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

A summary of the Masters dissertation submitted by

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INTRODUCTION

Infant mortality rates in South Africa are high and in order to deal with this issue, the South African Minister of Health, Dr Aaron Motsoaledi, issued the *"Tshwane Declaration of Support for Breastfeeding"* in 2011. The declaration emphasized that exclusive breastfeeding for the first six months of life would be promoted as an intervention to decrease infant mortality. The South African government adopted an exclusive breastfeeding policy for all mothers, including HIV-positive mothers[1]. In adopting the new policy, the declaration states that the distribution of free infant formula would therefore end (Department of Health, 2011). Since 2001, the government had provided HIV positive mothers with free infant formula as a way to prevent mother to child infection through breastfeeding (Ijumba et al, 2013). In 2003, the World Health Organisation (hereafter WHO) published guidelines on HIV and infant feeding, recommending that HIV infected mothers bottle-feed (WHO, 2003). Since then, new evidence has emerged that antiretroviral (ARV) interventions to either the HIV infected mother or HIV exposed infant could reduce the risk of post-natal transmission of HIV via breastfeeding (Iliff et al, 2005; Coovadia et al, 2007; Kuhn et al, 2007; WHO, 2010).

The recommendations were based on research that supports breastfeeding and its ability to keep infants safe. For example, according to Doherty et al (2010:62-63), breastfeeding offers many benefits in addition to reducing the risk of HIV transmission for HIV infected mothers. Drawing from a study conducted in South Africa's Prevention of Mother to Child Transmission (PMTCT) sites, Doherty et al (2010:62-63) argue that infants between zero to five months who are not breastfed have an increased risk of death from diarrhoea and pneumonia compared to infants that are breastfed exclusively. Moreover, infants that are mixed-fed have an increased risk of malnutrition and illnesses such as diarrhoea and pneumonia. Doherty et al (2010:62-63) argue that exclusive breastfeeding reduces infant mortality and morbidity associated with infectious diseases both in resource poor and rich settings. Breastfeeding has also been associated with reduced risk of asthma, obesity in childhood, lowered systolic blood pressure, reduced risk of type 1 diabetes, reduced atopic and allergic respiratory diseases up to age 17 (Wilson et al. 1998; Oddy et al. 1999; Sadauskaite-Kuehne et al. 2004). Therefore, the research cited and the language used shows that the promotion of exclusive breastfeeding is indeed a way of addressing the risk of infant mortality and one that the South African government supports.

Although many infants in South African are breastfed, many are not breastfed exclusively. Exclusive breastfeeding is a method chosen by few women (Department of Health, 2011). Evidence shows that despite a number of child health programmes, interventions, current policies and recommendations on breast feeding, such as the 2011 *Tshwane Declaration of Support for Breastfeeding in South Africa*

[1] I am aware of the different questions and concerns around HIV- positive mothers and breastfeeding. However, given the scope of this dissertation and the fact that I did not work with HIV- positive mothers, I do not discuss those issues in this thesis.

and the 2010 WHO *Guidelines on HIV and Infant Feeding*, rates of breastfeeding, especially exclusive breastfeeding, remain low in South Africa (Department of Health, 2013). Data from the 2013 South African Demographic and Health Survey (SADHS), and other studies indicate that although initiation of breastfeeding early post-delivery is a common practice, mixed feeding rather than exclusive breastfeeding is the norm, with some infants reported to have received complementary feeds before the age of six months (Department of Health 2013).

RESEARCH QUESTION

As a response to the factors mentioned above, the Health Impact Assessment unit (hereafter HIA) of the Provincial Government of the Western Cape, South Africa, approached the University of Cape Town (hereafter UCT) Knowledge Co-op with a central question: why do many women not exclusively breastfeed their infants for the first six months of life? (UCT Knowledge Co-op, Project #81, 2013)[2]. In order to begin answering the question posed by the HIA it was necessary to trace women's understandings and practices of breastfeeding. As a way to begin engaging with the question at hand, my research question was twofold: Firstly, what were women's experiences of breastfeeding and infant feeding? And secondly, what influenced women's infant feeding choices? I explored the local knowledge that existed around breastfeeding and infant feeding that influenced infant feeding decisions and that acted as a barrier to exclusive breastfeeding. I also looked into notions of good mothering and how they influence infant feeding choices. However, after weeks of field work, I realised that a focus on understanding infant feeding in order to address the issue of infant mortality was too simplified.

The question of infant mortality is one that deals with the loss of life. The risk of the loss of life is one that concerns everyone. However, a focus on exclusive breastfeeding was too limiting. It did not allow for a depth understanding of life and how, in the face of potential death, mothers keep their children alive. The question of exclusive breastfeeding closed spaces to engage with understandings of life itself and the different ways that one can sustain the life of their infant. Equally, it ignored the different actors beyond the mother that are involved in sustaining infant life. I therefore explored the different actions/behaviours that the mothers did with the aim of nurturing and protecting their infants from harm. I did this in order to allow for the opportunity to gain different kinds of knowledge about infant feeding and child care as opposed to a focus merely on exclusive breastfeeding and its barriers.

Drawing on notions of managing risk, my dissertation shows that in a world where life is precarious and always at the risk of death due to illnesses, poverty and other social ills that reflect the political economy of the different spaces, child care is about sustaining the life of an infant or protecting this

[2] http://www.knowledgeco-op.uct.ac.za/kco/proj/current

life from being lost. In arguing this, I explore the different ways that the state (in this case the Department of Health) and mothers imagine themselves to be sustaining infant life. Furthermore, I examine the complexities that arise when the state in conjunction with other external health institutions and the mother together with family and friends imagine the process of sustaining that life differently. This dissertation argues that infant feeding choices embody the different discourses that surround 'sustaining life'. In doing so, I demonstrate the ways that the state, represented through the Department of Health and Khayelitsha residents imagine firstly, sustaining infant life and secondly, managing the risks in the life of the infant. In this dissertation, I argue that the introduction of exclusive breastfeeding policies is one manifestation of state ideas on how to sustain life, and in contrast, the introduction of medicine and complimentary feeds reflects how mothers sustain the lives of their infants.

LOCATION OF STUDY AND PARTICIPANTS

I conducted my field work in Khayelitsha. Khayelitsha (translated from isiXhosa meaning 'new home') is about 35 kilometers from the Cape Town city centre and is the second-largest township[3] in South Africa. According to the City of Cape Town – 2011 Census[4], Khayelitsha had a population of 391,749. The demographic makeup of Khayelitsha is approximately 90.5% Black African, 8.5% Coloured and 0.5% White, with isiXhosa being the predominant language of the residents. In 2011 about 62% of residents were rural to urban migrants and mostly coming from the Eastern Cape. Khayelitsha is also one of the poorest areas of Cape Town and the median average income per family was R20, 000 (US$1,872) a year compared to the City median of R40, 000 (US$3,743).

This dissertation is based on the lives of six isiXhosa speaking women from Khayelitsha -Sontombi, Nolwazi, Thandiwe, Vuyiswa, Dumisa and Andiswa. My field work spanned from March 2014 to June 2014 and consisted of face to face interactions, as well as online interactions. I then returned to field work in December 2014 to February 2015. At the time that I conducted field-work, the children were between the ages of two days and 2 years old and the mothers I worked with were between the ages of 24 and 40 years old. I chose to do my research in Khayelitsha because it was one of the areas identified by the HIA as an area that had capacity and a need for research on exclusive breastfeeding. I worked with Xhosa speaking women because of the dominance of the language in Khayelitsha and because it is also my mother tongue. This made it easier for me to communicate with my participants without concerns of a research assistant or putting my participants in a position where they had to step out of the comfort of speaking one's mother tongue. I chose six women because in conversations with

[3] In South Africa, the term township usually refers urban living areas that are often underdeveloped. These are usually built on the periphery of towns and cities and dominant residents are usually non-whites (black Africans, Coloureds and Indians) - formerly officially designated for black occupation by apartheid legislation

[4]https://www.capetown.gov.za/en/stats/2011CensusSuburbs/2011_Census_CT_Suburb_Khayelitsha_Profile.pdf

my potential participants, I realised that child care is not a task only dealt with solely by the mother. Other family members suggest things and play a role in how the child is fed, bathed or any other child care activities. Although the mothers were my main participants, I spent considerable time with other family members.

METHODS

- Participant observation
- Facebook and WhatsApp conversations
- WhatsApp chat group
- Using WhatsApp and Facebook updates, posts and conversations as stimulus for our face to face conversation.
- Face-to-face informal interviews
- I also used voice recording when I could.
- Pictures

FINDINGS: BARRIERS TO EXCLUSIVE BREASTFEEDING

- Physical challenges (sore breasts, inverted nipples, back pain)
- Mothers were not confident about their milk supply and described how their infants were particularly hungry and demanded more milk than they could supply.
- Nothing bad will happen if I mix feed
- Work
- School

HOW THE STATE VIEWS BREASTFEEDING

- Exclusive breastfeeding is lifesaving
- Good (responsible) mothers exclusively breastfeed
- Incentives for practicing exclusive breastfeeding (Mother and Baby Friendly Hospital Initiative)
- Regulations Relating to Breast-milk Substitutes Promotion

HOW MOTHERS KEEP THEIR INFANTS SAFE

- Need to introduce medicines. (The most popular medicine was gripe water, saccheroi and *umthi wenyoni*)
- Water is life - for infants to quench their thirst and because it is healthy.
- Need to introduce food (solids)
- A well-fed looking baby

It was clear that the mothers had different priorities and concerns, and as a consequence, they conceptualized their children's bodies and health in different ways and as a result, acted differently from expectations of nurses. Mothers were taught that breast milk is sufficient when they visit the clinic. However, they had concerns about their children having enough food and improving the digestive function of their babies by introducing solids. For the women I worked with, there were also different goals to be achieved with food. They also wanted to achieve a big beautiful baby, a notion subjective to each mother, and healthy babies. These according to them, could not be achieved by exclusive breastfeeding which lead the mothers to pursue complementary feeds for their children.

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

CONCLUSION: WHO TO TRUST

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

> 'Nurses advise you to do things they do not do with their own children. They say the child must not have water whilst older people say the baby gets thirsty and needs water. And this thing of breastfeeding exclusively for six months, children do not get enough; you will find them crying all the time hungry because milk is a liquid… '
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> Still on the topic of who the mothers look at for guidance Dumisa followed and said: 'I have been told things by my cousin's mother. If I do not understand something, I ask the lady who

babysits for me or ask the baby's father who then asks his uncle because he was a manager at ABC clinic[5] on the children's section'.

From both comments, we can see that the mothers have multiple sources of information that they are in a position to pick and choose from. They draw on their different networks to get information on how to care for their babies. We can also see the level of distrust of how genuine the nurse's intentions and information is. Furthermore, mothers did not simply take on the guidance but also used their own experience and own initiative when deciding on what to do. After explaining that the baby's father's uncle who worked in the clinic told her to stop breastfeeding all together[6]- if she does not have the time to exclusively breastfeed, she must exclusively bottle feed, he said. Dumisa still mixed fed and said…' but I give him milk and breast milk, he is not sick'. Dumisa continued with this train of thought when I asked if the nurses had not explained feeding information to them, she said 'They do but sometimes they say crazy things because nothing bad happens to the baby'.

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

Ziyanda: So did they talk about exclusive breastfeeding at the clinic when you were still pregnant and after you gave birth?

Nolwazi: Yes, they said when breastfeeding, you must not give water to the baby but you know we get home and listen to our mothers because I was even going to give the baby formula but she [her baby] did not like it.

Ziyanda: So when did you give her water? Were you listening to your mother or mother in law?

Nolwazi: In December I went home to Eastern Cape and they [her mother and aunts] said I must give her water, she was two months old.

[5] Not the real name of the clinic

[6] According to the WHO (2010) Guidelines on HIV and Infant feeding, there is evidence from non-HIV settings that mixed feeding is associated with increased morbidity and mortality.

Ziyanda: What reason did they give, like why do you need to give the baby water?
Nolwazi: I don't know hey…

Mothers do not necessarily disagree with what nurses tell them about infant feeding and the benefits of breast milk and decide to actively rebel against it. In fact to a certain extent, they embrace it and take the nurses' advice into account. Instead, the mothers I worked with were being pulled by different knowledge about babies from health professionals, family and friends which led to mothers choosing to listen to whom they trusted and believed had the best interests of their baby at heart. This suggests ideas of who the mothers consider to be a knower and also the impact of differing knowledge on the ability for a mother to exclusively breastfeed. There is an idea of the grand mothers' experience in being a mother and raising healthy babies as important, that frames the grandmother as a person who is a knower or has knowledge about infant feeding. Although nurses are also seen as knowers to a certain extent, there is an additional element of the grandmother not only being a knower by experience but also being a knower a mother can trust. When the expectations and requirements from nurses clash with knowledge from grandmothers and friends, mothers then draw on their own experience and take initiative to decide which option is better for their baby.
An example on the issue of trust, Dumisa said: "The nurses advise you to do things they do not do to their children. They say do not give the baby water while older people [mother and aunts] say a baby gets thirsty and needs water. And also this thing of breastfeeding exclusively until six months, children do not get full and they cry because they are not full, milk is liquid"

This demonstrates that the mothers are receiving or one can even say being pulled by different ideas of child care. There is a level of trust between mother and grandmother so much that even though one has no idea what some of the medicines are for, they would give it to their child if their mother said so. Mothers place a great deal of agency in their infant, more so than the DoH is prepared to acknowledge in their public health messaging. In fact public health messaging places the agency of breast feeding and 'life saving' in the sole hands of the mother, with little regard to her lived reality or welfare and devoid of context. The creation of a good mother, does not account for the different kinds of sacrifices made by women who do not exclusively breastfeed. It also does not recognise the efforts made by mothers such as introduction of medicines and complementary feeds with the purpose of keeping their babies safe as an indicator of good mothering. Instead, these mothers are seen as non-compliant and therefore bad mothers. They continue to carry the 'blame' for their 'ignorance' as opposed to the blame being laid at the door of socio-economic conditions.

Infants are able to express likes and dislikes towards food and therefore shape the mother's ability and desires to breast feed. Equally, babies' cries indicate their hunger. Breast feeding becomes a dialogic process. Hunger is an aching reality in everyday South Africa, so it is little surprise that a baby's cry

when positioned against a mother's pressing desire to 'lure her child into life' will be understood through a framework of hunger. Mothers view food as medicine in itself, making their babies stronger, beautiful.

RECOMMENDATIONS

- The DoH (and researchers) need to pay more attention to a babies' agency and the way this is expressed through the lived conditions of their mothers.
- Mothers must not feel accused of not doing their best in caring for their children. There needs to be careful thought around the questions asked and language used. For example, "Does this baby like breast milk?" is less threatening than "do you breastfeed as recommended by the DoH?"
- There is a need for more knowledge around exclusive breastfeeding. Mothers were not always aware of the importance of exclusive breastfeeding which made it difficult for them to stand up for it when grandmothers suggested alternatives.
- The mothers were not equipped with enough knowledge to understand the difference between breastfeeding and exclusive breastfeeding and how to respond to grandmothers' differing opinions on infant feeding.
- There is also a need to include grandmothers in the messaging on infant feeding. The mothers see their own mothers as knowers and as people they trust to know what is best for the baby. In order to enable mothers to exclusively breastfeed, grandmothers need to also understand exclusive breastfeeding. The information cannot only be aimed at mothers and would be more effective if it is understood by the grandmothers that are already trusted and seen as knowers/experts in child care by the mothers.
- Exclusive breastfeeding was presented to them as an option or a choice and not as something that is really important and so the mothers did not think of it as something that is more important than other forms of feeding.
- Recognise and talk about personal and cultural issues that affect mothers - Such issues, along with many other cultural and personal issues need to be recognised and addressed when mothers are being told about exclusive breastfeeding instead of focusing only on the biological health benefits because the mothers need to know how to answer the tough questions when they get back home from the hospital and those questions and concerns are not just about the biological health benefits of breastfeeding.

PARTICIPANT Pseudonym	RECRUITMENT PROCESS	AGE	OCCUPATION	NUMBER OF CHILDREN	PERIOD OF EXCLUSIVE BREAST FEEDING	START OF MIXED FEEDING	OTHER FAMILY MEMBERS I ENGAGED WITH
Sontombi	Cousin	40	Stay at home mother	5	Less than 2 months	Less than 2 months	mother
Nolwazi	Met in a taxi	Early 30s	Student	2	2 months	At 2 months	none
Thandiwe	Stays in the same street	27	Student	2	6 months	After 6 months	none
Vuyiswa	Family friend	29	Grade R teacher	1	2 months	At 2 months	mother
Dumisa	High-School friend	25	Student	1	3 months	At 3 months	none
Andiswa	High-School friend	25	Student	1	2 days	On day 2	Mother and aunt