

BREASTFEEDING PATTERNS OF HIV POSITIVE MOTHERS IN THE CONTEXT OF MOTHER TO CHILD TRANSMISSION IN KWAZULU-NATAL

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the degree of Master of Arts in Gender Studies in the
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Declaration

I, **Thoko Cecilia Ndaba** (Registration Number 941333554) hereby declare that, unless otherwise indicated, this thesis titled ***Breastfeeding Patterns of HIV Positive Mothers in the context of Mother To Child Transmission in KwaZulu-Natal*** is my work and has not been submitted in part or in full for degree or any other purposes at this or any other University or Institution.

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Abstract

The focus of this thesis is to look at breastfeeding patterns in KwaZulu-Natal province, South Africa in relation to HIV infected women, who as mothers may, transmit the HIV virus to their child. It seeks to understand in depth the social context of HIV and AIDS in the time of the AIDS pandemic looking at gender culture; powerlessness of women in households in society. These dynamics occurring at such a crucial time and moment of this spiral explosive epidemic reflects a more broader concerted effort to understand and find solutions.

This study emerges from a larger research project conducted under the auspices of the Medical Research Council, which was examining the transmission rates of HIV infection in babies born to HIV positive woman for a period of six months, on breastfeeding having given these women nevirapine as well. The study was HIVNET 023, which looked at the use of NVP that was given to breastfed infants in order to reduce MTCT of HIV, Phase 1,11 Study. This work was conducted from 2000 and completed in 2001. This thesis seeks to further explore challenges experienced by these breastfeeding HIV positive women in the public domain (i.e. in the clinics, hospitals as well as in communities), and how these challenges impinge in their daily lives as women. Issues of gender inequality, the social context of culture in the midst of a health crisis, and suggestions for change in the context of clinical practice, make up the bulk of the thesis argument.

Graphs

Table 1: Comparison of infant feeding choices between rural / peri urban and urban sites

Source: Interim Findings of the National PMTCT Pilot Sites: Lessons and Recommendations. Health Systems Trust

Table 2: Vertical Transmission Rates

Source: Interim Findings of the National PMTCT Pilot Sites: Lessons and Recommendations. Health Systems Trust

Figure 1: HIV Positive Women in the ANC

Source: Nelson Mandela/ Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioural Risk

Figure 2: HIV Prevalence by Province, South Africa 2002

Source: Nelson Mandela/ Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioural Risk

Figure 3: Comparison of HIV Prevalence Levels by Province with the Department 2001 ANC Survey

Source: Nelson Mandela/ Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioural Risk

Figure 4: HIV Prevalence in Adults (15 – 49 years) South Africa

Source: Nelson Mandela/ Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioural Risk

Figure 5: Prevalence of HIV by age, South Africa 2002

Source: Nelson Mandela/ Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioural Risk

Figure 6: Prevalence of HIV by sex and age, South Africa

Source: Nelson Mandela/ Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioural Risk

Abbreviations

ARV	-	Anti-retroviral
AIDS	-	Acquired Immuno Deficiency Syndrome
ANC	-	Ante Natal Care
ARV	-	Anti-retroviral
AZT	-	Zidovudine
C/S	-	Caesarian Section
HIV	-	Human Immunodeficiency Virus
HIV+	-	Human Immunodeficiency Virus positive
HIV-	-	Human Immunodeficiency Virus negative
MTCT	-	Mother To Child Transmission
MRC	-	Medical Research Council
NVP	-	Nevirapine
PACTG 076	-	Paediatric Aids Clinical Trial Group
PLHA	-	People Living with HIV/AIDS
PNC	-	Post Natal Care
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
TAC	-	Treatment Action Campaign
UNICEF	-	United Nations International Children's' Fund
VCT	-	Voluntary Counselling & Testing
WHO	-	World Health Organisation

Introduction

1. Contextualizing Breastfeeding Patterns within an HIV/AIDS era

It is true that we have never had a disease free world. Having acknowledged the above statement, it is also a fact that diseases have affected, and infected human beings to a lesser and greater degree across all regions of the world. Some diseases have succumbed to treatment and cures and have disappeared over time. Some diseases from the past are still with us and are treatable. For example, medical history informs us that syphilis was one of the diseases that took generations of scientists to find a cure only in the 20th Century and did penicillin produce this effect. Despite its terrible global toll syphilis (a key sexually transmitted infection in many parts of the world in the last several hundred years) never had a mortality rate anywhere near what we see today in human immune deficiency virus and acquired immune deficiency syndrome (HIV/AIDS).

HIV and AIDS has been one of the worst epidemics that have ever been experienced by human kind in the world. It is the world's worst enemy ever experienced with extremely high infection rates resulting in high mortality rates across the board. The increased number of deaths are currently and continuously threatening the social security, the world economies, the institutions, namely education, the church, families, the corporate sector, etc.

The speed of its expansion is because, in many ways, HIV/AIDS was a pandemic waiting to happen in South Africa. Ten years ago Zwi and Cabral (Marks, 2002:17) argued that we needed “a new term – high risk situation – to describe the range of social, economic and political forces that place groups at particularly high risk of HIV infection”. They culled a number of features from a variety of settings in order to characterise what they termed “high-risk situations”: impoverishment and disenfranchisement, rapid urbanization, the anonymity of urban life, labour migration, widespread population movements and displacements, social disruption and wars, especially counter-insurgency wars. Broadly speaking, they suggested that in many of these situations, where daily survival may be precarious and social bonds loosened, there tends to be “diminished concern about health [or at least diminished access to health care], increased risk taking and reduced social concern about casual sexual relationships”. Transactional sex may be a crucial socio-economic as well as an emotional prop, and it is frequently characterized by unequal gender relations. Alcohol, drug misuse and high levels of sexually transmitted diseases (STDs) are all likely to be present in such circumstances (Marks, 2002:17).

On any scale of “high risk situations”, South Africa in the 1980s must have ranked near the top: its black populace experienced every one of Zwi and Cabral’s “high risk situations”. Given its underlying health conditions and its levels of social dislocation in that decade, it took no great precedent to predict that AIDS would wreck havoc in South, indeed Southern, Africa if and when it

entered the region. As a number of progressive doctors and social scientists warned already in the middle of that decade, it was simply a matter of time (Marks, 2002:17).

Since the beginning of AIDS epidemic globally, there has been an increase of the HIV infection, targeting people of all ages, race, and gender, poor and rich, educated and illiterate. This infection knows no boundaries of social class and status.

The World Health Organisation AIDS Epidemic Update records as of early 2002 that:

There are 42 million people living with HIV/AIDS world-wide. 38.6 million of these are adults, 19.2 million are women and 3.2 million are children under the age of 15. Five million new infections with HIV occurred in 2002 of which 4 million were adults and 2 million of them were women. A total of 3.1 million people died of HIV/AIDS related causes in 2002 (AIDS Epidemic Update – WHO & UNAIDS, 2002:2).

Sub-Saharan Africa, that, includes South Africa, has the highest number of HIV positive individuals (29.4 million people living with HIV/AIDS) followed by South East Asia (6 million). In North America there are 980 000 people living with HIV/AIDS, 570 000 in Western Europe and 1,2 million in Eastern Europe and Central Asia respectively. The number of HIV positive individual in Australia and

New Zealand has remained constant since 2001 at 15 000 people. In Latin American and Caribbean the figure is 1.5 million and 440 000 respectively. East Asia and Pacific have 1.2 million people living with HIV/AIDS. North Africa and Middle East have 550 000 living with HIV/AIDS (AIDS Epidemic Update – WHO & UNAIDS 2002:2).

South Africa has been the last country in the African continent to see the infection spreading like wild fire and highly uncontrollable. The first person that was diagnosed with HIV, a rare viral infection was in 1981 at King Edward VIII Hospital, Congella, Durban (Inaugural Address by Prof W Makgoba, UND, 2002). The kind of symptoms that this patient had were not so common but this infection was new and needed a lot of investigations, but according to what we know now that meant that the giant killer virus was already in the country, even ten years earlier.

Looking at such shocking statistics stated above, this thesis is going to focus on breastfeeding patterns of the babies born to HIV positive mothers. The study will focus particularly on vertical transmission (mother to child transmission). We now know that HIV positive mothers can transmit this infection to their babies through breastfeeding. The act of breastfeeding thus becomes a major public health issue both at the national and international level. International agreement has been achieved on the best infant feeding: breastfeeding is seen as the best form of infant feeding because of all its immune factors and nutrition as well as

ensuring bonding of mother and the infant. Breastfeeding has its cultural roots embedded in communities, and across the world methods of breastfeeding developed over generations cannot be wished away in the context of medical crisis (<http://www.lactations.com>). Yet, despite continuities in ideas and cultural meaning over generations, breastfeeding practices can also shift dramatically in one generation with migrations. Ideas about, and practices of, breastfeeding can and have changed and have responded to urgent commercial and social pressures. With the urgent context of HIV AIDS the long slow work of describing and analyzing breast feeding data (through ethnographic and other observations and recorded interviews) has been under pressure. It has become very important to look at ways and means of preserving health promoting practices of breastfeeding and finding ways to protect these practices when and where these exist, and to figure out how to sustain this protection in the era of mother to child transmission. (MTCT)

Two examples of this are:

- (1) the changes in status around breastfeeding brought by commercial drive by Nestle' and others in the mid 20th Century to promote their milk substitute powders (<http://www.geocities.com>), and
- (2) the fixation with "feeding on a time schedule" in the 1920 – 1960 era in many western clinical settings (<http://www.lalecheleague.org>).

The hope of this study is that a better understanding of breastfeeding in South Africa today can help public health authorities design progressive health promoting and women empowering interventions, e.g. public health implications.

2. Scope of the study

This study is going to cover the dynamics involved in breastfeeding patterns of isiZulu speaking HIV positive mothers in the Durban area, KwaZulu-Natal (KZN). It is divided into the following chapters and they are broadly structured as follows:

Chapter one will look at the HIV context globally and in South Africa and further outline how the issues and debates have developed over time. The chapter serves as an introduction to the entire thesis and the arguments that it will follow and engage. However, it is vital to mention the fact that debates referred to throughout the study have been chosen because they take into account the contributions that gender bias, inequalities and lack of equity have made to perpetuating the situation that the world's people and South Africans find themselves in as we face this epidemic. In these contexts women often carry the greatest health and social burdens of HIV/AIDS.

Chapter two will review literature covering debates around breastfeeding in general and dynamics in breastfeeding in the context of mother to child HIV transmission. The chapter will explore how breastfeeding practices and cultures

form part of gender and power relations, and take into account the extent of choice open to women and families, human rights issues, as well as debates about the extent of influence in breastfeeding of “natural” and “cultural” factors. The chapter continues to look at studies done locally, in Sub-Saharan Africa, and abroad on mother to child HIV transmission and changing breastfeeding patterns. **Chapter three** will look at breastfeeding patterns in KwaZulu-Natal. Here the impact on HIV positive mothers will be the focus. Mothers who exclusively breastfeed, as well as mothers who use exclusive formula feed, mothers who mix feeds as well and mothers who employ wet nursing methods in KwaZulu-Natal will all be discussed. Further, the chapter will look at health workers and their attitudes to breastfeeding by HIV positive mothers and economic issues (i.e. unemployment, poverty, prostitution) all underlying breastfeeding cultures. Other factors that are also contributing to the current context of HIV/AIDS transmission are political and economic in nature and have roots in the past (the migrant labour system, government decision(s), and positions on antiretroviral treatment). Also, behaviour patterns are crucial factors (such as empowerment around lactation, negotiations around condom use; polygamy and or multiple partners; unwillingness to go for VCT; the continuing efficacy of patriarchy). Psychosocial problems that are cultural in nature are also discussed (for example: stereotypes; discrimination; unwillingness to disclose HIV status; the isolation and shame of homelessness). My status and history as an isiZulu speaking nurse and researcher will be drawn into the analysis here including my application of gender sensitive critical thinking about social issues.

Chapter four will attempt to address the issues around counselling and breastfeeding patterns and the dynamics involved in home-visits. Further, will look at my role as a nurse and researcher in the MTCT at the MRC and the problems experienced in this project, from socio-cultural as well as economical challenges that participants are faced with. Also, the chapter will reconvene some of the major points of the thesis and offer some concluding points and some tentative recommendations on the subject.

The **research approach** that will be used is both qualitative and quantitative in nature, focusing on previous research on the issue of breastfeeding and impacts determined by psychosocial, economic factors, political, demographics and cultural and traditional practices, both in the past and present, looking at changes that have evolved over time. This will assist in providing deeper explanations so as to enhance our clinical understanding of how the breastfeeding has evolved and how breastfeeding has shaped the gender discourses with us today as we face the HIV and AIDS pandemic.

Chapter 1- Breastfeeding in a historical context, Globally and in South Africa

This thesis is about breastfeeding in one region of South Africa at the start of the new millennium. The thesis proceeds from the view that breastfeeding, while natural, is also historically shaped and influenced by economics, culture and social change. It is also about the challenges to public health and clinical interventions at a time of the HIV viral pandemic, one consequence of which is the transmission to infants of the HIV virus via breastfeeding. It is a fact that women who have given birth have the capacity to provide milk to their young. It would appear that breast milk is natural, free, readily available, sterile and at a correct temperature all the time, yet there are many historical examples of breast milk being paid for (for example some forms of wet nursing) as well examples of breast feeding becoming socially unacceptable or prohibited.

Breastfeeding practices and cultures have differed in different parts of the world. These patterns depend on environment, socio-economic status, demographics, cultural beliefs, health status, socio-political as well as individual choices made by mothers and their families, all of which have had an impact on breastfeeding or lactation patterns over time. Thus while breastfeeding is a natural method of infant feeding that nurtures newborn babies and takes care of infant growth from birth up to the time when babies are weaned, its meaning and the extent of use in society is as much socially as naturally determined. Over time clinical biomedical investigation has revealed what many communities realized in their

own way: mothers' milk has immune factor benefits as well as ensuring life long bonding. In previous centuries, for example in Western Europe, according to Schiebinger (1993:394) in the Judaic traditions mothers' milk was seen as concocted blood, and this belief continued well up to the 18th Century in the West. The belief held that the male equivalent of female milk was secreted as semen into the bodies of non pregnant women. This vital life giving fluid nourished their embryos. It was as necessary in the bodies of women in postpartum, as milk for newborns. These Judaic traditions found their way across the Mediterranean and Europe into many Christian cultures and shadows of these beliefs remain today, often without conscious knowledge, in contemporary culture.

It is true that women menstruate, fall pregnant, and lactate, and there is definitely a reasonable scientific connectedness in these engendered biological phenomenon claims. However, examining the belief that milk is secreted as semen, I would argue that this theory no longer holds as milk cannot be biologically changed to semen, neither to blood. The evidence gathered by gender theorists and historians of gender, such as Schiebinger (1993:394) is of great interest and historians such as this have kept research interests into cultural views of natural fluids alive. What comes out to be of great interest for this thesis is the realization that there were many differences in the application of knowledge of lactation, well before the 18th Century, across the world. The arguments and claims that milk was concocted blood, and that this fluid had to

change and in the same way be secreted as semen in males, and milk in females, clearly signifies the notion of engendered female and male bodies, where social meaning is not self evident from physiology, or what we today would see as physical fact analysis. The construction of female bodies is clearly starting to receive a clearer analysis especially in the disciplines influenced by Gender Studies, and clear reproductive health roles realized, but there cannot be separation from historical and social meaning (Martin, 1989).

As women menstruate, conceive and as mentioned above, give birth to their babies they are expected to breastfeed in many societies and communities and across most social circles, although this is under threat in many parts of the northern hemisphere. Yet despite much continuity breastfeeding patterns of the west in the past and those of Sub-Saharan Africa show temporal impacts and paradigm shifts. Looking at the West before the 18th Century, articles in the *American Historical Article Review*, explain how the word “mamma” was coined Schiebinger (1993:388). After the Enlightenment period in Europe began, western scientists chose new names for all reproductive systems. The singular form of “**mammae**” designated the milk - secreting organs of the female. It makes a lot of sense as the first syllable or word that toddlers would utter as they start to talk is “mama”, this is common in many languages, cultures and countries in the world. When babies are hungry and want to feed, they would in the past and now also call out “mama”, pointing at the breasts when at an age to do so or bottle or whatever method of feeding them, which is usually used at feeding

times. In the West during that time, historians have shown that there were examples of when a bear would suckle a child. What is important here is that “breast” and “milk” would cross species that human babies would be feeding from the bear breasts (Schiebinger, 1993:398).

What is key to my argument here is that the notion of breastfeeding being “natural” versus the theory of “nurturing” has been debated through time and in different societies. Gender theorists, and generations of feminists before them, have traced arguments about the extent of social experience as the key determinant in gender identity and practice versus universal natural givens. According to Schiebinger, (1993:398) throughout the middle ages, the faithful cherished vials of the “Virgins milk” as a healing balm, a symbol of mercy, an eternal **mystery**. According to many views of Christianity the Virgin Mary endured none of the bodily pleasures, and pains associated with childbearing, menstruation, sexual intercourse, pregnancy or even labour, except suckling. Jesus as an infant was suckled by his historical mother Madonna. Churches today still hold breastfeeding in high regard. Most organized forms of Christian church teaching preach that people should first get married and then have children.¹ Most churches argue that children need to be breastfed preferably in order to be well nurtured. The impact of the busy urban world has grown in Africa since the 1920s. In contrast to the middle ages women of today, employed for wages and working outside the home, both working class women

¹ Many texts and on-line sites contain moral teachings of world wide Churches and other organized faiths. See http://www.acme.com/jef/religion_sex/ and www.vatikan.va/archives/catechism

and upper income women joining the corporate world, find that the public arena has very little to offer in terms of validating or supporting a woman staying at home and breastfeeding babies on demand. Instead, and since the start of the 20th Century, alternative feeding patterns have been, and are now, resorted to.

In South Africa, the rapidly industrialized society in which we live in, has brought together massive Christian conversion, the remnants of pre-colonial indigeneous beliefs and the impact of migration, capitalism, racial segregation and political struggle. In these contexts some elements of life make breastfeeding cultures and practices very difficult to sustain. In South Africa and the world at large breastfeeding is a mix of exclusive breastfeeding, mixing feeds, exclusive bottle feeding, expressing breast milk, cup feeding, of the baby when the mother is at work. These are the shifts that have occurred over time and all of these shifts are worsened in the context of the HIV/AIDS pandemic evidenced at home visits in Umlazi area, KwaZulu-Natal. Many women and men still plan to get married one day, have babies from partners of their choice and look at motherhood and fatherhood as a great challenge. In this life-dream the plans are to have good coping skills with women being supported to breastfeed, raise children, and all the positive dynamics involved—but living this dream is not as simple as it may seem. The impact of breastfeeding in KwaZulu-Natal region of South Africa has links to the world, but some specific local points have been observed too that may be different comparatively (Coutsoudis, et al, 1999). I will but mention a few, i.e. teenage pregnancy, sociopolitical violence, homelessness, employment

and migrant labour, masculinity and polygamy, single parent either by choice or circumstance, modernity, women's growing assertions of choice, employment, HIV and AIDS debates, birth spacing and contraception, changing family relationships, the availability of wet nursing, powder milks or formulae.

In this region, as well as others in Africa and the world, breastfeeding was used widely for child spacing, so that breastfeeding women could recuperate from birth strain and gain full recovery. The WHO recommended birth space is two years and mother would then wean off their suckling infant if necessary or desired. At this time they would expect to fall pregnant at any time if they were still at a child bearing age. This has been the norm predominantly. Shifts have occurred that contraception has now been used. Women who breastfeed for shorter periods, if they ever do, and prefer using contraceptives (pills or injections), are mostly from a younger generation, made up of the educated and working women of today. According to Bledsoe (1999:5) in West Africa in the last 20 years women have often used contraception as part of their efforts to bear all the children that God might give them by adjusting the timing and circumstances of pregnancies.

In the West as well as South Africa Bledsoe, et al (1999) showed that the old method of child spacing by breastfeeding, if women would fall pregnant whilst breastfeeding, they would stop breastfeeding with immediate. The belief is that the milk of a pregnant mother is poisonous to the foetus or the unborn baby.

It is also very interesting to know that contraception has been used by other communities in Sub-Saharan Africa for other reasons that were not ideally designed for, i.e. in order to have more babies. In South Africa contraception was introduced by the former government to cut down on black population numbers. Some of us have personal memories of this, but the facts are well documented. This was a desperate effort to cut down on fertility rates of blacks. In an article where she summarized the history of state population planning and the work of Klugman, Brown and others, titled "Sex: Lessons from the past" by Burns (1996:85), she details this history. Despite the good and sensitive work of many women and other reformers, the South African state by 1960 had started to map out a very explicit "Population Policy", which meant black women became the targets for population reduction, and white women the targets for population expansion. Chemical contraceptives that were recommended for use by African women were not allowed to be used on white women (Burns, 1996:85).

This is the context for many black women's views of contraception today. So, it is true that women are oppressed and discriminated against, it is also true that strands of further oppression and discrimination are realized within women themselves in terms of class and race. The contraception issue is a clear example of discrimination by gender and race exerted by the state at that time.

Contraceptives which were regarded unacceptable for white women, were authorized for use by black women and campaigns were launched

throughout clinics and black hospitals to encourage black women to practice fertility control, with sterilization of women with several children a high priority (Burns, 1996:85).

In certain clinics most mothers were given contraceptives like Depo-provera and other oral methods where mothers were not clear what was done to them. The Depo-provera were given to mothers irrespective of them breastfeeding or not and also their ages were not taken into consideration. The criterion used was a black woman in this clinic X who has given birth and her fertility which needed to be controlled for as long as was possible in an effort to control birth rates.

One of the motivations propelling me to investigate breastfeeding and women's health in a gendered framework is the experiences I have had in my career. In my own experience as a nurse I have seen these alienating practices at work. For an example, Hospital X use to run a clinic which they called an Endocrine Clinic. All mothers that were given a contraceptive pill on discharge after delivery were asked to come to this follow up clinic on monthly basis for 3 months. Bloods were taken from them, and given a date to come back for results, but told they should continue to take these tablets. These mothers would be informed when to stop these tablets when they are ready for the next pregnancy. On their return date or follow up date, Dr Y would tell these mothers that you have completed your family. Mothers would say "No I want to have another child", and Dr Y would say, "I have told you that you have now completed your family

this is what the blood results are telling me". These mothers would be now complaining of hot flushes etc. Their ages were ranging from 26 – 34 years. Some had 1, 2 or 3 children at the most. Breastfeeding had been stopped by these mothers, full explanation of what was done to their health was not clear to them. The fact that they had now completed their families was also a shock to them. Dr Y was a male. There were no women who questioned the operations in this clinic, neither the patients nor the health givers. It brings a lot of questions up to me today. Such as: what was happening in this clinic? Were women given sterilization pills or contraceptives? Did women know what was happening to their reproductive lives? If they knew why were they shocked when told that they have completed their families. According to Burns (1996:90) in her article, she cited an interview of an experienced family planning nurse called Tyalimpe, concerning her ideas about the development of contraception, particularly for black women, as to whether were they an excellent idea in terms of curbing their birth rates. Tyalimpe's response was that she did not have mixed feelings at all about contraception in general, in fact she thought immediately that it was "good", but she said that her strong feeling was that contraception was only good if people were properly educated, and they need to be properly informed, as they came here thinking they would get help.

This example is useful for me as a means of show that as women's bodies and their productive lives are sometimes highly politicized, decisions taken on their behalf, on their reproductive lives, which were actually violations of their human

rights. In addition black women often battle to express their own rights. An example of this is black women's anxiety about asserting their rights. Women must learn to stand for their interests and rights of others rather to do the same.

Furthermore, African women tend to culturally be trained to follow rather than lead (Ngcongco, 1993:5). In this thesis people I argue that in general and black women in particular need to understand their human rights and strive to protect them, as well as the other peoples.

1.1 The Contexts of Pregnancy and Lactation

1.1.1 Teenage Pregnancy in an HIV/AIDS Context

Breastfeeding tends to lose ground with the escalation of teenage pregnancy mainly because teenagers mostly are really not ready for motherhood and as assertive as would be an older woman who has planned for having babies and may be settling down to breastfeed in stable environments. Most teenage pregnancies in South Africa today, are unplanned and as such impact negatively on breastfeeding and child nurturing. Some teenage mothers have to go back to school, want to visit their peers, be out in the day and late evenings, hang out in social clubs until early hours of the morning, and some join drinking sprees and forget that they ever had a baby to nurture. The older literature on Zulu society and culture during the 18th to 19th Century indicates that these are features of a 20th and early 21st century world. (Guy: 1990; Hunter: 2003)

All these socio dynamics leave nothing else but options like grandmothers suckling these babies as normally observed in some instances, bottle feeding using powder milks and if the powder milk is at all available. Preparation of these bottle feeds using the powder milk is also a dilemma on its own in other communities, where sanitation, clean water and sterilizing equipment are questionable. Bottle feeding works very well in communities where the availability of all the above resources are in place and the socio-economic status is able to cater for the formula feeds. The above mentioned realities are the reasons why breastfeeding today has changed.

1.1.2 Historical Contexts for the efficacy of breast milk

In the early and late 18th Century English women, who were elites did not expect that they should breastfeed. Breastfeeding of their babies was done by wet nurses. These women felt that most of their time would be taken away by breastfeeding, and over and above their husbands did not like them to breastfeed as well. Breast milk was reviewed with high regard, as the best food for newborn babies (Salber, 1993). Colostrum at that time in Western Europe was not universally regarded as important and nutritious until in the early 18th Century when physicians who had great influence to elite women's lack of breastfeeding their babies, thus recommended the values of colostrums (<http://www.pediatriconcall.com/for>). Although physicians may have contributed to elite women's breastfeeding problems in the 18th Century, it was, ultimately,

physicians who demonstrated the benefits of colostrum to newborn infants (Salmon, 1994:258). The elite women of the modern England and America had a paradigm shift in the 18th Century towards breastfeeding their newborn babies from the medical advice on colostrum, weaning, aspects of breastfeeding and care for ill and healthy infants (Salmon, 1994:254). It is of great interest that breast milk in the 17th and 18th Centuries was also used as medicine for newborns, elderly and the sick by the English and American women. In the province of KwaZulu-Natal breastfeeding women were and are still using breast milk as healing medicine for their babies, e.g. used as eye-drops in babies, discharging sticky fluid and substance in the eyes, in baby's ears if babies demonstrated discomfort in their ears by shaking the head and sticking fingers in the ears and so on. This same practice has been used over time. I am observing similarities here across all cultures. An example from Western Europe over 200 years ago reads:

To ease him of his pain, I wished him to foment his ear often with woman's milk and oil of roses warm, and drop it into his ear (Salmon, 1994:249).

It does appear that breast milk can also be used as medicine to cure some ailments, not only of the newborns, infants, but adults as well. Breast milk was useful in clearing the discharges that collected in infants eyes before the tear ducts began to work properly (Salmon, 1994:250). Recent anthropological and historical work on breast milk urges upon us these questions: Have we done

enough work around breastfeeding and breast milk itself? Breast milk draws similar characteristics across cultures. Could clinicians be missing some natural and nurturing properties in this breast milk that we should explore?

1.1.3 20th Century shifts in breastfeeding practices

As with cultures of lactation in Africa, in Europe the medical literature of the 17th and early 18th Centuries shows that infants were fed on demand, initially in small amounts (Salmon, 1994:256). In the early to mid 20th Century doctors and nurses in maternity hospitals began advocating “scheduled” breastfeeding. Time schedules were like 06h00, 10h00, 14h00 and 18h00 during the day and 22h00, 02h00 and 06h00 covering the night programme. These times were inclusive of napkin changing as well. The “Robot Programme” scenario has fallen away and napkins also, are now changed as need arises. It was really common sense to abandon it. Babies under it were as you would imagine left with a wet napkin on for 3 hours, because the programmed timing had not ticked.

Looking at a white community in South Africa in the latter part of the 20th Century, one realizes that breastfeeding has changed a lot during the past two decades. According to Bergh (1987:24) by the 1980s in South Africa breastfeeding was already receiving much attention. She mentions South African white women, especially the affluent class, demonstrating increasing numbers of interest in breastfeeding. This would have been a great change from the 1950s to 1970s

era when bottle feeding began to replace breastfeeding in this community. By the 1970s and 1980s public health programmes had begun to challenge bottle feeding with programmes like GOBI-FFF. Bergh describes this programme advocated by many public health experts. Bergh (1987:24) the GOBI – FFF which stands for:

- G - Growth
- O - Oral hydration
- B - Breastfeeding
- I - Immunisation
- F - Family planning / spacing
- F - Family supplementation
- F - Female education

In her article she mentions that the key issues to the renewed success interest of breastfeeding in South Africa and globally after the 1980s were child birth education and improvement of institutional practices harmful to breastfeeding.

1.1.4 South Africans of Indian Extraction

Whites today make up around 10% of the population of KwaZulu-Natal. Another significant minority is the community of people of Indian origin. Indian women also in the province of KwaZulu-Natal have a powerful tradition and culture around breastfeeding. According to Brookes (1991:7), a sample of Indian women that she analyzed in the early 1990s, all desired to breastfeed their

babies, and none mentioned problems with giving their babies colostrum which is the early or first milk, rich in nurturing newborn babies. None of these women looked at or mentioned colostrum as harmful for the baby. Brookes also showed the preparedness that these women had gone through as they had taken traditional maternal diet, masala and herbs to enhance lactation during their purperium period.

In this community (and many others) women prepared for motherhood consciously or unconsciously, playing and caring for dolls as girls while growing up. It is certainly an unconscious method and way of preparing for motherhood. According to Brookes (1991:7) Indian women consciously prepared for motherhood by learning hands-on from the role models of the senior Indian women, who undertook most of the care of the newborns and helped to foster breastfeeding.

1.1.5 Challenges of Breastfeeding

Breastfeeding and its experiences, a culture and tradition grantedly, should not always be taken for sure that it will be positive and simple. It should be remembered that lactation can present and respond to many obstacles depending on the prevailing circumstances and environment that mothers find themselves in at that particular space and time. Breastfeeding is an accepted tradition, but certain negative variables could and do destabilize this tradition. A

few key examples are: lack of motherhood preparation; maternal illnesses; confusing messages from health workers; family members and of course HIV positive status of a mother. The biggest challenge is: “how do we prepare our pregnant mothers for motherhood”, and “how do we assert ourselves to overcome problems as they arise”? How do we achieve our breastfeeding objective, if that’s the choice of infant feeding that we have chosen? As Bergh and others show, if the psychological obstacles can be overcome, many of the physiological and practical obstacles listed by respondents may also be overcome in adequately motivated mothers through education and practical assistance and support by care givers (Bergh, 1993:25).

1.2 Breast milk in so called “mother to child transmission”

The worst epidemic of our time that we are living with is the HIV and AIDS with its harsh realities of mother to child transmission through breastfeeding. It has set the whole world talking endlessly. The “mothers’ milk” is at the epicenter of breastfeeding debates. The ethical considerations of confidentiality and the powerful social stigma of HIV/AIDS, further compounds the problem of breastfeeding in HIV positive mothers. The fact that we use the term “mother” not “parent” or “woman” in our clinical definitions also underlines the prominence given to women as “mothers” rather than as persons in themselves (Duden, 1991).

How do we treat the mothers' milk, as we all agree that lactation is a physiologically possible and healthy process, and that infant suckling can and does save and protect infant life? How do we make breast milk safe for babies? How do we encourage disclosure by HIV positive mothers so that their families understand breastfeeding options? How do we tackle problems of HIV stigma so that the burden of HIV positive mothers is made lighter and safer for these mothers in communities and enable acceptance and support of different feeding infant choices and practices.

There are interesting several "breastfeeding" versus "bottle feeding" debates around HIV positive mothers. According to (Coutsoudis, Coovadia, et al:1999) the paediatricians in Durban, HIV positive mothers' are encouraged to breastfeed exclusively for a period of up to six months. The reasons being advanced for this recommendation is that breastfeeding is an old cherished mode of feeding babies that has been practiced for decades, a cultural practice that societies would not want to wish away. It would also make little sense to undermine years of public health programmes promoting infant suckling. Coovadia and his team support this stance by saying that in a community where there is poor sanitation, no running tap water and no provision of resource and equipment to sterilize feeding bottles, how can public health officials postulate that bottle feeding will be safe.

In my experience the above holds true. A further implication to this, is that the powder milk that is created for babies, is sometimes used by family members when having their tea, even by close neighbours as well. Secondly, the powder itself is mixed incorrectly by the mother so that it covers a longer period. What the baby gets at the end of the day is a weak solution of milk with sometimes unhygienic properties in the bottle, babies get ill with severe diarrhoea, electrolyte imbalances, dehydration, shock collapse and death. These consequences cannot often be dealt with in busy paediatric wards.

The Durban, HIV breastfeeding “camp” further argue that mixing feeds is even a worse option for these HIV positive mothers, as the bottle feeding method with all the unhygienic preparation might damage the intestinal gut, and when the HIV positive mother breastfeeds, the infected breast milk will easily enter the already damage gut, and this further infects the baby. Contrasting to this Durban work is the research done in a Johannesburg study (led by Grey et al) which strongly recommends that HIV positive mothers should not breastfeed but formula feed (Siedel, 1998). Both positions and views do acknowledge that mothers have the right to make their own choices as to how they would want their babies fed. Bottle feeding in affluent societies and societies that can afford milk powders with proper sanitation and clean water, formula feeding would be the route to go or an option to consider in an HIV positive community.

world of mother to child transmission so that stigma, disclosure and Nevirapine are looked at as change in space and time, and not as a confidential programme that is not fully accepted by families. The above concerns are mainly directed to rural women, where, as I have seen in the field work sites, the partner will want breastfeeding taking place, where the mother-in-law will expect *makoti* to breastfeed. Firmly rooted in these concerns and inequalities, is poverty, discrimination, being treated as a second class citizen, ignorance, illiteracy, unemployment, dependency, women oppression, patriarchy, powerlessness, cultural diversities, myths, sometimes lack of understanding the implications thereof, and the fear of the unknown. It is also a feature of gender imbalances of power that women in some cultures are reluctant, even under normal circumstances, to come forward and talk about conditions that stigmatize, less they are discriminated against even further.

1.3 Feminist View

In the wake of the 1994 transformation of political, power in South Africa, and the 1996 ratified Constitution—which guarantees equality for all women—how do we break through the culture of silence, especially with rural isiZulu speaking women? Their voices need to be heard loudly and clearly, that breastfeeding in the face of HIV epidemic needs serious attention by their partners, mother-in-laws and family members, and that as free and equal citizens and as women their dignity must be respected and protected and they must be able to exercise

their rights and make choices, including ones related to child care and motherhood, and that their decisions to bottle feed must be supported if they so wish.

In the light of these strong points around the rights of women as mothers and choice makers it is useful to consider where ideas about the individual location of “rights” within the personhood of women first emerged. In the English speaking world the views of Mary Wollstonecraft, who wrote and was active in the late 18th century, have been and remain very influential. (A collected edition of her works was republished in 1972). Wollstonecraft has been regarded through the 20th century women’s liberation movement as one of the most prominent feminists fighting for women’s emancipation which included respect for women’s maternal and nurturing roles. Her impact on liberal feminism and socialist feminism tackled issues of women’s “natural” versus women “cultural” stigmatization head-on. The fact that she died in child birth at the end of 1700s, soon after the publication of her most famous tract on women’s rights, has earned her a special position in the literature on women’s rights in the context of their biological capacities and differences viz a viz men. Since then all over the world women have waged versions of this struggle to identify themselves with the rights and status that men enjoy in the public and private domain. Over the last 150 years South Africa has had similar experiences of one kind or the other as somewhere else in the globe, e.g. Europe, United States of America, India and Africa. Briefly

South Africa has the following as its experience of women's struggle for emancipation:

- 1910 : Formation of the South African Union within the four provinces at the time.
- 1936 : White women get the vote – but on the “back” of black men losing vote in the Cape Province.
- 1950 : By this time Federation of South African Women came into being.
- 1955 - 4: Strikes by women against passes spread all over the country.
- 1960 : Sharpeville massacre, women continued their struggle against anti-pass laws.
- 1972 - 3: Pinetown labour strikes in the clothing industry.
- 1980 : Strictly white women got a vote.
- 1983 : Tricameral Parliament is established, a vote is extended to Coloured and Indian population, women included.
- 1984 – 1993 : Struggles continued and women playing a part as well.
- 1994 : All South Africans were afforded an opportunity to vote,

irrespective of gender and or any forms of discrimination (Abdool Karim, 1998).

In South Africa, women's situations have been made better to some degree, especially in the realm of law. This has been affirmed by the developments that the 1994 democratic dispensation culminated into legislation that came into existence, which caters for both their private and public life, namely:

(1) **private sphere** – Customary Marriages Act, Prevention of Domestic Violence Act, Termination of Pregnancy Act and Maintenance Act. In the case of the

(2) **public sphere**, first and foremost, is the democratic and liberal constitution of the country that guarantee all rights to all people irrespective of their gender (Constitution of RSA, Act 108 of 1996). In addition the National Parliamentary composes about 1/3 of women. Maternity protection has been guaranteed by law in employment section 17 of Basic Conditions of Employment. (Unfair discrimination in employment [as outlined in the Labour Relations Act – schedule 7: Unfair Labour Practice and Employment Equity Act). Tireless struggles of women in South Africa and abroad has been gradually changing over time. It is also safe to say that total emancipation of women has not yet been achieved to the fullest this demonstrated by harsh experiences that most women are faced with when they have to make decisions around exclusive breastfeeding, bottle feeding or mixing feeds from their mother-in-laws, partners and their extended families. Carter argued in 1995 that one might see bottle feeding as freeing women from the demands and restrictions of lactation, or on the other hand as imposed on women by the manufacturers of baby milk depriving them of unique womanly experience, based on centuries of skill and knowledge (Carter, 1995). Both of these possibilities exist for South African women, and their choices as far as breastfeeding is concerned will only be truly free and liberated when a variety of options are open to them. Of course socio economic freedom is, as we have seen, even harder to achieve than political freedom, and women and men are both constrained by poverty and its related pressures.

In the face of HIV and AIDS epidemic breastfeeding yet again experiences a shift in some women who would, if they were not infected, breastfeed, but instead in the face of infection, opt for bottle feeding. The women's movement in the early part of the 20th Century supported the option of bottle feeding with all its problems because it allowed women greater mobility and options outside of their domestic role, but later after 1968 the Women's Liberation Movement world wide debated the consequences of bottle feeding and the impact of male dominated infant feeding corporate strategies on women and children's health and had a change of heart and supported breastfeeding. Present day feminists, given voice in a handbook: "Infant feeding for health workers" (Carter, 1995) argue that breastfeeding confirms a woman's power to take control of her body and freely make decisions as a woman that reason and challenge whatever view prevails in medical hegemony at any one time. Given the debates over the last 100 years about the link between women's rights and responsibilities regarding breast feeding, the biggest question is: how do we empower some of our women in rural South African to acquire the skill and confidence to negotiate and make choices around breast feeding and bottle feeding options? Do we go the route of looking at partners, at mothers-in-law, and families first? Or do we create and educate trained strangers or outsiders to do this work? From other research we see that outside actors can assist with rural interventions, but stigma and fear are often locally rooted and it would seem that local role models are the best way to tackle issues of power and fear. This theme is borne out in the work of researchers who have examined the rise of HIV infection more broadly than the issue of MTCT.

In her work on HIV/AIDS in KwaZulu-Natal, LeClerc-Madlala has argued:

To say that AIDS carries a strong stigma in KwaZulu-Natal is an understatement. At present, AIDS carries an extreme stigma. In some communities found in a Thousand Hills Valley such as KwaNyuswa, Embo and Emholweni, people known to be AIDS sufferers (people living with AIDS) have had their houses burnt to the ground. Some barely able to walk have been chased by mobs into the bush. Here they have built makeshift shelters and receive food parcels and nursing care by visiting staff members from the nearby Hillcrest Aids Centre. As these dedicated health workers describe it, they basically risk their lives to get food and supplies to these poor souls banished from their communities and left to die alone. "You can't believe what poverty and superstition together can do to people. They can become like animals". This was the comment of one woman who had decided to dedicate the remainder of her life to assist those whose disease status invites the full wrath of a people so conditioned by violence and want (LeClerc-Madlala, 2001:32[1]).

Where would breastfeeding find place in such an environment for HIV positive women? These are realities and crux of the matter in rural South Africa. How do we find ways and means to strike the balance, between breastfeeding options removal of social stigma and domestic violence related to HIV and breastfeeding, in South Africa? The next Chapter will tackle answers to some of these questions.

Chapter 2 – Literature Review of Breastfeeding and HIV

2.1 Breastfeeding Patterns in KwaZulu-Natal in South Africa

2.1.1 The impacts of migrant labour system

Large scale movements of people are being triggered by a variety of situations. These include economic impoverishment, environmental degradation and alterations in the natural resource base, climatic change (including droughts) and population pressure. As a result people are being compelled to migrate in search of often elusive and mainly insecure and poorly paid employment. Migratory flows have increased considerably during the 1970s, 1980s and 1990s as a result of high natural population growth and resulting environmental, political and economic pressures. International movement has often been facilitated by lack of strict border controls (Oppong & Wery; 1994:11).

South Africa has a history of labour migration that was perpetuated by the then government and political situations of the times, where by and large black males of working age were forced into becoming migrant labourers in the mines of Johannesburg, and other areas in South Africa where gold and diamond mines were situated. Already this left a vacuum in the homes where these males were fathers and breadwinners. However, women who found themselves left by situations that they had no control over also found themselves compelled in one way or the other to fend for their children, because the breadwinners were only to be expected at the year end when the mines had closed for December holidays.

Effectively these women became the sole breadwinners out of choice and by circumstance.

A second form of migration by females is what Walker (1990:225-226) has researched. She was able to establish how these women who are supposedly expected to be running homes, house chores were not only expected to end there, but also leave their homes in search of supplementary income. This they did by brewing beer to sustain a settled family life but were, rather, refugees from marriages that had cracked under the strain of rural pauperisation and the migrant labour system. If these women had babies to feed, this meant that shifts and destabilisation of feeding patterns were unavoidable.

What has been outlined above are some of the negative impacts of migration system in South Africa. Also, such increased and forced human mobility and urbanization is also among the contributing factors that increased a number of sexual partnerships over a lifetime. This has also had its own unfavourable consequences on family life and breastfeeding patterns for women in these situations.

Homesteads in Zulu culture are matrimonial units where coexistence of families live and share family traditions. This is where cultural and social construction, a sense of belonging, the development of identities and the true belief and sense of Zuluness is practiced and entrenched. Elders in these homesteads are

custodians of culture and tradition which they transcend down family trees. Destabilization of such institutions has major impacts on many issues especially the one that this thesis seeks to look at shifts in breastfeeding patterns (mother's milk) from the migrant labour perspective in KwaZulu-Natal province. These women, according to Walker, (1990:226) have entered informal economic sector as migrants thus nurturing and breastfeeding of babies faces a serious and an inevitable challenged area as women have begun to enter the labour market at a larger scale than previously experienced and are forced to leave their babies in the care of others for longer periods.

Women of today are certainly, a different fabric in many ways in terms of breastfeeding. Lactating or breastfeeding mothers need to get back to work, after a programmed time frame, e.g. maternity leave is over. They then face problems of devising other methods of feeding their babies, feeding on demand during the day becomes problematic for a working mother, what the mother does now is to either express her breasts early in the morning, to a container so that the baby feeds when necessary during the day. If that expressed amount of milk finishes babies are then given formula feeds until the mother comes back in the afternoon and evening and then breastfeeds. Some mothers wean off their babies and go 100% on formula feeding. Caring and nurturing and the status of motherhood and womanhood known in the earlier centuries has had a tremendous shift as women now are also working mothers in the 20th Century and beyond and no longer staying in homestead and solely doing domestic work.

Marriage in the 17th – 18th Centuries for IsiZulu speaking women and for other cultures and communities largely meant that you as a married woman will now stay at your husbands homestead, do house chores, reproduce and breastfeed. This status in the 20th Century sees new forms of marriage, married women leaving these positions and joining the workplace. Divorce if they so wish unlike before where the elders use to emphasize to the *makoti's* (daughter-in-laws) to stay in the marriage even if it was highly abusive, hostile and unbearable. The reasoning being that it would be a disgrace to divorce your husband. Marriages of the 20th Century have changed. Some women divorce when and if they feel that it is necessary and in their best interest to do so. These psychosocial problems destabilize both breastfeeding and motherhood.

2.2 Polygamous Marriages and Extramarital Relationships

Culturally, Zulu males are allowed to have polygamous marriages, and would be dissatisfied if women would do the same, as it is unacceptable according to the tradition. We would remember the case of a Nigerian woman, Amina Laway, who the law, if she loses the case would be stoned to death because she gave birth to someone else's child her case is still pending. If men have children out of their marriages, the Zulu culture accepts that and the reverse with their women. The (Inkosi) would encourage severe punishment in Zulu communities if women would be discovered to have multiple partners or husbands. The 4th International IASSCS Conference held at the University of the Witwatersrand, according to

Hunter (2003:11) this was a conference on *Sex and Secrecy* (This was a title). Unfaithful women too could face severe beatings, indeed chiefs and Native Commissioners allowed men to use a certain violence to discipline women. The Natal Code of Native Law underpinned this rule through “customary law” and the code itself provided strong legislative backing for the uneven rights of men and women to have multiple sexual partners. According to (Walker, 1990) women used to leave their homes in search of salary supplementation and that meant that they would leave their babies, stop breastfeeding, resort to wet nursing, or bottle feed.

Men have by and large been allowed sexual space compared to women. These poor women have no say over what is sexually appealing to them, as they may face the law or worse physical violence. The bodies of these women are the property of their husbands. These husbands and partners have the final say on matters of sex, child birth, condom use if ever mentioned, and women have to tow the line and failure to do so translates to verbal abuse, physical violence, rape, disruption of relationships, etc. Sexual activities are generally on man’s terms (Hunter, 2003).

Breastfeeding and looking after babies is a big challenge that needs support from the male partners. Where would a woman get this kind of support if the partner is a migrant labourer. If men were breast feeders, it would be interesting to know if the same would apply. Women are not necessarily oppressed,

suppressed, abused by their partners only, but by the system, “powers that be” reflect this kind of scenario. I guess everyone understands that people should work for a living, but certainly not in a way that work, per se negatively impact on women’s vulnerability. Married men and women need to stay, live together (cohabitation). Women tend to breastfeed better with all the support they need to have from their husbands and partners and the family at large. Babies get severely neglected if they do not get that support from their families. They are huge psychosocial impacts caused by family separation due to this migrant labour system in a home environment. The letting down effect of breast milk for proper breastfeeding needs a stable mind. Women under these difficult circumstances mentioned above make breastfeeding difficult. These power relations are subtle but damaging. Unhappy women with psychosocial, economic and political disturbances would not be able to efficiently breastfeed.

All feminist theorists try to address female inequalities to get a balance of life events for women as they unfold. It sometimes happens that all these efforts are sometimes looked at as too much of modernity, too much of enlightenment, too much of Western ideologies of people wanting to shred off their own culture for what they do not fully understand. It is strange why people would entertain all these western philosophies.

A woman at the clinic, after a health education talk and breastfeeding responded by saying:

What is the point for me to stay here and listen to all this talk. It only makes me very heart sore, that even if I would like to breastfeed my baby, we stay hungry all the time, we literally starve as nobody gives us money. The father of my child is a migrant labourer and only brings money at home when he comes home for December holidays. I am so mentally drained and sometimes think I am going to run mad.

You hear of all these stories and ask yourself, if is this dependency? Why can't she have a small garden and plant some vegetables? You further ask yourself; does she have money to buy seeds? Does she have land for that garden? Does she live in a shack?

Men are never questioned by their wives about such lack of support as according to Zulu tradition men are never questioned by their wives around anything women are suppose to keep quiet. There is a need to strengthen the aspect of culture and tradition that benefit everyone, not just those who currently have power. Given the scarcity of avenues open to women to speak and air their views, their silent voices need to be further explored and given recognition (Magwaza, 2001:32).

2.3 Benefits of Breast Milk in Zulu Cultural Belief and Practice

Breastfeeding is an old cultural tradition of Zulu speaking women, which need to be preserved. The emphasis is not necessarily because of cultural issues but also for its protective mechanisms against acute respiratory infections, and diarrhoea related infestations. It contains all nutrients, antibodies and has the ability to boost the immune system.

Who would not want to sustain a tradition and culture that has such benefits? A practice that people understand well? A practice that is life saving? A culture that has made a nation to survive for decades? In the absence of all obstacles women with sentiments of motherhood, those that are mothers and have love for their children I would like to imagine would like to breastfeed.

The running of the home with all its demands is never shared with this man who is a migrant labourer for most of the time (about 90% of the time). Shouldering all the responsibility of a home is certainly a nightmare for these women. They go out to work and still come back to their children to breastfeed, and do house work. The specifics of how this gender system (with its roots in pre-colonial times) worked with the 20th century experiences of modernity and waged labour, is tackled in Walker's study. In her work she shows that in the later 19th and 20th century Zulu patriarchal ideas and practices were bolstered and added to with the patriarchal conceptions and practices in European law and society as well as European Christian religious practice. For example, as Walker shows, in Zulu

society the "...*Amakhosi* (chiefs) and homesteads heads and the colonial state, to re-assert control over women and tie them to homestead production. [worked together] ...in this alliance the respective gender ideologies of colonizer and colonized converged" (Walker, 1945:196). South African history is filled with example of where the sex-gender system of the colonized and colonizer worked together to subjugate women.

This has implications into the present day. Women in many rural areas could be interested in breast-feeding, but the environmental dynamics (which have roots as I have suggested in both Zulu society and also in Christianity and British and Dutch law) discussed above makes breastfeeding difficult to sustain. The big question is: how do we sustain breastfeeding in given this historically complex context, in the face of the HIV and AIDS pandemic?

In my personal experience as a nurse in this region working mainly amongst isiZulu speakers, most mothers liked to breastfeed their babies, responses from most of them were usually "Yes!". If you further probe as to why they would choose to breastfeed, they would respond by saying "Babies that are breastfed grow well, they do not get ill easily". These responses are all in support of breastfeeding and fundamentally supports the cultural origins of breastfeeding.

These ideas and beliefs are deeply rooted. Zulu women are viewed as custodians of culture who have a duty to transmit ethnic identity to the young.

Guarding the culture (Magwaza, 2001:26 – in Agenda, No.49, 2001) mother-in-laws are women and they uphold the culture of breastfeeding, and would never understand why the *makoti* (daughter-in-law) would not breastfeed. These views get challenge in the HIV / AIDS epidemic – but how much understanding do they have around vertical transmission? If they would understand the vertical transmission, would that make them change their strong stance on breastfeeding? How do we come around challenges of disclosure and destigmatisation?

The local problems and challenges we experience in KwaZulu-Natal have also been faced by other societies. As has already been indicated above world wide public health views, since the 1980s and before, support the concept that breastfeeding is the most efficient, nutritious method of feeding babies for as long as possible. These important aspects of breastfeeding are now threatened by the HIV vertical transmission scenario. In breastfeeding communities worldwide breastfeeding has only been contra-indicated if and when the mother is on certain medications and thus advised medically not to breastfeed and that process monitored overtime with the hope that breastfeeding can be re-started again. According to the American Academy of Paediatrics (1997:45), breastfeeding has over time reduced infant mortality rates, and also used as a good marker for child spacing. The emergence of HIV/AIDS has reversed all these gains in breastfeeding and good child health care and replaced them with a high rate of opportunistic infantile infections resulting in the escalation of poor

child health, frustrated families health workers, became of the load of work, understaffing and no resources crowded paediatric outpatients department and a statistical escalation of infant mortality and mortality rates. Armed with this international data let us now return to the local scenario.

2.4 Memories and Models: Breastfeeding in the recent past and the present in Zulu society

In the earlier Chapter (page 40) I asked what kinds of mentors we needed to create and draw-upon if we want to shift cultures of breast feeding in the context of the HIV epidemic. I pondered whether or not mothers-in-law, partners or other local people would be better than outsiders in terms of assisting with issues of stigma and empowerment. To answer the question now I need to depart from citing the published literature—there is almost nothing published about the felt experiences of women inside of Zulu culture around breast feeding. My own subjectivity—as a mother, as a nurse, as an HIV researcher, and now as a gender analyst, has to be drawn upon for me to provide analysis here. This is new ground, and subjective experiences, memories, songs, and dreams are all part of the effort to create a body of knowledge that will help contemporary policy makers and clinical workers such as nurses. This next section is therefore tentative and personal, but its value lies, I trust, in getting a dialogue with the past and present started in published form. The confidence to write this section is drawn therefore not from citing others who have gone before me but from the determination gleaned from my reading of gender theory that even a small start

may provoke a wider response from my sisters in nursing, research circles and from other sectors in South Africa.

As a woman I view myself as a mother and this is key aspect of my identity. Looking back at all the female gender roles that I have experienced myself from the early days of my very young life, when I remember seeing my mother breastfeeding my sisters and brothers. My mother has always breastfed all of her babies including myself. We are a family of five girls and two boys, and I am the fourth daughter in this homestead the first son comes after me. I had the opportunity and pleasure of observing three siblings being breastfed. This was within a period of 8 - 9 years, in the early and sixties. I observed my mother breastfeeding before I started going to school up to my early years in primary school. I have actually lived to see the operations of breastfeeding with two brothers and a younger sister. The milk around my brothers' mouth because he was very greedy as there was this up and down movement around the breast and the mouth and lips around mothers breast. I would see my mothers other breast wet, the dress she had on getting a tiny spot of wetness and this spot would increase with time. My mother would rub the other wet side of her breast with her hand. She would be singing and sometimes holding my brothers foot, because my brothers leg would be wiggled up in the air. I also started learning these songs and singing them with her when she was breastfeeding. This was my mothers' favourite song, which went as follows:

Thula mntwana x 2 : Keep quiet baby x 2

Ncela mfana ka ma x 2 : Suck ma's boy x 2

Umama uzokuncelisa uze ukhule : Mamma will breastfeed, you grow

Umama uzokugada uze ukhule : Mamma will look after, you grow

My mother would change him to the other breast and I would watch all the process as it unfolds. After my brother stops being breastfed and when his eyes start to close (drowsy) my mother would instruct me to keep quiet and stop singing because the baby was falling off to sleep. She would put her off to sleep and start doing some housework.

It is amazing how nosey one becomes when still at an early age. I cannot accurately remember all what happened when I was between 4 – 5 years of age, but this early autobiography of my life was told to me when I grew up.

It is amazing that at between 7 – 8 years, I would start the song first, when I had realized that my mother was now preparing to start feeding her child. I would also look at my chest to see if I had the breasts as well. It has been for sometime seeing my brothers' private parts at napkin changing. One day I asked her:

CHILD : Mummy what is this, pointing at my brothers private parts? I do not have the same like his private parts.

MUMMY: You will not have what he has because you are a girl and he is a boy. You are like me, I am a girl, and he is like your father, that is why your father is wearing a trousers and not wearing a dress. Girls wear dresses and skirts and boys wear pants. He will be strong like your father and do all what your father does and you will do all what I do.

CHILD : Do you mean that I am going to breastfeed too, like you?

MUMMY: Yes, when you are big like me.

At an early age this did not make a lot of sense to me at the time. It was too complex for me to understand and seriously deal with it, but it had already identified gender, sexuality, motherhood and the fact that women's bodies are mainly existing for reproduction and breastfeeding.

According to this discussion the mindset, in this homestead in the 1950s and 1960s in the Umgababa area, was that the roles of the girls and boys were different. The expectation again in the dress code has to be different. It is then unlikely that Zulu homesteads in KwaZulu-Natal, being so predominantly Zulus speakers in this Zulu community, would live and cherish a different perspective from the rest of their area, especially when you add to this that politically everyone came under one Inkosi (chief). My assessment and conclusion is that these kinds of families in this social construction yielded and still yields the development of male dominance over females. Women will have to make a

collective effort to make their voices heard by their male counterparts in the public spaces of these communities, and claim their South African constitutional rights, so that their positions as women enjoy the same equality in both public and private domains. Men should not be allowed to dictate what type of clothing should cover the female body in general. This should be a free private decision made by the individual who is equally respected and protected by the same Bill of Rights which is a Chapter in the Constitution of the RSA on Human Rights.

Looking at the present some roles have remained the same and others have changed in the homesteads in this area. Though, the more the youth gets educated, the more the younger generation seeks to change. Cooking, cleaning dishes and baby sitting is now currently shared unlike before. Educated females are now becoming vocal about what needs to happen in relation to their lives. This was unheard of before. Theoretical this is what you get to hear most of the time, but what actually happens practically may be different. These girls pressing for change would need to marry the two, i.e. theory and practice. Well things change in space and time, the then female social construction has changed over time. The female dress code before the 1970s, women were never seen in pants in this area. In the 1980s you then sporadically saw girls from certain families wearing pants. This was resisted very much by the elders in the area. It was so resented that the headman (induna) and chief (Inkosi) had a meeting to find ways and means of stopping this new unacceptable behaviour in the area. What came out of that meeting was that the girls parents should be

contacted and be informed that wearing of pants by girls is not acceptable in the area. The girls parents mentioned that they also did not like what their daughters were doing. The Inkosi told these parents that if this new style of dressing up by their daughters continues they will have to relocate before the entire village gets uncontrollable. These were mostly the girls working in the cities and from higher centres of education. As years went by more girls got educated, moved into big cities, and subsequently the use of pants by girls eventually got tolerated by the community in the area.

According to Mager (1996:13), she mentions and cites her findings way back in the Eastern Cape an African society no less than in other societies, these appropriate behaviours and meaning for males and females were socially constructed and attributed. Individuals of different sexes were taught that they are not of the same sex and as such their sexual roles are then different. This engendering was inculcated from the cultural teachings, in making feminine girls and masculine boys.

I reached puberty of my engendered female sexual construction in this homestead. My roles were different from my two brothers, I had to do cooking, clean the house, do their washing, dish for everybody if it was my turn, and my sisters had to do the same (effectively all household chores). Wash dishes, and not the brothers. Their job was to count my fathers cattle that they all came back to the kraal in the evening after grazing. Look after us in an effort to protect us

from whatever offender, mind you, they were also spying on my bigger sisters if they were chatting constantly with boys especially if it were the same boys all the time and report to my parents.

One thing very positive with my parents was that my father use to say: "they all have to go to school and should all find jobs where they will be professionals". Girls in my area, not all families were taking girls through high school, but all willing boys went through high school. These families use to say "it is enough for girls to only learn to read and write their names, but to put them through high school would be a waste of time and money because after all, they are not going to belong to this homestead, they are going to get married and belong to other families. All we are expecting to get from them is *"ilobolo"* and thereafter they need to produce babies. If you educate these girls they get so learned that they become bitches [*"onondindwa"*] and you never get *"ilobolo"* from them by getting married".

These strong cultural beliefs are highly female discriminating especially from education, which according to the Constitution of RSA today, is now a basic right across the board. These women according to this discussion were just destined for reproducing babies, and looked at as sex objects to bring *"ilobolo"*, meanwhile the boys were geared up to have a total control over these girls, awaiting to marry them and give them babies. One does not hear much said to these girls

about getting these men as husbands and make decisions about when and how to get babies, and how to manage breastfeeding.

When I reached puberty I was thirteen years, I had already developed some breasts. When I was undressing one afternoon from school my underwear was red with blood, I got so shocked and started shivering I did not know what to do with myself. What scared me most was that my mother use to speak to my three elder sisters and exclude me from whatever discussions, I would only overhear her voice when she was cross, scolding them, I used to hear things like "I have heard that you have been seen several times with X (a boy) and I don't want to hear about this again because girls that speak to boys a lot after school, fall pregnant and a lot of other things happen to them."

My parents never discussed sexual matters with us as their children. Schools never had sex education at that time, even when you use to ask your mother where this baby of hers came from, she would say: "it was brought by an aeroplane". The church also never mentioned anything about sex in the Sunday school classes except, no sex before marriage. The view was that people should get married and then have children. Polygamy which is culture and tradition of the Zulus, the church would not allow. This means that in certain aspects such as the recognition of ancestral power, the consulting of a devinar '*isangoma*' and polygamous marriage, the church seeks change. These ideas held true right through the 1960s and 1970s (Ngubane, 1977:3).

Coming back to my puberty and my menstruation as was a normal healthy stage reached by me, but instead I thought may be my mother would scold me if I tell her, like she normally scolds my sisters, because at that time I had already had boys 3 – 4 years older than me at school telling me that they love me so much. I then thought may be this is happening to me because the boys are mentioning love, etc. I then decided to tell my elder sister, who just laughed and said “whoo”!!! you are a big girl now and ran to tell my mother. My mother came to me and said I must show her what my elder sister is talking about. She further asked “when did this happen”? (meaning menstruation), I replied, “I saw this blood when I was undressing after school”. She further said “you must clean myself up, this is going to last for x number of days”. Further, she said that “you must not talk to the boys and if ever you dare have an affair and sleep with any boy (have sex), you will have a baby, and we will disown you”. I was then included in the talks my mother periodically had with my sisters. I never saw her doing what she did to me with any of my brothers. They use to speak to girls and sometimes my parents would see them and say nothing to them. My brothers would do anything and it was never questioned like they would do to us as girls.

After my high school education I then took up nursing as a profession, specialized mostly in mother child health. Breastfeeding has been the first word as advice to mothers regarding feeding their babies. This is what I know and have experienced from childhood. Most of my patients have been also forever

willing to breastfeed their babies, knowing and understanding the tradition, the culture and of course family and community expectation regarding breastfeeding.

Mothers would feel very proud that they have been able to give birth to a live normal infant, because according to the tradition they have lived and known, their worth has been proven. They would comment and say at least the '*lobola*' that was forwarded, has then proved its worth, I am able to reproduce. I am now going to be fully accepted by my in laws as a real daughter in law (*makoti*). As described above, in these societies cattle were necessary for marriage and women were denied the possession of cattle. Men exchanged cattle for women, the most important occasion being on marriage, when cattle were given by the husband to the brides father. This exchange was, however, conditional on the bride remaining obedient to her husband and proving fertile in the marriage. These conditions were crucial (Guy, 1990:39). The female bodies are constantly under surveillance in many subtle ways and sometimes remote controlled by partners in laws and significant other. Most women then and now viewed motherhood, reproduction and sexuality as giving them a certain status in their lives. The reason being the self realization of motherhood and all the caring that goes along with it. The fact that as a woman I am able to bear children, look after them and watch them grow to their full potential, with the initiation of breastfeeding. This thinking means that breastfeeding in its own right needs to be studied further, it is an area of such importance that researchers need more work to do around it. There are many strands that researchers still need to tease

out in breastfeeding such as sexuality and breastfeeding; mixed feeding and its implications; sex work and breastfeeding; religious ideas and breast feeding; hormonal shifts and breast-feeding; inter-generational tensions around differing ideas of breast-feeding; class mobility within one ethnic community and its impact on breastfeeding and so on.

As I have indicated earlier, breastfeeding is a historic culture of many communities in South Africa, it's a culture where difficulty is experienced in wishing it away. Yes breastfeeding shifts have occurred as result of mothers becoming part of an active component of the economic sector and coupled with the vertical transmission.

2.5 The Contexts of Breastfeeding Today in South Africa, in the Province of KwaZulu-Natal

As a nurse in KwaZulu-Natal breastfeeding has been the main mode of feeding neonates, so much so that if you would sit with expectant mothers that have delivered, they would tell you as a health worker about the advantages of breastfeeding if asked. It has thus become very important to look at ways and means of preserving the culture of breastfeeding and how it can be protected, and sustained during HIV pandemic. It becomes very important to establish why mothers would want and prefer to breastfeed.

Do women breastfeed because they grew up in settings where it was, and still is culturally accepted and expected that women should breastfeed?

Do women breastfeed because their partners have patriarchal power over them?

Do women breastfeed because of the love for their babies?

Do women breastfeed because of merely accepting advice from health givers?

Do women breastfeed because of poverty and breastfeeding happens to be the only option?

Do women breastfeed because women have a full knowledge that breast is best.

Do women breastfeed out of their own independent choices?

Do women breastfeed because they want to express their sexual identities, motherhood and bonding?

Do women breastfeed because the mother – in – law and the community around her to breastfeed?

Do women who are well counselled regarding breastfeeding pattern, breastfeed to hide the HIV positive status?

Do women breastfeed because of poor sanitation, no clean water in their areas?

In the early 1990s as a nurse I experienced, along with many of my colleagues, a period of anger, frustration sometimes total confusion at the realization of the true situation of the HIV epidemic that gave no hope of being cured. In the later 1990s one hoped for the cure to be discovered, and we all know the history of infectious diseases and how immunizations and vaccinations were discovered over time, with often many decades of research needed. Is there hope for HIV and AIDS cure?

This giant killer disease became a daily challenge to my daily nursing tasks with patients in general. Caring for these patients on daily basis was sometimes very emotional as one knew that they had a disease that was incurable and that there was a potential of vertical transmission. Throughout my midwifery training and speciality courses in paediatrics and neonatology breastfeeding has been the most preferred method of feeding babies. This is the theory that one has been teaching throughout the last decades in obstetrics, paediatrics and neonatal wards. In the same profession and same practice I found myself affected by shifts and changes that have diluted and switched the thinking and logic that informed the basis that most of us in the profession were always reinforcing and reiterating that breast milk is the best. It is in this light that one argues and

agitates further that more research is still needed in this area of breastfeeding so as to clear the contamination by a number of factors and interrogate the idea and concept that propagated the idea of breast milk being the best. These experiences lead to me wonder if over the last 10 years less arrogance and apparent certainty in our teaching and theory as well as in our clinical practice on the part of ourselves as nurse teachers and on the part of the medical profession more broadly, would actually have been more beneficial. When we do not have all the answers we should not pretend that we do. We should be open to dialogue and indicate when we are uncertain. This is very difficult for people trained in hierarchical and status-laden disciplines to take on, and is seen as a sign of weakness. But I wonder, in retrospect if pretending to have answers was our greatest weakness, and as we have been proved wrong or incomplete in our knowledge, and the wider public has picked up on some of this, whether this has in fact not undermined the profession we represent.

2.6 Studies Conducted on Breastfeeding of HIV positive Mothers

There are a number of breastfeeding studies going on worldwide trying to seek best ways and best methods of infant feeding patterns that would be suitable in an effort to try and formulate HIV infant feeding guidelines for decision and policy makers, while still allowing choices to be made by mothers regarding feeding their babies. Choices include exclusive breast-feeding, exclusive formula feeding and mix feeding. Studies to protect, preserve and sustain breastfeeding has

been done, i.e. conducted in Thailand, United States of America, France in Europe, Brazil, Nairobi in Kenya and Durban in South Africa.

2.6.1 Studies conducted in developing countries

These countries are concerned about preserving breastfeeding and saving lives in a new world of mother to child transmission. All these studies were using antiretroviral study drugs, namely either nevirapine (NVP), zidovudine (AZT) and 3TC. The majority of these studies were focused on perinatal rather than post natal transmission. The participants of these studies were voluntarily enrolled in these programmes whereby an informed consent had to be signed by the agreeable participant, detailing all steps that would be done in these programmes, countersigned by a witness. Some mothers would decide to mix formula feed, some breastfeed and others would opt for exclusive breastfeeding. These choices were respected and trends of infant feeding observed together with the HIV infection rates over time. There is a battle of finding ways and means of preserving breastfeeding, as well as finding ways of preventing infection whichever way that would come up with the result that better protects the body from vertical transmission. It is worth mentioning that with the HIV positive mother, the preference obviously would be to avoid breastfeeding for fear of possible vertical transmission. The huge problem arises when one looks at the situation in developing countries, where there are no adequate resources like clean water, poor sanitation, unemployment, a burden of other diseases,

poverty, discrimination, cultural issues regarding breastfeeding, patriarchy especially from partners and mother-in-laws. Under all these negative conditions there will definitely be problems, lack of hygiene as well. Formula feeding and bottles will still pose a health hazard to these babies.

2.6.1.1 Study done in Brazil

According to a small retrospective study in Brazil a developing country their study results showed a trend towards an increased risk of transmission with mixed feeding, bleeding nipples and the duration of breastfeeding, showing a rise in infection rates (PACTG 076:1994).

These results clearly support all what has been mentioned above regarding developing countries.

2.6.1.2 Study done in Durban, KwaZulu-Natal - South Africa

A study done in Durban in 1999 looked at breastfeeding patterns of 549 HIV positive mothers, who were also part of a vitamin A study. Transmission rates were compared of mothers that were exclusively breastfeeding, exclusively formula feeding and those that were mix feeding.

Of the 549 women, 393 (71.6%) initiated at least some breastfeeding, 316 (57.6%) were still breastfeeding at one month, 226(41.2%) at three months. The median duration of breastfeeding was six months. Among 391 breast feeders

with information on exclusive breastfeeding, 191 (48.8%) breastfed exclusively for one month and 103 (26.3%) breastfed exclusively for three months. The median duration of exclusive breastfeeding was one month (0 – 3) (Coutsoudis, et al, 1999: 354; 471- LANCET).

The results of the study was:

Coutsoudis, et al (1999:474) argues that their results do not accord with conventional wisdom because they suggest that the vertical transmission of HIV 1 through breast milk is dependent on the pattern of breastfeeding and not simply on all breastfeeding. Exclusive breastfeeding carries a significant lower risk (almost half the risk) of MTCT of HIV than mixed feeding. Although the risk of HIV 1 transmission associated with a non exclusive breastfeeding seem to be substantial (risk of HIV 1 infection by three months was 24.1% in the mixed feeding group and 18.8% in the never breastfed group, giving a difference of 5.3% presumably due to post-natal infection), exclusive breastfeeding does not seem to convey any excess risk of HIV 1 transmission over formula feeding. Transmission rates by day 1 (about 6%), which reflect in-utero infections only were similar in the three feeding groups.

KwaZulu-Natal has been up to the recent past been a pro-breast feeding community. This has largely cut across cultural groups (see Brookes 1991 Bergh 1993). Clearly, it becomes evident that breastfeeding has its historical origins

worldwide, with slight variations here and there, but by and large, it has for centuries retained its position. An interesting counter example is a study done in Kenya and Malawi which looked at viral loads (amount of virus in the human system), looked at the CD4 counts (immune system) and infection rates as to how they occur, etc. the interest being to establish ways as to how breastfeeding could be preserved in the presence of HIV infection.

Breastfeeding in KwaZulu-Natal is also the cultural preferred and accepted proactive. High numbers of HIV positive pregnant women in this province at antenatal care clinics is alarming. "Based on antenatal survey findings, KwaZulu-Natal has been believed to have the highest provincial HIV prevalence rate. In 2001 antenatal survey KwaZulu-Natal recorded the highest at 33.5% (CL: 30.6 – 30.4%), followed by Gauteng 29.2% (CL: 25.6 – 32.8%) and Mpumalanga recorded 29.2% (CL: 25.6 – 32.8%), and the lowest prevalence rate was recorded in the Western Cape, 8.6% (CL: 5.8% - 1.5%).

The above mentioned statistics are depicted in **Graph1: HIV Positive Women in the ANC** – Source: Nelson Mandela/Human Sciences Research Council (HSRC) Study of HIV/AIDS Prevalence, Behavioural Risk and Mass Media – 2002.

According to the South African National HIV prevalence, behavioural risks and mass media household survey done in 2002, however suggests a different provincial prevalence rates with KwaZulu-Natal ranking fourth and the Eastern Cape the lowest.

2.6.1.3 Study done in Guinea Bissau, West Africa

A study done in a developing country, Guinea Bissau in West Africa, a society without a large HIV prevalence rate at the time, over the 1991 – 1992 era looked at reasons for termination of breastfeeding and the length of breastfeeding. They had enrolled 1, 678 children. All children in the study were followed until they terminated breastfeeding, by either moved out of the area, congenital abnormality, had milk from mom or never breastfed from birth.

The results showed that the median length of lactation was 22.6 months. Only 5 children were weaned off from this total sample. The reasons for weaning off these babies were as follows:

- One did not start breastfeeding because the mother died giving birth;
- The second, the baby had a cleft palate;
- The third, the baby has become paretic after birth;
- The last two children the mothers thought their breast milk was bad and would make the children sick.

I am mentioning this study to compare emphasize and re-affirm the importance of protecting breastfeeding more so for mothers who are HIV negative. This population as you can see was not looking at the HIV status of these mothers. It says more about the origins of this culture of breastfeeding, its benefits in terms of health and that it may still be a better option for developing countries for many reasons which are mentioned in this thesis. The big question for South Africa and this province with the highest rates of MTCT, is how do we protect this asset. In this study, the term 'weaning' refers to the complete termination of breastfeeding and the introduction of other food in diet (Jakobsen, 1996:115).

2.6.1.4 Breastfeeding study in Nigeria

Another breastfeeding study done on the Yoruba community in Nigeria in 1997 which was looking at socio-cultural factors and the promotion of exclusive breastfeeding in rural Yoruba communities of Osun state in Nigeria.

This study did a questionnaire survey of 256 third trimester pregnant women. All women in these communities were breastfeeding. The study conducted 10 focus group discussions among homogeneous groups of grandmothers, pregnant women, lactating mothers community health workers and husbands. These women were breastfeeding their babies on demand. It is of interest that these women strongly believed that they should give their babies as early as at 0 -3

months water porridge and herbal tea. The colostrum was discarded as it was culturally believed that it is pus.

It is also of interest that the health workers in these communities were also supporting the early initiation of supplements, e.g. teas, porridge and water. This support then answers the question of the diarrhoea that these babies periodically suffered from. Many epidemiological studies have shown that any breastfeeding protects against diarrhea and other diseases in infants during the first few months of life (Davies-Adetugbo, 1997:114).

This study concluded that infant feeding patterns and practices reported here were similar to those reported for some rural areas in Zimbabwe. The concerns were the same of poor sanitation, lack of clean water as causes for diarrhoea and other diseases with these babies. Infant feeding patterns were definitely of mixing of long duration and given on demand.

We emphasize here that breastfeeding in these rural Yoruba communities is universal and of long duration. It is clear that women in these traditional societies have been more successful at breastfeeding than Western women and urbanized women in developing countries (Davies-Adetugbo, 1997:123).

I would further add by saying there are really very limited options for rural women in developing countries, when faced with realities of poverty, poor sanitation,

unemployment, discrimination, powerlessness, no clean water and an added burden of MTCT.

2.6.2 Studies conducted in developed countries

In developed countries with resources in place, and a comfortable stable economy, genuine choices are made and are sustainable. Studies in developed countries will support this statement.

2.6.2.1 Studies done in the USA & Europe

The study done in United States and Europe, developed countries has shown a perinatally acquired AIDS incidence that has declined by 66% from 8.2/100 000 in 1993 to 2.8/100 000 in 1996 due to AZT use [IAS AIDS International, 1993:9; Recent Therapeutic Advances in Preventing PMTCT of HIV].

2.7 Breastfeeding experience – first hand

1. Breastfeeding in my own home
2. Breastfeeding of myself by mom
3. Breastfeeding of my own sisters and brothers
4. Involvement of family (Dad) in this breastfeeding
5. Extended families called “*umndeni*” how it looked at breastfeeding

(I was a child restrained in this environment as a girl and handled differently to boys in this homestead)

When I was in high school all events and demarcation of what to do, how to do it and the explanation that girls do not have to behave in certain ways as compared to boys was clear and glaring. Each and every mother in the area who fell pregnant would breastfeed. Even when I was a child I would call this a “semi rural” as the missionaries were already in the area and our families had begun to urbanise.

Bodies of women and breastfeeding are highly politicized in these rural areas. Even today people argue that their ancestors encourage them to see breastfeeding as the only method of feeding babies. Traditional birth attendance by and large, is still common and there were very few enlightening church going families who would consider hospital deliveries. It was tradition, culture and general practice in this rural community to have separate well defined roles. Female bodies compared to male bodies were obviously recognized as well as different dress codes to empower the difference. Female duties in the house compared to male duties were handed out according to gender.

These ideas that associate very separate spheres for women and men and a highly domesticated role for adult women have transformed in many societies. Can the period of the Enlightenment and modernity itself be held responsible for

such a dynamic paradigm shift in this generation? Can civilization be held responsible? In my childhood breastfeeding was practiced until the next pregnancy occurred, and this would have been true for many of the world's women. Speaking as a Zulu woman from childhood, school life, professional standpoint, the last thirty years motherhood have meant breastfeeding interruptions because of paid work, the introduction of mixed feeds due to work pressures, away from home for days sometimes. Despite shifts in de facto practice, people in KwaZulu-Natal have roots embedded in the culture of breastfeeding. In this region my fieldwork has shown that this factor is key. This is so much so that some babies are breastfed by the family members, namely grandmothers and aunts, in order to maintain the breastfeeding tradition.

A case I know is of a sister who also has a 10 month old and breastfeeds her sister's baby cause she has died, gone to town, taken a new job, or has decided to abandon her baby, and for arguments sake the foster mother is HIV + what are the chances of this baby who might be HIV+? Thus a huge questions and concerns that needs to be addressed. The scenarios are still happening in KZN.

A grandmother in KZN was found breastfeeding her daughter's baby because the daughter would be back in the afternoon and baby was crying and hungry. The mother is HIV positive baby has now a milk set of teeth, constantly bites granny because most probably nothing comes out of the breast. Granny shows scars around her breast some healed some not. The grandmother says that, the

mother expresses and sometimes the expressed milk is not, enough and there is nothing to feed the baby in terms of other food, have no money to buy either the formula or, mealie pap some other days, have to wait for the daughter to get paid, and thus have no option except to pacify the baby in this way. What sustainable mechanisms can be devised, put in place that such situations are addressed?

It was clear from our fieldwork experiences that some young women's aspirations (inculcated in them by some of their elder women) included that it is important:

- To “*soma*” (thigh sex)
- To get married
- To respect your mom
- To accept polygamy
- To bear children
- To breastfeed them
- To keep quiet and be submissive
- To stay in fruitless abusive relationships
- Not to get highly educated
- Be a home maker

Out of the above also emerges the features of how labour and behaviour are perceived by some of these young women in some of these homesteads e.g.

- Do all female roles in the house

- Respect your brothers even if younger than you, carry out their orders whether the orders are not sensible that is another story.
- Submissiveness must be the outstanding feature in all interactions between the boy and girl child and finally adult male and adult female.

As a married Zulu woman, expectations are that:

- You must listen to your partner
- He has the say all the time
- He makes decisions
- He involves himself in extra marital relatives
- He gives money when he pleases
- He instructs around breastfeeding
- He instructs when to have sex
- He decides how to have sex
- He decides when to have babies and who should name babies born to this marriage
- He decides what to buy in this house
- He decides how to bring children up
- He decides which children will go to school and for how long
- He decides who your friends should be and especially how to run your whole life

These powerful gender divisions are clearly present today.

2.8 Changes in South Africa and KwaZulu-Natal:1990s

Employment and the quest for high paying jobs and promotions by men in power around making decision as who to employ has led female to engage in sexual relations for exchange of job opportunities, as known that men still dominate in most powerful economies, and still do decide who to allow to access job opportunities. The Constitution of the RSA, clearly sets out the promotion and protection of gender equality at the work place, women still find themselves exchanging sex for accessing these job opportunity. It does look for a second that there is no win - win situation in these gender power relationships. Do women perpetuate this kind of situation by allowing themselves to be sexually exploited by men for reasons of getting employment? Are women driven by certain circumstances that we still need to find out and research, to find out as to why this exchange happen? Are women driven by a sense of helplessness that they allow themselves to be sexually abused? Are women driven by a sense of wanting to drive beautiful cars, state of the art cars, carry expensive cell-phone wear every type of fashion that is current? Are women driven by self centred ego of wanting to belong to a certain upper class of their choice? All these questions need to be answered in studies around culture – gender – power.

Do men super power in these position exchange sex for these high positions because they look at themselves as masculine? Custodians of gender power relations in their own historic social construction? Do they look at women as willing sex objects? In this modern world of economic globalization, are men

looking at women as part and parcel of this globalization? Where has all the respect for female bodies gone to?

What are the driving forces behind all this discourse. As a Zulu woman from the province of KwaZulu-Natal, tradition and culture of womanhood was self respect, not allow male counterpart to have sex with except and if only there was a relationship, and that kind of sex was also not penetrative sex, it was thigh sex, as womanhood had to be kept sacred (virginity) until marriage. Women were all expected to have their own homestead after marriage and than bear children. If women were to have sex before than it would be *ukusoma*. Male counterparts knew that and understood it very well. Selling sex or exchanging sex was unheard of. I am talking the culture and tradition that every Zulu person in KwaZulu-Natal knows, has lived and practiced, generation after generation. What has now changed this culture, what dynamics has influenced this overwhelming change?

The head of the family has always been the father, who has the duty to protect support and guide his family together with the elders in his extended family, called *umndeni*

2.9 Health Worker Attitudes

Health worker attitudes at this site (undisclosed site – for its protection) were sympathetic by and large especially for married women who were shocked and very devastated at the post counseling session, when they had to learn for the first time that they were HIV positive.

Towards the younger women that had a history of having left parents home and now staying with boyfriend, who was now the father of the unborn baby, attitudes here would reflect some anger , as you would over hear some of them saying:

Why did you leave your parents home?

See now you are pregnant and having this disease, they would never say you are now HIV positive

Where is this boy of yours?

Has she left you now?

Who is now paying for ANC? (This centre is semi-private and the ANC fee was R30 per visit)

Who is going to buy clothes for your baby?

Are you going to go back to school next year?

Analyzing this conversation which was really semi lateral as they were few responses, coming from the mother because there was very little chance allowed for responses from the mother.

You would observe some degree of anger, power, sympathy, as there is a question of funding out about this mother. Really these were mixed feelings from some of the health workers especially from the older group.

Looking at participant's rights, confidentiality, psychological support, it was evident that this was missing from the health worker. It was clear from both the participant and health worker that the burden and stresses of the pandemic is unbearable, and so overwhelming that people are not infected they are certainly affected by this scourge one way or another. Health workers find themselves all of a sudden with an increasing load of work as the epidemic escalates. The high pressure of work normally clouds issues of caring, assertiveness and an ultimate goal of providing a professional health service that is judgemental free. Pregnant HIV positive mothers find themselves uncomfortable at ANC clinics due to lack of individualized care, as numbers become the issue and not quality become the order of the day in the face of the HIV epidemic.

One would argue that women oppression is also seen in these crowded ANC clinics. Providing appropriate facilities in terms of beefing up infrastructure and stepping upon human power to have an acceptable holistic standard of care. This is happening because its women that fall and find themselves using these under resourced facilities with under staffing

Chapter 3 – Breastfeeding Patterns in KwaZulu-Natal

3.1 South African Scientist Overview on MTCT

Since the early 1990s scientists have known that HIV can be transmitted from mothers to their babies through breastfeeding.

There has been very little work and research done on understanding the breastfeeding patterns in the vertical transmission, so much so little that even with the availability of nevirapine (NVP), the big question still remains as to how long should babies be breast-fed, would it be six months of exclusive breastfeeding, should it be more? Should it be less? Further, research is still needed, in South Africa for rural communities to understand the lactation dynamics in the context of NVP.

This study emerges from a larger research project conducted under the auspices of the Medical Research Council (MRC) which examined the transmission rates of HIV infected mothers given NVP syrup and exclusively breastfeeding these babies for a period of 6/12. The name of the study was HIVNET 023 funded by the National Institute of Health, United States of America (USA).

This was a Phase 1 Study to Assess the Safety and Plasma Concentrations of NVP given daily, twice a week and weekly as prophylaxis in breastfeeding infants

from birth to 6 months. It was done in Durban, South Africa and Zimbabwe, the studies were running concurrently in these two sites.

3.2 Population size

The people screened were 186, excluded at screening was 121 and excluded at enrollment was 9. We had a total number of mothers thus enrolled were 56. Mothers enrolled but lost pre-delivery were 9. Mothers that delivered were 47. Babies delivered were 48 because one mother had a set of twins. The babies excluded at randomization were 9. So the total number of babies randomized was 39.

3.2.1 Sample size

38 isiZulu speaking mothers who chose to breastfeed were randomized into three arms. Arm one was given one dose of NVP once a week. Arm two given two doses a week and arm three single dose each day in a week. All these 3 arms were exclusively breastfeeding for a period of 6 months.

At the ANC these pregnant women were recruited by the study team at St. Mary's Hospital an urban hospital at Mariannhill, Pinetown in the lying areas of Durban and surrounding, KwaZulu-Natal, South Africa.

3.2.2 Outlining of procedure to participants

The whole study was explained to them all, questions addressed to the satisfaction of both, the participant and the study team and members. If the mothers were willing and agreeable they then voluntarily and consented to join the study they were then enrolled. Enrollments meant signing the informed consent which was also explained in detail to them.

3.2.3 The study's overall objective

This study's main aim as you realize sought to find an NVP dose that would prevent vertical transmission better in the three arms that it implemented. Look at a number of babies that sero-converted, number of babies that would stop breast-feeding, look at blood results and trough levels of NVP in these bloods. How many babies were lost to follow up? How many deaths occurred during the study period, and if any, what were the causes?

The study was also observing NVP use in newborn babies, as thought and believed that this drug may help reduce the chances of passing the HIV infection from mother to her baby during breastfeeding, but it was not known for sure, if this would be the case.

Vertical transmission is the main way and route which young babies and children become severely infected with HIV, and all HIV positive women who planned to

breastfeed and had met all the screening criteria were then illegible to join the study if they so wished. After, meeting all the study requirements and a voluntary willingness to participate was expressed by these participants to the study team, they were then enrolled. The NVP breastfeeding consent form was then signed and witnessed by the study member concerned.

Those participants thus enrolled would have their babies randomized into one of the three NVP breastfeeding study arms and entered into the three infant NVP dosing schedules for a period of six months.

These women will return to their hospital of their choice when labour starts, to receive the above mentioned doses for both mother and baby. If and when the NVP tablet has been taken and, the women was in false labour the tablet would be given to her again, when she is in established labour. If the labour gets prolonged for over 48 hours the NVP tablet would be repeated, or given to her again. If she goes for a caesarian section (S/C) the tablet would be given to her 4 hours before the caesarian section is performed.

If the baby vomits the syrup after being administered the dose gets repeated. The NVP is not a cure for vertical transmission but what it does it reduces rate of transmission. There is yet no cure for HIV/AIDS to date.

Mothers were allowed to take the NVP tablet home in case they had concerns about transport problems, especially those living in rural areas where they were also poor telecommunication facilities as well as the unavailability of ambulances in these remote areas. Another major concern was a high crime rate and hijackings that is rife.

The team had to make sure that the NVP is given to the mother when she is in labour, and also to her baby after delivery within 48 hours, and to follow this NVP treatment to the baby for a period of six months. The NVP process was monitored and observed during the time of treatment for any reactions like rashes. The three different regimes of NVP that were given to these babies were to find out as to which regime would be the safest to use in future, and that would best reduce the vertical transmission during breastfeeding.

The mothers were given two hundred milligrams (200 mg) in a pill form and the babies NVP was in a syrup form. The known percentage of passing HIV infection from a mother to her baby is about 25% or 1 in every 4 babies born to these mothers.

Each mother infant pairs will return to the clinic for seven follow up study visits. At discharge from the hospital, mother and baby will now visit the clinic at 2, 8, 14, 24 and 36 weeks if need arises. These are all weeks post delivery.

The following procedures were done at these visits:

- Full examination of mother
- Full examination of baby including weight and length
- Taking bloods from mother and baby
- Taking of data from a breastfeeding questionnaire
- Checking the immunization schedule if they are done
- Checking of skin conditions, i.e. rashes which is a known side effect of NVP
- Counseling of breastfeeding patterns and counseling in general
- Collecting breast milk for laboratory analysis.

Breastfeeding patterns were discussed at length. The main focus was to establish if the baby is still exclusively breastfed and whether there are any problems regarding NVP and breastfeeding patterns and if the mother still remembers that she has to stop feeding at six months and what plans she has about feeding patterns.

In the USA and SA the NVP is approved for use as a combination drug for reducing HIV in adults. Fewer studies that have been done has also proved that NVP is safe to be used in children and is also priced reasonably, especially for developing countries, with their ailing economies. This is evidenced by work published by UNAIDS (2000) which states that the low cost of NVP and simplicity of administration make it a good candidate for low income countries where

women generally attend antenatal care irregularly or late during pregnancy, or where many deliveries occur in home settings.

A recent study has also shown that NVP given to the mother at delivery once as well as once again to her baby at birth reduces the chance of transmission by half, however evidence proving the use of NVP to prevent passing of HIV to her baby, who is breastfeeding, indefinitely is still experimental. A single dose given to the baby has shown minimal risks.

No drug has shown the ability beyond doubt to completely prevent the chances of HIV being passed on to these babies during breast-feeding. Protection of breastfeeding in the HIV community still needs more research work to be done with the objective of breastfeeding for both infected and non-infected mothers, in the face of vertical transmission. Testimony to this has been confirmed by UNAIDS (2000) in their publication where it is stated that “there is currently insufficient information to recommend wide-scale implementation of NVP for MTCT prevention. Long-term follow up of mothers and children exposed to NVP or other anti-retrovirals for the prevention of MTCT is required.”

Breastfeeding counseling sections were held with these mothers periodically to further explain about breastfeeding for six months while their babies are getting NVP, but throughout the study some of them raised concerns about weaning babies so early as their mother in-laws will just not understand why this is

happening. The pressure was so much that some of them would prefer to move house and stay away from her, when baby turns 6/12, so that there would be no pressure regarding, continuation of breastfeeding.

Some mothers would say they would find a way of deceiving this mother-in-law and the family as to why the baby has to be weaned off so early.

The partner was also giving so much pressure to some of them, wanting to find out as to why a baby is no longer breastfeeding. Explaining from the mother as to why all this has to happen was difficult especially for some of these mothers as $\frac{3}{4}$ of these participants had not disclosed. According to the Constitution of the Republic of South Africa, you do not have to disclose your HIV/AIDS status, to anybody if you so wish. But this right and protection against discrimination against HIV/AIDS positive people was also posing a problem for treatment. In situation where it could have been understood why breastfeeding has to stop we would need much wider disclosure, and acceptance of other choice.

3.3 Neighborhood

They would also mention that if you do not breastfeed in their area, neighbors, would assume that you are HIV positive. That alone carries such a stigma. They would mention that you could easily be rejected by the partner, loose financial support and a relationship that surely ends.

In the neighbourhood you could be violently assaulted, as you would remember the case of Gugu Dlamini, who was murdered by the youth in her community because she disclosed her status.

3.4 Tuck-shop or Tavern

I recall a participant whom we used to spend time together at the clinic on each of her visits, she would mention that, for survival she runs a tavern at a taxi rank, which is a take away, her clients by and large are taxi drivers. She used to tell me that if they can come to know that she is HIV positive, she is sure that they would kill her, as she is handling their meals on a daily basis. HIV does not get transmitted through preparing meals for anyone. She would respond saying she is aware of that and she also thinks they are, as well, but the fact that her status would have been divulged, that would be enough for her to get murdered. She would further say, she lives in this area, knows what goes on around she does not doubt what she is telling me.

Sometimes when a participant misses two or more three visits, what normally used to happen was that we would visit them to find out if they are not well or have decided to withdraw from the programme which we would accept. She used to tell me that I must never visit her at home because she is not sure how the family, neighborhood, the partner and the taxi drivers would handle that. She used to call

me whenever she had a problem. She did though participate till the end of the programme.

3.5 Condom Use

Most of these participants were unable to negotiate condom use with their partners, because firstly their partners would never consent to that, secondly, they had not disclosed, and thirdly, in participants culture and gender does not allow women to negotiate sexual matters with their partners. Balance of power, patriarchy, women used as sex objects comes out clearly.

Some participants fell pregnant, as they would not negotiate condom use, and knowing the HIV status, the counseling that has been done for that, it would appear that what matters in this whole scenario is keeping the relationship together, meanwhile the fact of the matter is woman's vulnerability.

By focusing on women's vulnerability to HIV, it is not suggested that men are not vulnerable, but instead that women are more vulnerable (Tallis, 1999:9).

This kind of information would give women knowledge, power to reason, on breastfeeding patterns of their babies; Be able to negotiate condom use, abstinence, stick to one loyal partner, use contraception to prevent future

pregnancies, or better still decide on termination of pregnancy if so desires, including leaving a relationship without fear of being abused by the male partner.

The HIV positive status and the risk of MTCT may be well known to the woman, but the state of poverty and fear of physical abuse from their partners' clouds making reasonable decisions.

With the various measures in force, and being called upon to keep women in their place (Siedel, 1999:78).

Some women were very uncomfortable when visited in their houses, but that is where the true picture of their lifestyle is well assessed, gathering of quality data around breastfeeding patterns. Some of the mothers liked these visits by researchers anyway.

The child should be weaned off completely from the breast at the age of 3, according to Galen, or in the opinion of Soranus, once he was taking cereal food readily, and had teeth to chew more solid foods which in the majority of cases takes place around the third or fourth half year (Fildes, 1986:35).

3.6 Experiences within home setting

As was outlined earlier in Chapter 1, this chapter seeks to reflect the real situations of breastfeeding mothers in general in relation to gender and other forms of power within families, siblings, partners and so on. However, emphasis would be on HIV positive mothers and their experiences within home settings.

3.6.1 *Partner Relationship*

Partners would not understand why mothers were stopping to breastfeed at six months, as breastfeeding should continue as long as the baby was still taking the breast. In the absence of all contra indications for breastfeeding like, baby refusing to be breastfed, mothers medically advised to stop breastfeeding, if the mother falls pregnant, or if and when a mother has bleeding nipples, critically ill and cannot breastfeed, or would have been advised by a traditional healer (*isangoma* or *inyanga*) to stop breastfeeding for whatever reason the partners would then take that as acceptable.

If mothers would stop breastfeeding their partners would also remind them that all clinics as far as they know strongly recommend breastfeeding. They would further say this is reasonable, cheap and readily available and this in a way would help partners because it is economical. Yet it is sometimes the father's family who insist on giving formula milk in addition to breast milk. It is their way

of demonstrating their care and involvement with the child, e.g. by buying and providing the formula to the mother.

All these suggestions are fairly reasonable, but only in the absence of HIV and AIDS. According to the Children's Status Act, No. 82 of 1987, a provision for paternity and status of children, the interest to protect according to the law is demonstrated. This is shown by the interest of a male for him wanting a child to be breastfed for reasons outlined above. However, this raises serious contradictions in terms of a right to disclose and or not to disclose by an infected person, where a female partner may decide not to disclose and yet put both her child at high risk and also not being transparent as to why she wishes not to breastfeed.

3.6.2 The Family

Some infected people look healthy for a long time, provided they eat nutritious food and look well after themselves. As a consequence of this other family members least expect that the virus may have struck in the family. This results in family members disassociating themselves with the possibility that their pregnant female member may be infected with HIV. Such infection may then be transmitted to an unborn child. When the undergoes antenatal care and she discovers that she is HIV positive and is counseled around infant feeding options available and thus chooses not to breastfeed.

This causes a total confusion amongst family members as to why the baby is not breastfed, as this is the accepted norm within this society. There would be pressure from family members demanding to reasons as to why the baby is not breastfed. The pressures present themselves in various forms, i.e. abuse from family members. The latter happens in the majority of cases, as the pressure mounts and powerlessness thus leaves the women vulnerable and the baby exposed to vertical transmission.

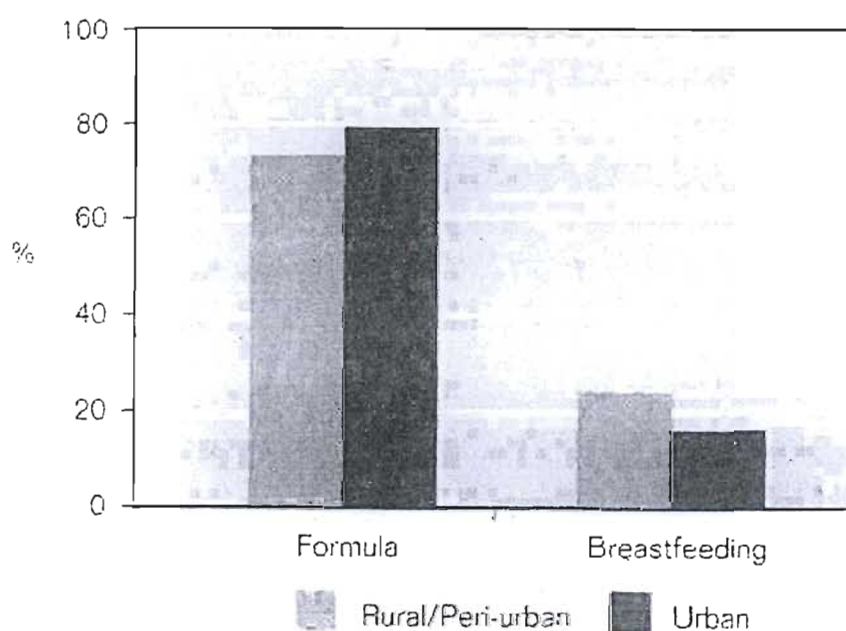
Gender inequalities stand out clear, as the mother of the baby puts the baby on breast with full knowledge and understanding of the consequences and implications of such an action. These mothers have undergone post-counselling as well as MTCT infant feeding patterns. These discussions are done twice or more each time these mothers visit the clinic, and whenever they so request. The pressure that she experiences in her own family overrides all decisions that she had independently. According to Siedel (1998:45), a woman from a group who had been advised to stop breastfeeding by a health worker after her baby suffered severe bouts of diarrhoea was both verbally and physically abused, by her brother for not breastfeeding.

The cry countrywide has been about the provision of HIV drugs, including NVP for pregnant women. After intensive debates and discussions by all stakeholders involved, namely government machineries, Treatment Action Campaign (TAC) activists and business sector, the roll out programmes of NVP occurred

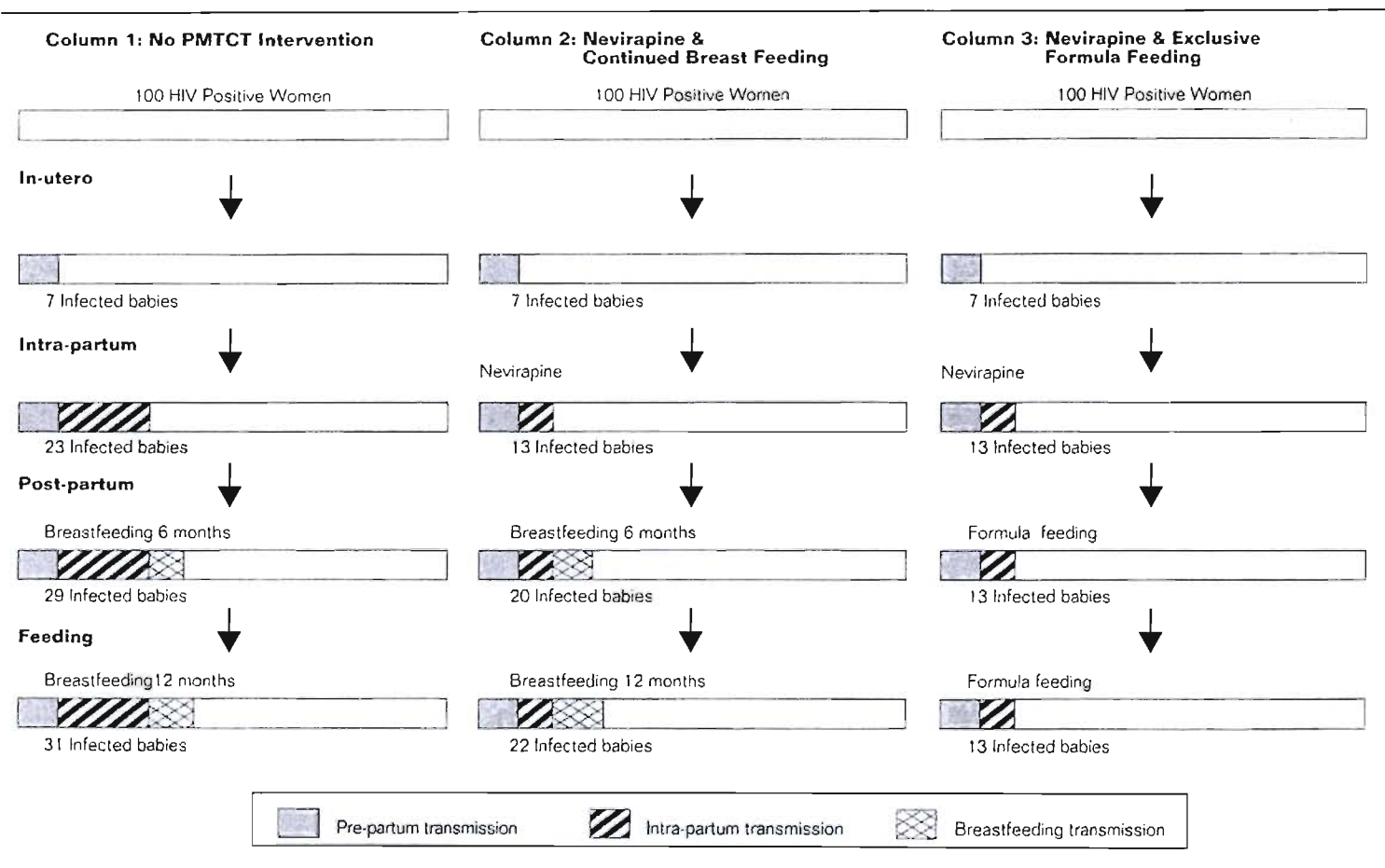
throughout the nine provinces of RSA in 2001 respectively. Each province initially started with two sites. This is evidenced by Table 1, indicating all the provinces with the site name, start date and comparison of infant feeding choices between rural/peri-urban and urban sites (provincial report, department of health). Table 2 shows vertical transmission rates.

Province	Site	Start Date	Rural/Urban	Exclusively formula feeding	Exclusively breast-feeding
Gauteng	Natalspruit	May 2001	Urban/Peri-urban	96%	3%
	Kalafong	June 2001	Urban/Peri-urban	85%	15%
Western Cape	Guguletu	Jan 2001	Urban/Peri-urban	95%	4%
	Paarl District	May 2001	Rural/Peri-urban	73%	27%
Northern Province	Mankweng	Aug 2001	Urban/Peri-urban	73%	7%
	Siloam	Mid Nov 2001	Rural	N/A	N/A
Mpumalanga	Shongwe	Sept 2001	Rural	74%	26%
	Evander	Oct 2001	Urban	89%	11%
Free State	Virginia	July 2001	Urban	77%	23%
	Frankfort	Aug 2001	Rural	68%	32%
KwaZulu Natal	Durban	June 2001	Urban	40%	42%
	Pietermaritzburg	June 2001	Rural	65%	35%
Eastern Cape	East London complex	Oct 2001	Urban	69%	31%
	Umzimkulu	Oct 2001	Rural	54%	46%
Northern Cape	Kimberley	Aug 2001	Urban	82%	8%
	De Aar	Aug 2001	Rural	100%	0%
North West	Tlhabane	July 2001	Urban	81%	19%
	Lehurutshe	July 2001	Rural	79%	0%

Comparison of infant feeding choices between Rural/Peri-urban and Urban sites



Vertical Transmission Rates



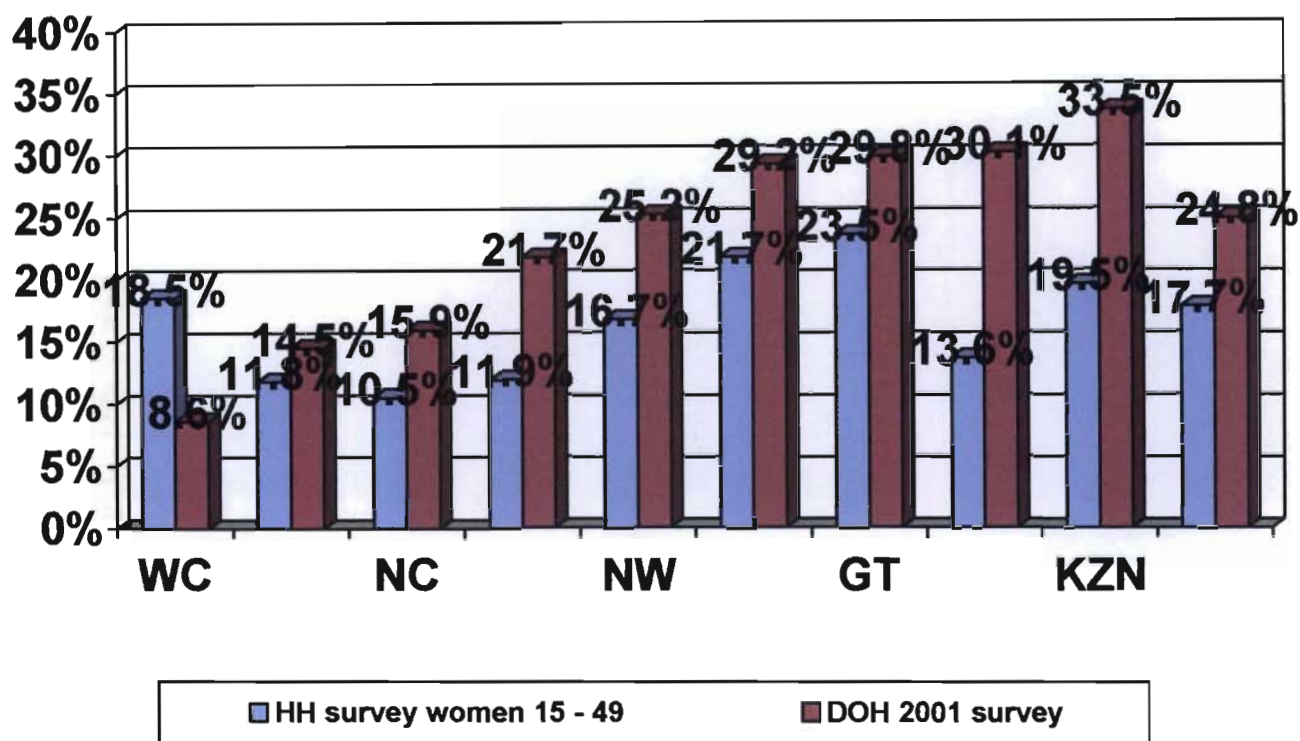


Figure 1: HIV Positive Women in the ANC

Source: Nelson Mandela / Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioral Risk

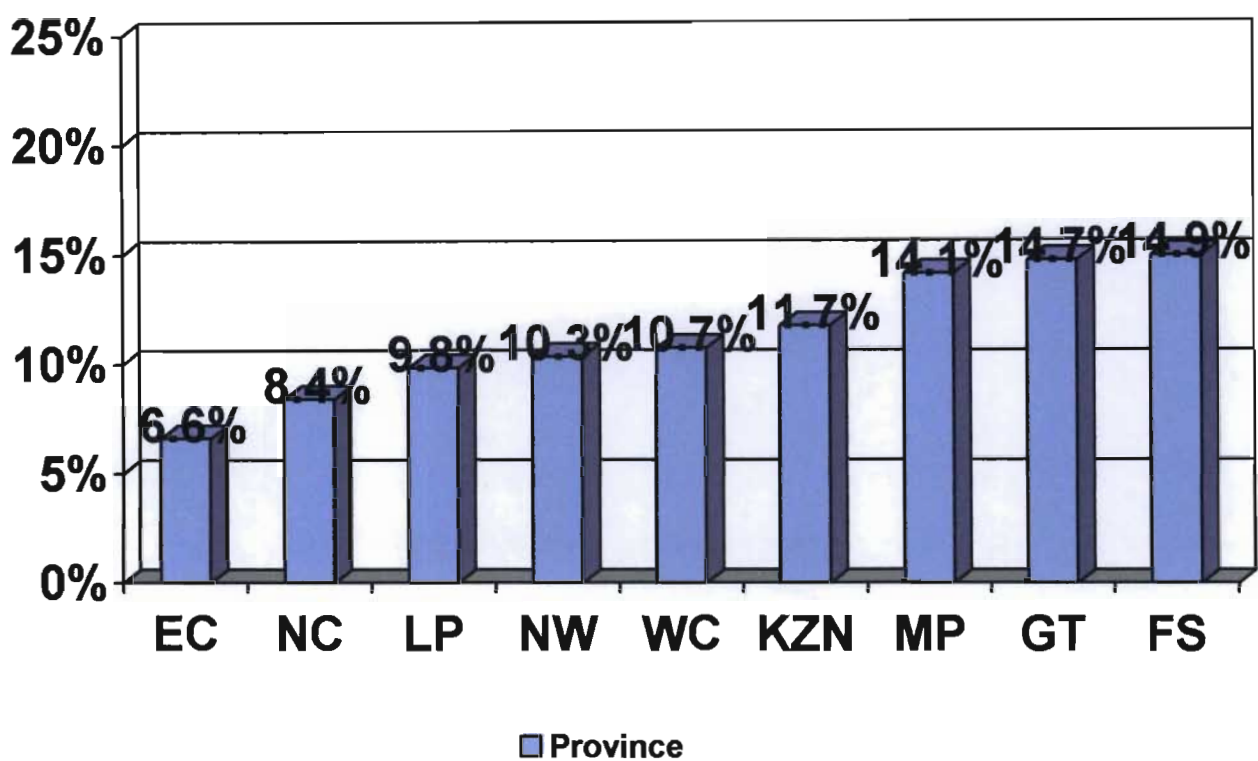


Figure 2: HIV Prevalence by Province, South Africa 2002

Source: Nelson Mandela / Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioral Risk

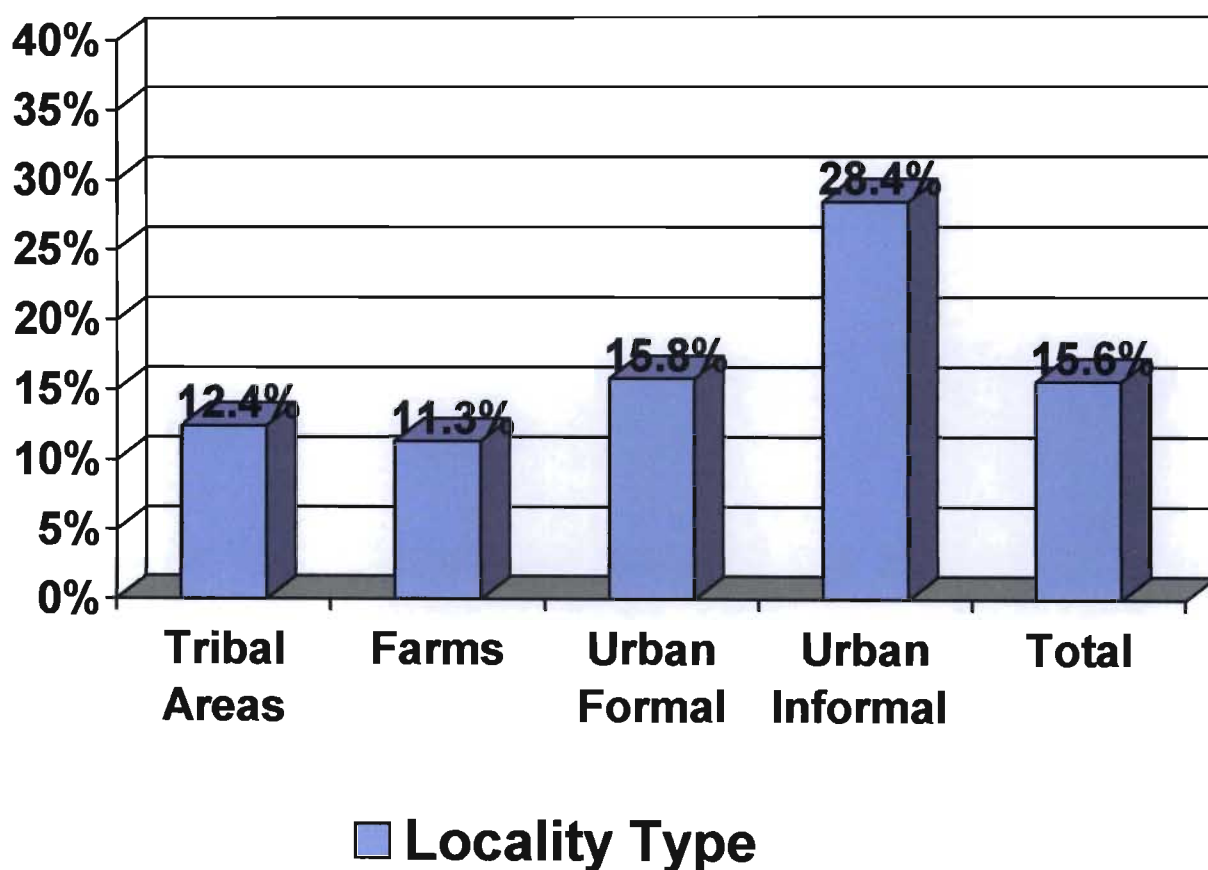


Figure 3: Comparison of HIV Prevalence Levels by Province with the Department 2001 ANC Survey

Source: Nelson Mandela / Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioral Risk

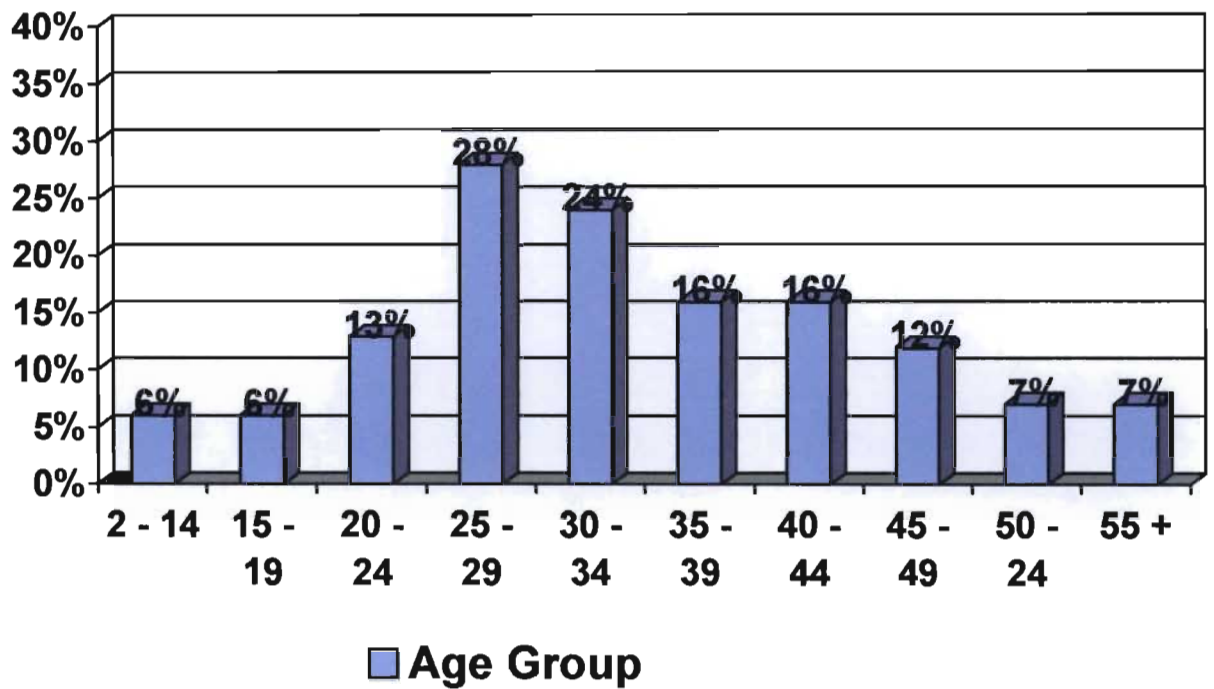


Figure 4: HIV Prevalence in Adults (15 – 49 years) South Africa

Source: Nelson Mandela / Human Sciences Research Council Study on HIV/AIDS Prevalence, Behavioral Risk

Chapter 4 – Counseling, Breastfeeding Patterns and Dynamics in Home Visits

4.1 Conclusion

Breastfeeding patterns for the isiZulu speaking women in this study showed that numerous breastfeeding patterns and related discourses exist between parents, their wider family and the extended family (especially with mother-in-laws and the biological mother) as well as the neighbors, friends and the community. Most of the parties mentioned above could not understand why babies should stop breastfeeding so early.

Some participants were not happy with the powerlessness they had or failing to take independent decisions around the choices that they felt comfortable with because of the fear of verbal abuse as well as domestic violence that might ensure or erupt.

Economic and social pressures came up almost all the time in our discussions in the clinic. One participant told me that she is not employed and the partner has left her because of the squabbles they have had over the condom use, she now has no money to buy formula, and as the baby was crying and hungry, she had no choice but to put the baby back on breast.

She confessed and said she did this with the full understanding of how harmful this could be but I think it is better than giving water to the baby each time the baby is hungry. I have no job, what should I do, these are some of the pressures that compel people to be prostitutes.

Another incidence was when the participant informed us that the mother-in-law verbally abuses her, saying that she is stopping to breastfeed now because she wants to abandon breastfeeding so that she can get back to her old promiscuous behaviour. She also wants to waste her sons money unnecessarily.

Breastfeeding patterns in HIV positive mothers is proving to be a huge dilemma. In an AIDS free world women have always been oppressed, with this epidemic the oppression has gained momentum. Sexual behaviour is determined by their partners; as to how and when to have sex, what to do with their breasts, when to have babies, and how to feed them, completely disempowered.

Poverty, homelessness, unemployment, illiteracy, dependency, patriarchy, helplessness, gender, lack of access to information, vulnerability, discrimination, socio-cultural female construction are all major variables that construct an environment where women find themselves in today in this new world of HIV positive status and breastfeeding of their babies.

Breastfeeding patterns in HIV positive mothers still need a broader partnership of all stakeholders, policy makers to re-visit this phenomenon and further studies, that would also involve, husbands, partners and mother-in-laws and the significant others.

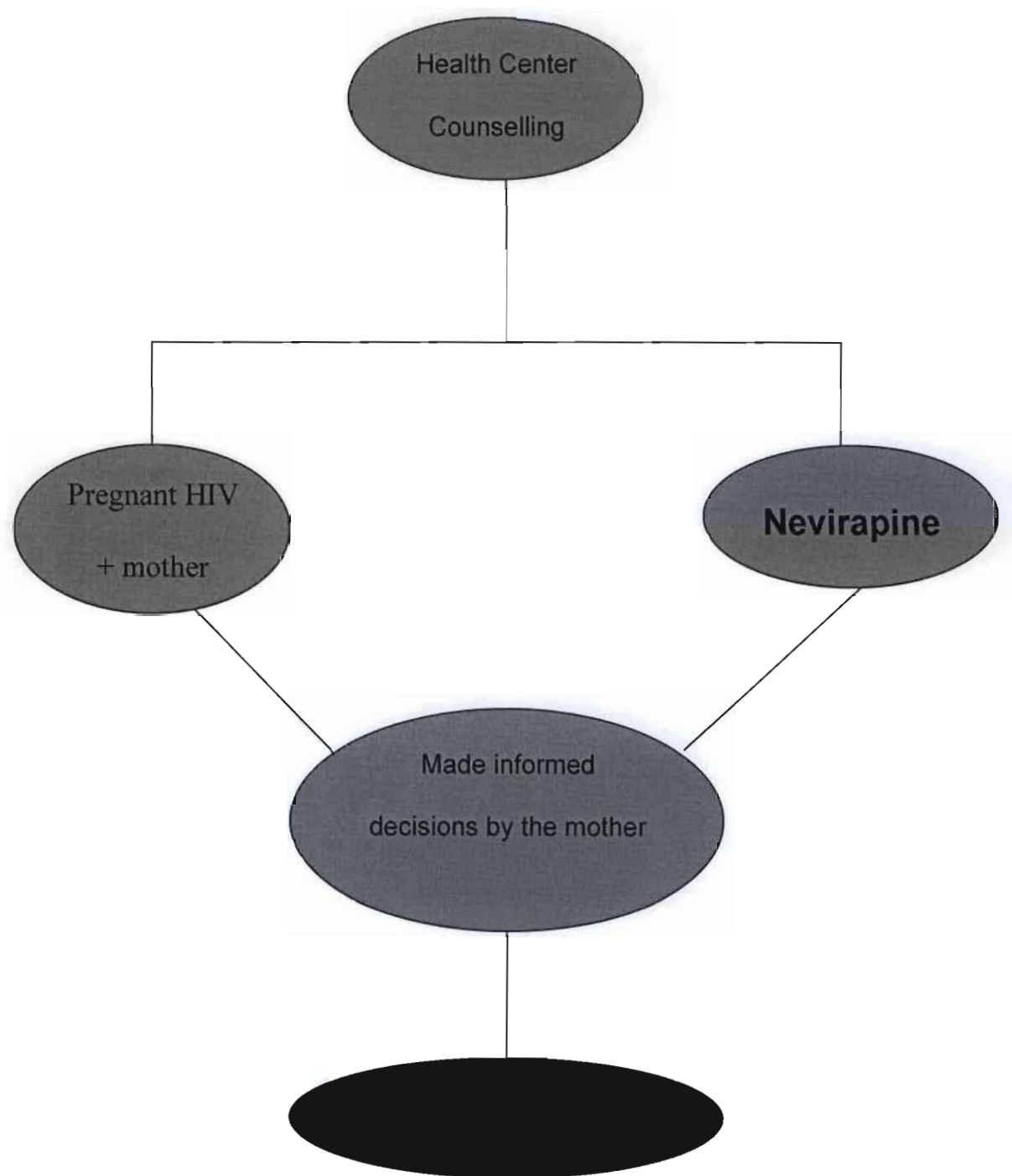
Clinic visits of these HIV positive mothers and their babies in these breastfeeding studies are just a scrap on the surface. The major co-variable that need to be investigated which is in the centre of the HIV positive breastfeeding pattern of an HIV positive mother has not been tapped. The issue of social stigmatization of HIV appears to be the major problem, among all else.

What one sees in the clinic is by and large a total different scenario to what happens in the home environment. Follow up and home visits of agreeable mothers over a reasonable time during the breastfeeding period, might inform researchers, media, anthropologists, sociologists, paediatricians, nurses, health-workers, scientists, Non-governmental organizations (NGOs), government, policy makers, the church, etc. so that developments from these findings can further direct what more needs to be done.

The issues raised by these participants need to be explored and understood well scientifically as why they occur, how do they occur? Where do they occur? And who is the perpetrator by and large. What is the woman's self image and esteem in the context of MTCT – the possibility of educating women in the

categories mentioned above around understanding MTCT and breastfeeding issues and rights.

Breastfeeding needs to be protected for the KwaZulu-Natal communities. The conditions in rural KwaZulu and the shacks and squatter camps in and around, nearly all urban areas is shocking, with no infra-structure, no sanitation, tin houses, informal settlements with no tap water in these shacks as well as electricity but a newborn baby is almost in and every second shack from an HIV positive mother. I have been a physical foot soldier in these areas. This is a true and a real situation and picture that I am describing of these areas, mentioned above.

HIV + MOTHER DYNAMICS IN A HOME ENVIRONMENT

4.2 Recommendations

Out of this piece of work done the following come up as some of the recommendations that can be made for now, however, these are not exhaustive, but for the purposes of this thesis, the following is thus recommended:

- Choices around breastfeeding should be clearly explained to participants and decisions made thereafter.
- Clinical staff should read about and be counseled in the historical and anthropological realities of Zulu women's lives.
- Pregnant women should be offered classes and workshops where they can come together to discuss far wider issues around their health, family life, their social role and their new rights defined in the Constitution. Breastfeeding discussions will only then be entered into.
- Community mobilization, involvement of non-governmental organizations, Amakhosi, the church and other key influential institutions within these communities. This will encourage these structures to care, support and love people living with HIV/AIDS. This could be done by forming support groups, organizing HIV/AIDS campaigns in order to destigmatise the disease.
- Additional information is needed within clinical research to ensure that questions are most appropriately asked in order to obtain the most accurate responses, e.g. to infant feeding practices.

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Definition of Terms

- AZT (also known as Zidovudine – ZDU) - is an antiretroviral drug which inhibits HIV replication. It is used in the prevention of mother to child transmission.
- Cessation of breast feeding - means a process to stop breast-feeding completely
- Colostrum - is the thick yellow milk secreted by the breast during the first few days after delivery that gradually evolves into mature milk 3 – 4 days postpartum. It contains more antibodies and white blood cells than mature breast milk.
- Complementary food - means any food, whether manufactured or locally prepared at home, but suitable as a complement to breast milk or infant formula, when the breast milk alone becomes insufficient to satisfy the nutritional requirements of the infant.
- Early postpartum – means 3 – 6 weeks after delivery
- Exclusive breast-feeding – means giving an infant only breast milk and no other foods or drink, not even water or juice except syrups as medication.

- Intestinal Lumen – means the tubular space of the intestine
- Intrapartum – means a period during onset of labour and delivery
- Mature breast milk – means breast milk produced at 14 days to the cessation of breastfeeding
- Mixed feeding – means giving breast and other milks, liquids or food
- Mucosa – means mucus membrane
- Neonatal – means a period immediately after birth to 4 weeks of age
- Pneumonia – infection of the lung tissue
- Weaning off breastfeeding – means a process of slowing down to stop breastfeeding completely