BREASTFEEDING IN SOUTH AFRICA
Social and Cultural Aspects and Strategies for Promotion

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OPSOMMING

Die voordele van borsvoeding word toenemend dwarsdeur die wêreld in wetenskaplike literatuur beklemtoon. Tydens swangerskap spreek meeste vroue ook die wens uit om te borsvoed. Daar moet vasgestel word wat vroue beïnvloed om nie te borsvoed nie, of om borsvoeding vroeg in die postpartum tydperk te staak.

Faktore wat borsvoeding beïnvloed is ekonomiese faktore; advertensie en kommersiële druk; die voorbeeld van die hoër sosio-ekonomiese groep; veranderde waardes en statussimbole; wedywerende ideologië; *te min melk*; kulturele voorkeur aan vet babas; beskikbaarheid van ondersteuning; invloed van gesondheidsvoorligting; hospitaalbeleid; gebrek aan hulp in die eerste kritieke dae en gebrek aan selfvertroue.

Daar is 'n tendens weg van borsvoeding af met ernstige gesondheidsimplikasies en ons het derhalwe 'n verantwoordelikheid om borsvoeding te bevorder. Strategieë wat aangevoer word is onder meer navorsing; hulp vir die werkende vrou; beperkinge op die bevordering van melkformules; voorligting; opleiding van gesondheidspersoneel; veranderings in hospitaalroetines; 'n nasionale projek om borsvoeding te bevorder en 'n ondersteuningstelsel in subekonomiese gebiede.

INTRODUCTION

Every week from 5-10 new scientific papers on the topic of breast-feeding are published (Jelliffe, 1983). Many of these emphasise the advantages of human milk over modified cow's milk. The increasing evidence highlights the nutritional advantages, the immunological benefits, the enhanced bonding between mother and infant, and the child-spacing advantages of breast-feeding. In developing countries these advantages can prove to be life-saving.

Although infant mortality figures for South Africa (especially Africans) are difficult to obtain, a review of statistics available from Local Authorities in the Western Cape shows that two of the major causes of death are gastro-enteritis and respiratory infections. The incidence of these infections is far lower among breast-fed infants. Experts agree that breast-feeding alone could have a significant effect on the infant mortality rate. Any perceived trends away from breast-feeding, especially in sub-economic areas cause great consternation, and often provoke the question, *Why aren't these women breastfeeding*?

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Many studies have focused on when the mother makes her decision about how to feed her baby. It is interesting how many women express the wish, during the pregnancy to breast-feed. In a recent survey (Carter, 1984) the investigators found that 98,3% of pregnant women interviewed at Maternity Obstetric Units in Cape Town said they wanted to breast-feed their babies. Marina Petropulos of Fair Lady magazine, who receives approximately 1 000 letters each month with questions on infant feeding, says that she is *often struck by the strength of womens' wishing to breast-feed.*

What happens to this desire to breast-feed? An interesting study conducted among urban Zulu mothers revealed that 72% of the infants had commenced formula feeding at between one and five weeks of age. (Ross, Loening, Van Middlekoop, 1983). Obviously it is necessary to examine what happens between the time the desire to breast-feed is expressed during the pregnancy, and the subsequent infant feeding, to determine why women do not initiate breast-feeding, or stop feeding early in the postpartum period.

FACTORS INFLUENCING BREAST-FEEDING

Economic factors

Economic factors are perhaps the most important ones influencing a woman's decisions about breast-feeding. We need to consider the costs of breast-feeding. The first is the price of extra food for the lactating mother. Increasing the food intake of the mother need not be a problem if there are inexpensive, locally produced, nutritious foods. It is likely that in most areas this would be less expensive than the modified milk needed to replace the breast milk.

Furthermore it has been noted that malnourished mothers do lactate adequately. In ongoing research comparing lactation among Gambian and English women, Whitehead and associates have found that all produce similar amounts of milk. On the question of whether the malnourished mother's milk has lower levels of nutrients, Whitehead reports *the principal constituents — protein, carbohydrate, and fat — are well protected even on a very low plane of nutrition* (Whitehead, 1983).

Supplementing the mother's diet in this instance, although it made no significant difference in her breast milk, did increase her energy level, and general state of health.

It does appear then, that feeding the mother is more cost-effective than providing modified milk for the infant, especially in sub-economic areas.

The second, more important economic question is, if breast-feeding means losing work, can a woman afford to do it? It is clear that many South African women must work (whether they earn the sole income for the family, or a supplemental income). Can these women breast-feed, and for what length of time?

An examination of Maternity Rights and benefits is necessary. Protection from dismissal is not guaranteed in South Africa. Barbara Klugman found that all the countries investigated in the European Industrial Relations Review and Report provide this protection (Klugman, 1983). Furthermore Botswana, Lesotho, and Swaziland also guarantee re-instatement (International Distributive Trade In Southern Africa, 1982).

The fact that this protection does not exist in South Africa has implications for breast-feeding because a woman may need to be looking for another job during the time when she is meant to be on maternity leave. The only guaranteed benefit she has is a maternity leave of one month before and two months after birth, with 45% of income provided by the Unemployment Insurance Fund (if certain requirements are met). Many working women, for a variety of reasons, are not eligible for this. Even those who are, always have the fear that there will be no equivalent job for them at the end of their leave. Poor working women in South Africa face major obstacles if they wish to breast-feed.

It is essential however, to point out that many women are not breast-feeding for reasons other than economic ones. A number of surveys in South Africa have addressed this issue. In surveys administered at two child welfare clinics in Heideveld and Manenberg (subeconomic residential areas of Cape Town) *80% of the mothers were not working at the time of the interview, and of these, 55% were wholly bottle feeding.* (Power, Wolloughby, De Waal, 1979).

Only 22% of mothers attending a KwaMashu clinic were introducing supplementary foods because they were returning to work (Ross, Van Middelkoop, Khoza, 1983). In a Black urban area (Zulu speakers) it was found that *Eighteen per cent of the mothers gave their return to work as a reason, but there was often a gap of several weeks between introducing formula-feeding and actually returning to work.* (Ross, Van Middelkoop, Loening, 1983).

These statistics make it clear that we must look for other explanations for a decline in breast-feeding in addition to the economic ones.

Advertising and commercial pressures

Advertising codes

Much emphasis has been placed on the effect that advertising and commercial pressures have in persuading women to bottle-feed. At present each company which manufactures a modified milk has a Code which is intended to provide guidelines for promotional activities. Some of the companies adhere to the W.H.O. Code. All of the codes prohibit direct advertising to the public. There is no method of enforcement by outside sources, so whether the companies adhere to them is questionable. It is possible that the companies monitor each other's promotional activities. Some observers feel that the companies are at times competing not only for the market, but for an image of ethical conduct where promotion is concerned.

It does seem plausible that promotional activities vary geographically. For instance, it would be very unlikely that questionable promotional practices would occur in Cape Town, where a Breast-feeding Liaison Group, the Breast-feeding Association, and La Leche League are active. However, in other areas where there are no groups particularly interested in breast-feeding, promotions and advertising may continue unquestioned.

Indirect advertising

Since direct advertising theoretically does not exist, it is important to look at other means of indirect advertising and promotion. Although the companies themselves refrain from advertising to the consumer, it is permissible for the distributors of the products to advertise them. Supermarkets and chemists compete for the market, and offer certain modified milks at reduced prices.

They often advertise these *specials* in newspapers, and they have special displays in the stores. These special prices may have the effect of convincing pregnant or lactating mothers that they should try the product. **The danger is, of course, that they perhaps do not realise that their own breast milk supply will diminish when modified milks are introduced. In situations where there is not enough money to purchase these products continuously, or when uncontaminated water is not available, the problems multiply.**

Other indirect forms of advertising include the literature available from modified milk producers. These always recommend breast-feeding as the preferred method of feeding, but also obviously present their own line of products. These materials are always very colourful and appealing. The babies are fat and healthy looking, and the mothers are neat and attractive. Lay organisations promoting breast-feeding, for financial reasons, cannot produce pamphlets and literature with a format as appealing as that offered by the modified milk manufacturers.

Given a choice, mothers would probably opt for the more attractive booklet, which may give questionable advice about breast-feeding, and may omit information about the effect of supplementing on the breast milk supply. Also, there are times when accurate breast-feeding information is not available in the form of a pamphlet for the mother, so the modified milk producers *fill the gap* with their literature.

Sales representatives of the formula producers are sometimes permitted to speak to groups of mothers in clinic situations. *Health education talks*. It is questionable whether these representatives supply accurate information about breast-feeding, when their primary job is to promote their product. A paediatrician in Natal comments:

They will come at a time when the nurses are very busy and ask if they would like them to give a health talk to the mothers. It is unusual for the sister to deny them that opportunity, since they rarely can find time and material for their ***health education*** *obligations. The representatives will then advise the mothers to breast-feed but should they have insufficient milk then their product is just as good. Hence the vast majority of mothers find that they have insufficient milk.*

Potentially more dangerous forms of promotion are the free samples which may be available for women through hospitals, doctors, or clinics. There has been much controversy about the effect free bottles and samples have on the lactation performance of women. Some studies indicate that a woman receiving these samples is much more likely to stop breast-feeding earlier than a woman who has not been offered them. If a woman is unaware of the supply and demand function of breast-feeding, she might use the samples, not realising the effect this would have on her own milk supply. In subeconomic areas this can be particularly problematic.

Promotion by shop owner

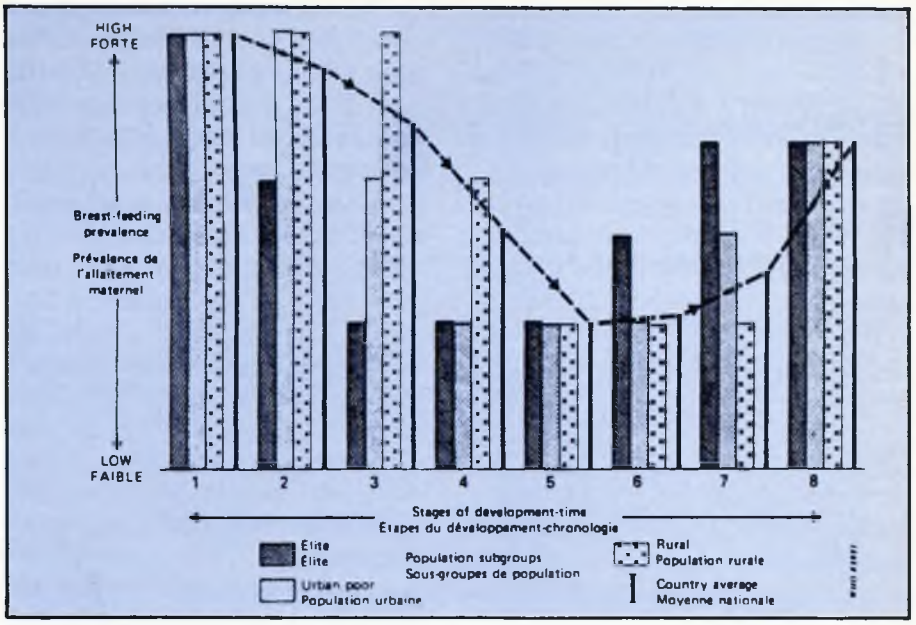
Another form of promotion is that which is done informally by the owner of the shop or cafe. Many people have remarked on the variety and number of modified milks which are available in all areas. In Cape Town at Crossroads every little shop is well stocked with these products. It would be very interesting and revealing to investigate the sales, and the involvement of the cafe owner in those sales. It is quite clearly very easy for the proprietor to recommend a particular type of formula to a prospective buyer, it is in his best interest to do so.

A survey conducted by Ross, Loening, and Van Middelkoop to find the sources of information concerning infant foods, concluded that the storekeeper is most frequently cited (Ross, *et al.*, 1983). It would appear then that the cafe owners, who have more access to poor mothers than health care providers do, may be doing much more harm than all other forms of promotion.

One should be somewhat cautious about overemphasising the effect of advertising on women's choices. By placing full blame on advertisers we assume that there are no other influences in a woman's life. Anthropologist Judy Johnston comments, *the idea doesn't make anthropological sense.*

The potency ascribed to advertising would suggest that mothers around the world are poised waiting to be told what to do and what they want and, in the interim, are living lives of no reality, no culture, (Johnston, cited in Edson, 1979). Dana Raphael, a social anthropologist who has done a great deal of lactation research agrees with this and adds that between the advertising message and the response to it *numerous intervening variables mediate behaviour* (Raphael, 1982).

FIGURE 1. Breast-feeding prevalence between developing and developed countries (WHO, 1982)



The trend-setting elite

We must recognise that with increasing industrialisation and commercial pressures poor women seek to imitate wealthier women, and may therefore follow their lead in infant feeding practices. In 1982 the World Health Organization presented the results of an extensive survey of information readily available on breast-feeding prevalence. Figure 1 compares prevalence between developing and developed countries, and prevalence within regions. It is clear that the elite lead the trends, whether it is toward bottle or breast.

Changing values and status symbols

Increasing commercialism convinces us that anything purchased for a high price must be valuable. Sheila Kitzinger, childbirth educator and social anthropologist comments, *Commercial pressures in Western society persuade many women that doing the best they can for their babies means spending money on them, and since artificial milk involves expenditure they believe bottle feeding must be superior to breastfeeding* (Kritzinger, 1979).

The author was surprised when speaking to women in a clinic in Langa, a Black township outside Cape Town, to find that even those mothers who were breast-feeding, were supplementing with the most expensive processed baby cereals.

They seemed to feel that what was best for baby had to be bought, and could not be provided by nature.

Obviously breast-feeding education needs to stress what is best for baby, not what is cheapest.

Competing ideologies: rural/urban, traditional/modern

Among many peoples there has always been a traditional pattern of early supplementation of breast milk. The native foods which are introduced are prepared in a form acceptable to the small infant. This practice, in combination with breast-feeding works well for several reasons. Breast milk helps to protect the baby from the harmful effects of contaminated water which may be used to prepare the food, and it also improves the availability of nutrients in other foods the baby eats. In a society where mixed feeding begins early it does not necessarily have an adverse effect on the breast milk supply because by the time mixed feeding starts the supply is well established.

However, introducing anything which reduces the suckling time at the breast (including dummies) also reduces the milk supply. In this instance the substitution of a cow's milk product and a bottle before the mother's own supply has been well established results in a diminished breast milk supply which necessitates more frequent use of the substitute. This snowballing effect may result in lactation decline or failure. In this instance, as with others, it is the combination of traditional practices with modern *conveniences* which may lead to a decline in breast-feeding.

Cultural prescriptions have a role to play in a woman's decisions about infant feeding. For example, among the Xhosa speaking people it is reported that there is a prescription against sexual intercourse after the birth of a baby, during the period of lactation (information collected during intervies with women in Crossroads, Cape Town, 1981). Yet it is also said that *these are things of the past*. A Black nursing sister in Cape Town comments, *How can a woman whose husband is a migrant labourer refuse to have intercourse when he returns home? She must, because otherwise she might lose him to the women in the city*. If this is the case, would a woman bottle feed in order to resume relations with her husband? Research on the effect of sociological factors, such as migrant labour, on lactation patterns would be useful.

Some people believe that there is a proscription prohibiting suckling immediately after birth. A number of nursing sisters in Cape Town report that *Africans believe that colostrum is poison*. This seems highly unlikely, since it would mean finding other sources of nutrition, or other women to breast-feed for the first two to five days.

Monica Hunter's *Reaction to Conquest*, the result of her fieldwork among the Pondo, mentions a twelve-hour wait after the birth, during which the baby was given water, and an infusion of plants (Hunter, 1936). It is possible that there is some similar practice today among some groups but it is quite likely that it is a short period of time before the infant goes to the breast. In South Africa there is much conjecture about *how everyone else does it*. Without reliable anthropological data, these reports can only remain conjectures.

Not enough milk

Many studies have focused on why women stop breast-feeding. The most frequently given reason for stopping is *not enough milk*. The statistics in table 1 indicate the percentages of mothers who give this reason for discontinuing breast-feeding.

It is interesting to note that this seems to be a world-wide phenomenon — all of the literature reviewed on this subject suggests that *not enough milk* is most frequently cited as the reason for introducing other foods. In order to better understand this, it is necessary to look at the draught or let-down reflex of breast-feeding.

The release of the hormone prolactin results in the production of breast milk. However this milk is only accessible to the infant if the hormone oxytocin is released. This results in ejection of the milk. This mechanism is called the let-down reflex, but it is important to note that, *This key neuroendocrine reflex differs from other breast-feeding reflexes in that it is psychosomatic. Its function makes the difference between making milk and giving milk.* (Jelliffe and Jelliffe, 1978). This is critical to this discussion because there are many distracting, distressing situations which will inhibit this all important mechanism.

Geissler's work among low and middle socio-economic class women in Iran prompted this statement, *It has not been sufficiently appreciated in the past that environmental psychosocial stress can have an effect on lactation performance. Such stress is occasioned by poverty and unemployment, by poor housing and crime, by illegitimacy and family instability, and by cultural confusion and uncertainty, and is probably manifested through the effect of anxiety on the let-down reflex.* (Geissler, *et al.* 1975).

The applicability to the South African situation is obvious — we have ample evidence of all those conditions listed above. **In these circumstances *not enough milk* may mean *I'm very worried about other things, how can I relax and breast-feed?***

TABLE 1 Percentage of women who gave *not enough milk* as reason for discontinuing breast-feeding in three studies

54%	not enough milk	(Ross, Loening, Van Middelkoop, 1983)
32%	baby not satisfied	
21%	not enough milk	(Ross, Van Middelkoop, Khoza, 1983)
27%	milk dried up	(Jacobs, unpublished statistics, 1979)

Cultural bias for fat babies

There exists a cultural bias toward fat babies which is also involved in the trend away from breast-feeding. Bottle-fed babies, by gaining weight quickly, are also more likely to gain the approval of relatives, friends, nursing sisters, and doctors. The mother herself may want her baby to be fat.

A breast-feeding counsellor who had worked with Malawian, Zimbabwean, and South African Black women told me that this comparison between fat formula-fed babies and their thinner breast-fed counterparts was the biggest problem she encountered in promoting breast-feeding.

Under these circumstances the mother may think her *milk is too weak*, or that it is *drying up*. The resulting anxiety may result in a loss of confidence in her ability to feed her baby, and further problems with the let-down reflex. If she perceives that her breast milk is the problem, switching to bottle-feeding may be the solution.

Presence or absence of support

The immediate social environment of the mother is also very important to the success or failure of breast-feeding. The presence or absence of a *doula* or supportive person, as defined by Raphael in *Breast-feeding: the tender gift* (Raphael, 1973) is one such factor in the social environment. Raphael's survey of the postpartum period in 278 cultures found that almost all of these societies have a support network for the new mother to cushion her during the critical stage which Raphael calls matrescence: *that time when a woman first takes on the responsibilities of motherhood.*

The doula takes on other responsibilities, enabling the new mother to relax and enjoy her baby. Without the supportive help, the milk ejection reflex may be inhibited, or may fail. The loss of the extended family household in South Africa means fewer doulas. Migrant labour, forced removals, and any other sociological factors which result in the absence of support (both physical and emotional) may be implicated in trends away from breast-feeding.

Influence of health education

It is of course necessary to look at health education. There are many different *authorities* who have an opportunity to discuss breast-feeding with pregnant women and mothers in the clinic situation. There is the clinic staff itself, State Health Nutrition Advisors, Family Planning Advisors, City Council Health Education Officer, the Voluntary Sterilization Group, the Cape Nutrition Education Unit, and any other volunteers, such as members of the Breast-feeding Association. It is only very recently that an attempt was made to bring these various groups together to discuss what kind of education was being done and where. Health education for pregnant and new mothers has not been a co-ordinated effort.

In Sister Carter's survey, referred to earlier, it was found that many mothers had not had any health education talks at all, and others had only had an opportunity to hear a portion of a talk (Carter, 1984). It is also possible that some women hear the same talks several times. Without overall co-ordination of this education, there are many *gaps*, and there may be duplication of services. Lies Hoogendoorn, the Community Health sister in the Child Health Unit and co-ordinator of the Breast-feeding Liaison Group, feels that this *fragmentation of services* is a major problem.

However, even a well controlled, and co-ordinated health education programme for breast-feeding is not necessarily the solution to the problem. Ross, Loening, and Van Middelkoop compared the breast-feeding practices of a group of urban Black mothers who had two half-hour sessions of education on the advantages of breast-feeding and practical advice, with a control group which had no education. The result showed that the mothers who had the health education actually introduced formula feeds before the controls did, even though they scored better on a breast-feeding test which was administered to both groups.

The authors comment *'Health education' is frequently carried out without any systematic analysis of the factors likely to lead to the desired health change, and the results of educational attempts are rarely evaluated to see if changes in behaviour do in fact occur.* They conclude that there are other environmental factors which must be contributory factors (Ross, *et al.*, 1983).

Hospital policies

Another important consideration is the hospital policies which may interfere with a successful breast-feeding start. There is now considerable evidence that certain drugs administered during labour cross the placenta. These drugs may affect the baby's willingness to suckle immediately after the delivery. It is quite clear that the optimum start for breast-feeding is an undrugged labour, and immediate contact for mother and infant. There should be an opportunity for the baby to suckle at this time, since the sucking drive is strongest immediately after birth (if there have been no drugs administered during labour).

Bottles, whether they contain water or formula, interfere with lactation because they reduce the hunger or thirst which would motivate the baby to suckle the breast. Also the baby becomes accustomed to a bottle, from which liquids flow with little effort. This is very different from the action of breastfeeding which requires that the baby draw the nipple and areola into his mouth, and suckle. Patterning on the bottle teat rather than the mothers nipple may cause *fixing problems.*

The influence that the opportunity for bonding between mother and baby has on breast-feeding has been shown in a number of studies internationally. Mothers who have the opportunity for early close contact with their babies are more likely to initiate breast-feeding, and more likely to continue for a longer time than those who do not. Ross reports that babies breast-fed immediately *were significantly more likely to be fully breast-fed for a longer period of time than those suckled later on the day of birth* (Ross *et al.*, 1983). In Oxford, Sloper and associates found that simple modification of hospital practices, along with orientation of

sisters and health visitors, had significant beneficial effects on incidence and duration of breast-feeding (Sloper *et al*,1977).

Absence of help during first few critical days

The first few days following the birth are critical as well. For *at risk* deliveries in hospital there is usually a two day period when the woman remains in hospital. With a staff which is interested in encouraging breastfeeding, this woman may have some help with those first feeds.

However, the majority of women delivering in rural or urban areas, in hospital or Maternity Obstetric Unit, are discharged several hours after the birth. They may or may not have had an opportunity to suckle their baby. Not only do many of these women have to resume their responsibilities at home, but they do not have the benefit of someone to speak to if their breasts are engorged, or their nipples are sore.

Theoretically they should be visited by MOU staff the first day after they return home. It is said theoretically, because the MOUs are often very busy. Matron Squire of Groote Schuur comments, *Staff numbers are fewer, and the demands are greater*. Delivering the babies must obviously have priority over home visits.

So who is available to help the woman at home who is struggling with various problems in addition to trying to establish lactation? Ross, Loening, and Van Middelkoop comment: *Withdrawal of home nursing services from the Black community and apparent lack of support for breast-feeding from other family members make the mother very vulnerable to the temptation to reach for the easy alternative at the first sign of difficulty*. (Ross, *et al.* 1983)

Confidence in ability to breast-feed

There is a pattern which emerges from this discussion. It can perhaps be seen as a woman's lack of confidence in her ability to produce an adequate amount of breast milk for her baby. Those factors mentioned above produce feelings of anxiety, doubt, and fear which suppress the reflexes necessary for successful breast-feeding. **Any strategy aimed at improving breast-feeding prevalance and duration, must attempt to provide conditions in which women feel confident about their lactation performance.**

NEED FOR OBJECTIVITY

When considering infant feeding practices in circumstances of poverty it is necessary to try to remain objective about breast-feeding. The main concern is not the prevalence and duration of breast-feeding, but rather the health of the infant, mother, and other family members.

Peter Hakim of the Institute of Human Nutrition at Columbia University wrote, *It is hard for people working in the area of health and nutrition to accept the notion that low-income women who reject breast-feeding are acting in their own and their families' best interests particularly since that choice often turns out so prejudicial to the objectives we seek* (Hakim, 1979).

An understanding of the full complexity of factors influencing women's choices would help us to understand how and why in some instances the bottle feeding of an infant may better serve the interests of a woman's family. The primary task then is to *find ways to make breast-milk substitutes available to those who really need them, without implicitly or explicitly promoting their use for the whole population* (Baer, 1981).

STRATEGIES FOR PROMOTION OF BREASTFEEDING

Although there is little published research on breast-feeding in South Africa, it is clear from existing data that the rural/urban differences in breast-feeding prevalence noted internationally hold for South Africa as well (Ross, *et al*, 1983). It is also clear that there is a trend away from breast-feeding among poor women in urban situations (Power, *et al*, 1979); Watson, 1979; Ross, *et al*, 1983). In view of this, it is believed we have a responsibility to promote breast-feeding.

Need for research

The need for more research cannot be overemphasised. National planning for breast-feeding promotion is impossible without a thoroughgoing analysis of the determinants of infant feeding decisions. This has not been attempted in South Africa. Superficial surveys and questionnaires may help to determine breast-feeding prevalence and duration in a particular area. More information is needed on the exact time women are introducing bottles. This could help us to determine whether there is a critical time when the mother has no help or support. However, surveys alone are inadequate. We need to ask women why they stopped, and what they thought might have helped them to succeed.

The Human Lactation Centre has completed interesting investigations in lactation by focusing on the lives of the women they were studying. Eleven social anthropologists, funded by Aid for International Development worked in their respective field sites investigating infant feeding practices (Raphael, 1977). Participant observation proved to be a much more reliable means of data gathering than surveys or questionnaires. Women tend to say what they believe the investigator wants to hear. In this instance, some women called themselves breast-feeders but daily observations revealed that they breast-fed only during mornings and evenings, and other foods were given by caretakers throughout the day. It was only by observing women in their homes that a researcher could construct a true picture of feeding practices (Raphael, 1982). Programme designs based on the kind of information gleaned from this type of research would have much more applicability and acceptability in the communities where they are implemented.

Anthropological reseach provides useful information about traditional practices and how they have changed with the introduction of Westernized medicine. It has been recognised that many traditional practices bring comfort to very large numbers of people.

Health or medical intervention which ignores these practices runs the risk of being completely unacceptable to the community it serves. To say that people are not responding to health education or intervention because they are ignorant is in fact a confession of ignorance on the part of the speaker who is ignorant of the social and cultural factors involved in decisions about health care.

It is also important to recognise that traditional practices are not fixed and unchanging. The introduction of hospitals and clinics adds more options for people in rural situations. Marion Heap, a social anthropologist at U.C.T. reports that in rural villages in Lesotho women usually deliver in hospital, but return home very soon afterwards and are confined to their home (with the newborn) for the first three months. This is an example of how the traditional practices combine with the modern, according to the situation.

This flexibility allows for *timely intervention by professional health workers if they could only appreciate what their appropriate role might be within the structure of their community* (R.H.O. Bannerman, 1982). It is the responsibility of those who provide modern health care to be aware of traditional practices, and rather than deny them, recognise their function. Craig and Albino, who work with urban Zulu mothers write, *If the health care facilities are to be patronized and the community's health needs are to be met, recognition of the apparent coexistence of acceptance of Western medicine and beliefs in traditional health care seem important* (Craig, *et al.*, 1983).

It is obvious that we cannot stop promoting breast-feeding while we are waiting for the results of *definitive studies*. Therefore strategies are suggested which have achieved success in other countries, and could be investigated for applicability in South Africa.

Help for working women

Legislative changes to promote breast-feeding might include protection from dismissal during maternity leave and nursing breaks for lactating women.

The Commercial, Catering and Allied Workers Union of South Africa has an excellent maternity agreement. Any woman who has worked for twelve months or more qualifies for a twelve-month leave with a guarantee of re-employment in a position of similar status with pension fund benefits intact and medical aid benefits available throughout the leave if contributions are paid. Also, she may apply for an extension beyond that period. (Health Information Centre, n.d.) This provides ample flexibility for those mothers who wish to breast-feed.

Sympathetic employers could encourage breast-feeding in various ways. Providing crèches for breast-fed infants to permit mothers to feed throughout the day is one possibility. Due to the long distances many women must travel and the length of the working day, this is not usually a viable alternative. However, when a woman lives close to her work, permission to return home periodically for feeding would be an encouragement. Employers could also permit women to express breast milk during breaks, refrigerate it, and take it home to be given to their baby while they are working.

Nursing breaks for lactating mothers have been legislated in Botswana, Lesotho, Zimbabwe, and Papua New Guinea, (International Distributive Trade in Southern Africa, 1982). In certain work situations this could work in South Africa.

In addition to these measures, providing education about, and motivation for breast-feeding (through industrial nurses) would encourage breast-feeding.

Restrictions on modified milk promotion

Strict control of the distribution of modified milk is another strategy which has been used with some success. In Papua New Guinea a health workers prescription is necessary for the purchase of a feeding bottle. Ghana and Jamaica restrict the import of infant formula, and Algeria has nationalised its importation.

Other countries seek to control the use by enforcing the World Health Organization code (Baer, 1981). Currently there are three countries which have the Code in effect as law. In a survey of 114 countries (South Africa was not included), 13 had government controls on distribution and marketing. 111 of the countries have, or are preparing codes. Some of these are voluntary codes prepared by industry, others are government prepared codes (IBFAN, 1984).

This issue can be a very controversial one. Some experts argue vociferously that banning advertising and promotion is essential. A smaller minority would advocate even stronger measures, such as those implemented in Papua New Guinea. Others argue that thousands of infants would perish if modified milks were not as easily available as they are.

The author believes that a policy of negotiation and engagement with the proprietary products industry would be useful. However, for the purposes of enforcement a code which is legislated is preferable. The Department of Health and Welfare has proposed a new code for South Africa, which is currently under study. In order to be effective this code must: control promotional activities, prohibit free samples, exclude sales representatives from clinics, prohibit all advertising and incorporate some means of enforcement.

Breast-feeding education

A co-ordinated programme for breastfeeding education would be very advantageous. Lay organisations which promote breast-feeding in liaison with other bodies involved in breast-feeding education could produce literature and suggested programmes. In this way a more unified approach to breast-feeding would result.

Slide/tape programmes are an effective way to reach women waiting in clinics. The Breast-feeding Association and Divisional Council have produced one for Xhosa speaking mothers. This is being used in Cape Town, but is also available for hospitals and clinics upcountry.

However, breast-feeding education should ideally begin long before pregnancy. It should be included in school curriculums as part of a family life unit or a nutrition unit. Furthermore, every effort should be made to interest community organisations such as church groups, youth groups, and women's groups. Using networks which already exist in communities ensures acceptability. The recent efforts of Sister Ray Carter to co-ordinate various education efforts is a major step forward.

Continued liaison between the Department of Health and Welfare and all other groups promoting breast-feeding could alleviate the fragmentation which now plagues breast-feeding education.

A note on content of education is necessary. Too often breast-feeding education consists of a list of advantages of breast-feeding only. It is necessary to dispel some of the myths surrounding breast-feeding and to provide some practical pointers as well.

A morning at a Divisional Council clinic in Langa discussing feeding with mothers of babies under six months revealed some problem areas. A simple explanation of the supply/demand function of breast-feeding is necessary to dispel the myth that allowing the breasts to *rest* will help to increase the milk supply. The effect that introducing any other food has on the breast milk supply needs attention. Some knowledge of the let-down reflex could help mothers to understand how stress affects their breast-feeding. These more practical points should be an integral part of breast-feeding talks.

Teaching the *teachers*

The health care delivery system would also benefit by a co-ordinated effort to provide education on practical aspects of breast-feeding management. In recent years there has been more emphasis on breast-feeding education for doctors and nurses in training. The physiology of lactation is covered, but what is also required is some practical application of the theory, some *hands-on* experience. Some enterprising medical school and midwifery lecturers have made provisions for this, but this needs to be part of the curriculum for everyone involved with mothers and babies.

Furthermore, even if we reach those in training now, that is not enough. There are hundreds of practising nurses and doctors who do not know enough about lactation to be able to help mothers. Lay organisations who counsel breast-feeding mothers have countless calls from women who have been given no support or encouragement, or worse, have actually been given advice which is detrimental to successful breast-feeding.

Obviously retraining is necessary. This could be accomplished through videos or slide/tape programmes on the practical management of breast-feeding. Continuing education in the form of special conferences and/or seminars on breast-feeding would also help to solve the problem. Once again the Department of Health and Welfare could be the co-ordinating body. With the help of lay organisations and the Breast-feeding Liaison Group, accurate and complete information could be assembled and distributed to doctors and nurses.

Changes in hospital routines

If the initiation of breast-feeding is a priority, a close examination of any hospital practices which interfere with a mother's access to her baby is necessary. Hospital administrators should be urged to investigate ways to promote breast-feeding. Some suggestions are:

- rooming-in for mothers and babies
- no water and milk feeds
- in-service training for staff, covering motivation for breast-feeding and helping mothers with initial feeds.

National breast-feeding promotion

Strategies to improve hospital procedures for breast-feeding mothers have become permanent fixtures of health care in countries throughout the world. In 1981 29 countries had undertaken breast-feeding promotion campaigns which involved these kinds of changes (Baer, 1981). Since breast-feeding has received so much attention since then, there are probably many more countries which have initiated programmes in the interim.

A very interesting strategy employed by some countries is a Mass Media campaign. All forms of media are involved in a co-ordinated programme to promote breast-feeding. In Brazil this was done very effectively. In addition to newspaper and magazine articles, radio programmes and radio and television advertisements for breast-feeding were produced. Actresses, actors, sports stars, and other famous people were enlisted into this effort. A famous football player's mother appeared in a commercial to say that she had breast-fed her son (Chetley, 1984).

South Africa could do a similar campaign. In fact it has already been done for family planning. A similar kind of effort for breast-feeding could help to give breast-feeding more appeal, by giving it a more glamorous and successful image.

Support networks in subeconomic areas

In the process of preparing this paper the author has spoken with many people involved in the health care delivery system. Their opinions on the promotion of breast-feeding vary considerably, but there seems to be one common denominator. All agree that hospital, clinic staff, and doctors are very busy and cannot necessarily be expected to take the time required to discuss breast-feeding with mothers.

Perhaps an important strategy is to take the responsibility of supporting lactating mothers away from the health care system, and give it back to the community. Breast-feeding mothers could form a support network within limited geographic areas. They could provide:

- breast-feeding education and motivation
- advice for new mothers
- empathy
- time
- help during those critical first few days postpartum.

The Breast-feeding Association and La Leche League operate very successfully on a mother-to-mother support basis. Attempts have been made by both organisations to reach lower socio-economic groups. La Leche League in South Africa has one Black leader who conducts meetings in Soweto. The Breast-feeding Association has volunteers who show slide/tape programmes and speak to women in clinics and MOUs. Some community health workers and nursing sisters have done the BFA training course.

However, few attempts have been made to tailor these courses to the communities they are intended to reach. Dr Marion Jacobs, a lecturer in Pediatrics at the UCT Medical School has suggested that a new approach might be to use existing training programmes to create a new teaching course which would be more acceptable. Mothers who have breast-fed and are interested in promoting it could do this course. Their responsibility would be to visit all mothers in their immediate vicinity who have just returned home from the hospital or MOU.

The potential for successful breastfeeding when mothers in subeconomic areas have a support network is being realised in several areas of Cape town. The Retreat Maternity Obstetric Unit has initiated a programme which involves finding motivated, successful breastfeeding mothers who are willing to act as helpers for other women in their neighbourhoods.

Mothers who live in the areas covered, are given the name of their counsellor when they are discharged from the hospital or M.O.U. Then, if they find they need help, advice, or reassurance, they can contact their counsellor. The volunteer counsellors have a mini-course in breastfeeding, conducted by the sisters at the clinic and the Breastfeeding Association, and they seek their help if they encounter a problem which they cannot handle. The counsellors themselves are very motivated, and enthusiastic, and obtain a great deal of personal joy through helping other mothers to breastfeed.

Offering advice, support, and help, at this critical time could help to fill the gap left by the scarcity of health visitors.

Several medical practitioners who are active proponents of breast-feeding have indicated an interest in a pilot study to determine the efficacy of such a programme, with surveys administered before and after to determine breast-feeding prevalence and duration. In view of the success of this type of support in many areas of the world, perhaps the time is right to initiate this type of intervention in areas of South Africa where breast-feeding is declining.

CONCLUSION

Women in poverty clearly have fewer options. Considering the seemingly impossible circumstances in which they find themselves, it is quite amazing that breast-feeding can succeed. Without attention to those circumstances which make breast-feeding impossible or difficult, nation-wide campaigns and promotions will treat the symptoms and not the cause.

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