"Our Children Cannot Survive on Breast Milk Alone"

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Abstract
This paper aims at reaching a comprehensive understanding of the complex and varied stakes for mothers involved in their decisions on child care actions, breastfeeding in particular. The expected outcome would be to recommend improved information on breastfeeding, to make sure that local clinics are up to date on information from WHO. However, the relation between knowledge and practice is not linear and automatic and has to be questioned critically to improve child health in a genuine and sustainable way.

Key words: Breastfeeding, mothers, Luo people, Kenya
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Introduction

It was a beautiful morning with sunshine and a mild breeze when mothers approached the clinic, passing the beautifully blooming bougainvillea opposite the marketplace with their babies on their back. They sat down in the shadow, waiting for their turn for the baby's vaccination. When the group of mothers had all been through, they were gathered for group counseling conducted by the health care worker:

> You should breastfeed the child for six months. Cow's milk is not good for him or her because it will give so many diseases, and so, you should be the one taking a lot of cow's milk so that you will have sufficient milk. You should not have a lot of worries while breastfeeding because it will interfere with the milk let down. You should eat vegetables like *sukuma wiki*, cowpeas (local vegetables). Cow's milk (for the child) will make the food the child takes to be hard in the stomach of the child and therefore it is not good. After the six months you can now look for millet and finger millet, ground nuts and peas, make it into flour and prepare porridge for the child. The child should also be given fruits like bananas, particularly a variety called *odhigo,* and oranges because they are appetizers. The child should also be given vegetables, particularly the traditional ones. The child should also take papaya and avocado. You should also look for tomato leaves and cook for the child as they are good for body building. You can start giving the child other foods apart from breast milk after six months. You should take porridge made from finger millet flour to enable you to have a lot of breast milk.

After the lecture ended, the health worker asked a couple of questions, apparently to make sure, mothers could repeat what they had been told. For example, the mothers were asked "What do you usually give to your child?" In response one mother answered "I give breast milk and cow's milk because I have insufficient milk in my breasts. I thought that cow's milk is

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not good because it makes the child have diarrhea and it also makes the food the child has taken to clump together in the stomach." The next question followed and the health worker did not touch upon why breast milk is insufficient or how production could be increased. The authoritative nature of lecturing does not support ideas about a dialogue-based form of counseling.

After the counseling I arranged a short FGD in the clinic and I asked six mothers what they feed their children. All the children were less than six months old and none was exclusively breastfed. The mothers told me that they do listen to the advice given, but they practiced differently because "you as a mother of the child see that breast milk alone does not satisfy your child, because it reaches a stage that even though you are breastfeeding him or her, he or she keeps on crying and does not stop and so, this will make you add something extra" (mother 34 years old).

Thus, the mothers don't believe that it is possible to increase breast milk production to satisfy the baby. They argue that some mothers are not having enough physical capacity, that hunger and also poverty are important obstacles and that their lives are too stressful. Although they see that cow's milk gives the child diarrhea, they do not know an alternative, as they say; they do not have access to modern baby food.

The biomedical knowledge mothers 'have' is at a first glance situated in a certain field in Bourdieu's sense of the word (Bourdieu 1990). The mothers can repeat the biomedical health messages in the clinic or when a researcher comes with a lot of biomedical '*habitus*', asking questions about their practice[1]. Yet, they are "non-compliant" to the recommendations of exclusive breastfeeding when it comes to practice.

The prevalence of malnutrition, in terms of stunting (low height for age) in particular, is high in rural Kenya, as is also early childhood mortality. Stunting is the best parameter for chronic malnutrition. The national survey in Nyanza, where my study area is located, shows that 30.8 % of children under five are stunted and 11.2 of these are severely stunted (KDHS 1998:122). Stunting has been documented as correlated with an early introduction of complementary food (Onyango *et al.* 1998 in Onyango 2000). Moreover, the under-five mortality is the highest in Kenya, at the alarming rate of 199/1000 in the 1998 survey of Nyanza. Nationally, the rate is even higher in 2003, while the new rates for Nyanza in particular are not yet available (KDHS 2003). Improved breastfeeding practices could influence these features positively (WHO 1998, ACC/SCN 2000).

The aim here is to illuminate what is at stake for mothers when they practice child care and breastfeeding in particular, to reach an understanding of not so much why they do not follow the recommendations but rather *why they do what they do*.

Methods

The present study is based on a three months stay among Luo mothers in a community in Nyang'oma in Western Kenya (see Figure 1).

The study is based primarily on qualitative methods, although it also included quantitative elements. I conducted more than 40 semi-structured, open ended interviews, mostly with mothers, but also a few with fathers as well as with health care professionals. I went for lectures in clinics and in schools and I did several group interviews of which some turned

[1] I realised after some time that some mothers had answered my questions in accordance with what they thought was the correct answer. Hereafter, through my focus on concrete practices and by returning to the same question again in later conversations, I reached answers more in accordance with real practices, I believe.

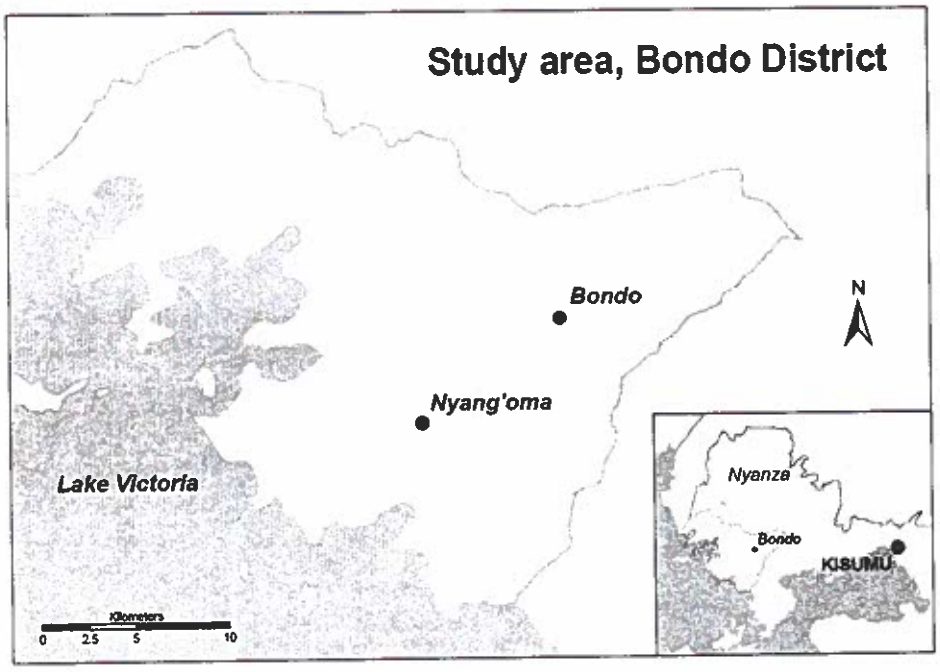

Figure 1: Map of the Nyang'oma study area, western Kenya

out to be focus group discussions, partly as follow-up in relation to the counseling in clinics, partly in some of the existing women's groups. I conducted two surveys, one with 100 mothers and another small one with 15 men, and I measured the height of 70 children in nursery schools.

Results

Mothers' agency, knowledge's currency

To improve children's situation in the study area as well as elsewhere in the region, identifying the limitations of mothers' choices are crucial. How can we rethink child health and survival in an anthropological perspective, with a focus on opportunities and constraints on practices of childcare, to strengthen women's capacity as mothers? Mothers act from a perspective on the future as well as on the past and the present. Their motivation force is coming into being as a proper mother. Mothers' actions make sense in the light of principles and ideals of motherhood on which the mothers (and others) agree in general. I will refer to a conversation on breastfeeding practice with Karen (not her real name), as this will illuminate how child care practice comes into play. Karen is by no means representative for mothers in Luoland. The variation among those is wide in terms of age, economy and entitlements, family relations and friends. A young mother, recently arrived at her husband's *dala*, is in a more vulnerable position than an older mother who has different considerations. I emphasize that practice of child care can be understood by looking at the particular concerns and struggles of mothers as they express them in words and acts. The scientific validity is not based on objective criteria such as representativity here[1].

Case story: Karen

Karen is a joyful, 27 year old mother of a

[1] See the article by Teglhus in the present issue of *Mila*.

beautiful and healthy girl, nine months old. She also has a son, three years old, who is suffering from a chronic disease. This disease gives Karen more work than usual with a three year old, but she is described by everyone around as a caring, patient and loving mother.

Karen went to school, up to Form 4 (12 years of schooling) as did also her husband. The family used to live in Nairobi, where the children were born, but they came to live in the homestead when the girl was only a couple of months old. They now live in the extended family with the father-in-law as the head of this family. When I arrived at the homestead, I always noticed how the women were outside their houses, gathered in a group under a big tree when preparing for lunch or maybe just chatting two or three together. The atmosphere in this homestead was pleasant, and it was obvious that Karen had a very good network in this family. For instance, the mother-in-law invited me to her house one day to ask how she (and her son) could support Karen with her son and if I thought it would help to take him to the hospital. Karen also referred advice she was given from older women in the homestead, as for a child suffering from diarrhea, milk should not be given.

Karen has good support in relation to child care, as the other women in the extended family very often will cook for the children and also when it comes to discussions on what is good for the children, the other women in the household are a source of knowledge and advice, according to Karen.

I will now refer parts of my interviews with Karen to share with you the understandings that directed my analysis.

Lene (L): What do you think of breastfeeding in terms of child health?

Karen (K): I think breast milk is the best, like for me, I will breastfeed for two years, that will be enough, but when you stop early, it affects the child's growth.

L: In what ways do you think breast milk promotes health?

K: The colostrum from the mother is good as it prevents against diseases.

L: And in terms of nutrients?

K: I think it has a lot more than cow's milk...

L: At what age did you introduce other liquids than breast milk, such as water and cow's milk?

K: For water, I started early, almost at birth, no, at four weeks, and for cow's milk, at the age of 2 months....

L: And then, about porridge?

K: Porridge, hmm..., about 5 months, I think.

L: Ok, where did you give birth to your daughter?

K: In Nairobi

L: Did they give you information on child care there?

K: ....Ya, I guess, when you ask me now, they told us to breastfeed exclusively for 6 months. For 6 months, before you introduce them to these other forms of food, like you know, for us, what we think when you give birth to a child they usually have these stomach problems, we give them gripe water or water with sugar.

L: So you give them this just after they have been born?

K: Not immediately, let's say, after one week ..., for the stomach discomfort.

L: Your experience is that the child has a discomfort in the stomach, how do you see that, what are the signs you see?

K: That is when they cry unnecessarily and unusual. So you give them gripe water, and you substitute that if you can't afford to buy the gripe water, with water and sugar.

L: Well, so when the child was one week old you saw the stomach problem and

the only way to solve that was to give the child the gripe water or what reasons will you mention?

K: Yes.

L: What were your considerations when you started giving her cow's milk instead of exclusively breast milk?

K: I guess it is influence, just like when you come here, ... the people think that breast milk is not enough. When I came back from Nairobi I was influenced by the women here in the *dala* and I guess I decided to give cow's milk when she was about three months old, because they told me, when she was crying, the cause was hunger, they told me she needed more food, other than breast milk.

The conversation shows us how Karen's choice about giving her child cow's milk is based on the influence from the women around her more than on the advice she was given in the hospital. However, I will not leave it as a matter of power relations as have several others (see for example, Ringsted 2000, Whyte and Kariuki 1997, Kryger 1992 among others from the local ethnography). Karen was definitely not suppressed in her extended family. As also another, even younger informant told me, when I was "after" power relations and asked her about who could give advice to whom in the extended household. She reported among others that:

> we can help each other because sometimes you don't have something, then you will get some from another in our household, and we can also just ask each other for advice because in this world there is no individual who is clever and knows everything and this other knows nothing (Betty 20 years old).

Still, this is not to say that knowledge is free of value and that different knowledge cannot be hierarchically organized in particular situations and relations. To know what to do when your child is sick might of course be of utmost importance for the survival of a sick child. However, the "right thing" might not be an agreed issue, different explanations and ideas are coming into play, even sometimes contradictory ideas as we see it in the case of the practices of breastfeeding. What is important though, is the process of maneuvering. Karen was maneuvering in her local world. Even I did not discuss with her whether she had actually discussed with her in-laws about breastfeeding, it was obvious that she had orientated her towards the local understandings more than towards the information she had been given in a hospital far away. She needed to belong in her new family and she wanted to be recognized as a good mother. Especially when she is left on her own in the *dala*, when the husband is away, she needs to be part of the community as they gathered in the shared yard in the middle of all the houses of the *dala*. Child care is a very much shared concern in a *dala*.

Most women living in extended households answered that several other family members are responsible for taking care of children, while those living in nuclear families most readily reported that children are the responsibility of the parents only. This means that in a *dala* if a child cries, other women will play a part in the action process for a mother; they might suggest that she gives the child other foods than breast milk. Karen will do as they suggest, not (only) because of power relations but because she wants to come into being as a good mother. However, the question about who defines what a good mother could be seen is a matter of power relations of course. Yet, my statement is that Karen participates in defining herself as a good mother rather than just accepting that certain practices defines a good mother. She attempts to become what she is not; when her child cries from what might be hunger, she has

to act, not only to stop the crying but also to come into being as a proper mother and to make a whole of what is not; to establish a congruency in the landscape that she orientates herself towards. Being an actor means having the will to do, to act, as an attempt to "become what we are not and to make a whole of which is not" as Hastrup (2004) has put it.

Similar to what Jessica Ogden describes about women in the Kifumbira area of Kampala, life of Luo mothers is both domestic and intensively public. As she notes the "scrutiny under which these women live out their days is intense: what an individual does, when, with whom and in which manner is general neighborhood knowledge. It is not surprising, therefore, that there are strong ideas about what constitutes a good or a bad neighbor, a good or a bad woman, and most people work hard to make their behavior and ideals appear to match" (Ogden 1996: 169). She discusses the "Proper Woman" as a normative concept that "covers a whole constellation of these norms and values" (Ogden 1996).

My study shows that a master motive of mothers is the desire of becoming a good mother. To become a good mother does not only imply that the child will survive and grow healthy, but it is important for what Jackson has phrased "existential integrity", meaning that mothers need to "belong to and engage effectively in a world of others, having some say, some voice, some sense of making a difference in the group with which they identify, yet without occluding or denying the comparable needs of others" (Jackson 1998:16).

Mothers argue that their breast milk is not sufficient for satisfying their baby. Their breastfeeding practices do not promote the satisfaction for the child, mainly for three reasons. One is that mothers breast feed many times during both night and day, but only for a short time in each instance; in many cases because they are disturbed by other children or by other duties in the house. Some of the duties are related to feeding the rest of the family as mothers are the overall food providers. This takes us to the second reason for the lack of the infants' satisfaction in breast feeding; mothers are forced to leave the child behind when going for the small-scale business that gives them the means for survival. Thirdly, mothers' own argument is that the quality of their milk is not good enough because they lack sufficient nutrition themselves.

Similar to what Johnson (1997) noted on the Maasai, hunger is a recurrent fact to cope with and it is accepted as a condition of life. This means that poverty and hunger are aspects of the local world at the same time as they are structural, politic-economic features. Poverty and hunger are dealt with here in the recognition of the fact that poverty and starvation are part of everyday life in this part of the world. Poverty and hunger are not temporary or acute problems, except during potential famines. Rather, they are part of reality that there is, although seasonally differentiated, a rather constant lack of food and other basic commodities. Kirsten Hastrup argues that hunger and starvation are "total social facts" that makes no sense outside their social and cultural context. "While the need of nutrition is universal, the feeling of hunger is culturally mediated", she states, and argues that starvation is part of the collective memory (Hastrup 1993:730). I do not agree entirely in this rather relativistic statement, as I anticipate that the feeling of hunger has also rather physiological aspects, which is not culturally mediated. However, her core argument is that starvation and other brutal facts of life, such as poverty and high child mortality, are non- temporary conditions experienced and dealt with as *a part of the normal order of things.* This means that people deal with it as a condition of life, not that they passively accept it.

Given these difficulties, it is clear that mothers are cautious about their children's entitlements and potential support. Therefore, to illuminate how child care practice is formed not only by the local living conditions, but also by the relations and interactions that determine entitlements and support, is important in relation to the understandings of how acting and knowing are dynamic and relational processes.

Discussion

Knowing a process in progress

Acting is not to be understood by splitting it into pieces of meaning and intention; meaning is emergent, not prefabricated, and intentions have more to do with acts of no or only little significance in terms of moral value (Hastrup 2004). Thus, I am not suggesting causal explanations about motherhood and practices of child care. Mothers act, not from "a general map of social and semantic coordinates, allowing them to play their 'culture' in general; rather they act to the moment, filling out their itinerary as they go along" (Hastrup 2004: 55). In other words, mothers know as they go (Ingold (2000:29); they act from a knowledge process in progress.

Mothers practices are characterized by shifting orientations towards different aspects of her landscape[2]. This landscape is not to be seen as a background or as the premises of mothers' practice of childcare, rather, practices are constituted by the landscape at the same time as the landscape is constituted through acts and practices. With Ingold's own metaphoric expression: "The stream does not flow between pre-cut banks, but cuts its banks even as it flows" (Ingold 2000:167).

Mark Hobart has in his introduction to the essay collection "An anthropological critique of Development. The growth of ignorance", noted that "ignorance is not a simple antithesis of knowledge. It is a state which people attribute to others and it is laden with moral judgment" (Hobart 1993:1). Luo mothers, among many others, are constituted as underdeveloped and ignorant and their "traditional" knowledge is at best treated as an obstacle to the rational progress. As an example of this that is even more clear than what was to be suspected after the introductory notes on the relation between knowledge and practice, we will see how it is put in an interview with the local Medical Officer of Health. He talked about kwashiorkor, a serious state of malnutrition that, according to him, affects about 30-40% (in accordance with KDHS 1998 & 2003) of the children hospitalized. He explained that

> culture says that the child has somehow been bewitched. Most mothers, when they are admitted to the hospital, we want them to understand that the malnutrition is caused by lack of food, but they claim that it is caused by *chira* and they have kept the child for so long while treated with herbs. So they only come when they realize that the baby is not responding to their treatment .... Level of education and ignorance is a very, very big problem around here. Most mothers are not well informed; they leave school early and thus cannot internalize these ideas (about breast-feeding) very efficiently, so that makes work difficult. Culture is another thing. It is not only a matter of knowledge. We can't all be nurses and doctors.

The statement shows the ideological theory of rationality and medical epistemology that forms the discourse of knowledge. There is a general assumption among the local elite (as well as in many development projects) about culture and ignorance as the obstacles to proper

[2] Landscape here is inspired by the way Ingold uses it in his phenomenological theory of practice. This implies among other things that people are perceived as actors and health behavior is practice.

child care. The local "tradition" or "culture" as systems of knowledge is dismissed as non-rational, in some cases even as ridiculous.

Conclusions: Dilemmas of development

Mothers do not make use of the advice they are given as they don't see how it could work for them back home in the *dala.* Their experience and the shared understanding is that children cannot survive on breast milk alone. Mothers' practice of childcare is complex in that it is a result of whole range of considerations as the case story illustrated. But as practice can be influenced by new ideas and understandings as long as these not only makes sense to mothers but also is practically applicable and recognised as advantageous. No mother would reject antibiotics to treat her sick child, if she can afford it. Thus, information and new technology can be integrated into practices. My argument is that information should be formed in a dialectic process between public health information and local knowledge, between providers of knowledge and users.

Mothers should simply be met where they are and their knowledge and experiences should be taken seriously by providers of health information. Principles of participation and empowerment should be applied in accordance to the principles of 'democratic pedagogy' (Jensen & Schnack 1994) and an equal recognition of 'western', biomedical understandings and local knowledge about the world in which Luo mothers struggle along.

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