

The History and Politics of Breastfeeding in South Africa in the Context of the Current HIV Driven Breastfeeding Crisis

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Part I

Introduction

The history of breastfeeding in Southern Africa is ill understood. This is true for all class and social groups. The lack of critical historical and anthropological analysis of the wide-range of extant textual evidence¹ about breastfeeding cultures and practices over the last two centuries has hampered and undermined many attempts to analyse the powerfully gendered forms taken by the physiological and social causeways of the HIV epidemic. The blame, stigma, fear, and also of course isolation in the midst of physical suffering and illness, all implicated in responses to HIV infection and transmission, have roots in the past.² Limited oral history gathering projects, asking questions about breastfeeding cultures and practices in the region, reveal the rich and layered perspectives offered by a study of the past. These studies point to the positive resources and energies a study of the past has to offer, as well as the more ambiguous shadows and spectres that some past breastfeeding practices and beliefs cast in the present.³ The stigmatization of HIV positive women, who bear and give birth, as “infectors”, and the power dynamics in women’s homes between infected mothers, their male partners, and their mothers-in-law and grandmothers, as well as male and female neighbouring and kinsfolk, is recognised in much published commentary on the epidemic, but is still not well understood. Breastfeeding has become, as Jeffery Weeks said of sexuality nearly two decades ago, a “transmission belt for wider social anxieties”.⁴

Public health initiatives internationally and nationally concerned with maternal health, lactation, weaning and all aspects of infant nutrition have, since the late 1990s, been beset with pressured decisions; about-turns in policy; internal tensions and

¹ These include: missionary texts; travel accounts; scientific and medical treatises—especially missionary papers before the 1930s; autobiographical accounts; archives of personal letters; anthropological research; nursing, public health and social welfare documents emanating from non-governmental as well as state associations and so on, as well as commercially motivated evidence gleaned for marketing of infant nutritional products.

² Mandisa Mbali “History of responses to HIV/AIDS” correct title Unpublished Honours Thesis; University of Natal; 2002; Suzanne leclercq-Madlala “The Stigmatization of Women in the HIV/AIDS epidemic” Unpublished PhD; University of Natal, 1999; Susan Sontag *Illness as Metaphor* and *Aids as Metaphor*; Aids and Stigma literature; Illness and Somaticization of illness in socioaological; literary; anthropological literature. Suffering and the body literature.

³ Thoko Ndaba “Breast Feeding Patterns of HIV+ Mother in the context of Mother to Child Transmission in KwaZulu-Natal, South Africa.” Unpublished MA, University of KwaZulu-Natal, May 2004; also cite the MRC related “Analysis of MTCT Transmission in South Africa: Case Study of Umlazi/Reitvlei/Paarl sites. MRC Project” Durban; see data gathered and referred to in A. Coutsoodis, K. Pillay E. Spooner, L. Kuhn, H M Coovadia “Influence of infant-feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study”. *Lancet* 1999;354:471-76 and A. Coutsoodis, H.M. Coovadia, K. Pillay, L. Kuhn “Are HIV-infected women who breastfeed at increased risk of mortality?” *AIDS* 2001;15(5):653-5. Incomplete: add ref.s from Ndaba Thesis.

⁴ J. Weeks *Sexuality and its discontents* London: Routledge, 1985.

contradictions in theory and in practice. The complex pathways of transmission of HIV from parents to children (what we will start calling ‘Parent to Child Transmission’ or ‘PTCT’), through the conception, gestation, birthing and lactation associated with childbirth, has been reduced to ‘MTCT’ or ‘Mother to Child Transmission’ in health discourses. We argue that not only is this a poor political and strategic choice of acronym—further subjecting women as mothers in the role of “the transmitters”—but it is a poor choice in any efforts to socially embed the responsibility for HIV prevention and care.

This is especially true when considering the research into breastfeeding conducted since the late 1950s, and widely disseminated since the 1970s: successful breastfeeding by any measure (exclusive; predominant; partial; or intermittent breast feeding—terms discussed later on) at all, depends on a woman’s participation and on the social, familial and partner support around her. Women who are not the biological parents of born infants can also provide infant lactation to other women’s offspring—not only as wet nurses (through familial or commercial/labour arrangements), but also as adoptive mothers—with the help of nipple stimulation (practiced for thousands of years) as well as (more recently) hormonal and chemical assists, and other interventions. In many parts of South Africa and the world infants are suckled for comfort or nourishment, both intermittently and often, by relatives and care givers. This has huge implications for HIV/Aids transmission and research. Thus, to narrow the terminological field to an individual “mother” and her “child” is both retrograde and counter-productive.⁵

Local Context: why we need an historical and gender-sensitive analysis of breastfeeding in South Africa today

In the late 1940s and early 1950s South African medical and health professionals began collecting and assembling data on breastfeeding in the wider context of social or community health initiatives. To this end they read the published anthropological literature and took account of earlier generations of medical and social commentary on breastfeeding. One of the most extensive and interesting collections was undertaken at 4 Durban sites and in Pholela, in rural southwestern Natal. The research on this theme was headed by Dr Eva Salber and the team of nurses, doctors, health educators and researchers gathered around the Institute of Family Medicine. At the core of the research were the various Health Centres—part of a wider scheme, set up by Dr Sidney and Dr Emily Kark with the help of Dr Gluckman, Dr Gale and other leading health officials in J. C. Smuts’ last cabinet. Salber’s research, published first in the early 1950s, showed that, of children born in a clinic or hospital in South Africa:

...at the beginning of their lives white babies were the heaviest, Indian babies the lightest, and coloured and black babies intermediate between the two. By the end of the year white babies were still the heaviest, but black babies had overtaken the coloured infants. Indian babies grew as fast as whites for about two months, but fell away increasingly thereafter. Black babies overtook white ones at about one month, and maintained their lead until thirty weeks of

⁵ Here indicate the “top 10” of popular and evidence based studies of successful breastfeeding from Thailand; Nigeria; Brazil; the UNICEF publications; the Core Agreements; the WHO publications.

age after which they dropped below them. In interpreting these results I suggested that white infants were underfed in early life due to strictly regulated by-the-clock schedules of nursing. Paediatricians at that time lectured mothers on the dangers of overfeeding. Babies of the other ethnic groups grew well in early life due to their mothers' accepted practice of nursing on demand. But when the latter's children needed other foods in addition to breast milk, the mothers could neither afford the purchase nor were they sufficiently educated in child nutrition.⁶

Salber and her colleagues such as Kark were very positive about many of the practices and meanings associated with breastfeeding amongst isiZulu-speaking and also South African Indian women. As this paper will show they appreciated the confident and powerful management of breastfeeding that many women in these communities evinced and their commitment to this labour and duty (as it was, and is still, seen by many) of motherhood. They also appreciated the role grandmothers and kinsfolk as well as fathers played in supporting breastfeeding: from support with food and rest and infant care through to particular religious, sexual and social observances, lactating women and their infants were treated carefully and with special regard. As we will explore later in this paper, Hindu breastfeeding practices elaborated by South African Indians in Natal, and those associated with isiZulu speaking South Africans in the region, were unlike in many respects. Yet in their many positive associations with status and care for breastfeeding women these two communities in Natal shared similarities that separated them from more rapidly changing cultures of breastfeeding amongst white South African women.

Like anthropologists and sociologists before them in South Africa (for example Junod, Hunter, Schapera, Longmore, Krige, Kuper) Salber, the Karks and others also concluded that breastfeeding practice was itself embedded in a bigger basket of beliefs and practices, carrying specific understandings of the porous, vulnerable and virtual "skins" that separated pregnant women from potential evil doers and the ancestors of these women and their menfolk. In turn these virtual "skins" (and the real and virtual membranes, fontanelles⁷ and actual skins) between "the world" and the infant life of small children, were part of a continuum of health beliefs. In isiZulu-speaking communities breastfeeding in particular was powerfully associated with these porous, vulnerable "skins". For isiZulu speakers, as well as their counterparts in many ethnic groups south of the Limpopo, a woman's sexual arousal, her contact with ejaculated sperm, or her dreams, could all poison her breast-milk. Moving through a certain poisoned space (along a river bank, across a road or path) could poison breast-milk. Women could be fed or sprinkled with poison which would infest their breast-milk. A lot of attention was given to protecting infants from evil forces, but breast-milk was particularly vulnerable. In Durban and in Pholela, Salber and her co-researchers witnessed the effects of these beliefs and associated practices. Sidney and Emily Kark summarised their observations made over several years in their 1999 text,

⁶ E. Salber *The Mind is not the Heart* Durham: University of North Carolina Press, [1989] 1993 p. 116 See also E. J. Salber "Growth of South African Babies in the First year of Life" *Human biology*, 1957: 24: 12 E. J. Salber & E. Bradshaw, "Birth Weights of South African Babies" *British Journal of Social Medicine* 1951, 5:113-19.

⁷ "One of several membranous spaces in the head of an infant which lie at the adjacent angles of the parietal bones. (*Syd. Soc. Lex.*) In some animals it is permanent." From <http://dictionary.oed.com> May 2004.

commenting also on the extensive work Salber and others did in ensuing studies. The Karks revisited the comparisons Salber made across both her clinical and other health records wherein she showed that mortality among infants and babies under one year in Natal was heavily associated with early weaning and the onset of infant mixed and cereal feeding as a response to infant illness amongst the isiZulu speaking majority of Durban and Pholela. Salber and her colleagues devoted research time to this issue, drawing out many layers of complexity in cause and effect and suggesting interventions. Of this work Emily and Sidney Kark wrote:

Most Pholela residents and many in Lamontville believed that diarrhoeal diseases were transmitted through the mother, congenitally and through breast feeding. Mothers were believed to have been infected by an ill-wisher who had directed them, by supernatural means, to walk across a place that had been struck by lightning, or by a bird (*inyoni*) that had previously flown over the site they traversed. The traditional practitioners treatments were focused on the diarrhoea itself, involving the use of grass reed enemas, twirling the reed in the anus to draw blood. Their advice to stop breast feeding was consistent with local traditional concepts of causation. Both the advice and the treatment were considered by us to be harmful. However, with the mother's belief that her breast milk had been rendered detrimental and a cause of the baby's illness, neither she nor her mother-in-law could be expected to comply with the advice to continue breast feeding.⁸

To understand how these health professionals attempted to address this challenge to their practice of community-embedded health services, and to weigh the usefulness and impact of their findings in the current HIV/AIDS-related breastfeeding crisis, we have to move away from the specifics of the South African case for a time, and trace a history of breastfeeding internationally, before the advent of HIV/AIDS.

The management of the female human breast: A history of debates about the duration and form of breastfeeding and the ascription of "expertise".

The first idea that has to be disabused in this paper is that "breastfeeding" is pre-eminently a biological or physiological process and that it carries the same meaning and function across time and space. This is demonstrably false. The link between physiological process (hormonal and chemical and so on) and psychological process for breastfeeding, from the milk-duct opening "prompts" in the so called "let down" reflex, to the actual production of breast milk, is better and better understood and one of the most powerful examples of the falsity of mind/body splits in the description of the lived experience of being human.⁹

⁸ Sidney and Emily Kark p 144

⁹Valerie Fildes, *Breasts, bottles and babies: a history of infant feeding* Edinburgh:Edinburgh University Press, 1986; B.D. Jelliffe and E. F. P Jelliffe *Human Milk in the Modern World* Oxford: Oxford University Press, 1978; I. G. Wickes "A History of Infant feeding" Part I; II ; III and IV in *Archives of Disease in Childhood*, 1953: 28; Roy Porter (ed) *The Cambridge Illustrated History of Medicine*: Cambridge University Press, 1996; Roy Porter and W. F. Bynum *Companion Encyclopedia of the History of Medicine*, London: Routledge, 1993.

Throughout the history of formal ethnographic studies, social and biological scientists have been interested in tracing—through sacred and popular written materials; as well as performed; poetic; oral; visual; architectural; sculptural; archaeological and other sources—comparisons between regional histories and forms of human lactation.¹⁰

Expert knowledge on this subject from the past is much easier to glean than the popular and ordinary knowledge of our women and men ancestors. In terms of elite knowledge, classical scholars in the middle East, India, and western Europe, have combed the corpus of medical treatise devoted to “infant health”, much of which was in circulation through elite networks thousands of years before the western scientific renaissance. These scholars have found that ancient Roman; Greek; Arabic; Egyptian and Sanskrit texts spoke of breastfeeding practices as “commonplace”, naturalizing their own social context, and hence offering little deep description. The ancient Roman and Greek medical writings (from Hippocrates, Soranus, and especially Galen) included infant health and feeding to some extent in their broader treatises on health. Porter, Fildes, Jelliffe and Jelliffe and others have traced the pathways of these beliefs. These beliefs were carried into the Middle Ages by the schools of Arabian and Persian researchers, and were analysed and disseminated by medical writers in the renaissance. A route from these ancient texts, through to expert literature from the 16th to the 19th centuries, can be traced. Even in the later 20th century references to these ancient scholarly understandings of breastfeeding are repeated in some sectors of the infant and paediatric literature. The study of the movement of the so-called humoral (or “hot versus cold”) theories of disease-causation, which had roots in north Africa, much of Asia and the Middle East, and which may have travelled via the Moors to Spain, and was possibly carried by the Spanish conquerors and colonists into South and Latin America, has provided clues for the spread of expert exegesis on other body practices such as breastfeeding. Histories of printing and the globalisation of literary texts have shown that these expert and elite ideas reached a wider audience in Europe with the advent of printing and the use of vernacular languages in the fifteenth and sixteenth centuries. As several scholars in the field of lactation histories argue, they may lay behind notable similarity of many descriptions of “traditional” beliefs about infant feeding found throughout the world today.

Our ancestors clearly debated and tried out different ideas about how to manage breastfeeding in the context of agricultural and mercantile lifestyles, as well as industrial and plantation economies, over thousands of years. For the last several thousand years at least experts have recorded debates about when to introduce mixed feeding; when to allow wet nursing and artificial feeding; and when and how to supplement breast milk feeds in the life of an infant. Estimates of the typical duration of months or years of breastfeeding in the post 1500s ethnographic and traveller literature reveal huge variation across regions and even within regions over time: from weaning at 1 year (Tyroll and other parts of Italy and Germany) to 4 years (Hawaii and Northern Cape). By the 19th century breastfeeding over 3 years was increasingly deemed harmful and a *Lancet* paper published in 1842 recorded a physician’s views that childhood epilepsy and other conditions could be linked to long durations of breastfeeding.

¹⁰ A. Hymansen “A Short Review of the History of Infant Feeding” *Archives of Pediatrics*, 1934, 51.

In India, Fildes Jelliffe and Jelliffe and others have recorded instances in Brahminical medical literature in the second century BC which exhorted believers to express and disregard colostrum¹¹. In these texts references are made to the natural honey and clarified butter products which were fed to an infant to speed up the excretion of infant meconium¹². Lactation management references in French and English infant expert literature refer to colostrum taboos through to the 17th, with references in these texts to roman and Greek supporting classical sources. Jelliffe and Jelliffe showed that devices and pumps to assist with breast milk production have been found in many regions of the world with preserved objects and related texts dating from the 1500 BC era. They argued that this prevalence of assisting devices proved that the so-called "let-down" reflex many have been inhibited in many settings through "fears of bewitchment or guilt over non-observance of taboos, especially of a sexual nature." ¹³ The links between infant suckling and production of milk seemed to be well understood by ancient societies. The presence of feeding bottles or containers for expressed human milk and goat, sheep or cow milk for infants have been found and preserved from all over the world, and Clay feeding vessels were found in graves with infants from the first to fifth centuries AD in Rome. In his study of the history of breastfeeding Ted Greiner found that:

'Hand rearing' was criticized already by Soranus of Ephesus, a Roman physician of the second century AD who chided those foolish people who begin artificial feeding too early (16). This concern first shows up commonly in writings from the Renaissance. This is hardly surprising, since records from foundling homes in England and France show that the vast majority who were artificially fed died. Sir Hans Sloan wrote that the mortality of suckled infants in Britain in 1660 was 19%; for dry nursed infants it was 54%. In Rouen, France data from the two-year period 1763-5 showed that of 132 foundlings fed diluted cow's milk, with pap, soup and cider added at three months, only five survived ... [for example] In 1753, the governor of the Vasa District in

¹¹“ Colostrum is the first milk produced by breasts in the early days of breastfeeding. This milk is low in fat, and high in carbohydrates, protein, and antibodies. It is digest...low in volume but high in concentrated nutrition for the newborn. Colostrum has a laxative effect on the baby, helping the baby to pass early stools, which aids in the excretion of excess bilirubin and helps prevent jaundice. Breasts will begin producing mature milk around the third or fourth day after birth. Milk then increases in volume and will generally begin to appear thinner and lighter in colour. Colostrum contains large quantities of an antibody called “secretory immunoglobulin” A (IgA) which is a new substance to the newborn. In utero, babies receive the benefit of another antibody, called IgG, through the placenta. IgG works through the foetus’ circulatory system, but IgA protects the born baby from ex utero infection: namely the mucous membranes in the throat, lungs, and intestines. Colostrum has an especially important role to play in the baby's gastrointestinal tract. A newborn's intestines are very permeable. Colostrum seals the holes by "painting" the gastrointestinal tract with a barrier which mostly prevents foreign substances from penetrating and possibly sensitizing a baby to foods the mother has eaten. Colostrum also contains high concentrations of leukocytes, protective white cells which can destroy disease-causing bacteria and viruses.” Extract from <http://www.lalecheleague.org/> April 19 2004.

¹² “Meconium is the thick, sticky, tarry appearing foetal stool that is passed in the several days after birth (and sometimes before birth). It is the digested residue of swallowed amniotic fluid, which contains foetal skin and hair cells in abundance. Passage of meconium is facilitated by the ingestion of mother's colostrum.”<http://www.drhukk.com/EncyMaster>, April 29 2004.

¹³ Jelliffe and Jelliffe, p. 164

Sweden received permission for the King to fine those mothers who did not breastfeed ...¹⁴

Some of the infants of mothers who did not breastfeed survived. The history of wet nursing has been extensively written about by historians, anthropologists and infant health experts. In Fildes' work on the subject she makes clear that both the character of wet nurses as women, and the quality of their breast milk, was the subject of much discussion and checking in all the societies for which she found wet-nursing evidence. The explanations for this are clear: the character of the wet nurse as a person was seen as transmittable through the quality, viscosity and taste of her milk. European, African, Middle Eastern, Asian, Pacific and other sources all underscore this in her research. Yet poorer and less healthy women were often employed despite these beliefs. Clearly the individual wet nurse's moral and milk qualities could supersede her poverty, at times her ethnicity and her "race", and even her religion. In France in the late 1600s and 1700s concern for the infants of wet nurses resulted in the passage of a law to forbid their employment until their own infants were 9 months. This law, and the debates around its passage, suggest that wealthy people were increasingly concerned for the infant life of the rich at the expense of the poor, but also that little anxiety was generated by the actual daily acts of thousands of rich children being suckled by thousands of poor women. Only in the later 19th century, with the rise of eugenic theories about "race decline" and pseudo scientific miscegenation theories of contamination, was "wet nursing" as a whole the subject for concerted critique by elite experts working often on behalf of the state or church. It took until the eve of World War One before breastfeeding was accorded the status of an international conference, with state and civil society participation: in 1913 in Paris the first—but certainly not the last—international conference was held on bottle feeding and other artificial infant feeding techniques, considering social and political aspects as well as nutritional issues at the highest state levels.¹⁵

One of the most salient issues in reviewing this literature, in the context of the current HIV/AIDS epidemic, is the homogenisation of ideas about the moral effects of specific practices of lactation "duration" in globalised processes of publication and didactic persuasion, as well as commercialisation of artificial infant nutrition production. In the 1940s to early 1970s infant, and maternal health exporters and western paediatricians, and their counterparts in many sectors of the developing world (for example East Asia and the Pacific rim; as well as Congo/Zaire and South Africa), argued that to breastfeed an infant "on demand" was a maternal practice of incivility—children nourished in this way would display tendencies towards savage mentality; laziness; over-sensuality; over-dependence and immaturity; and so on. In this literature, the moral and social consequences of indolent infant "demand" feeding were ascribed harms which varied with prevailing psycho-social and intellectual trends in scientific and public health literature.¹⁶ National, and increasingly after 1950, international breastfeeding literature stressed the individual woman's responsibility for 4 hourly or "by-the-clock" feeding and paid scant if any attention to the role of fathers; friends or kin folk, let alone wet nursing; shared suckling; work

¹⁴ Ted Greiner "History of Breastfeeding" citation to Swedish text and translation on web site.

¹⁵ Wickes; Part IV, p. 416-422

¹⁶ Cite my PhD thesis; work on infant rearing and campaigns aimed at the European working class; and colonial sites: such as Anna Davin; the eugenic literature: Gisella Bock; and a summary of the colonial sites of this by Nancy Rose Hunt. Give full cites.

environment demands; psycho-social conflicts or other contextually crucial issues. Instead the health educator, the nurse, the doctor, and the social worker were the mediating experts. The state's health mechanisms and regulating bodies were given a major role in breast management. This was true in South Africa as in Europe—though here the particularities of white infant health as a key state goal often muddied the waters of public health policy for far longer than in other contexts.¹⁷ The late 1903s and early to mid 1940s era of World War Two and its aftermath produced a challenge to this: communal non-commercial infant milk-banks were established (in some cases re-established—some had existed in the World War One era, and one started operating in Boston for working women in 1910) in the same ways that blood banks were set up, and infant feeding was for a time regarded through the lenses of non-interventionist, non-marketable, communitarian social health goals.¹⁸ This era was short lived.

In the 1960s and 1970s the “by the clock” view predominated in expert discourses and around the world women moved away from breastfeeding towards bottle feeding in greater or lesser numbers. Tragically in places such as Botswana and South Africa—where clean water sources and cheap or subsidized infant formula were restricted to small parts of the population at the time—the cost of new infant formula feeding was a rise in infant and child mortality.¹⁹

By the 1980s, public health expertise, pressed into reconsiderations of prevailing views and practices by non governmental organisations, many of the led by women health activists such as the La Leche League International, began to draw on what was considered fringe research into infant nutrition and breastfeeding in the 1970s. An attempt was made to turn the behemoth of “clocked and controlled” breastfeeding around. By the later 1980s evidence for the long term ill-effects of formula infant feeding in the west, and well as the developing south and east, and results of large scale research on the chemical and hormonal and physiological apparatus of lactation, (through which they “discovered” that clock feeding would reduce overall milk production as well as the content of human breast milk) were diffusing through medical and other expert literatures.²⁰ From 1990, when WHO and UNICEF after years of report writing and meetings decided that the evidence for breastfeeding as “best practice” for infant health world wide and in every setting, was conclusive, these bodies jointly adopted the “Innocenti Declaration” (named after the town where they met) titled: “The Protection, Promotion and Support of Breastfeeding”. After this point all national governments were been urged to develop national breastfeeding policies and set appropriate national targets. This Declaration and related maternal and infant health Conventions also required that states set up national systems for

¹⁷ See work of my PhD: Burns; Barbara Brown; B. Klugman; S. Klausen; NAMDA and anti apartheid nursing texts; work of Cedric de Beer; and other “Apartheid and health” texts and papers which critically examine the differences between South African state policies for infant care across race and class and regional groups.

¹⁸ B. W. Laubengayer “the Evolution of the Art of Infant Feeding in Relation to the Development of the Science of Nutrition” Unpublished PhD Thesis, Ithaca: Cornell University, 1935. Cite here the Women and War texts from England, Eastern Europe and Russia.

¹⁹ T. Greiner cite his world review and the 4 WHO sites and conventions on this which gathered data from 1987.

²⁰ A useful summary of all nutritional science of breastfeeding literature from the 1950s to 2000 is in Michael C. Latham's *Nutritional Data on Breastfeeding: Food and Agriculture Organization of the United Nations* Rome: UN Publications, 1997

monitoring the attainment of targets. In addition the Conventions critical of the role and profiteering of major infant formula production corporations were debated, published, and adopted through the 1980s by many governments, and by world bodies. These Conventions restricting and controlling the commercial sale of infant formulas set up a legislative and bureaucratic code and regulating framework, preventing commercial formula producers from giving out free formula samples at birth clinics and ante natal sites especially in poor and under resourced regions; prevented advertising of these products in many forms of media; prevented advertisements from making false claims; and prevented the emergency or appropriate use by state or UNICEF/ WHO-sponsored health service of formula products from displaying branded names. These drastic measures were adopted with a wide degree of international recognition of the previous decades-long fiascos in breastfeeding “expertise”, a degree of agreement unmatched in many other arenas of international co-operation. These Conventions and Declaration also came into effect at precisely the time when the Union of Socialist Soviet Republics (USSR) was breaking up; many other eastern European states were in a state of great upheaval and change, and in South Africa, the Apartheid regime was finally crumbling via a complex constitutional hand-over of power away from the white minority state to the country’s citizens. In South Africa the ANC’s Health Desk and nationally constituted progressive health organisations such as NAMDA, as well as public servants and policy makers in the last white government’s health divisions, began laying out and even implementing some of the “best practice” maternal and health policy ideals and goals set out in these infant health Conventions. In recognition of the distortions and injustices of the past and the imbalances in South Africa’s health resource management, one of the first acts of the new Mandela government after 1994 was the creation of free public health access for all children under 6 and pregnant women. Lactation support and a positive approach to breastfeeding was a corner-stone of the plan.²¹

In addition a new version of “breast is best” entered centre stage with this global take-up of breastfeeding discourses: by 1990 to 1992 the mood in public health, paediatric, and maternal health discourses and associated recommended practices, had swung 360 degrees: the new science of breastfeeding now demanded, what was termed for the first time, “exclusive” breastfeeding as “best practice”, and required at least 6 months of this regimen for optimum effect, as well as suckling frequently and variously—depending on infant need; and “in relationship”, with mother and child, father and support context, all involved. Much of this new mantra was sound scientific advice, but little research had yet been done on just what “exclusive” breastfeeding would mean in lived experience for the people, especially the lactation women of the world.

²¹ Helen Schneider published papers reviewing ANC health policy; David Blaauw and Loveday Kekana on “Maternal and Infant Health” policy in late 1980s to 2002 (2002 report); NAMDA publications; SAJM review pieces; Add in: *UNICEF* sites with all the relevant papers archived; *La Leche League*; cite major articles from *Lancet* and *Journals of Lactation* and *Human Biology* as well as reproductive rights journals.

Exclusive breastfeeding: an invention of public health doctrines

Two crucial questions frame this section of our paper: What is exclusive breastfeeding? And why does it matter in the current HIV/AIDS crisis around transmission of HIV through breastfeeding? To answer these two crucial questions requires more historical explanation!

For most of the 20th century scientists, maternal and infant health advocates spoke of “exclusive” breastfeeding when infants derived most of their nourishment from suckling their mother’s breast milk.²² Studies conducted in and published, in internationally peer-reviewed journals, on India; the Caribbean; Malaysia; Ireland; Congo/Zaire; Nigeria; Tanzania; Togo; Sri Lanka; Thailand; Sweden; the U.S.A; South Africa; Brazil; Chile; Cuba²³—the list is extensive and itself the subject of critical reviews of comparative data methodologies and analysis²⁴—have convincingly shown that in no site on planet earth did women until recently in some carefully regulated spaces, routinely “exclusively” breastfeed. This is according to the definition of “exclusive” in which “no food or liquid product”, other than mere drops for medication, or less than 10 millilitres of water or juice over time, are given until the age of 6 months of infant life has been reached. A PhD thesis by Clara Aarts, and associated published papers emanating from a breast feeding research centre in Uppsala, Sweden has provided a rubric for determining “exclusivity”, and by this measure most mothers in most parts of the world breastfeed their biological infants exclusively for less than a month. In addition to mixing breast milk with some bottle feeds of milk replacement (an almost ubiquitous practice in the developed world, and wide spread in poor countries as well) and in addition to the adding of cereals and other foods to the diets of very young infants—common on many parts of Africa and the Caribbean, some women across the world routinely share suckling of infant young with non biological mothers, as many of our ancestors may have done, and also feed water and fruit juices instead of human or animal milk. In addition infant exclusive breastfeeding may be delayed by a few days at the start of life: in India, parts of South Africa and many other places, women routinely express their colostrum²⁵ and replace this with other feeding for 2 to 5 days.²⁶ Already, by the late 1980s, a critique of mixed feeding existed where public health and maternal and infant health activists and experts questioned the widely taught theory that infants needed to be weaned onto high protein foods and that bottle feeding with formula feeds were a good way to gradually start weaning children world wide. A revolution in infant feeding ideologies and technologies was underway, and without warning, a new health epidemic forced

²² (NOTE: this section is a very rapid assessment of the literature and will have to be fleshed out later with some incorporation of Thoko Ndaba’s MA thesis literature review as well).

²³ See bibliographical references on these major studies we have searched via the Bibliography of Nancy Wight “Breastfeeding Coalition”: California: San Diego, 2003.

²⁴ See for example Maria Ines Couto de Oliveira et al “Extending Breastfeeding Duration Through Primary Care: A Systematic review of Prenatal and Postnatal Interventions” and M. Jane Heinig “Development of effective Strategies to Support Breastfeeding” both in *Journal of Human Lactation*, 17:4, 2001

²⁵ www.lalecheleague.org/FAQ/colostrum.html

²⁶ Clara Aarts “Exclusive Breastfeeding-Does it make a difference?: a Longitudinal, Prospective Study of Daily feeding Practices, health and Growth in a Sample of Swedish Infants” PhD Defended and published by the University of Uppsala, Sweden, 2001. Clara Aarts, E. Kylberg et al “How exclusive is exclusive breastfeeding? A Comparison of Data Since Birth with Current Status Data” *International Journal of Epidemiology* 2000: 29; Indian citations; Asian and African cases; Salber; Krige; Ndaba and others for South Africa.

much of this work against the wall: the discovery that HIV infection could be transmitted by human lactation.

As late as 1989 it was still unclear to the world's virologists if HIV infection could be transmitted through human lactation. In their survey of the HIV/AIDS transmission literature, "HIV Infection in Developing Countries" then world experts in the emerging field of HIV/AIDS, Drs M. Carael and P. Piot wrote:

As elsewhere, there is no evidence for HIV transmission in the tropics by casual contact, by anthropods, or within household and occupational settings such as the hospital .../. . . The potential for transmission of HIV by breast-milk should be elucidated urgently because of its important public health consequences.²⁷

By 1990 the first papers were being published establishing breast-milk as a possible transmission from and work was underway to protect milk banks at major state hospitals through out the world and then to measure and analyse viral load in breast milk; to establish the layers of infection possibilities for HIV Infected infants; and in HIV free infants born to HIV infected mothers, to establish ways to maintain their negative HIV infection status.²⁸ By 1992 the pressure was intense and scientists began proposing the cessation of breastfeeding in all HIV positive mothers of new borns and infants.

[This is where Thoko Ndaba's MRC study will come in: why and how South African health professionals responded; why and how the studies with and without Nevirpene; with and without infant formula; with and without mixed feeding; were set up in the late 1990s to 2003 era; how samples were collected; how bloods were tested; how mother and child units were chosen; the politics of field worker training; the reasons for Rietvlei, Paarl and Umlazi in the Western Cape/MRC/Johns Hopkins study; their connections to other Durban and South African studies; the debates between the Wits teams and the Durban teams and so on].

In 1999 Coutsooudis, Pillay, Spooner, Khun and Coovadia and their team, working from Durban, published the first of a series of articles on "exclusive breastfeeding". The work of key individuals on this team received wide spread dissemination and cross citations spread through the web of medical and health journals. Studies in Nigeria, Ireland, Thailand and other places repeated, or took issue, with these findings, and in South Africa, a team in Johannesburg based at Chris Hani Baragwanath Hospital entered into debate with their fellow researchers.²⁹ The Coutsooudis et al work began building a case for advising that even HIV positive mothers could breastfeed with little risk if they employed "exclusive" breastfeeding, and that even if this method risked some infection this was a potentially better public health choice than the already established riskier choice of infant formula for women unable to keep up the costs and the correct proportions of mixed formula, and unable

²⁷ M. Carael and P. Piot "HIV Infection in Developing Countries" in *Journal of Biosoc. Sci.* 10 1989, p.44

²⁸ Cite the Thoko Ndaba examples here on King Edward Hospital in Durban; as well as papers and references in Coutsooudis et al.

²⁹ Thoko Ndaba MA thesis references here for details and debates.

to provide 100% sterile water and bottles to prevent other life-threatening infections. The literature on infant ill health in poor communities with latter conditions was, as we have mentioned, already well established. The abstract of their piece is worth quoting extensively:

BACKGROUND: The observation that mother-to-child transmission of HIV-1 can occur through breastfeeding has resulted in policies that recommend avoidance of breastfeeding by HIV-1-infected women in the developed world and under specific circumstances in developing countries. We compared transmission rates in exclusively breastfed, mixed-fed, and formula-fed (never breastfed) infants to assess whether the pattern of breastfeeding is a critical determinant of early mother-to-child transmission of HIV-1. .../...
INTERPRETATIONS: Our findings have important implications for prevention of HIV-1 infection and infant-feeding policies in developing countries and further research is essential. In the meantime, breastfeeding policies for HIV-1-infected women require urgent review. If our findings are confirmed, exclusive breastfeeding may offer HIV-1-infected women in developing countries an affordable, culturally acceptable, and effective means of reducing mother-to-child transmission of HIV-1 while maintaining the overwhelming benefits of breastfeeding³⁰

A key concluding clause, “exclusive breastfeeding may offer HIV-1-infected women in developing countries an affordable, culturally acceptable, and effective means of reducing mother-to-child transmission of HIV-1” set experienced South African researches, such as Thoko Ndaba and her MRC colleagues to deep thinking. Familiar as she and others were after years in local clinical services and in neo natal and maternity wards of the region’s biggest tertiary hospital at that time, King Edward VIII’s hospital in Durban, familiar too with the local contexts of poor households and the complex challenges faced by poor families and mothers caring for infants and their children in impoverished homes, the research coming out of labs and clinical wards and reported on in the piece above and others like it begged huge questions: What were the “culturally accepted” forms of breastfeeding referred to in the piece anyway? And how had these developed or changed over time in other contexts of pressure or challenge? And if they existed, even in mediated and various forms, how could these cultures of breastfeeding be adapted to “exclusive breastfeeding”? And then, how could successes and failures be ethically determined and studied in field work involving such crucial matters of life and death?

In 2000 Thoko Ndaba, already enmeshed in the MRC study referred to above, embarked on a path to research the history and meaning of breastfeeding in the context of isiZulu speaking practice and meaning-making, in the context of powerful gender inequalities in identity, social power, status and decision making; and in the context of the HIV/AIDS epidemic in the region. The Conclusion to her 2004 Masters thesis made clear that an extensive archaeology was needed of the complexity and variation that underlay much of what people practiced as “culture and tradition” in breastfeeding. We began working together on this process in April.

³⁰ A. Coutsooudis K. Pillay, E. Spooner L. Kuhn, H. M. Coovadia “Influence of infant-feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study. *South African Vitamin A Study Group*” *Lancet*. 1999 Aug 7;354(9177):471-6.

Ethnographic Accounts of Breastfeeding Cultures and Practices in South Africa, 1930 to 1960s

Eileen Jensen Krige's study, "The Social System of the Zulu" was first published in 1936 and republished in 1950. It is "...a compilation rather than the result of personal investigations in the field, and is intended primarily as a collection and scientific coordination of the information scattered about, or lying concealed in various publications."³¹ Drawing from material published in the 1880s and from the work of Callaway, Bryant and Samuelson, Krige devotes a detailed chapter to "birth and childhood". Extracts from these pages reveal a huge emphasis, in birth, infant care, and lactation practices, on strengthening the child in ways other than strictly nutritional: feeding children meant much more than latching on and suckling. She wrote:

When the child is born, a small hole is made on the *umsamo* of the hut, and this is smeared over with dung to form a basin in which the baby is bathed, A small plant, the *uMalali* plant is sometimes used for washing a newborn baby to make it a quiet child, not given to crying, for the water is always medicated with some *intelezi* (medicine). This *intelezi* water is always thrown away very carefully so that no wizard gets hold of it. .../... Great care must also be taken of the umbilical chord and after-birth, which is buried in a hole in the *umsamo* of the hut, and then carefully smeared over to remove all traces of the spot. Both baby and mother are then smeared with fat.

The mucus in the stomach of a child at birth is brought out by an administration of the roots of the *umThambane* plant (*Stephania hernandoefolia*), and then the child is fed on fresh cow's milk or *amasi*, for it must not drink its mother's milk for the first few days. It is through that the mother's milk could cause sickness. The *amazi* is given by being blown out of the hands into the mouth of the child.../...

The most important observances connected with the birth are, however, the various methods of strengthening the child against the dangers that are through to threaten it during the first few months of its life. Soon after birth every baby is held in the smoke of burning animal charms, comprising a small particle of every possible animal of ill-luck. This is supposed to counteract all *izinyamazane* diseases which the child may have contracted while in the womb, through its mother having walked over tracks of harmful animals, or that may be brought in by people who come to visit the baby with bad medicine of this nature. To make quite sure that the strengthening medicine will be effective, some is given to the child to drink with its food, while the ashes of the burnt medicine charms may be put as medicine in a necklace for the child.³²

³¹ E. J. Krige *The Social System of the Zulus* Great Britain: Longmans Green &Co. Ltb 1936; Pietermaritzburg: Shuter &Shooter 1950, v.

³² E. J. Krige *The Social System of the Zulus* Great Britain: Longmans Green &Co. Ltb 1936; Pietermaritzburg: Shuter &Shooter 1950, p. 65 to 68.

Krige then went on to demonstrate that in some communities these “smoking” ceremonies were more elaborate, taking place over a longer time, involving parts of particular rock substances; parts of the father’s skin scraped skin cells and sweat and repetition of smoking ceremonies at particular intervals. The reasons for these elaborate strengthening precautions lay in the tainted nature of newborns:

Every child is supposed to be tainted at birth with a constitutional defect called *isiGwemba*, which is held to be the cause of several ailments, such as unusual sexual irritability, causing lecherous inclination in adults, or disposition to eczema, etc. To get rid of this taint, the stem of a castor oil or an *umSenge* leaf (*Cussonia spicata*) or stalk of fibre is thrust by the mother into the rectum of the child and vigorously twirled round between both hands, until, by scraping on the membrane of the bowel, blood is copiously drawn. Not infrequently children die from this treatment.³³ .../... Even when the baby has come out of the gut of seclusion, it is still considered to be unable to resist the dangers of this world and great care must be continually exercised that no harm befalls it. For the first month or two after birth, anyone entering the hut of the baby is rigorously expected to perform the *ukuLumula*—nibble of a small particle from certain charm-grasses, herbs, etc., hung over the doorway, and spit it out upon the child so that any injurious *umkhondo* which he may have inadvertently have brought in with him may be thereby rendered innocuous. .../... When the mother leaves her child for a few moments she may squeeze a few drops of milk over the head, breast and back as a protection in her absence. It is also advisable for a woman to carry medicine with her to spit over the child at convenient moments to protect it against the “evil eye” of visitors. The child may be protected from harm by wearing charms, and long strips of skin used to be wound round the necks of infants for this purpose.

Krige’s detailed summaries of the ethnographic literature available in the 1930s is remarkably similar to the explanations and descriptions provided by the Karks and by Salber some 20 years later in their work from Lamontville and Pholela. Kark was also concerned to establish the infant feeding patterns of isiZulu people after neo natal dangers had subsided somewhat. Like many accounts written about weaning in Pedi, Sotho, Xhosa, Tswana, Swazi, Khoi/San and other communities in the region, Krige found convincing evidence that:

Zulu babies are not weaned until they are two or three years old, by which time they are already walking about. Should an infant be slow in learning to walk, it is cured by having pieces of sponges rubbed into incisions on the knee.... It is not permissible for the mother to become pregnant again before the child has been weaned, or if she does, the child will be stupid. At the time of weaning a goat is slaughtered for the purification of the mother and the child, whereupon sexual intercourse may again take place. To wean the child a certain very bitter medicine .. may be tied around the neck of the child and smeared upon the breast of the mother ...³⁴

³³ Krige, 76, 70 to 73; She also cites the work of M. Fuze *Abantu Abamyama*, from p. 51-52: Fuze pointed out that was done every day at a certain time at three months and then later when the child was older, with variations depending on sex.

³⁴ Krige, 73.

The timeless quality of this text and its almost rigid divisions and classifications typical of its day, do not undermine the compilatory worth of her extensive readings, her mainly isZulu –speaking researchers’ observations, and her analysis of large patterns across space and time. Writing and researching in Johannesburg’s black townships two decades later, the urban sociologist of “sex and the city”, Laura Longmore wrote extensively about the infant and mother endangerment nexus, and the context of breastfeeding and weaning, in what was then Eastern Native Township, drawing also on Alexandra and other township data and on clinical and social work records. Her observations and data analysis, collected in several published papers and in her study; *The Dispossessed: A Study of the Sex-Life of Bantu Women in and Around Johannesburg*, press upon the centrality of multiple intimate partners as a feature of urban African life, and it is through this discussion that she enters into her sections on maternal health and infant care. Polygyny is a much discussed issue in this text: long sections on how and why people make marriage and partnering decisions, and the role of religion, especially the experience of family and personal conversions to Christianity, shape the work. The impact of working lives, of long term and long distance migration are also key themes. Longmore gives over a great deal of attention in her monograph to gender power struggles and roles within households and relationships. Her work is useful, for all its flaws, for these reasons and because she embeds her data in the context of South African local and central state laws. She is at pains to site specific instances of sexual, religious and cultural beliefs and memories, and often the work reads as a series of anecdotes gathered by a prim and disapproving school teacher! One of consistent reasons she reports being given for why urban African men declared they wished polygyny was still fully acceptable and practiced, focused on the interplay between sexuality and weaning. This theme is repeated in contemporary debates as well as published accounts throughout the later 19th ad 20th centuries.³⁵ Echoing Krige and other ethnographers of the region she wrote:

Children could be weaned adequately—a process taking almost four years—without a husband making sexual demands on his wife when he had other wives.³⁶

And later in the study:

In tribal times a woman would take as long as two years or more to wean a child. This is another reason why polygyny is advocated. A man would cohabit with another of his wives when one was breast-feeding a baby, In urban areas there is no definite time for weaning children; they are all weaned differently. The clinics advise mothers to wean their babies after 9 to 12 months, but most African mothers in town have their own ideas, and decide for themselves when a baby should be weaned.³⁷

We find it suggestive to consider the implications of these findings: African urban mothers were working in new ways with combining different infant feeding ideologies and practices: they were drawing in cereals earlier on in infant care; and

³⁵ Agenda debates about polygny and the new Constitution; site Gender Commission Reports;

³⁶ *The Dispossessed: A Study of the Sex-Life of Bantu Women in and Around Johannesburg* London: Jonathan Cape, 1959, p. 82

³⁷ Longmore, p.153.

adding cereals to bottles with milk—both powder form and fresh cow milk. This suggests to us that older ideas about continuing breast feeding for a long time were able to coincide with a very new economy of breastfeeding: different times; different caloric value; different physiology. On the other hand sex with men could resume and because of this new balance: less breast-milk, less potential for harm if sexual relations resumed. On the other hand women were still to blame if their babies fell ill: there was no bargaining it seems with that long surviving idea.

Continuing with the speculative and question-raising tone we have adopted for this section, we read other evidence in Longmore in a similar vein. She argued that:

Many urban mothers have to return to their jobs soon after confinement. The babies then have to be cared for by hired nurses, old women, many of whom are physically or otherwise unfit to nurse babies or children below school-going age, and are hardly able to look after themselves. There is a firm belief that when a mother is breast-feeding a baby she should not have complete sexual intercourse because it poisons the milk. A man should not sleep with his wife because it is considered that the baby will be a weakling if the mother sleeps with the father while she is suckling it, and urban Africans say that the elasticity of the vaginal orifice suffers from early intercourse after pregnancy. But urban wives complain that, although their husbands may concede to let them alone for a while after confinement, a husband all too frequently starts with other women, and when his wife is ready for intercourse he continues to have other women. Some husbands argued that, if their wives refused them conjugal rights while they were breast-feeding they were simply forced to go to other women.³⁸

Longmore takes care in her section on childbearing to detail the kinds of rural ideas and practices still present—although adapted—in urban settings of the Reef townships of the 1950s. She underscored the vulnerability of the new born and her/his mother and the special precautions taken to ward off evil: methods of “smoking” the infant; woman prevented from eating certain foods or associating with certain people at certain times; and the continuing emphasis on wearing special medications:

Most babies wear beads and medicated strings around the ankles, neck, wrists and waist as a protection against the evil machinations of evildoers and wizards. The Zulu and Shangaan peoples especially make a great use of these things.³⁹

After describing how medicines are made for protecting the new born she writes:

In some instances, if a baby has eye or ear trouble, the mother suckles milk into the eyes, ears and nostrils, and the vagina (if it is a girl) and the penis (if it is a boy)...⁴⁰

She also writes at length about the use of physical spaces to treat ill children—especially the topical rubbing of medicines made from coins and animals fats to plants and the products of mole hills. She also cites instances of people worried about

³⁸ Longmore, p.154.

³⁹ Longmore, p.155.

⁴⁰ Longmore p. 155/6.

bewitchment⁴¹ of crying babies, and the taking of them, wrapped in certain charms, and the placing of ill babies on “powerful” spaces, such as on railway tracks.⁴² Longmore also spends much time echoing other monographs: seclusion of baby for a month; then the carrying by the mother of special herbs and remedies which she can blow or spit around the baby to ward off danger.

Long sections follow these on the ill health of children, in which in towns, sites where people of many ethnicities mix, and where complete strangers live cheek by jowl, create an atmosphere of suspicion, heightening the already existing sense of the vulnerability of infants and babies to purpose-driven illness. Longmore’s references and her bibliography make clear that she wrote these sections fully aware of the context of the huge anxiety about high infant mortality in the towns and in Johannesburg in particular at the time. She writes about the presence of healers from competing healing ethnic traditions and in addition the confusion caused by the presence of biomedical clinics in the area. She reports a great deal of conflict between clinical advice given and the advice other mothers, herbalists and healers. Grannies and care keepers, looking after the infants of wage earning women in the day, also drew conflicting views and practices of infant care into daily dispute.⁴³

Her interpretation of anxiety around infant’s stools and the connection between this flashpoint and breast-milk is interesting to contrast with that of Krige’s account, and with that of the Kark’s and Salber—who were writing and researching at around the same period, but far away in Durban, probably unaware of her work.⁴⁴ In Longmore’s urban African “vortex” there is at the very least a reinterpretation of “breastfeeding cultures” being described, especially in the light of clinical and biomedical interventions and services:

... the African believes that milk is good for a newly-born baby and yet at the same time he believes that milk is water and that once a baby has had a motion he must be fed. The nurse says milks is a balanced diet by which a baby can live up to a certain age, during which he must be breast-fed, and she also advises that a motion does not necessitate refeeding. Yet is it common in urban areas to find an African baby that is breast-fed and is only a month old being given other foods. The reason for this is that the African believes that milk is not enough to make the baby grow. When other liquid foods are forced into the baby’s mouth, and the baby does not seem to enjoy the feed, the mother or granny sings ‘*Dla uzikhula*’ (‘eat that you may grow’). In families where the mother of the baby believes in the clinic routine and her people-in-law do not, there are always clashes between the two parties. Her people often accuse her of starving their son’s baby to death.⁴⁵

⁴¹ Burns PhD thesis.; Contraception paper, 2004 forthcoming..

⁴² Longmore, p.157.

⁴³ She does not mentioned wet nursing but this is implied in some cases—though most nurses are referred to as old women—often unfit to care for young—and smaller girls—often too young in Longmore’s eyes. And, interestingly, Longmore reveals her agreement with the “4 hourly feeds” and only “boiled water between” thinking of the clinics at the time (p241).

⁴⁴ We argue this because although the Karks and Salber certainly knew of Krige, and through Kuper, of many other works of anthropology--sometimes referring to these in their work, none of them ever cite Longmore’s work.

⁴⁵ Longmore, p.243.

In her study Longmore paid attention to the impact of clothing, new tastes in foods, new media consumptions and new ideas about the self and body. She comments with convincing detail about shifts in regimes of infant feeding in the light of new commercial products making their way into reef townships at this time with great speed:

These are some of the foodstuffs used for feeding a newly-born baby who is also being breast-fed: ordinary baking flour is put into an iron frying pan and roasted until it goes brown; then it is put into boiling water to cook for a few minutes. Alternatively, *incumbe* baby-food, or ‘nutrine’ is used for feeding the baby. The clinic advises that fresh *incumbe* or ‘nutrine’ should be used, but most mothers prepare food in the African way. A big quantity is made, enough to last for the whole day. In most cases the baby is made to take cold meals, and worse still, the left-overs are not thrown away, but are a starting point for the next meal.../...When a baby is fed by an old woman, the spoon first goes into the woman’s mouth and then to the baby’s mouth. The clinic nurse objects to that and says that by the time the baby takes the food, it is full of germs. In some cases the nurse says so while her *own* child is fed in the same way by a hired nurse.⁴⁶

Longmore argued that, at the time, and for all of these reasons less than a third of reef infants were taken to receive clinical care: the perceived vulnerability of the baby after birth; dangers all around heightened through the mix of ethnicities and strangers; and tensions about “clinical” versus “home and community” explanations for disease and health. Her study quotes sources saying that many people believe their babies will be in greater danger at these sites.

There is one final area in which Longmore’s study shines light upon a poorly understood relationship: that between breastfeeding and sexuality. Reading her published data we speculate that her materials reveals that women in Johannesburg at the time may actually have wanted to continue public performance of breastfeeding (even when they were mixing this with other milks or foods) to ward-off or delay resumption of sexual relations with particular men, including their husbands. We wonder if this issue could be better researched in the light of data from white South African family life. Today could a woman marshal arguments about breastfeeding “culture and tradition” to legitimate a delay over sexual relations. Could public breastfeeding today form part of a longer continuum of strategies of adult sexual transaction? And if so, what implications could this have for infant formula programmes in the context of often violent and iniquitous sexual relations in families and households with individuals suffering with HIV/AIDS. It seems to us that not only may infant formula feeding flag HIV status but it may remove some cultural explanation for sexual withdrawal for a woman coping with her diagnosis as well as after birth exhaustion. Longmore details what she saw as her informants’ explanations for the links between sexuality and breastfeeding:

Often among urban Africans, when babies die, the deaths are attributed to the parents’ lack of decent sexual habits. Many mothers have been accused of trying to kill their own babies by indulging in sexual intercourse while the baby is being breast-fed. The belief is that when a mother is breast-feeding a

⁴⁶ Longmore, p.243-4.

baby she should not have complete sexual intercourse because it poisons the milk. Sometimes the death of a baby is attributed to the bad milk of a mother who gets pregnant before weaning the baby. In that case the mother is said to have caused the death of her own baby.⁴⁷

Many researchers of sexuality in South African societies and regions have begun examining the link between inter-cruial sex and courting; as well as marriage relationships over time. We have not yet taken into account the tensions and complexities of lactation and infant life in relations between adult women and men.⁴⁸

How and to what extent can contemporary researchers make use of the insights of sociological and anthropological experts living and working over nearly 50 years ago or more in building a deeper understanding of the constraints and material as well as emotional lives of our parents and the parents of our fellow citizens? This is an issue Thoko Ndaba addresses at the close of her thesis, and in her chapter on her own rural childhood in the 1950s and 1960s—exactly the time that the work of the Karks and Salber was undertaken? It is to a closer examination of the value of this work that we now return.

The Kark/Salber Model approach to Breastfeeding Research and Intervention: Models from the Past for the Present and the Future?

Much has been written about the social or “community oriented primary health care” model—which was given life in South Africa first, in the Durban sites and the Pholela site set up through collaboration with the then Union Health after the war, and Sidney and Emily Kark and their staff. Health during pregnancy, neo-natal care, and care for newborns and babies, was a central concern of the Karks and their teams.⁴⁹ It took until 1978 before the world community recognised, at Alma Ata, the wide definition of “health” described by people associated with the Kark’s in the late 1940s. Many papers, several edited books, dozens of dissertations and two books now exist concerning the coming together and after the late 1950s the dissemination and development of what became known as “COPC”.⁵⁰ Just in terms of the knowledge

⁴⁷ Longmore, p.241.

⁴⁸ Cite here the work of Erlank; Glaser and Delius; Hunter Burns

⁴⁹ Sidney Kark, and Emily Kark *Promoting Community Health from Pholela to Jerusalem* Johannesburg: Witwatersrand University Press, 2001.

⁵⁰ Cite works of S. Marks; A. Jeeves; E. H. Cluver *Social Medicine* Johannesburg: Central News Agency, 1951; K. W. Deuschle “Community Oriented Primary Care: Lessons Learned in Three Decades” and J. Geiger “The Meaning of Community Oriented Primary Health Care in the American Context” in E. Connor & F. Mullan (eds) *Community Oriented Primary Health Care* Washington D. C.: National Academy Press, 1983; D. Yach and S. M. Tollman; “Public health Initiatives in South Africa in the 1940s and 1950s: Lessons for a Post Apartheid Era” *American Journal of Public Health* 1993, 83: 1042-1050; S. M. Tollman “The Pholela Health Centre: The Origins of Community Oriented Primary Health Care (COPC) *South African Medical Journal* 1994, 84: 653-658; D. J. Ncayiyana “The Pholela PHC Model: No Need to Rediscover the Wheel” *South African Medical Journal*, 1994, 84:84-89. S. L. Kark and J. Cassel “The Pholela Health Centre: A Progress Report” *South African Medical Journal* 1952, 26; S. Kark and G. W. Steuart (eds) *A Practice of Social Medicine* Edinburgh: Livingston, 1962; S. Kark and J. Chesler “Survival in Infancy” *South African Journal of Laboratory Clinical Medicine* E. Kark “Puberty in South African Girls II: Menarche in Relation to Social Class” *South African Journal of Laboratory Clinical Medicine* 1956 2: 84; E. J. Salber “Growth of South African Babies in the First year of Life” *Human biology*, 1957: 24: 12 E. J. Salber & E. Bradshaw, “Birth Weights of South African Babies” *British Journal of Social Medicine* 1951, 5:113-19; Philips;

their teams brought together of both physiological and social forms concerning people from widely differing and sometimes segregated economic class and ethnic groups, their work is still fresh and experimental when read today. Their Durban work is unusual also because reproduction, health, and related issues—in the lives of working class and lower middle class whites—were also considered alongside those of black women and men making use of the Centres. Detailed research concerning family life; reproduction; physical maturation; maternal, infant and child health was generated through the work that the clinicians and demographers health centres and via the health educators. In addition larger comparative projects on infant feeding and weaning; infant anthropometric statistics; on menarche; sexuality and reproductive maturation, were conducted under the auspices of researchships generated through the Kark's efforts, (awarded to teams led by physicians such as Dr Eva Salber and anthropologists such as Dr Hilda Kuper). This work too continues to be salient and a precious body of evidence for contemporary researchers. No one has achieved these kinds of detailed comparative data even in the present.

In a special study of the health of working-class mainly South African Indian and isiZulu and Xhosa-speaking people of Durban –in comparison to rural poor in Pholela district (drawing on data gathered at sites in Merebank, Springfield and Lamontville), the Karks and their teams were able to discern several key patterns, which Emily and Sidney Kark (just before the latter's death) were able to summarise in the late 1990s:

We undertook a comparative study of mother and child health care in the communities of Pholela with a rural Zulu population, urban Lamontville in Durban also with a mainly Zulu population, and the predominantly Indian suburb of Merebank in Durban. These communities provided considerable contrasts in their life style and environments, as reflected by marked differences in birth rates and infant survival, infant stillbirth and mortality rates. There were, however, similarities with regards to the duties of motherhood and the welfare of babies.(133) .../. There were differences in maternal behaviour between the rural and the urban black communities , and both were quite unlike the urban Indian community. Nevertheless they all shared similar beliefs in certain aspects, for example, the initiation and continuation of breast feeding as the basis of health promotion and survival of their infants, and hence a cardinal function of motherhood. (134)

Breast feeding as a Socially Embedded Practice

The Karks and Salber were able to show in their work linkages between breastfeeding and wider social dynamics that have taken other researchers around the world⁵¹ many more decades to establish. The work of the Karks, and that of their team members, as it began to be assembled, analysed and later published, showed the powerful links between successful breastfeeding and maternal care more generally; between birth labour experiences and breastfeeding; between breastfeeding and family and

Susser; Stein; Burns; Reid; Zuma; Shisana; Geiger; Gale; Abrahamson; Cohn; and dissertations such as Burns, Noble, L. Vis (forthcoming M Med.); M. Scholtz.

⁵¹ Cite the work of the Uppsala research team under Tim Greiber and others.

community support; as well as between breastfeeding and fertility rates; birth spacing intervals; and infant mortality and morbidity rates.

The Karks were able to point to differences in ideas about and practices concerning maternal care; neo and post natal traditions; and infant feeding patterns across these communities and compare this data with much more readily available but more general data on whites, as well as detailed data on a small community of whites gathered at their Woodlands site. Because they viewed people as parts of families and communities they examined individual variation as well as patterns and sought significance in both variation and commonality. They were able to show how poverty influenced decisions and outcomes, but also to show that economic resources had little impact on the persistence and elaboration of some maternal and child related practices and beliefs. Of central concern to this paper is the data they collected around practices related to breastfeeding and infant care and to weaning.

Let us examine in greater detail the prevailing “best practice” clinical ideas around breastfeeding in the late 1930s and early 1940s when the Karks were trained? This was a period of greater openness on the subject—before the commercial presence of the formula companies in the later 1950s to 1970 era, and also before the 1980s and 1990s debates.

Although white and middle class South African women were still largely breastfeeding in the 1930s and 1940s, this was about to give way to an era of clinically supported practice where these South African communities—in line with western and northern women—began to turn to bottle feeding as a preferred health option for their children. It took until the 1990s before the South African state was able to begin reversing this trend. However the “bottle over breast debate” was weakly established in the late 1930s and early 1940s, with most biomedically trained professionals still focused on breast nutrition for infants, especially in poorer communities and in the absence of nutritionally even vaguely competitive manufactured alternatives. In addition, as with many community-oriented physicians concerned with preventative medicine and clinical care, the Kark’s and their team members were concerned to support breastfeeding as the best form of infant and baby nutrition. Although there were not yet the wide spread national or international campaigns against infant formula advertising described above, the period of War disruptions had created fertile ground for cow and goats milk substitutes to be developed and marketed world wide, and for tinned and powdered cows milk to become widely available. In fact skimmed cow milk powder was one of the key “foods” that Dr Eva Salber and her team were able to get from the State under medicine budgets and to prescribe to malnourished mothers and infants and children through the health centres.⁵² Salber, whose work soon centred on infant and maternal care, and who submitted her M. D. on the subject for the University of Cape Town in 1955, discusses at some length her and her colleagues conversion to activism around “breastfeeding on infant request”⁵³ rather than the 4 hour food regime then recommended by a variety of mothercraft and infant welfare experts in South Africa and internationally. Salber and her colleagues observed how infant suckling (frequent and in response to infant need) and infant carrying (close to the body all day and

⁵² Salber *The Mind...*p.104-121.

⁵³ We prefer this term to “demand”.

night) promoted milk production and confident feeding. Over time the Karks, Salber and their colleagues in South Africa and in the primary health care movement in the world, came to praise the infant feeding successes of many poorer post partum mothers in rural and urban settings and decry the newer clinically led breastfeeding regimes of the USA. Salber and the Karks contrasted the successful way South African Indian and African women breastfed with many white women whose hospital births and clinical post partum stays as well as experiences of didactic “4 hourly regime” maternal education instructions, were undermining their confidence and eventually milk production. They were well aware therefore in their work of the links between psychological support; physiological process and ultimate lactation success. For her part Salber was so concerned with the chemical and hormonal aspects of lactation that she paid special attention to her South African data and later on became a world expert in the links between fertility and exclusive breastfeeding and the links between some cancers and lack of breastfeeding experiences in older women.

As Salber noted in her 1955 thesis and her autobiography, despite the fact that white women had started to come under the influence of paediatricians who supported “by-the-clock” feeding, she was still able to show that in the late 1940s and early 1950s that in the first 10 days after giving birth women 93.4% of white women in her data sets were “solely breastfeeding”. The comparative figures for other mothers were: 98.6% black (by which she meant women of indigenous but not mixed parentage) women were “solely breast feeding”; 97.9 % of the small number of coloured women in her samples were “sole breast feeders”; and 71.1% of South African Indian women. She found that very few Indian babies were bottle-fed only but that most were mixed fed from the start. She commented:

We believed that the poor nutritional state of the Indian mothers—due largely to a most inadequate intake of calories and protein—plus their high fertility rates resulting in big families with closely spaced births, was probably responsible for their difficulty in establishing a sufficiency of milk.⁵⁴

This concern about the amount of food South African Indian women were getting, eerily echoes calls made today for HIV positive women who have given birth to get other nutritional support. Many people can see the madness in pushing for infant food supplements in the absence of food to poor HIV positive mothers. Salber’s response to maternal malnutrition in the 1950s was to “prescribe” skim milk powder to mothers as well. As Louise Vis’s M. Med. thesis (in production) shows the health centres and the Health Educators there worked very hard on nutritional aspects of health, establishing gardens and food sharing depots. Here the work of the Stott Clinic and Health Centre experiment, also started in the late 1940s and 1950s by physician Dr Halley Stott, in the Valley of a Thousand Hills—later called “The Valley Trust”—has also received close attention for its emphasis on nutrition as the key to good COPC and sickness prevention programmes.⁵⁵

⁵⁴ Salber *The Mind*, p.116.

⁵⁵ See the work of Diane Wiley as well here and Burns and Nobel paper to the 50th Commemorative Conference of the Valley Trust; Durban, July 2003.

“Traditional” Midwives as Breastfeeding Supports: part of a wider context of support

Just as they were struck by the poor nutritional level of South African Indian women so the Karks, Kuper and Salber were particularly struck by the role of the “traditional” (in quotation marks here as a reminder that by the 1940s and 1950s these professionals provided a service which was a combination of ancient south Indian birth rituals and practices and modern biomedical practices) South African Indian midwife—a recognised and designated category of person by the local state as well. These designated persons had since the late 1920s come to be nominally supervised, to a lesser or greater degree, by local health authorities in Natal, such as the Durban City Council Health Department. The role of these midwives in staying with the labouring woman through labour and the period afterwards; providing her with emotional and physical support; acting as somewhat of a bulwark against the possibility of too authoritarian mothers and mothers-in-law, and crucially helping with infant breastfeeding and infant disorders after birth, especially management of diarrhoea, was the subject of much analysis. The work-in-progress on the history of South African Indian nursing (by Rabia Cassimjee) and work on family life, reproduction and fertility of Indian South Africans (by Nafisa Essop Sheik) will hopefully take both of these subjects much further. Kark and Salber writing in the 1950s and again in the 1989/90s era began writing about the lack of traditional and community midwives in African families in rural and in urban settings as a key lacunae in the lowering of infant mortality and morbidity. Their ideas fed into some planning and policy making in the 1950s but ultimately the “midwifery model”, or a mix of traditional and bio-medically trained midwifery model, was never taken up by the local or central state authorities.⁵⁶ We await the work of Cassimjee and Essop Sheik to discover more about the impacts on South African Indian health of the movement after the 1950s into clinical settings for birth labour and the role of professional South African Indian nurses, as well as a comparison between Hindu birth and breastfeeding practices and that of Muslim and Christian South African Indians.

Infant Spacing and Female Fertility Rates

The research teams were interested in a feature of the Durban and Pholela communities which seemed relatively new in terms of reported rates (flawed as that reporting often was) for previous decades. Instead of infant spacing being 3 to 4 years, as they were expecting from ethnographic and other data from earlier in the century and the end of the 19th century, they found infant gaps less than 2 years as a common feature in isiZulu speaking communities. They also found that while high birth rates were a feature of all the poorer communities, with whites in Woodlands exhibiting a slightly higher rate of fertility than the national averages for whites, less than 16% of rural isiZulu speakers in Pholela district had more than 6 born babies by the early 1950s in given age cohorts, compared with 26.2% of women with more than 6 born babies in Merebank and 20.5% of women with born babies in Lamontville. They established to their satisfaction (though doubts remain as to the degree of natural contraception such as pessaries; sponges and oils; induced abortions; withdrawal of the male before ejaculation or intercrural sexual pleasure and so on) that these were

⁵⁶ Helen Schneider, Blaauw and Loveday Kekana; also Marks; Burns; Deacan papers on midwifery; And Kark’s *From Pholela*. chapter where they discuss recommendations.

largely non-contracepting communities and the Karks and their colleagues avoided any hint of didactic contraception advice in their practice, keenly aware of the rising interest in fertility limitation programmes for black people on the part of the state at the time. Nevertheless they were aware of the emerging scientific literature—still hotly disputed in the 1950s—of the link between family spacing (natural contraception) and breastfeeding. Only much later on did studies establish the key relationship between breastfeeding and temporary infertility. In Merebank the teams of researchers set out to find why in a breastfeeding-supporting and poor community, birth intervals were so low and rates of fertility were so high. A by-product of some of that research was the finding that malnourishment and poverty of many South African Hindu Indian women was a contributory factor in their sense of inadequate supplies of breast milk for their infants, a subject returned to below.

“Stable family Units” and links to Breastfeeding; Fertility Rates; and Infant Mortality Rates

Thus excellent data collection on breastfeeding was woven into these studies across the spectrum of maternal and infant health. For example, fertility rates and infant mortality rates were compared and analysed. In Lamontville—the best resourced of the black communities served by the Health Centres—the fertility rates were highest at 47.6 per 1000 in the 1948 to 1951 period. In rural Pholela the rates were just over 40 per 1000 and in Merebank with its mainly South African Indian community, 32.8 per 1000 was the recorded rate. The white fertility rate in South Africa at similar periods evinced much lower rates of 25.7 per 1000 in the early 1940s and 26.5 per 1000 in the late 1940s. The Karks were concerned to find out whether or not higher fertility rates translated into higher rates of population growth. Their findings were interesting and suggestive for studies even 50 years later.

The Karks and their colleagues found that family stability was a key indicator in infant survival, child hood health and thus population growth. They were able to observe early on, even before their health data supported this more conclusively, that there were high rates of infant morbidity and mortality in Merebank, Lamontville and Pholela and far less infant death and sickness in Woodlands and white areas of Durban. Yet the great variation between infant mortality in Merebank and Lamontville alone was puzzling—economic factors were not as powerfully determinant as perhaps they had thought. So they turned to more nuanced family and cultural observations and data gathering attempts. Before proceeding we need to note that the Kark’s and their teams did not regard “families” within the strictures of a legally bounded nuclear household. Early on in their work they noted the high rates of households with a variety of cohabitation arrangements and so they worked with a more flexible definition of a “stable home” than would many of their peers in the 1940s and 1950s. Stable families were thus people, residing together in a household over long periods of time, relying on one another and working together for the good of the unit—either multi generation or nuclear, and whether or not the people in the unit were legally married or blood-related. The existence of stable units was for them soon clearly linked to better maternal and infant survival outcomes. The successful feeding of infants and care of the woman after her birth labour, a central subject of several of the studies that they and their colleagues conducted, was, they found, best achieved when stability of support existed and most compromised in the case of

intergenerational conflict; isolation, and lack of support for infants and mothers in the first year of new life.

Even if economic resources and educational levels of parents were taken into account, less formally educated and poorer parents and their infants in Merebank outlived their isiZulu speaking peers in Lamontville, where fertility rates were highest in the health centre comparisons. In several publications Sidney and Emily Kark, Eva Salber and Hilda Kuper reported that Hindu post-birthing practices were seldom contrary to biomedical and “best practice” clinical advice of the day compared to that of isiZulu speakers. Although both communities were concerned about the extreme vulnerability of both a woman and her infant after birth, and both attended to supernatural needs in this regard with amulets and protection for “evil eye” influences, Hindu regimens concentrated on the post partum woman’s body with regulated massage with oils, special bathing preparations, preparations for breast feeding, and generous support of the mother for her sleep and rest. In contrast the family units in Lamontville, and even in rural Pholela where there were larger intergenerational homes still functioning, young mothers were often left alone; often had to prepare foods for their families and spouse; and had to return to heavy work sometimes after a few days. Fathers were also often absent as were mothers and mothers-in-law. When present there were often conflicts around post birth care of the infant. Although in both communities striking similarities were noted in the smoking ember practices and medicinal preparations for both infants and mothers, and although rural isiZulu women were provided with animal hide and woven garments to support their abdomens, their emotional and physical well being was not the subject of the careful communal and extended family attention lavished on Hindu women post partum. Illness causation and health beliefs were soon the target of much of the research.

Thus, although the Merebank community of Indian South Africans was poorer than the households in the Lamontville development, the latter area exhibited high rates of absent family members; lack of intergenerational support; isolation of the newly born infant and mother and a host of other social conditions which the Kark’s and their team concluded were detrimental to infant and post pregnancy health.

This was despite the fact that in the Durban data the Indian South African Merebank babies were most likely to be born at home (with about 63% relying on the services of a traditionally skilled midwife, and about 12.3% relaying on unskilled family members and only 25% being born in a clinic or hospital or under the care by 1950), and although few had any access to running water and better housing facilities, their survival was better than the Lamontville infants. In the latter case 86.1% of babies born to mothers in Lamontville were born under clinical supervision with 95.3% receiving ante natal care as well. In rural Pholela where, similar to Merebank, just over 29% of infants were born under clinical care, infant mortality was also very high. In this case poverty, lack of water-borne sewerage and running water, and related factors, were all seen as key. In Lamontville with most women received what was deemed “skilled care” at birth and babies weighed more than the Merebank infants. In Merebank the Karks and others expected to find higher rates of infant morbidity and mortality. They established that many Merebank women worked for wages part time, did large amounts of family related sustenance labour, carried heavy loads and undertook strenuous labour daily just as in neighbouring communities. Their daily

caloric intake was deemed insufficient for health. In Merebank many women reported worrying they had not enough milk and although breastfeeding was validated by families, restricted public or semi public space for this were permitted in daily life. As in isiZulu families in Pholela the Merebank mothers were considerably lighter than the Lamontville mothers and their caloric intake was less than their Lamontville counterparts. The lower rates of infant morbidity and mortality in Merebank fascinated the Karks, who summarised these findings in 1999 thus:

In all the communities, pregnancy was regarded as a very special condition, with both the mother and the baby being vulnerable to illness or injury. In the rural conservative Pholela community expectant mothers were warned to avoid dangerous exposure to the machinations of witchcraft by an illwisher, or behaviour which would lead to punishment by the ancestral spirits. Although somewhat less obvious in Lamontville, such beliefs in external forces as the cause of complications were widespread. By contrast, the Hindu of Merebank and Springfield believed that misfortune was a result of the 'self' rather than an external agent. Failure to become pregnant or to have complications such as natural abortions or still births required expiation of sin or wrong-doing. Throughout pregnancy women in the Hindu community were supported both emotionally and socially in their varied needs and dietary requirements.⁵⁷

And again:

[In the Hindu community] .. Many protective treatments, secular and religious, were undertaken for the child's health. One of the most widespread beliefs was the 'evil eye' or jealous eye, but unlike the witchcraft beliefs of the Zulu community, this was not considered to be deliberately inflicted by an ill-wisher.⁵⁸

One final area for further research that the Karks and their research teams investigated and about which they left enough data and material upon which to build far more nuanced present day studies concerned with HIV infection and breastfeeding, is the cycle in poor communities created between breastfeeding cessation, bottle feeding, and infant morbidity especially gastroenteritis.

Breastfeeding and Babyhood Gastroenteritis and Infant Diarrhoea: the links to Cultural Practice; Traditional Midwives; Poverty and Sanitation.

In Eva Salber's autobiography she devoted chapter to her time in Pholela working with her physician colleague and husband, Harry Phillips. Her chapter is replete with commentary on both what she saw as the health affirming aspects of life in Pholela and factors in the late 1940s early 1950 Pholela social life that undermined good health. Echoing Krige's compilation of the 1930s Salber wrote::

African mothers breast-fed their babies freely, both for nourishment and for comfort, but when a baby developed the syndrome of frequent, green, watery stools, and dehydration that spelled the dreaded *Inyoni*, it

⁵⁷ S. and E. Kark *From Pholela* p. 138.

⁵⁸ S. and E. Kark, *From Polela*, p. 142.

was abruptly weaned. An *inyanga* was consulted in such cases to confirm the diagnosis and to validate the mother's belief that an ill wisher had put *muti* on the path she had walked on, thus making her milk toxic and causing the baby's symptoms. The *inyanga* would prescribe purges, enemas, and, worst of all, weaning the baby from the "poisoned" breast milk. We lost many babies that way. Sometimes mothers would come to us when they saw that the *inyanga*'s cure wasn't working. And though I didn't dispute the diagnosis I managed at times to persuade mothers to resume breast-feeding. Once I for a baby back on the breast three weeks after weaning!—and the baby recovered.⁵⁹

In their summarising text covering the work of the Institute and health Centre projects and their successes and failures as a whole, the Karks wrote:

Among the main causes of illness and death in infancy were summer epidemics of diarrhoea (gastroenteritis), the more severe forms manifested by green loose stools with undigested curds of milk. This was rapidly followed by marked dehydration and marasmus, and was often fatal unless adequately treated. Modern oral rehydration therapy (ORT) was not yet known or practiced. The health centre team treated these cases with reconstituted skim milk powder and vitamins; this treatment proved to be very effective but was certainly not as simple or inexpensive as ORT.⁶⁰

For Kark and his team the reasons why infants in Lamontville and Pholela got as sick as they did and died with greater frequency, and the reason that just as poor or poorer Merebank infants with gastroenteritis fared better although complex, nevertheless had a lot to do with the belief system underlying breast milk and its meaning and mediation of sickness. The links between an infant's excretions, especially a sick infant, and the infant's mother's breast milk remain under-researched and linger today. We argue tentatively that in fact that the context of HIV/AIDS, with the discursive environment supporting maternal responsibility; the stigmatising of women; and with popular translations of biomedical debates resulting in much confusions and obfuscation, the links between a lactating woman's responsibility for her contaminated breast milk and her infant's illness may have been developed and elaborated rather than being a mere "lag" or hang over of past practices and beliefs.

Thus in the 1950s, and no less today, the role of enemas and related medications was key to understanding dilemmas facing public health experts concerned with infant survival and care. Kark summarised the dilemmas he and his team faced dealing with gastroenteritis in the 1950s. We can find echoes of this in the writings of medical missionaries and bio-medically trained health professionals working in and with African communities south of the Limpopo, from the 1880s to the mid 20th century. In the works of Junod; Bryant; McCord; Trant; Xaba; Ngubane; Stott; Bennet; Barker⁶¹ and many others the story of rectal interference is iterated and reiterated as a key

⁵⁹ E. Salber, *E The Mind is Not the Heart: Recollections of a Woman Physician* Durham: Duke University Press, 1993 [1989]. p 95

⁶⁰ S. and E. Kark *From Pholela*. P.143.

⁶¹ Provide full citations from Junod; Hunter; Taylor to Xuma, Gelfand, Schapera etc.

response to, and then instigator of, stool analysis and infant diarrhoea or sickness. At the centre of this nexus was and remains the search for explanations of illness on the part of African mothers and especially grandmothers, as well as herbalists, diviners and healers.

Kark, examining the similarities and differences between South African Indian and isiZulu communities and their responses to gastric infection in Durban and Pholela in the late 1940s and early 1950s wrote:

Our treatment was based on concepts far removed from those of the black communities, more especially rural Pholela. Most Pholela residents and many in Lamontville believed that diarrhoeal diseases were transmitted through the mother, congenitally and through breast feeding. Mothers were believed to have been infected by an ill-wisher who had directed them, by supernatural means, to walk across a place that had been struck by lightning, or by a bird (*inyoni*) that had previously flown over the site they traversed. The traditional practitioners treatments were focused on the diarrhoea itself, involving the use of grass reed enemas, twirling the reed in the anus to draw blood. Their advice to stop breast feeding was consistent with local traditional concepts of causation. Both the advice and the treatment were considered by us to be harmful. However, with the mother's belief that her breast milk had been rendered detrimental and a cause of the baby's illness, neither she nor her mother-in-law could be expected to comply with the advice to continue breast feeding. The health centre's advice to use the special skim milk powder preparation diluted with cooled boiled water, using sterilised bottles and rubber teats, was, fortunately, acceptable to them.⁶²

Hindu newborns were also thought to be in need of protective cleansing and treatment. However, non-invasive treatments such as massage of mother and bay wit various oils together with prayers and incantations were used.../... In the Durban Indian communities of Merebank and Springfield there did not appear to be any conflict between the concepts of cause and treatment of gastroenteritis or acute respiratory infections with those of the health centre practice. They assigned the cause of illness or misfortune to themselves; some of the vows they made as to future behaviour if the baby survived or got well were very demanding, and were taken in order to expiate their feelings of guilt.⁶³

The history and aetiology and the “assigning of the causes” of infant illness, and the location of therapeutics in breastfeeding cessation, is obviously a key contribution that the examination of the ethnographic and historical record makes to current debates and understandings: to what extent do current exhortations to formula feed—because of “poisoned” milk (directed towards HIV infected women with babies—stimulate and develop this already deep therapeutic tradition? To what extent do exhortations to “exclusively breastfeed”, for yet other HIV positive women with infants, clash with

⁶² S. and E. Kark, *From Polela*, p. 144

⁶³ S. and E. Kark, *From Pholela*, p144.

these understandings, making it impossible either ideologically or materially impossible for women to “successfully take up advice and act upon it”. Evaluations of health education interventions and the role of public health nurses and clinical HIV experts has to be seen against this backdrop.

Tentative Conclusion to Part I

From our point of view both of these explanations for health causation in Hindu and isiZulu Natal families in the 1950s, provided by the Karks in their summary of infant sickness, are worth deep examination: 1) an externalising explanation for ill-will (but which still places all the onus for cure and altered behaviour on women as mothers) and 2) an internalising explanation (placing emphasis for sickness on the level of a individual woman’s goodness and worth). These explanations linger as spectres and ghosts of our pasts. They linger in the feed-back given in interviews by the Umlazi field workers with the MRC-study; in the recorded views and reported speech of women participants in clinic programmes and trials from Paarl in the western Cape, to Rietvlei in the eastern Cape, to Umlazi in KwaZulu-Natal. These spectres need to be traced and named and studied, and need to be juxtaposed with the vibrant and affirming aspects of breastfeeding and infant cultures from our collective pasts. Ignoring the history and the legacies of breastfeeding and infant care will further entangle and drag down public health efforts to eradicate HIV/AIDS infections and deaths. Human suffering has already been the cost of rushed and ignorant interventions. The last 8 years of confusions and tensions in the biomedical and scientific world around breastfeeding and its links to HIV/AIDS—filled we know with the work and plans of many well-intentioned and very hard working women and men—risks yet again miscasting women as mothers only, and as the sole engines of transmission as well as infant survival. Why aren’t the “parents”; the “fathers”; the “families” and the “neighbours” named in these acronyms, and the research projects they summarise? “MTCT”: Do all HIV/AIDS papers on HIV infected infants, and the HIV infected women who are their mothers, have to end with the theme of poison, stigma and guilty women? We hope this story will eventually conclude another way and the carefully planned team-based work of the Karks provides just such a model for the work ahead today, as much as it did in the 1950s.