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Abstract

Next to the severity of the scourge of civil wars, HIV and AIDS is an epidemic that has caused existential despondency for humanity in the sub-Saharan African region. Whereas the HIV infection among adults is principally accounted for by heterosexual intercourse, virtually all infections in infants are due to mother-to-child transmission (MTCT) largely through breast-feeding. A study of this nature is essential and desirable because child feeding and breast feeding in particular has become a source of anxiety and psychological distress among HIV positive mothers. Cultural beliefs and indigenous practices are still influencing what constitutes appropriate child feeding even when they are contradictory to the recommended modern child feeding practices in the contemporary era of HIV and AIDS epidemic. The paper observed that breast-feeding is a complex process governed by psychological and physiological factors which in turn, are conditioned by a wide spectrum of socio-economic and cultural circumstances. The study reflected on the indigenous cultural practices among the Shona people in southeastern Zimbabwe which could be used to compliment modern public health education in the advocacy towards reducing the transmission of HIV virus from mothers to children and thereby improving their maternal well-being. In the context of the HIV and AIDS, the study established that a child born to an HIV-infected and affected mother is stigmatised to the extent that the child is labelled as totem-less and thereby disrupts the legitimacy to survive well both in the family and society as a whole.

Keywords: breast-feeding, child-feeding, culture, HIV and AIDS, ritual, Shona, Zimbabwe

INTRODUCTION

HIV and AIDS as a relatively new disease, has caused unspeakable distress to millions of people in sub-Saharan Africa more than anywhere else in the world (Kalipeni and Zulu, 2008). The reality behind this epidemic, thirty years after it was medically discovered, is that its impact is visibly seen in almost all age segments of the population and in all spheres of human life (Dube, 2003). Although most HIV infections among adults in sub-Saharan Africa are attributed to heterosexual intercourse, virtually all infections among children are due to mother-to-child transmission (MTCT). As Ritzer and Griesel (1998) have pointed out, more than 90% of HIV-1 infection in children occurs by vertical transmission. Moreover, infant feeding is one of the most critical interfaces between HIV and child survival (World Health Organisation, 2010).

It must be noted that the transmission of HIV from mother-to-child especially through breast-feeding is a source of major anxiety and distress among breast-feeding mothers living with HIV in sub-Saharan Africa. This is because breast-feeding is a complex process governed by psychological and physiological factors, which in turn are conditioned by a wide spectrum of environmental, socio-economic and cultural circumstances (Obermeyer and Castle, 1997 as cited in Shirima, Gebre-Medhin and Greiner, 2001). The challenges emanate from conflicting information between the contemporary public health education and the traditional child-feeding practices as well as high levels of poverty in sub-Saharan Africa. On one hand, health-care providers frequently phrased questions about infant feeding in ways that inhibited mothers from revealing their customary daily practices. Accordingly, breastfeeding mothers are likely to be stigmatised for not breastfeeding because, in contexts of high HIV infection rates, formula feeding may become a social marker for infection (Ritzer and Griesel, 1998).

In the traditional African context, cultural child-feeding practices might pose both challenges and opportunities for improving some contemporary recommended feeding practices in the context of HIV and AIDS. This article proceeds from the premise that the understanding of cultural practices which had long been informing nursing mothers might help to reduce the transmission of the HIV virus from mother-to-child as well as improving the maternal well-being. Oyewumi (2003) as cited in Frimpom-Nnuroh (2004) argues that motherhood occupies a special place in African cultures and societies,
serving as the essential building block of social relationships, identities and society as a whole. The birth of a baby was and is still not only a family event but a celebration of the whole community. It must be mentioned that the celebration is done ritually because birth is an important rite de passage (stage of life) in African traditional cultures.

The traditional rituals performed after the birth of a baby reveals the centrality of fertility and significance of childhood in African society. In addition, the rituals are significant because they reveal a strong metaphysical belief system about procreation. The belief that God takes part in the creation of the baby raises the act of procreation above the level of the profane and gives it to it sacramental significance (Aschwanden, 1982). It must be noted that rituals constitute a symbolic representation of an intimate relationship and interdependence between the physical and spiritual worlds. The spiritual world is ritually venerated because it dispenses and nurtures life.

It must be stated that in African traditional perspectives, newly born babies are considered to be surrounded by a plethora of some physical and mystical dangers (Aschwanden, 1982). Therefore, the feeding of a baby is strictly monitored not so much to prevent the passing of bacteria to the baby through contaminated food but also to avoid what the Shona people call kuroyiwa, that is, bewitching. The Shona perceive food as a substance which could be used by witches to kill their targets. The traditional cosmological beliefs about nurturing a new life in African indigenous society show that child-feeding is characterised by a value system which interfaces metaphysical and physical notions of life. For instance, the linkages between breast-feeding and postpartum abstinence in Zimbabwe were articulated around the beliefs that breast milk is poisoned by intercourse and that a child must therefore be cleansed after drinking “impure, dirty milk” (sic) from a pregnant mother by inducing diarrhea and vomiting (Cosminsny et al. 1993 as cited in Van Esterik, 2002). Sexual intercourse is regarded as a sacred process of procreation. Therefore, the more breast-feeding is valued the more it would be embedded in regulatory rules and patterns of interaction unconnected to infant feeding (Van Esterik, 2002).

It must be noted that child feeding in traditional African society is laden with proscriptions and prescriptions which are markers of obsession about fear of harm from uroyi (witchcraft). In fact, although the biological mother played a central role of ensuring that a baby had been adequately fed, elderly women especially maternal and paternal grandmothers were and are more or less intimately involved in monitoring the well-being of the child. In the traditional Shona culture, elderly women especially those under menopause, continually scale the child by using mere hands to monitor the health of the baby. Popkin et al (1986) as cited in Ritcher and Griesel, (1998) pointed out that infant feeding is not simply a biological process in response to the metabolic demands of the infant but also a complex web of behaviours involving the actions and reactions of other people. Those actions and reactions are responses emanating from meanings that people hold, conditioned by ontological myths and beliefs about the vulnerability of babies to nature and evil spirits. In general, this reveals a holistic view about child-feeding and child-caring. As Gelfand (1985) noted, it is customary to keep a newly born baby indoors for a while to prevent it from becoming affected and infected by what the Shona people call mamhepo, that is, evil spirits.

It is shocking to realize that HIV and AIDS is causing a plethora of problems in Africa, in general and in sub-Saharan Africa, in particular among breastfeeding mothers. Therefore, child-feeding has become a critical role for women living with HIV in sub-Saharan Africa largely because the patriarchal norms created a situation whereby child care is the principal responsibility of women. Furthermore, continuing breast-feeding in this context might generate feelings of despair since the disease is surrounded by stigma. Moreover, while studies have suggested that exclusive breast-feeding for up to six months was associated with greater than 50% reduced risk of transmission of HIV compared to non-exclusive breast-feeding, exclusive breast-feeding is not a norm in most parts of sub-Saharan Africa (Ministry of Education Sports and Culture & UNICEF, 2000).

It is important to mention that an understanding of the impact of HIV and AIDS on child feeding is essential and desirable. Accordingly, two crucial reasons are put forward. First and foremost, it has also come to the fore that an understanding of the issue of child-feeding involves an interrogation of gender inequalities which are a threat to child and maternal well-being. HIV and AIDS epidemic has brought greater urgency and importance to the issue of care-giving, including in terms of the division of labour between men and women (Muchena, 2009). Secondly, a study of cultural beliefs and indigenous practices which influence child feeding is important because it helps to understand the basis upon which people have become to re-define what constitutes appropriate child-feeding in the contemporary era of HIV and AIDS epidemic.

**Mortality Trends in Zimbabwe**

Infant and child mortality increased in the early 1990s before it decreased in the early 2000s indicating a manifestation of the impact of HIV and
AIDS on children under five years of age. The Zimbabwe Demographic and Health Surveys (ZDHSs) (1994, 1999, 2005-06) suggests that mortality among children under five years showed a sharp increase from 77 per 1000 live births in 1994 to 102 per 1000 live births in 1999 but declined to 82 per 1000 live births in the 2005-2006 survey (See, Figure 1 below). Again, it is interesting to note that the decline in infant and child mortality corresponded with the general decline in HIV prevalence in Zimbabwe. Overall, the HIV prevalence had fallen from 25.7% in 2002 to 17.7% in 2006 to 14.3% in 2009 (Government of Zimbabwe, 2009; O'Brien, 2009; Zimbabwe National AIDS Council, undated). The relationship between the under five mortality and HIV prevalence is significant given that this decline in childhood mortality took place when Zimbabwe was undergoing the worst economic crisis since 1980 when the country was characterised by a dysfunctional health delivery system and grinding poverty. According to the Zimbabwe Food and Nutrition Council and Ministry of Health and Child Welfare (2010), 41% of deaths among children under five years of age are attributed to HIV and AIDS in Zimbabwe.

According to ZDHS 2005-06, mortality among women aged between 15–49 years increased rapidly between 1994 and 1999 when the impact of the AIDS epidemic was first being experienced and continued to rise during the first half of this last decade by around 40% (See, Figure 2 below). Although HIV prevalence among pregnant women (15–49 years) declined from 30% in the late 1990s to 16.1% in 2009 it is still above national average (National AIDS Council, undated).

METHODS AND MATERIALS

First and foremost, the study was based on fieldwork which was done among the Shona people who live in the two districts of Chipinge and Chimanimani in southeastern Zimbabwe. During fieldwork, the in-depth interviews were conducted to gather primary data from participants. The participants were largely breast-feeding mothers, mothers who had been advised by health personnel not to breast-feed their children on account of ill-health. Some husband of the said breast-feeding mothers were also interviewed to corroborate the information provide by their spouses. Moreover, the study benefited from information drawn from secondary sources like books, printed media and government gazettes. These sources provided the national picture on the critical issue of the HIV and AIDS.

However, there were a number of limitations to study. Firstly, a study on cultural practices invokes...
sensitive issues. Therefore, participants were somehow reluctant to discuss openly the cultural practices which they knew were discouraged by medical health personnel. Secondly, cultural norms discourage women to freely talk openly about secrets of breastfeeding and other maternal practices.

RESULTS
The study found out that child-feeding practices among the Shona people in Zimbabwe are part and parcel of the cultural beliefs which are expressed through the observance of taboos and therefore have little or no link to the availability of food in the household. Child dietary patterns are inextricably linked to socio-cultural prescriptions and proscriptions mainly because the idea is to protect an infant from harm, particularly from *uroyi* (witchcraft). From a strict Shona cultural perspective, the behaviour and growth of an infant is interpreted symbolically. Aschwanden (1982) argues that symbolization is a perfectly intelligible process because a symbol is something to which effects and attributes have been transferred that were originally experienced within another reality; these transposed characteristics are identified with the original ones. And therefore, a symbol does not only refer to those ‘symbols’ which one might call signs or metaphors, but rather, it refers only to those symbols which arise out of the process of identification (Aschwanden, 1982).

Moreover, in the Shona cosmological world view, the crying of a baby has different meanings in particular existential contexts and situations. One of our informants, who is a seasoned traditional midwife, mentioned that sometimes a baby’s health and behaviour might reveal covert social malpractices of either the mother or father particularly as linked to sexuality. The informant remarked, “Mwana anokwanisa kungochema asingarwari uye akaguta. Pane zwaanenge achitaunza nekuti mwana mudiki in’anga.” (Sometimes an infant can incessantly cry yet it is neither sick nor hungry. There is something peculiar it wants to reveal because an infant is a traditional healer). For instance, if a baby cries in the father’s arms, people will suspect that the father is having extra marital relations. It is interesting to note that there was a general consistency in the narrations of the interviewed traditional midwives, arguing that the resumption of sexual intercourse between the wife and husband must not follow immediately after the birth of the baby. The earliest time mentioned when couples can resume sexual intercourse was three months and the latest being six months. If the couple resumes sex as soon as the baby is born, they will lose weight (*kureruka*). There was an emphasis of delaying in relation the resumption on sexual intercourse in order for the uterus (*chibereko*) to return to its original position. Evidently, this is part of the taboo which reveals the centrality of motherhood and wifehood in Shona culture. In African indigenous communities, which are patriarchal in their sociological profiles, women experience a double jeopardy in terms of their roles. As exemplified by this study on the Shona indigenous society, several informants agreed that the role of women in Shona culture is enormous. For instance, the mother is expected to take care of the baby, equally as she must take care of the husband. In general, this is how traditional culture is a site of struggle in Africa. The perception is that if the husband and wife resume sex as soon as the baby is born, it then means that the husband will be contaminated with the perceived dirty still in the uterus which the Shona people refer to as *tsvina yemwana* (a child’s dirty). Before three months it is believed that there is still blood in the uterus. In other words, a woman takes of both the baby as a mother and the husband as a wife but they must not share the dirty due to the nature of the social relations between the baby and the father. This reflects the sacredness attached to human genitalia especially for women. She further remarked, “*Amai ndivo vanochengeta mwana nababa*”. (It is the mother who takes care of the child and the husband). Such metaphysical beliefs are used to monitor not only the health of an infant but also of the nursing mother. In the context of the HIV and AIDS epidemic, child feeding has become more complicated particularly among HIV-infected nursing mothers due to the conflict between African traditional epistemologies and pedagogues on one hand and recommendations derived from western culture on the other.

As part of the findings, breast-feeding is not only a norm in the traditional Shona culture but also a source of honour to women since it confirms motherhood. Therefore, not wishing to breast-feed is a source of ridicule and curse. One of the informants for the study, who was a traditional midwife, reinforced the unquestionable need for breast-feeding as part of societal expectation and basic requirement of nurturing babies by exclaiming that “*Hazvina unhu mai kuyamwisa mwana acaiku dzza nejira*”. (It is a taboo for a mother to breast-feed while covering the child with a cloth). In other words, the breast-feeding behaviour of the mother might be used to interpret some socio-cultural relations which have nothing to do with child feeding because a woman is not expected to conceal her pride concerning some existential ethics associated with womanhood, motherhood and wifehood. She further says, “*Kana achiyanwisa acaiku dzza anenge achihwandisir chit? Zvimwe mwana wacho anenge asina babu*. (What will she be hiding to breast-feed while covering the baby with a cloth? Maybe the baby will be fatherless). It must be realised that motherhood has no social space outside culturally recognised marriages in the Shona culture in Zimbabwe. According to Frimpong-Nnuroh (2004), motherhood
which is a life-long commitment and often associated with nature, resides in the spirit and not in the being. Therefore, babies born out of culturally accepted marriages do not have totems and are euphemistically referred to as totem-less children (vana vasina mitupo) or children of the bush (vana vemusango). The argument is that totem-less children do not have fathers and therefore they are culturally illegitimate.

Furthermore, all traditional midwives interviewed for the study, strongly encouraged breast-feeding and they mentioned that they gave the mother the baby as soon as all procedures concerning the rites de passages (stages of life) are completed. It was noted that there is the belief that breast milk is produced and comes out when the newly born baby starts to suckle. In most cases, the procedures from cutting the umbilical cord to dressing the infant took at most, the duration of one hour. Although the traditional midwives strongly support that the infant must be breastfed as soon as it is born, exclusive breast-feeding does not confer the same status. There is no fixed time when it would be found appropriate to introduce supplementary feeds but exclusive breast-feeding is not a norm in the Shona traditional socio-cultural context. Van Esterisk (2002) argued that exclusive breast-feeding is rarely practised in all cultures and among women of different socio-economic status in both western and non-western countries because to these mothers, exclusive breast-feeding means denying children something mothers or others think they should have. One traditional wife mentioned that “Mwana anotanga kapiwa chekudya chero nguva kana vhiki chairo achingobva kuberekwa. Hazvina basa”. (A baby can be given supplementary feeds any time even in one week after birth. There is no problem). This posits a dilemma because it is in conflict with Principle 4 of World Health Organisation (WHO) Guidelines on HIV and Infant Feeding (2010:22) which states in part, thus: ‘When a national authority has decided to promote and support breastfeeding and ARVs, but ARVs are not yet available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of replacement feeding’.

However, the study revealed that the introducing of supplementary foods depends on both the context and circumstances embedded in the particularistic realities and experiences that breast-feeding mothers encounter mainly because there were no specific taboos mentioned which discourage exclusive breast-feeding. Most of the factors which were highlighted have no direct relationship with culture but are more related to reactions and responses to problems that nursing mothers encounter during offering care to children especially when babies are still solely dependent on them. Aschwanden (1982)’s argument about symbolisation as related to giving meaning to a particular behaviour transposed with identified characteristics experienced within another reality is significant in understanding the factors which influence the timing of introducing solid and semi-solid foods. This is imperative because the constructions of traditional midwives during interviews revealed the centrality of symbolisation in monitoring the food demands and eating patterns of a child. We raised the issue that mothers are recommended to exclusively breast-feed their infants up to six months because breast milk is enough to meet all the nutritional needs of the infant. Mothers insisted that breast milk is not enough to meet all the food needs of the child up to six months. They argued that sometimes babies cry even soon after breast-fed. One of the midwives reinforced this argument by saying, “Achungopedza kayamwa mana yake inenge ichirova zvine simba. Zvinotaridza kuti haana kuguta”. (Sometimes the baby’s heart will be beating fast soon after breast-fed. This shows that he/she will be hungry). Moreover, village women rarely prioritise their diets in terms of nutrient content and natural selection of foods rather they simply make dietary selections according to what nature provides, according to known cultural dietary function and/or attached meaning (K’Okul, 1991).

It must be argued that child-feeding and child-care in general, are embedded in patriarchal systems which perpetrate gender inequities against women. In this context, the language of traditional midwives seems to reveal more about the challenges women encounter in the whole process of child care. They were adamant that “breast milk is not enough” to meet the nutritional requirements of an infant up to six month also to show the magnitude of the burden of child care among women. One of the traditional midwives in enquired that “Dzimwe nguva amai vacho vanonoka kudzoka vaenda kunocheva mvura apa mwana anenge ochema. Saka ndingaita sei?” (Sometimes the mother of the baby might delay to come back while go to fetch water yet the baby might be crying. What do you expect me to do?). Child-feeding adds more burden to other time-intensive domestic tasks well before the infant reaches the age of six months. This is when female members, particularly paternal and maternal grandmothers of the extended family who usually offer assistance during the first months withdraw help on baby-sitting within three months after birth because by then the mother would have been recovered from labour pains.

The study also noted that the health and nutritional status of the mother is also contributing to early introducing of semi-solid and solid foods. Interviewed traditional wives were cautious about timing because they argued that in a few months well before six months many mothers perceived that
breast milk would not be enough. The notion of “not-enough” tends to reflect that it would be nearly impossible to breast-feed the baby on demand because this had implications on mother’s nutritional needs. Traditional midwives argued that a breast-feeding mother needs nutritious foods and has to eat regularly despite that the food might not be available.

In general, high levels of maternal mortality in Zimbabwe are also adding to a plethora of problems being faced in child-feeding and child-care. In cases where the women die during labour but the baby survived, there were and are mechanisms in traditional Shona culture which were used to take care of babies who had befallen by such a calamity. Both paternal and maternal relatives have a role to play to ensure the survival of the baby. The traditional wives pointed out that the paternal relatives may request for a wet nurse from the maternal relatives. It does not matter if the wet nurse is not breast-feeding but should have given birth and breast-fed before. A traditional healer makes some cuts (katemera nyora) on the breasts and rubs some medicines in those cuts. This would make the breasts to produce bountiful milk. The paternal female relatives particularly the grandmother or auntie take over the role of caring for the baby. However, no rituals are performed but they feed the baby with goat milk which must be boiled before feeding. This is in conflict with recommendation 4 for WHO Guidelines on HIV and Feeding (2010:36) which states that; ‘Home-modified animal milk is not recommended as a replacement food in the first six months of life’.

CONCLUSION
Child-feeding in the indigenous Shona society does not only depend on the availability of food but also on symbolisation whereby effects and attributes that were originally experienced within another reality are transferred to monitor food demands and eating patterns of a child (Aschwanden, 1982). The observance of taboos interfaces between child-feeding and the values of motherhood. It was made evident that child-feeding is a key element of a complex socio-cultural system which legitimises the survival of a baby. In addition, it was made clear that motherhood is an embodiment of social relations which determines legitimacy of a baby to belong to a particular kinship within the society. The study also established that babies born out of culturally-accepted marriages do not have totems and are euphemistically referred to as totem-less children (vana vasina mitupo) or children of the bush (vana venumusango). In the context of HIV and AIDS in Zimbabwe, child-care and child-feeding in particular are sources of psychological distress among the HIV-infected nursing mothers. This is because Shona cultural value systems intersect HIV and AIDS with strong notions of human immorality. Practically, a confirmation of an HIV infection by a woman preludes divorce or termination of matrimonial relationship within the Shona society in Zimbabwe. Therefore, a baby born to an HIV-infected mother is stigmatised and given labels which disrupt the legitimacy to survive in one’s family and society as a whole.

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