived with in-laws or family,

they relied on their in-laws for transport and other financial resources. This also served to minimize negative effects of low SES.

Finally, it may be that SES as a variable only becomes relevant at a stage where the infant is not as dependant on the mother for survival. At this stage, culture is a more important variable affecting the nature of mother-infant interaction.

University of Cape Town

Chapter 4

Conclusion

4.1 Limitations

Due to difficulties in the recruitment of participants, as well as limited time frame, the study sample comprised of only ten participants. The small study sample prevented the researcher from making inferences and generalizing results to the wider population.

The researcher based the description of SES on literature in the field (Bradley & Corwyn, 2001; Hauser, 1994; Leatt, 2006a, Noble et al., 2006), and some information from experts in the field of health economics (M. Thiede, personal communication, April 24, 2007). Future studies could explore more comprehensive, formalised indicators of SES in collaboration with experts from the field of health economics.

A bathing activity was used to observe mother-infant interaction. Observing mother-infant interaction in different contexts may display a variety of different behaviours.

4.2 Implications and Recommendations

4.2.1 Clinical Implications and Recommendations

Within the small sample studied here, it appeared that mother-infant interaction was uniform for the Cape Malay Muslim cultural group across SES

groups. SES was also confirmed to be a complex variable which is difficult to describe and measure. Speech-Language Pathologists should not make assumptions that low SES translates to less adequate mother-infant interaction. Rather, Speech-Language Pathologists need to assess and make use of individuals' resources. Speech-Language Pathology students could also be educated about the multidimensional nature of SES.

The observations of mother-infant interaction showed that these Cape Malay Muslim mothers displayed three distinct behaviours that did not appear on the checklist used. The behaviours were namely, kissing the infant, talking "for" the infant and verbalizing their actions. This provides Speech-Language Pathologists with insight into the nature of normal mother-infant interaction in the Cape Malay Muslim population. Furthermore, Speech-Language Pathologists must be aware of the existence of strong social support networks, which serve as a socio-economic resource in this cultural group. Not only does the social network offer emotional support, but it also aids the mother to gain access to resources which may minimize negative effects of low SES conditions.

4.2.2 Research Implications and Recommendations

This study focussed on investigating whether SES as a variable affected the nature of mother-infant interaction during the zero to three month period in a homogenous cultural group, namely, Cape Malay Muslims. Results indicate that SES is not an easily defined or reliable variable in affecting the nature of mother-infant interaction. Further research is needed to investigate whether this result is true for different cultures and in different contexts. Variables in

low-context cultures should also be explored. A bigger study sample is recommended in order to obtain generalisable data.

Similar studies could also be carried out for older infants, where the infant is not totally dependant on the mother for survival.

It is also recommended for studies investigating SES and aspects of Early Intervention, that the description of SES be carried out by an expert in the field of health economics.

4.3 Conclusion

The findings of the current study have raised questions regarding SES as a variable influencing mother-infant interaction. Literature states that mother-infant interaction is influenced by the mother's socioeconomic background and that low SES conditions are synonymous with inadequate mother-infant interaction thereby acting as a risk factor for later communication development (Bakerman et al., 2004; Hammer & Weiss, 1999; Hoff, 2003; Kolobe, 2004; Leyendeker et al., 1997; Owens, 2005).

The results of this small-scale study showed that mothers in the Cape Malay Muslim culture displayed uniform mother-infant interaction behaviours, as well as beliefs regarding infants. Their interactions and beliefs were uniform across SES groups. Thus, the current study illustrates that SES is a complex variable that is difficult to isolate and measure. The findings of the current study highlight that SES is not a dependable, contained variable which has an effect on the nature of mother-infant interaction for the Cape Malay Muslim culture during the zero to three month period.

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APPENDIX A: Ethics Approval

UNIVERSITY OF CAPE TOWN



Health Sciences Faculty
Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
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10 April 2007

REC REF: 139/2007

Ms Z Price
Communication Sciences and Disorders
Health & Rehabilitation Sciences

Dear MS Price

PROJECT TITLE: AN INVESTIGATION INTO THE EFFECTS OF SOCIO-ECONOMIC STATUS (SES) ON THE NATURE OF MOTHER-INFANT INTERACTION

Thank you for submitting your study to the Research Ethics Committee for review.

This study is approved. Please would you indicate in the consent forms and letters to the institutions that the study has been approved by the Human Research Ethics Committee in the Health Sciences Faculty of the University of Cape Town? We also recommend the following rewording in the consent forms:

What are you required to do?

You will be asked to allow me to visit your home within the next 4 weeks ... (the word 'accommodate' can inadvertently imply that you literally want to stay with the family).

Should you find that a mother is experiencing problems with her infant, you may want to consider a channel or mechanism for referral for help.

Should other adults and children be living in the home, it may be difficult to secure a private and quiet place for the interview so this may need to be negotiated with mothers beforehand.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

A/PROF. M. BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

APPENDIX B: Letter requesting permission to recruit participants at clinics



**Division of
Communication Science
and Disorders**

**School of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital
Observatory 7925
Telephone: 406-6313**

Fax: 406 6323

March 2007

To Whom It May Concern:

PERMISSION FOR IDENTIFICATION AND RECRUITMENT OF POTENTIAL PARTICIPANTS:

I, Zahrah Price am currently conducting my Masters' Dissertation in Speech-Language Pathology. I am particularly interested in investigating the differences in the nature of mother-infant interaction in low versus high socio-economic groups. There is very limited research in this area.

Speech language pathologists are involved with the area of Early Communication Intervention. This project hopes to bring to light socio-economic effects on the nature of mother-infant interaction and subsequently broaden therapists' knowledge. Thus, this project may affect the assessment and management of this population.

In order for me to complete my dissertation, I would like to recruit participants to partake in my study. I would therefore like to identify and recruit potential participants from your institution. Should they agree, participants will be asked to sign an informed consent form.

Would you please provide me with written permission to identify and recruit possible participants from this institution?

My supervisor is Martha Geiger and should you require any further information about the study, feel free to contact her or myself on the numbers below.

Yours faithfully

Zahrah Price (082 519 0434)
REC REF:139 / 2007

Martha Geiger (021 406 6314)

University of Cape Town

APPENDIX C: Consent Form for participants

Would you like to participate in a research project?

Please read through the following carefully before signing the consent form.

About the Researcher:

My name is Zahrah Price. I am a student at the University of Cape Town (UCT), conducting a **research** project in order to fulfil my Master's Degree in Speech-Language Pathology.

What is the research about?

The purpose of this study is to describe the way mothers **naturally** interact with their babies.

What are you required to do?

You will be asked to allow me to visit your **home** within the next 4 weeks to **video record** $\pm$ 20 minutes of you interacting with your baby and an **interview** for $\pm$ 30 minutes. Therefore, you will be required to provide me with your address and contact number in order to arrange a time and date for the home visit.

What will the researcher be doing?

I will be observing and recording you interacting with your child in your home. I will try to be as discrete as possible so as to ensure that you are not uncomfortable. The interview will also be recorded.

What are the risks and benefits of participating in this study?

You and your baby will not be physically harmed in any way. The information gathered will be used to further knowledge in the area of early communication intervention. Please note that regrettably, there will be no material reward for participation.

Do you have a choice to participate?

Yes! You have the right to decide whether you would like to participate in the study or not. You may also withdraw from the study at **any** time without obligation.

All videos will be **kept safely** by me after the study has been completed. All information observed or gained from you will be confidential and your and your baby's names and/or pictures will **not** be made known to anyone apart from the researcher.

Please feel free to ask the researcher any questions.

Please note!

In the unlikely event that a baby is abused in any way, I am legally obligated to report such behaviour to the authorities.

.....
I _____ hereby give consent for my baby and I to participate in this research project.

Signature

Date

APPENDIX D: Form for participants' biographical details

Thank you for your participation in this study! Please ensure to fill in **all** the details required. All information will be strictly confidential and will be used for the researcher's purposes only. Remember that you have the right to withdraw from the study at any time without obligation.

Name : _____
Surname : _____
Age : _____
Physical Address : _____

Contact Number : (h) _____ (c) _____

Highest Education completed: _____
Current Employment: _____

Household income **per year** (Please tick the appropriate box).

Household income is an indication of the total amount of income all working persons contribute to the home.

R1 – R4 800	☐	R50 001 – R 76 800	☐
R4 801 – R9 600	☐	R76 801 – R153 600	☐
R9 601 – R38 400	☐	R153 601 – R307 200	☐
R38 401 – R50 000	☐	R307 200 +	☐

I, ... hereby declare that this information is correct.

Signature

Date

APPENDIX E: Checklist for Mother-infant Interaction

Mother's Name: _____

Setting: _____

Activity: _____

Date: _____

a) Infant's pattern of interaction

	O	R	E
1. Maintains brief eye contact during feeding.....	I	I	I
2. Shows differing responses to caregiver's vocalization.....	I	I	I
3. Crying diminishes with adult eye contact.....	I	I	I
4. Smiles purposefully in response to caregiver's face or voice.....	I	I	I

(From Rossetti, 1990)

b) Mother's pattern of interaction

Key: 1: rarely/never; 2: sometimes; 3: often; 4: optimally

1. Provides tactile and kinaesthetic stimulation.	1	2	3	4
2. Mother displays pleasure while interacting with infant.	1	2	3	4
3. Responds to child's distress:				
a. Changes verbalization.	1	2	3	4
b. Changes infant's position, attempts to distract.	1	2	3	4
c. Provides positive physical stimuli, e.g. rocking, patting.	1	2	3	4
d. Avoids negative physical or verbal response.	1	2	3	4
4. Positions self and infant so eye-to-eye is possible				
a. Attempts to make eye contact.	1	2	3	4
b. Reciprocates eye gaze.	1	2	3	4
5. Smiles contingently at infant				
a. Consistently returns infant's smile.	1	2	3	4
b. Smiles in response to infant vocalization.	1	2	3	4
6. Varies prosodic features				

a. Uses higher pitch.	1	2	3	4
b. Talks more slowly.	1	2	3	4
c. Exaggerates intonation.	1	2	3	4
7. Encourage "conversation"				
a. Uses rising intonation patterns.	1	2	3	4
b. Waits after vocalising and looks expectantly, providing infant turn.	1	2	3	4
c. Imitates child's vocalisations.	1	2	3	4
d. Repeats own sounds, words or phrases.	1	2	3	4
e. Answers when infant vocalises.	1	2	3	4
8. Responds contingently to infants behaviour				
a. Touches or responds with facial expression within 2 seconds after infant vocalises.	1	2	3	4
b. Vocalises within 2 seconds after infant moves arms, head, etc.	1	2	3	4
c. Vocalises within 2 seconds after infant vocalisation.	1	2	3	4
d. Stops own activity or verbalisation in response to interruption by infant's vocalisation or movement.	1	2	3	4
e. Responds to infant from a distance of more than 2 feet.	1	2	3	4
9. Modifies interaction in response to negative cues from infant.				
a. Changes activity.	1	2	3	4
b. Reduces intensity of interaction.	1	2	3	4
c. Terminate attempts at interaction.	1	2	3	4

Comments:

(From Kritzinger & Louw, 2002)

APPENDIX F1: Participant 1

R: We going to talk about....basically about your baby and your experiences with the baby...and you can also talk about your experiences with your first baby.

P1: talk about both of them or just one?

R: you can speak...well, this one, but if you feel that there is anything significant about that then you can also say it.....because you'll hear from the questions that its very general....so to start off, what were your expectations about your new baby...so while you were pregnant you were dreaming about this new baby you were gona have..

P1: well for me, my sister had a baby and obviously when I had my first baby I didn't know what it was gona be like, but I did get to see what its like during pregnancy and whats its like having a child and everything and all the stuff that goes with having a child so I had that so my expectations were basically based on her experiences

R: and when it happened, when you had your baby did it turn out to be what you expected or?

P1: ja, you see um...with a first born. You don't really know what to expect even though you've seen it (cant hear) but you still don't know what to expect so I can I mean I, if you don't know what to expect then if something happens then that's the way it was then obviously that would be what you would've expected, do you know what I mean? With your second child, you know what to expect and you expect that and I was I did get exactly what I expected to be, you know like the science of it and stuff so I basically expected what happened. I expected a similar birth to the first one...

R: and about the baby? What did you like not temperament really, the way that the baby is, what were your expectations about that? Like how the baby would be?

P1: well, the first one, it was a bit tough coz obviously it's tough to have a newborn, and your first one, because with all the, specifically for me breastfeeding was a challenge, firstly it's very painful and secondly it's very complicated it's not a simple thing were you just breastfeed. And obviously the sleepless nights that just adds to your frustration coz you don't get rest so obviously you gona be much more susceptible to being irritable and. stuff, but after a while once you get over that, once the first month passes, for me I found that, I actually found that it was easy to have a baby and everything. Once you get the hang of things and you can get your baby into a routine, then you.. the first 3 weeks actually.

R: what were your initial reactions and feelings about the newborn?

P1: I was just very, to be quite honest, I was actually shocked that it was over, if you have a natural birth, it's very, it's hard to explain unless you went through it. after its done you're just in such shock, physical shock you know that you don't know what happened, you're just in a bit of a daze, then they put the baby on you and you're just so shocked that its there and you just don't really accept it. I mean its not like you don't accept it, it's just that you don't feel, you can't believe it's over. The whole pregnancy thing and the stomach's gone and the baby's on you and it's a lot to digest at one time.

After you wake up, then you start feeling close to the baby, especially once they let him latch onto you for the first time and the baby is suckling, it makes you feel like this is my baby and I gave birth to this baby and now this baby needs me and (cant hear) and I must feed it, you know and you basically feel responsible for it, you know and then all that emotions just comes basically for me when he was breastfeeding was when I felt this baby is my baby.

It was like in the first 20 minutes. When you give birth naturally, they let the baby come out, they immediately put the baby on your chest and then you're supposed to bond, but at that point, you are so in a daze because you're just experienced the most excruciating pain of your life so you obviously not totally going to concentrate on the baby, you first going to concentrate on oh my word its over. So once they take the baby away and they let you relax a bit, then they bring the baby back, that's when I basically felt anything else than its over.

R: what are the traditions that you know of or that you've experienced around newborn babies?

P1: I suppose, we don't really have a lot of traditions when it comes to newborns, the only traditions we have are maybe shaving the hair which all people maybe don't also do because not everybody believes in that., but some people will shave the baby's hair off because they believe it to be impure but not everybody feels that way, I didn't shave my kid's hair and another thing is they have the usual namegiving ceremony and things like that, there's nothing unusual that I picked up in our community around newborns.

R: did you do any of those traditions?

P1: I only had the namegiving with some people coming over and having a little ceremony and that's that.

R: what about the family? Do they come over a lot do they help you with the baby?

P1: in my community the mothers play a big role. The mothers of the new mothers. You heard in the bath session the mother had to come in because the mothers are very involved I mean most girls actually live in with their mothers, like I lived with my mother, most do that until they get the hang of looking after their newborn because you know they feel more comfortable and they wana be near their own mothers. So that's what I found around, I mean I have lots of friends who have given birth and they've all gone to their mothers so I picked up that that's what everybody does in my community.

R: do you think in some circumstances that the grandmothers take over the responsibility?

P1: not the newborns. Ok when I had my first child I had a lot of help with the bathing and things , but now with the second one I know exactly what to do. I'm sure in other situations lots of mothers to everything for t he young mothers. Also some people believe that you must lie in bed for days, but I mean hardly anybody does that. You cant lie in bed with a newborn, its just impossible. But some people do think that the new mothers must be in bed and the grandmothers should do everything. I also don't believe in that because the child is gona bond more with the grandmother.

R: what is the most important thing to you about rearing a child?

P1: the most important thing to me is that I believe the way you behave is the way your child is going to behave. What they see in their parents is the only thing they can really base life on and how they understand they world. Coz you're the only people they really interact with in the beginning in the most important years of their lives, before they go to school, that's when they spend most of their time with you and parents are everything to them and they understand everything from their parents so if you gona behave in a certain way then they gona think that's how it should be done, that's the way that you should behave so its very important for parents to be responsible around their children

R: Do you think boys and girls are treated differently in our community?

P1: in my community they should be I think, girls are obviously very different to boys, the way boys are mentally built, boys are vastly different from a girl, like girls cant run around in the round and play cricket, they have to basically act like little girls and they have to be taught to be respectable and grow up to be respectable women. Boys are different, they grow up and do their

own thing, and move around you know they've got much more freedom. Also in my religion, boys have more freedom and they're allowed to do a little bit more than girls, coz girls need to have a male family member with them if they want to do anything, they need someone who can take care of them. So they should be treated differently because they are different.

University of Cape Town

APPENDIX F2: Participant 2

R: When you are pregnant, what are your expectations about your new baby?

P2: Ag, I don't think I was expecting anything, because at the end, I've had so many problems also, I've had miscarriages. So even though I was looking forward to it, I was also a bit scared that something was going to happen. And its only now after he's born that I'm actually enjoying him. I think the main thing was just that I was hoping that he was gona be a healthy baby.

R: When you just gave birth to him, what were your initial feelings or reactions?

P2: I was actually in a lot of pain. There was such a lot of things also, I actually didn't even see him. Because I saw him from a distance and then I couldn't hold him after the birth because obviously I had the Caesar and that and I was still very much out of it. My husband actually held him for the first time and he showed me but ith me not actually seeing him. I think I only saw him, not even visiting hours, he ws still at the nursery. So my husband and my mother-in-law were the first two that went down to the nursery and saw him and then they came to tell me who he look like. And when they eventually brought him to me I was very, because I was in such pain, I was very concerned as to how I'm gona take care for him, because if he had to cy, you mos know in Groote Schuur there you have to do everything yourself and that, but there was this one sister that was so marvelous. She came to me and she said no you must rest and she took him away and fed him and cleaned him for me.

R: What are the general traditions surrounding newborns in our community?

P2: The doopmal, obviously with the namegiving and then I think with the boy obviously the circumcision. You like supposed to stay in bed also just for a few weeks and that and also just bond and that, but I must say if it hadn't been for the c/s I most probably wouldn't have bonded as much as I did because if I compare him to the other two that I had, I had normal birth and I was like in the first few days I was up and doing my normal chores whereas with him I was forced to stay in bed.

R: Do you get many other visitors?

P2: yes, in the beginning and also like in our family, we haven't had a baby we haven't had a baby for a couple of years now, and everyday thre's always someone popping in coming to keep the baby and so. I made a joke with my husband, I said o him I'm gona put a board outside and say when there's visiting hours. But when he's born and that you're actually so glad that they also come and come and hold him for a bit coz then it takes that off you as well because you also need time that you have to heal and so, so I actually enjoy it. I enjoy them holding and so, it gives me a break.

R: Does anybody help you with him?

P2: no not really. Only in the first week my mother-in-law used to come and bath him because obviously I couldn't do that. I didn't have to do anything with the housework coz I had somebody that came in every second day to come and clean up. And then my mother would make my food so I didn't have to worry about that as well. That's also why I feel like I'm enjoying him more coz I had time to bond with him and talk to him and just be with him.

R: What to you is the most important thing to consider when rearing your child?

P2: The main thing is the respect that they must have and also we try to, especially in our religion, you obviously have to form at an early age that Islamic foundation, because that is not there then you can forget. And that is where with or Islamic foundation the respect for elders and

being obedient as well, not just to the parents, but also reminding them that at the end of the day Allah comes first, so when they obedient to Allah and Allah's rules then everything else will fall into place. So I feel that is really the important part. If they already got that scaredness in them that they gona do wrong coz Allah says you mustn't do this the automatically they gona be obedient to the parent and they'll respect elders and that. So the foundation, that's very important.

R: Do you think that male and female babies or children are treated differently in our community?

P2: I think also with this society with all these things happening, I suppose you cant say that more things happen to females than to the males coz nowadays its both of them. But girls should be protected and if you don't teach them from young when they become big, they become very rebellious. I think girls is more difficult than boys.

University of Cape Town

APPENDIX F3: Participant 3

R: When you are pregnant, what are your expectations about your new baby?

P3: Your expectations are more around the emotions that you feel. There's excitement, but to a certain extent anxiety and fear around are you going to be a good mother. Personality, it was he'll be who he wants to be, he'll turn out the type of person he was meant to be. I didn't have any expectation about his personality. I was very comfortable in handling a baby, but when it was my own it was different. The comfortableness came around my brother's kids and my cousin's, it was always somebody else's where the responsibility isn't as huge as when it's your own.

R: When you just gave birth to him, what were your initial feelings or reactions?

P3: I had a c/s so let's say a couple of minutes before he came out I was extremely emotional. But eventually once I was on the table and I couldn't feel the lower part of my body I started calming down, then I became excited about, I'm actually gonna meet my son now, I'm gonna see who he looks like, there's going to be contact, it's going to be our first meeting. I kept on saying I want to see him coz they take him away and I didn't see him immediately and I could hear him scream and that first scream, it creates so much emotion in you coz you hear your son crying for the first time, you hear this little person who has been growing inside you. When they brought him to me and they put him on my chest, I remember thinking he looks like my father. I don't think you can actually describe the emotions you feel when you meet your child for the first time. It's a feeling of, it's an abundance of love and wow this is mine!

R: When did you feel you initially bonded with him?

P3: The first bonding moment is immediately in the first 2 minutes when they put him on your chest and you look into his eyes and you see his face. I think there's an immediate bonding that takes place. When I eventually got into the ward, they brought him to me then and they put him on my chest and I looked at him and counted his fingers and his toes and I looked at his face, I think that's also instant bonding. I think more so when you try and put him on your breast and you try to feed him, definitely is a bonding between mother and child.

R: What are the general traditions surrounding newborns in our community?

P3: I think it's definitely the circumcision when it's a boy, your child has to be sunat within the first 7 days. Before we even get there it's will be the doopmal and in our case it was a big doopmal and I think there's a lot of pressure on the community that you have to have this big traditional doopmal and it has to be with a doopmal rokkie, in his case he wore his father's doopmal rokkie and it was the midorah that the baby has to lie in which was his grandmother's. So there's a lot of traditions on the culture that we have to go through, plus it's the dress, it's the midorah, it's the flowers that you put around the midorah, it's the whole procedure when they give the name.

R: Which ones do you not agree with?

P3: There's another saying where they say you have to lie in bed for the first 7 days. I don't think I even got an opportunity to lie in bed. I was up and about from day one. I think from my own experience also, we haven't really been out, because there's this whole don't go out with the child for the first 40 days so my mommy's very funny about that so we've only been to the clinic with him. A lot of people shave the baby's hair, I didn't do that.

R: Tell me how does the family get involved with the newborn?

P3: To a large extent during the day, my mommy plays quite a big role, but more supporting me with other responsibilities like cooking, that my mommy will do so that I can take care of him. She will wash his clothes, those types of things my mommy will do for me so that I can have more

time with him. When she sees that I'm tired she will take him and feed him, she'll burp him, she'll put him to sleep. She allows us to do most of the bonding. You need to build that bond between mother and child. His father will feed him and burp him and put him to sleep. My mom's eldest sister, for the first week I was home coz I had a c/s, they said no don't worry we'll come and bath him so in the morning she'd come and bath him for me.

R: Do you get lots of visitors?

P3: Lets not even go there, that was my biggest nightmare. I had visitors from the first day I came home, the doopmal itself was 150 people plus. So we had people here all the time. Coming home from hospital and walking into a doopmal was not the ideal situation, you tired, you sore, baby needs time to adjust to a new environment. From then up until today we still get visitors daily and it tires you out. There's not time for you and baby to sit and bond. To a large extent having people around affected the breastfeeding coz we never had an opportunity to sit like 2hrs straight and just try coz there were people in and out. You know the mom needs time to sleep and when you get visitors in and out all the time there is no time to do that.

R: What to you is the most important thing to consider when rearing your child?

P3: you need to teach the child that unconditional love between a mother, not only a mother and child, but parent and child is of utmost importance. That the child needs to feel loved and to teach respect as well. And I think respect links in with our practices in Islam and Islam is a way of life and in order to earn respect, you need to show respect.

R: Do you think that male and female babies or children are treated differently in our community?

P3: I don't know if they've treated differently in terms of how the community sees them, I just think there's more of an expectation that your first baby is a boy.coz its your wakeel, but either way I would've been fine with it. Maybe the community doesn't treat boy and girl babies differently, but I think adult males and females, they put more pressure on the males than the females and there's different expectations of males versus females.

APPENDIX F4: Participant 4

R: When you are pregnant, what are your expectations about your new baby?

P4: I think that I didn't necessarily have any expectations as such because for me it was a first. I have to be honest in terms of what went through my mind, I thought it was going to be a much easier process, basically, you know, that you wouldn't have that many sleepless nights, that you would have a colic baby for instance, those are the things that you didn't expect, but I didn't have any expectations about what my baby was going to be like, not at all.

R: and personality wise?

P4: personality wise, or what he was going to look like or anything like that. Nothing whatsoever.

R: so, just in terms of handling the baby?

P4: yes. I thought, to me it was like how difficult can it be? You know? And only when she was there, when she arrived, I realized that there was much more to it than what I expected.

R: When you just gave birth to her, what were your initial feelings or reactions?

P4: Mine was that I can't believe this baby is mine, a minute ago she was inside of me and now this little baby is looking at me and it was very over-whelming, and for me it was, I can't believe this is my baby, I have a baby! Oh my God! Ja, that was my initial response and she looked so perfect to me. It was just very overwhelming, I looked at her and I thought is this really my baby? (laughs)

R: When did you feel you initially bonded with her?

P4: immediately when they wheeled me out of the theatre, we went to, I don't know if it was a general ward, but there were many other people lying in that section of the hospital and she was put on my chest and that's where I first talked to her immediately when they put her on my chest. Basically, they stitched me up; they wheeled me out into a general area where I had to wait to be wheeled down to my room. So Ja, that was immediately after...actually not, when I was in the theatre while they were busy doing the stitches, she was already on my chest.

R: What are the general traditions surrounding newborns in our community?

P4: Our namegivings, that's called a doopmal, that's a tradition, but I don't think that's very different to any other culture.

R: or the way its practiced?

P4: will be different yes. Obviously if she was a boy, she would've been circumcised, that's also one of the laws of our religion. Within 7 days you have to give the name which is obviously different to any other faith, but I can think of anything else.

R: Tell me how does the family get involved with the newborn?

P4: Oh too involved, too involved! Everybody just, you know the day that I got home from hospital there was about, without lying to you 80 people. It was at my house, it was at my mother-in-law's, we had it there. We had the namegiving there and obviously the whole world and their sisters and uncles were there from both sides of the family and the advice that I was given from every possible cousin, aunt, uncle, everyone has something to say. As time goes by you learn that people want to help and you take what you can from that advice, what works for you and if it doesn't work for you then (Shrug), but everyone gets involved. Shame but you also realize that without their help, if I look at, I had my in-laws who helped me with her and without their help I

would not have coped. Because I stayed with my sister-in-law for a couple of days and when I was tired I could give her to them and I could go and take a shower or go and take a nap and they would help me bath her and change her nappy and things like that until I was into a routine and then I came home. But from that perspective the help was enormous and I don't think if I had to come home to my own house and be alone with this baby I would not have coped because it's an experience, especially for me because you know we were married for 4 years before we had her so it was this new little person you're responsible for and it was a big experience, but I can't imagine my life with her now (smiles)

R: Some other traditions are that the mother lies in bed for 7 days, lives with her mother for the first month, stay indoors with the baby for 40 days...which ones do you not agree with?

P4: Without a shadow of a doubt the 40 days. I don't see why I should stay at home with a baby for 40 days coz if I'm able to be out and she's ok, she's well, what is the reason behind the 40 days? I know that a lot of people place a lot of emphasis on the 40 days and they say that you need to heal and that's the reason behind it and the baby needs to, but I mean I didn't stay in 40 days and we're here and there's nothing wrong with us. I absolutely disagree with the 40 days.

R: and the others you agree with?

P4: the circumcision definitely yes, and the namegiving. If I have another baby I would do it over again. It's a nice opportunity for the family to get together. Everybody wants to see your baby so absolutely I would do it again.

R: Do you get lots of visitors?

P4: more than what I thought. We had visitors for the next 2 weeks after she was born and that is something I wouldn't necessarily agree with, but you know what, I do it, everybody does it. When a baby is born you want to see the baby. You go there, but you don't know what strain you put on the mother. I was fortunate I stayed with my in-laws because you don't sleep at night during the day you want to sleep. So when the baby sleeps you need to sleep and when you have visitors basically you don't sleep at night and you don't sleep in the day so I don't agree with that, visitors for the next 2 to 3 weeks after she was born. If I could cut that out completely I would.

R: What to you is the most important thing to consider when rearing your child?

P4: I can't single out one thing there's so many. I'm not going to do justice to that if I say one thing. I think that obviously your child needs to be loved; they need to feel the love. You need to show your child the love by touching and feeling and also communicating with them and I think telling the child all the time that you love them. Apart from the fact that you need to show the love I think that this is your responsibility and you need to take care of that child 24/7 and to be there for your baby and to be a responsible parent. It's important to me, I think to bond with your baby in the first couple of months. So I would say to be with your child as much as you can, but also not to neglect yourself because you do become tired and you need a good support system in the first couple of months.

R: Do you think that male and female babies or children are treated differently in our community?

P4: I can't answer that question coz I've only had a girl so I can't draw on a previous experience to compare.

APPENDIX F5: Participant 5

R: When you are pregnant, what are your expectations about your new baby?

P5: Firstly, when I found out I was pregnant I was crying coz I was extremely emotional. I went straight to the Dr. and the Dr. told me no, you are pregnant, and I cried and when it eventually sunk in, I was like, ok am I ready for this? I remember phoning my sister and told her I don't know if I'm ready for this, how am I gona be a good mother, sometimes I cant even look after myself, things like that go through your head. I didn't really have any expectations, I just wanted everything to go well, I wanted the pregnancy to be, I wanted the baby to be healthy, I wanted the finances sorted out, so I was stressing over everything else besides what's gona happen after the baby is born.

R: personality? Looks? Did you ever think about that?

P5: I just wanted him to be, I dunno, just strong, strong in his, just everything about him must be strong.

R: When you just gave birth to her, what were your initial feelings or reactions?

P5: At that moment you don't really, its just strange. Its like 5seconds before that I was in excruciating pain and all of a sudden, the head's out and everything goes so fast and they put him on my stomach and I'm like this baby just came out of me and he's huge. And he was staring up at me, he didn't cry. I don't even know what I felt, you're sort of like in awe. It was just weird I cant explain it. I was exhausted but I didn't want to go sleep tired. I could feel my body was drained but I was like on this high.

R: What are the general traditions surrounding newborns in our community?

P5: The doopmal has to be really big. The entire world needs to know about the doopmal, the preparation. The doopmal itself was very traditional with the big pillow and the roses around and he had to have a specific outfit on and then not traditional in the sense that my husband gave his name.

R: Some of the traditions mentioned by other mother, is the doopmal, staying in bed for the first 7 days, being inside with the baby for the first 4 days, living with grandmother, getting lots of visitors and so on.

P5: Oh yes I heard about that, but there wasn't place by my mommy! I was told to stay in bed for 7 days, but it just didn't happen.

R: Which do you not agree with?

P5: The fact that everyone comes to help you, you really appreciate the support, but you also want to know that you can handle it on your own. I think the cool thing about staying with you mom is probably cool. I just wanted my mother. I think they all gave a certain basis, they all meant well. They all meant to assist the mother and that is what the mother needs, but she also needs time to adjust to the fact that she is now solely responsible for the care and stuff, so maybe not be overpowering at that time.

R: Tell me how does the family get involved with the newborn?

P5: For me it was very supportive. Everybody was, my mother-in-law she cooked and stuff. I didn't have to clean, and my mommy for the first 2 or 3 days, she was here the whole day and she helped me with the bath coz the day I came back from hospital I was very emotional because I suddenly realized I had no idea what to do, coz you come home and you think you really don't

know what to do. So you rely a lot on your mommy. My family, even his family was very supportive, allowed me to sleep when he was sleeping and assisted me when he was crying, come fetch him I cant handle it so..

R: Do you get many other visitors?

P5: Oh yes! Everybody! It's so funny because when you pregnant, everybody wants to see you. When you give birth, everybody comes to see the baby, its like you faded into the background.

R: What to you is the most important thing to consider when rearing your child?

P5: Establishing that bond firstly. To me it seems easier for the baby to establish that bond with the mother, but to establish he bond with the father to me was very important. I think in the future, its getting to know his faith is very important. Being strong in that, he knows what is expected of him. The head has to be strong and independent, but still enough not to be independent, to still rely on the parents for certain things. So the most important thing is his faith coz everything really stems from there

R: Tell me about the first time when you felt you bonded with him

P5: It was defiantly not after the birth. I was actually thinking about it the other day and the bonding for me was gradual. It wasn't there's the baby and now you bond with it. The time I spent with him at first, I didn't know what to do with him. And now everything is just natural. I don't think there was that one moment where I found ok that is where I bonded with him. It was everything, initially when I was breastfeeding, that in itself is a bonding. And when he started to smile and no he's starting to respond to me a little and react to thing and that just heightens the bonding.

R: Do you think that male and female babies or children are treated differently in our community?

P10: All babies when they born they given all the attention. As they grown older I think there's a difference rearing a boy and a girl. Like in the community, rearing a boy he needs to be independent and strong and he can walk barefeet. And if you have a girl they closed off and they tend to be mothered more.in any community I suppose they see the boy that needs to be strong, independent and can handle things. Whereas a girl she can be mothered, if she cries you can hugs her and if a boy cries you u just tell me to stop.

APPENDIX F6: Participant 6

R: When you are pregnant, what are your expectations about your new baby?

P6: The most important thing that you expect is for her to be healthy, that's the first thing that gets to your mind because I suppose for me as the mother that is the main thing, with all my pregnancies.

R: Personality? Looks?

P6: You looking forward and you do think who might the child look like because it's not all the time, you don't know how deep your generation goes also.

R: when you've just had your baby, what were your initial feelings?

P6: With each child that I had, especially when she was born, my emotions were very, I was very emotional, I cried when I saw her, it's not an easy road and yes by knowing that your child is born healthy with all five fingers on each hand and I suppose that is what makes you, made me very emotional when I saw her. It doesn't really matter what you're carrying, if it's a girl or boy.

R: What traditions are practiced around newborns in our community?

P6: I think the general tradition is more the name giving and what the baby's needs are, like the tradition is it has to have a pram, it has to have this, I think that is to me more, a lot of people base their whole concentration is on all those things except what if anything goes wrong at birth.

R: Some of the traditions other moms mentioned was that the mother must lie in bed for seven days and that she and her baby should stay indoors for 40 days. Also some girls go and live with their mothers. Looking at all the traditions, which do you not agree with?

P6: I'm not too keen on the doopmal story, reason being it's not such a big issue the namegiving for me it hasn't been. If there's one thing that could maybe be done away with is the namegiving look, it's only a tradition like you said, the 40 days and things coz it's not a must that the mommy must teach you for 40 days and really pregnancy is not a disease, you don't have to be seen to after your first 5 to 6 days if you had a normal delivery you're fine then you can walk around I mean even it's your first born and you're a strong mommy and then you can walk immediately after your baby has been born. It's really not necessary, you're not ill, it's just a condition.

R: How does the family get involved?

P6: Like my daughters they get into bathing her, my dad will spend a lot of time with her, even her dad. It's more, they get involved with bonding more with the baby than anything else. Physically that's how they get involved.

R: Do you still get many visitors?

P6: She's one month two weeks and I'm still getting visitors everyday. The funniest part is it's an old baby, somebody came to wake me up 11 o'clock this week to come and see her and she's very fortunate, she's even getting gifts up till now. She's got a closet full of clothing up to 2 years old. At the same time I believe each child gets born with their own riziq.

R: What to you is the most important thing to consider when rearing a child?

P6: I don't know how to put it to you. The most important thing is rearing a child with morals and goals. Ek wietjie hoe sê 'n mense in engels nie, like they say with imaan and aglaak, that is the most important thing. Yes education is very important but foundation starts at home. It's respect,

it's the goals and the morals and the child knowing right from wrong. You see it comes into this world and it's got no one else to look up to but you. So whatever you gona do wrong, the child is gona follow in your footsteps, so I feel it a very important job for the parent because that starts at home.

R: Do you think male and female babies or children are treated differently in our community?

P6: Sometimes I do yes. I suppose because the girl is the feminine side. The girl gets reared more gentle, boys get reared more harsh. Most important is the responsibilities also. I believe a parent can't promise a child something and not keep it because automatically the child will grow up making promises and not keeping it themselves, because nobodies keeping their promise.

R: Why?

P6: In the Islamic community it's different because we've got a culture and even in the black community, when we come amongst the whites its completely different. And I would say it's to do with the culture. Most important when it comes to Islam it's to do with the laws of the Qur'an and they say the shariyah which we have to abide by.

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APPENDIX F7: Participant 7

R: When you are pregnant, what are your expectations about your new baby?

P7: Basically I just wanted to have a healthy baby. You more excited about the idea of having a child. For me personally it wasn't about whether it was a girl or boy or how they look or what was going to happen. It was just that I would be healthy and him. I was fine so that was basically it, just asking everybody about what their experiences were and obviously everybody is different.

R: When you just gave birth to him, what were your initial feelings or reactions?

P7: to hold the baby, I wanted to be by the baby all the time and obviously overwhelmed. It was just a relief. It was excruciating pain. Once the baby's there you forget about everything. But literally I found you go through labour and it's such an intense pain and the baby just comes and you're fine and totally aware of everything.

R: Tell me about the first time when you felt you bonded with him, what was your initial bonding moment?

P7: well he breastfed a few minutes after he was born so from then already. You just went through all that and you feel emotional and you crying so you start bonding almost immediately when you start breastfeeding so that's how I felt.

R: What traditions around newborns are practiced in our community?

P7: I know the doopmal is like a massive thing. I know some people have where the woman doesn't go out for 40 days, you just sit there with the child at home and looking after the child.

R: Which of the traditions did you practice?

P7: well the doopmal we had, which is why I can't think of anything else coz that's what I do and basically nobody tried to force anything else down my throat.

R: Which do you not agree with?

P7: The 40 day thing I don't know if I don't agree with it, I haven't experienced it, but I'll feel very trapped. How do you feel for 40 days just being in one place doing the same thing everyday and I don't think it's healthy coz it's very depressing and depression is a major thing when it comes to mothers. It can become daunting.

R: Tell me how does the family get involved with the newborn?

P7: well they visit often. They take him off your hands for an hour or so and it helps. Makes you feel also when you have visitors that you have people to speak to, besides your husband, you see your husband everyday, you need other people since, even though I wasn't forced to stay at home everyday, you don't want to take the child out if the weather is bad, so having family around really helps.

R: How do you feel about visitors?

P7: you can't have too many visitors because I think it's bad for the child and you don't know what germs are around. Also the child sleeps most of the time when they're just born so they need some time to rest without being bothered. I think it's a bit much when people want to spend the whole day everyday with you. But it could be a help if one of the people pop by and they just gives you a breather and with conversation they make you relax.

R: What to you is the most important thing to consider when rearing your child?

P7: The most important thing I thought about is obviously keep the child healthy and keep yourself healthy and also to bond with the child so that type of thing in the beginning and then later you can think of their developments kinds of things to consider. Everybody wants their children to have good values and not be brats. To be stable children, they need to be disciplined, the need to focus basically, focused children that develop steadily. Obviously they will develop in their own way.

R: Do you think that male and female babies or children are treated differently in our community?

P7: I think so, I don't know if its in a negative way in the community. I know in the family generally it depends on whether they're in favour of either sex because a lot of fathers want boys or sons first and they will bond more with the boy a little more than a girl. I think its not a general thing, it's personal and each person has their own preference.

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APPENDIX F8: Participant 8

R: When you are pregnant. What are your expectations about your new baby?

P8: All that I, well I'm only just expecting that she's whatever it is, healthy and that the pregnancy goes smooth coz when I listen to other people, they always got such a lot of trouble so you always hope for that. And I always hope that or she is just healthy that's my expectations that I must have and the birth must be. I make lots of dua for that.

R; Personality wise?

P8: No, not really.

R: What are your initial reactions or feelings when you've just had your baby?

P8: I don't know how to describe this, you so excited and nervous, even though this is my 4th one, it's the same, you so excited and you scared coz if you think about all those things they must still go through then that's where the scared part come in, but the excitement takes over you and you look at them and you just can't help but be happy.

R: What are the general traditions around newborns in our community?

P8: Well the doopmal that's for sure, that's what I had a big one with her coz I didn't give a big doopmal for her and then it was a "big" thing. That in CT is something that you must have. It's like, my birth is very different from my sisters coz I had a home birth. I always had a home birth and I think that is something people are afraid of.

R: You say the doopmal is a huge thing, do you mean like with all the people there, and the baby is dressed in a special rokkie, with roses all around.

P8: Ja, you must have all that stuff and you don't have it, it's like (raises eyebrow).

R: Some of the other mothers also mentioned the 40 days one where the mommy must stay inside, um where the mommy must lie in bed for seven days.

P8: 10 days minimum.

R: and also they say that the mother must stays with their mothers

P8: I know about that also, but we don't have that. Ok I have my own house so I don't have to worry about, but I mean my mother in-law was here a lot and my husband was here but I think after the 2nd or 3rd day I was out already. I think it's all about how you feel coz why must you restrict yourself if you can move around why must you, you don't have to lie in bed, I mean if you not feeling well, but I was fine.

R: So you don't agree with when the mom must stay in the house?

P8: I think people who have c/s their story is completely different, I know coz when I speak to my friends and that coz their bodies must heal, I understand that but I mean if you have natural birth, usually within 2 to 3 days you fine, ok some people's experience is different, but mine, I'm really, I was on my feet within 2 or 3days.

R: Any of the other traditions you don't agree with?

P8: I think a tradition is all fair as well but at the end of the day it is your decision to make, whether I'm gonna give the doopmal or not. It doesn't matter what anybody says, it's between me and my husband.

R: How does the family get involved with the newborn?

P8: Well my mother in-law is here while I'm in labour coz she has to look after them. But this time she hasn't, coz she was born 10 to 12 the night so they were all fast asleep and my mommy usually come make food for me for the first couple of days or if she can't then my mother in-law for the first week and then after that I, my sisters they phone and ask, but mostly I rely on my mother in-law and my mommy.

R: Do u get a lot of visitors?

P8: Within the first week oh yes! Especially my husband's family lives close by so they were always popping in the first week and my sisters also go visit, I'm also like that I want to go so I can't exactly, but sometimes you just want to be, you want to sleep or do your own thing. But I know it's just for a first couple of days so I just take it as it comes.

R: What to you is the one thing that is most important when it comes to rearing a child?

P8: Manners, definitely. That is just something that I'm very, I mean I know some children are rude, but then you get rude and you get (waves hand) you know? So I always tell them, you can get angry and that but say it in a nice way so that you just come off. The children nowadays I mean (shakes head) it's just downright disgusting.

I mean manners you must teach from small they must grow up, especially my eldest son, I teach him and then because they follow him, I can see, if he start throwing tantrums they follow. So if he shows a good example and he gets it from me and my husband. If we show him ok this is the right way, coz sometimes it takes time for him to calm down. To me that is the biggest thing coz I believe once you get that right then they can learn from there.

R: and looking to the future?

P8: I think good manners takes you very far, that's something that I've learnt so, the other things will follow but for me that is important.

R: Ja the respect

P8: Ja coz children just don't have respect anymore. Ok I don't think I'm that old, but still I mean if you look at the children now (shakes head) it's just not the same. There's no respect.

R: Do you think that females and male babies or children are treated differently in our community?

P8: I think I is coz now 2girls and 2boys and somehow around the girls there's just, there's more. I can see it and you can't deny it and I don't know why. For me it's the same, I can't, I dunno why I think people's always girls is more cute, they would always say oh she's so cute and then the boy, I dunno, for me it's just different. They treat them differently. With girls I think it's like that because girls is mos delicate creatures boys is maar just like ok. Girls as they grow up older there's more restrictions on them compared to boys, sometimes you look at it and think it's just not right but that's just how it is, that's how our religion is. Sometimes you think it's just not right but when you read up on it you understand why.

R: When was the first time you felt you bonded with your baby? Tell me about you initial bonding moment.

P8: No, she's on me immediately, she's just out and then they put her on me immediately and then they cut the cord and the placenta, but I mean, I think when they put her on me then it's like she's actually out, that for me when you first see her and she's lying there with all that blood but it doesn't even matter coz then it's real I mean for the 9 months you carrying her, you know she's there and everything, but I mean its not, but when they put her on you and she's lying there, she's amazing.

R: it seems overwhelming

P8: It is, I think I get more overwhelmed once she's out before they put her on me when she's out you feel a sense of relief coz she's out and the pain is gone obviously, and just to think for yourself, it actually came out of you I think that's what you feel when you – it's so much to take in once she's out I mean it's unbelievable. There's no feeling like it. When she's out and everything is there that must be there, and she's healthy and go fine. Its an amazing experience

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APPENDIX F9: Participant 9

P9: My first experience with this baby now. With my other two children I was long in labour. The first one wasn't sickly, but the second one with the chest, and he had TB, with this one I hope he not gona, but he's fine, its only the, I asked the Dr about his, this drinking and the nurse told me its coz of his drinking woman, but otherwise he's fine.

R: Do you think about what the baby is gona be like.

P9: Oh I was thinking bout everything, I don't mind, but some people told me he's gona be a moffie or that, but its my baby, don't worry about what to feed because its my baby I will grow him up.

R: Did you give normal birth? Or?

P9: yes, I did give normal birth yes.

R: What were your first feelings or reactions when you just had your baby?

P9: Dua, dua I make and that the baby can be smooth out, Allah must put me through the pain and that the baby don't come out with one ear, or that, but hy't baie mooi uit gekom. I'm feeling glad and that and my stomach I'm feeling nothing and hungry after birth, you very hungry after birth. The thing is the feeding for the baby is a little bit sore, but this is the first child I'm looking after now coz the other two I didn't look after them, my first time I got the experience and all of that how to (breastfeed) him.

Yes, they take the baby out and they first wash him and that then, when the baby come out your eyes is open and you see your child, they put the baby first on your breast and that, then they wash him, then they go into the incubator to get a little bit warm, see the baby's got his penis and everything. When he was laying there. Many people say that retreat isn't nice to give birth but it is nice to give birth there, you must just work with them and they work with you.

R: When did you feel you had your first bonding moment?

P9: The first time the baby is coming out. Coz you're waiting for 9 months you don't know if the baby's coming out dead or alive.

R: Tell me about traditions in our community around newborns. For example, other moms spoke about the doopmal. Can you think of what else people do?

P9: You going all out when the baby's, you don't have to go all out when you don't have money, because with all my children I was at home. I don't have money that's why Imam coming in and give name and cut his hair and everything and make dua, but otherwise the people go all out with the dress and the roses and give paaltjies, you don't have to do it if you don't have money, that's the thing.

R: Ok, some of the other traditions mothers mentioned was that you cant go out for 40 days, you must lie in bed for the first seven days.

P9: Nool With her (eldest) I give birth Wednesday, Thursday she must go see clinic, they say every three days, otherwise I walk with them, you must close their heads in then. With him I was, with the other one (son) I was everyday in the street with him, before 12 you must come in the house yes. That's all things and before 4 o'clock you must bath them, you cant bath them after 4.

R: So you don't agree with all that old traditions

P9: (shakes head no) Its new generation

R: Tell me how does your family get involved with the new baby?

P9: It was my sister, the night I gave birth, every child I have my sister is bathing them, because I don't know how to bath the baby with this needle, I don't know and after that I was, with him I bath him, because I must mos learn so next time if I have another baby I will know how to deal with things like that.

R: So she helped you a lot in the beginning?

P9: Yes. Only for three days, after that when his needle is off then I must deal with my own baby.

R: Other your family? Your mother?

P9: Yes she's help me a lot. I'm working and she's looking after the one. I can't give all to her coz she's also sieklik and that I cant do that. I give Ameer to my mummy and the other one to her.

R: Do you get many visitors to come see the baby?

P9: Yes all my friends and that, but otherwise I'm just sitting here in the house. Or I go to my friends because I have a lot of friends who drink and I told them they mustn't come in here because there's mos salaah people here that's why.

R: How do you feel about having the visitors?

P9: I first ask them if they drinking, if they say yes, I say ok I'm coming down to you because you must have respect for my mother also. She don't mind, but she cant stand the smell.

R: What to you is the most important thing to consider when rearing a child?

P9: Respect. Don't touch. When you come into other peoples house and the child is coming, touching on the TV, the peoples don't like that. They say yes it's ok leave them, but when you leave they talk.

APPENDIX F10: Participant 10

R: When you are pregnant, what are your expectations about your new baby?

P10: That she's healthy and that especially when I was pregnant, I just wanted it to be, towards the end. I just wanted it to be over with.

R: and personality wise? Looks? Did you ever think about that>

P10: No I don't actually worry about that. I don't like surprises so I wanted to know from the beginning what it was. So I went for that scan at 2 months even I went and the Dr wasn't wrong, it was a girl, but it didn't matter either one, although I'm happy it's a girl, I like girls.

R: When you just gave birth to her, what were your initial feelings or reactions?

P10: She's ok, its over, actually it's a relief that its over. It takes a few minutes and you're lying there and you don't know what's happening coz you cant see everything, but that she was healthy and that it was over

R: What are the general traditions surrounding newborns in our community?

P10: I don't know really. I think everybody handles babies differently. You know they always tell you, you mustn't listen to your mothers and the grandmothers but I think you do, your mothers they do know, they did raise babies before, they do know a little about that so if thy wana give you advice and they wana tell you stuff, you don't have to take it, but sometimes it does work, it does help, so that passing of advice, don't put them off and listen to them coz sometimes they do have sound advice.

R: Some of the traditions mentioned by other mother, is the doopmal, staying in bed for the first 7 days, being inside with the baby for the first 4 days, living with grandmother, etc. Which traditions did you practice?

P10: We had the doopmal, I didn't want one initially coz I said I'm gonad come from hospital, I'm gonad be tired, I'm gonad be sore, I don't know..so I said to my husband, you and my mother can organize it, don't involve me or anything coz I know what kinda person I am. I'm like don't ask me nothing. The same day I came home from hospital I had it so the sooner the better, then its over and done with coz they wanted to have it. They invited everybody, and they borrowed somebody's midorah, the neighbour's opposite coz hey had to have one of those and put flowers on and take photos. Ok, I didn't want one coz to me it doesn't matter either way its not important, but no, you must have one and its important so I was kinda bulldozed into it. The whole 40 days thing I don't take much note of. I think I went out after 3 weeks and I went to work and showed her off to my colleagues. I think she was 3 weeks old, and we went shopping do that 40 days I don't pay much attention to that. I don't really pay much attention to that staying at home coz you get so claustrophobic, you feel like the walls are closing down on you and you looking at the same four walls. No, you need to get out and life revolves around the baby so you need to see other people.

R: Tell me how does the family get involved with the newborn?

P10: They are very much involved like babysitting, especially like here, with my first baby I was very like, "don't touch my baby" I was very paranoid, but with this one, "oh please, take her, let me get some sleep". So they like to take her and hold her and walk her up and down. So they interact with her. I've got lots of sisters and brothers, they're always here, lots of children around and lots of people.

R: Do you get still get many other visitors, beside now your brothers and sisters?

P10: That's why I wanted to have the namegiving immediately so that the visitors would be here and gone and then I wouldn't have to see them again. That's why I said as soon as possible when I come home from hospital, so I don't get visitors again, I don't really like visitors.

R: What don't you like about visitors?

P10: Their bodies do get sore so it's like going from one arm to another arm. You have a routine, they say you need to put your baby in a routine like she was, every 4hrs she had to get a feed and then there this one holding her. I like to be alone when she's getting a bottle, you don't want disturbances.

R: What to you is the most important thing to consider when rearing your child?

P10: Their safety, their wellbeing, teaching them life, teaching them about their religion, their family background, to me that's very important and just interacting with them. To me that's important, teaching them everything you know and trying to better what you know and keeping them happy.

R: Looking to the future, should they leave the house one day, what would you like them to leave with?

P10: Just a good sound religious background, that they mature and responsible adults. That they'll act responsibly in any situation that they are put in. that they won't, that they'll be independent. That they won't need anybody or anyone that they can see to themselves and stand on their own two feet. That they can have that independence and not forget their religion.

R: Do you think that male and female babies or children are treated differently in our community?

P10: From what I can see from my brothers and sisters, they've got boys. They treat their babies exactly the same so in our family the babies get treated exactly the same. But I can see it, I do see it happening, they tend to let the baby boy, he's like the boy so the daddy tends to treat him differently and he's special and they do tend to spoil him more. When they're older they do tend to place more restrictions on the girls than the boys. The boys you can do whatever you want to do and it'll be ok, but if a girl does it, then it's not ok. So there is a distinction.