Chapter 1: Introduction

Perceptions of HIV positive motherhood is an area that is relatively explored and under-researched. As a stigmatised category, little is known about how HIV positive mothers are viewed by other mothers. It is therefore important to explore perceptions around HIV positive motherhood because of the level of stigma attached. Kruger (2006) has pointed out that there is little research on motherhood in South Africa. HIV is a particular crisis of motherhood in South Africa and is therefore important to investigate.

HIV positive motherhood is a category where HIV and motherhood collide. In order to explore perceptions of HIV and motherhood from a fresh angle, HIV negative mothers were chosen to access social perceptions. This study explores HIV negative mothers' perceptions of HIV positive motherhood, with specific focus on black, working-class mothers, as it is this group of women that are most vulnerable to HIV infection in South Africa (Strebel, 1995).

HIV negative mothers were chosen because they share the social category of motherhood and not HIV. The research was interested in a sample that would engage more personally with the social category of motherhood while holding an outsider perspective on HIV. By choosing the sample of HIV negative mothers, HIV is fore-grounded in relation to motherhood and the stigma of HIV can be highlighted. In this way, social perceptions of HIV positive motherhood can be explored from both an insider and outsider perspective.

Aim:

This research aims to describe and interpret HIV negative mothers' subjective feelings and perceptions in relation to HIV positive motherhood. The intention is to explore issues around stigma, blame and maternity in the context of HIV/AIDS by talking around a vignette. It is through this conversation about a dilemma faced by an HIV positive mother that respondents' perceptions and presumptions about the mother as well her child emerge. The research also intends to understand how HIV and motherhood fit together and where stigma is located within HIV positive motherhood.

This research aims to explore perceptions around both HIV and motherhood and the way in which they link. There are therefore three components to the research focus:

1. *Social Perceptions of HIV* aims to explore patterns of stigma. It intends to explore how HIV negative mothers respond in relation to social perceptions of HIV. Also of interest are perceptions of the causes of infection and an exploration of subjective feelings of vulnerability to HIV infection.
2. *Perceptions of Motherhood* are looked at in terms of what the respondents imagine it means to be an HIV positive mother. It is also interested in what respondents' perceptions are about what is important for the HIV positive mother as 'mother.'
3. The perspective of the child is explored when *The Mother-Child Relationship* is considered. This focuses on the perceived implication on the child on having an HIV positive mother.

The research specifically aims to explore perceptions around HIV and motherhood. Because perceptions are intricately related to stigma, blame and discrimination understanding these perceptions is important, in and of itself.

Rationale:

Kruger argues for the need for more research on motherhood in South Africa that looks at the subjective experience of marginalised mothers. She says,

> It is clear that gaps in South African mothering research are manifold. First, very little research has been conducted in general. Second, research on the subjective experiences of mothers themselves is virtually non-existent. Third, the impact of race, class, culture and sexuality on motherhood experiences and mothering practices has not been sufficiently researched. (2006, pp. 194, 195).

This research intends to explore subjective perceptions of mothers around issues of motherhood and HIV. The focus on race and class, and the incorporation of sexuality in the focus on HIV/AIDS is in line with the gaps in the existing literature.

When Kruger (2006) highlights the insufficient research on the impact of race, class and culture on motherhood experiences, the same can be said to be true of psychological research on motherhood in general. Historically, psychological research has been based on the normative experiences of white middle-class women and the deviance of black and working-class women (Phoenix & Woolett, 1991). This trend is seen particularly in relation to motherhood, where research on 'normative' motherhood has predominantly focused on the experiences of white middle-class mothers. Although there has recently been a growing trend towards research on black women, this interest is neither focused nor sustained.

The researcher's interest in black motherhood is highlighted by the 'triple oppression' that characterises black women's experiences. As the research sample, domestic workers especially are subjected to racism, sexism and class bias. These categories are referred to as 'triple oppression' where black, working-class women face discrimination and decreased access to resources based on these categories. Kiguwa (2004) argues that ''psychology has focused almost exclusively on sexism and gender issues and as a consequence has had little or no applicability to the special position of *black* women in a white social structure'' (2004, p. 293). It is with this in mind that this research focuses on the perceptions of black mothers.

The 'triple oppression' structures the lives of black women and positions black mothers in particular and constraining ways. It ensures that black women will be found predominantly in the working class and as a result, a greater number of black women will be faced with poverty. These women are more likely to be less educated and to have jobs that are low-paying. Their social status also ensures that this group of women are more vulnerable to infectious diseases and will be more powerless in heterosexual relationships due to their economic dependency (Strebel & Lindegger, 1998). In this way, they are more vulnerable to HIV infection.

As a group, HIV positive women have generated much interest in recent research. Although there is a growing body of research on HIV positive mothers, it mirrors previous research on motherhood that studied mothers in relation to health issues (Forehand et al., 2001) and as appendages to children (Burman, 1994). Hence, meanings and perceptions surrounding HIV positive motherhood has been under-researched. Long (2005) is one of the few researchers to explore the actual experiences of HIV positive mothers. She highlights various themes in the ways in which HIV positive mothers talk about their experiences, among which are themes of

disclosure and stigma, where there is a tension around self-stigmatisation. It has been found that HIV positive mothers are reluctant to disclose their status and as a result cannot access the social support they require for themselves and their children (Parker & Aggleton, 2001), perhaps in part because of dominant (often prejudiced) perceptions within society that HIV positive mothers draw from. Long's (2005) study shows how HIV positive mothers' experiences of motherhood are drawn from shared (dominant) assumptions that set up experiences of motherhood in particular ways. In her interviews with HIV positive mothers, she highlights various themes, including concerns regarding stigma and how they are perceived by others, but does not investigate where these assumptions come from and whether these assumptions are shared by other mothers who are not HIV positive. This research begins with the premise that it would be useful to investigate the perceptions of HIV negative mothers in order to add to the body of research around the meanings of HIV positive motherhood

An analysis of the ways in which HIV positive mothers are represented helps in theorising about how issues of stigma reflect and constitute HIV/AIDS meanings. It also allows for consideration of the role of stigma in HIV/AIDS policy and in this way may assist in interventions when mothers are diagnosed as HIV positive.

Research Questions:

The research questions attempt to explore respondent's perceptions of HIV positive motherhood in relation to patterns of stigma and blame. Perceptions of the impact of the mother's HIV positive status on the child was also explored. The following research questions were addressed:

1. How do HIV negative mothers perceive HIV positive motherhood?
2. In what ways are the causes of infection understood? How do these relate to patterns of responsibility, stigma and blame?
3. How do HIV negative mothers perceive themselves as mothers in relation to HIV positive mothers? Do they identify with HIV positive mothers? What meaning does HIV positive motherhood hold for HIV negative mothers?
4. What meanings do maternal practices (e.g., breastfeeding) hold in being a good mother? What meaning does breastfeeding hold in HIV positive mothering practices?

5. How is the mother's HIV positive status perceived to impact on her child?

Structure of the Report:

The following chapter attempts to locate the research within current literature. The *Literature Review* explores various strands of motherhood: white, middle-class motherhood, black, South African motherhood and HIV positive motherhood (with particular emphasis on stigma). Breastfeeding is explored, with particular attention to perceptions of breastfeeding in relation to HIV positive motherhood. The literature review also explores perceptions of HIV positive mothers in the scientific literature with an eye to exploring whether the mothers in this study may hold similar perceptions.

The next chapter explains the *Method* used to explore HIV negative mothers' perceptions of the HIV positive mother. This chapter will outline the qualitative approach, the process of data gathering, sampling method and the interpretive technique of thematic analysis as the means for making sense of the respondents' conversation. Ethical implications of the research method are included.

Analysis follows on from the *Method* chapter. The analysis is divided into three main themes, which are further subdivided. These themes correspond with the research questions and are focused around three main sections. The first section explores respondents' awareness of stigma, subjective feelings of vulnerability and perceptions of blame with regards to HIV infection. The second section focuses on Perceptions of HIV positive motherhood and considers similarities and differences that respondents perceive when they compare themselves to the infected mother. The third section looks specifically at the impact of maternal infection on the child to highlight a shift in the respondents' perceptions of stigma.

The final chapter, *Discussion and Conclusion*, brings together the themes generated in the analysis and makes the point that HIV negative mothers' perceptions around stigma are acted out differently in relation to the mother and her child. The conclusion demonstrates that respondents appear to identify with HIV positive mothers as poor and black, as vulnerable to HIV, and as powerless in heterosexual relationships. The conclusion will highlight that when motherhood was viewed from the perspective of the child, respondents stressed maternal responsibility that

ensures that the child ‘turns out right’. In this way it will be seen that respondents draw on instrumental assumptions that mothers are responsible for producing healthy children.

Limitations:

1. Throughout the study there was an awareness of gender, culture and race. The research question could have been focused on these categories specifically but the since the research question focused on motherhood and HIV in particular, it was felt that explicit focus on these categories would have taken away the focus of the research question.

2. There existed a power dynamic between the researcher and respondent in terms of language. As second-language English speakers, respondents were disadvantaged at having to converse in a language they were not fluent in. Although they did succeed in conveying what they wanted to say, the data may have been richer if the interview was conducted in a language that they were more competent in.

3. Choosing a sample of domestic workers is a very specific sample driven by convenience and the aim of choosing a homogenous sample of working-class mothers. Although the sample was chosen to enhance homogeneity, this makes it a very specific sample and limits generalisability.

4. Another limitation of generalisability is the relatively small sample on which the research is based. Although this was done to obtain depth in interviews, a larger group would have allowed one to state factual conclusions around process and perception.

5. Respondents, in talking around a vignette, talked in the abstract as this was less threatening. The content of their talk might have been different if they were asked to deal with Thandi directly. This may have generated different perceptions around HIV positive motherhood as there may be differences between what people say and what people do.

Chapter 2: Literature Review

Introduction

The research question seeks to explore HIV negative mothers' perceptions of HIV positive mothers. This intersects with a number of different areas of literature that may help to explore this topic further. The literature review discusses literature on motherhood in general, black motherhood in particular and aspects of HIV/AIDS.

The literature begins with a review of feminist critiques of the essentialised 'ideal' mother to show how taken for granted assumptions set up an ideal that constrain mothering practices. Much of the literature in this section draws on the concept of an essentialised mother who is the white, middle-class mother. This critique sets the context within which ideal motherhood is perceived as 'good' whilst motherhood that does not conform to this ideal (Black, single, HIV positive motherhood) is perceived as 'bad.

The literature review moves on to the related discussion of how psychological knowledge about motherhood is produced. This section also illustrates how this knowledge comes to be incorporated into taken for granted knowledge within society.

A discussion around black motherhood follows, with a particular focus on how colonial assumptions of motherhood merged with indigenous understandings, creating the various 'motherhoods' that exist in black South African communities today. The limited research on Black, South African motherhood is also highlighted.

HIV positive motherhood, as another strand of motherhood that overlaps with ideal and black motherhood is considered next, with a focus on how society and scientific literature perceives and portrays this type of mothering. In conjunction with the bodily experiences of pregnancy and breastfeeding, stigma is discussed in relation to understanding the metaphors that surround the HIV positive mother and lead to discrimination.

The chapter ends with a consideration of the high prevalence of HIV/AIDS amongst black women in South Africa and attempts to do this by locating gender within the social and economic context. The argument will be made that it is the combination of gender, race and class that contributes to the vulnerability of black, working-class women to contracting HIV.

Ideal Motherhood

Feminist writers link the notion of mothering to the notion of gender as each is a constitutive element of the other (Glenn, 1994). It is women's reproductive function of childbearing, more than any other aspect of gender, that has rendered motherhood to be essentialised as natural and universal (Glenn, 1994). From a feminist perspective, it is argued that in many societies women's biological ability to give birth to children and breastfeed them renders it 'natural' for their 'maternal instinct' to allow them to be the ones who care for and nurture children both physically as well as emotionally. It is not just what the mothers physically do but their own emotional investment and attitude in which they respond to their children that is seen to help children develop normally (Richardson, 1993). Although many societies would deem this a normal aspect of daily living, research and general perceptions amongst women indicate that, contrary to the belief that mothers instinctively know what is best for children, many mothers worry about whether they are bringing up children ''the right way.'' (Richardson, 1993, p. x).

Motherhood research focusing on experiences of motherhood (e.g. Dally, 1982; Kaplan, 1992; Parker, 1995; Phoenix, Woollett & Lloyd, 1991) came about as a reaction to the way mothers were (and still are) portrayed in relation to the normal development of children (Marshall, 1991). These portrayals bestowed upon mothers the responsibility of bringing up children in the 'right' circumstances thus ensuring that their children 'turn out right' (Phoenix & Woollett, 1991). In this way motherhood has been idealised and these idealised ways of mothering contradict the everyday lived experiences of a significantly large number of mothers.

In particular contexts, certain taken for granted practices and ideas of mothering marginalise other ideas and practices, rendering them other than normal (Glenn, 1994). These ways of mothering are viewed as deviating from dominant accepted practices and ways of being. As such, mothers who do not conform to 'normal' (also viewed as 'good' and 'ideal') mothering, are labelled as 'bad' mothers (Dally, 1982). Glenn (1994) cites Patricia Hill Collins who adds that motherhood theories fail to acknowledge diversity in mothering and view white, middle class mothers' experiences as universal.

In order to conclude that there is diversity in mothering, and that motherhood is not a universal category, post-structuralist feminist writers have examined motherhood historically and explored

cross-cultural experiences to show that, although there have always been mothers, motherhood is an invention (Dally, 1982). This means that the meanings and practices associated with motherhood in different historical periods are not universal, as these meanings are not an inherent part of being a mother, but are constructed by the structures that define motherhood. So, for instance, a patriarchal culture that reinforces the gendered division of labour would depict mothers as the primary nurturers who stay at home to care for their children. In other societies/cultures where women's economic contribution is valued, mothers are encouraged to work and 'motherhood' is extended to other females within the community/family (Glenn, 1994).

In attempting to understand the normative quality of motherhood, feminist researchers have examined accounts of childless women and women with reproductive problems to highlight the assumption that all women who are married or in stable heterosexual relationships are expected to become mothers, ''and it is considered 'normal' for them to want to do so'' (Woollett, 1991, p. 55). Within psychology in particular, feminist writers (Burman, 1994; Phoenix & Woollett, 1991) came to the conclusion that motherhood is not a universal construct when they re-examined developmental research. Burman (1994) acknowledges the role that developmental research played in viewing motherhood as a universal category where knowledge of motherhood was assumed, and where mothers existed as the environment for the children that were studied. When mothers were the focus of research, there was an interest in those mothers who were perceived to be deviant, rather than those mothers who were assumed to be normal. Phoenix and Woollett (1991) elaborate that ''there are psychological studies of depressed mothers, lone mothers, employed mothers, working class mothers, and mothers in their teenage years. This interest in mothers considered marginal rather than considered mainstream made us think about the ways in which 'good mothers' and hence 'deviant mothers' are socially constructed'' (1991, p. 2).

In her elaboration on the distinction between the 'good' and 'bad' mother, Woodward (1997) argues that motherhood is constructed within a moral context. Idealised representations of the Madonna, the self-sacrificing mother-figure, represent western attitudes towards women. Woodward puts forward her argument when she states, ''The perfect mother is a mother and a virgin and is idealised as asexual. The cult of the Virgin Mary affirms that motherhood should be

unsullied by sexuality and that mothers should not be sexual'' (1997, p. 250). In contrast the 'bad' mother is the opposite of the 'good' mother who is self-sacrificing and self-effacing (Woodward 1997).

In a similar vein, feminist writers argue that the dominant perception of 'good' motherhood is defined in a child-centred society as maternal sacrifice, where children's needs and rights are frequently placed before women's (Richardson, 1993; Burman, 1994). The idealised view of the 'good' mother is someone who willingly gives her time and energy to ''meet the child's needs for nurturance and stimulation'' (Richardson, 1993, p.40). Motherhood is perceived to be central to women's identity and is viewed to be an all-consuming identity. For a white, middle class mother in general this means that she is obliged to view intensive mothering - where she is the sole carer of the child, as part of her job (Hays, 1996). This encourages mothers to stay at home and raise their children in nuclear families and causes tension for those mothers who work outside the home (Hays, 1996). Phoenix and Woollett (1991) inform us that when mothers fail to raise their children in these circumstances they are rebuked when social welfare intervenes or when scientific research draws on their experience to reinforce their deviance. They assert that normative assumptions can be made explicit by examining the circumstances in which public censure of, or concern about mothers is expressed. They use the example of welfare policy to show that traditional assumptions about families are dominant. They say, ''politicians and others from the New Right explicitly stated that children should be reared in 'real' families (heterosexual couples) rather than 'pretended' families (gay or lesbian couples). Lone parent families similarly fail to qualify as ''real families'' (Phoenix & Woollett, 1991, p. 15). Mothers who do not practice intensive mothering or who are not part of a nuclear family are also looked down upon for raising children in 'broken homes' where they may grow up to create problems for society. Hays (1996) argues that these ideas about 'intensive mothering' where the mother is primarily responsible for the process of childrearing (which is child-centred, expert-guided, emotionally absorbing, and financially expensive) stem from an economic system which is based on competitive individualism. Further, professionals who do intervene on behalf of the state (social workers and psychologists) are more likely to have been born or educated into the middle classes and are thus more likely to share dominant assumption about 'the family' and 'the mother's role'. ''They are, therefore, likely to perceive mothers who are poor, working class, single and black as more problematic'' (Phoenix & Woollett, 1991, p. 19).

Feminist writers attempt to look at the experiences of women of colour to illustrate that universal theories of motherhood are not applied across all societies. Glenn (1994), for instance, explains that historically women of colour were excluded from the ‘‘dominant cult of domesticity’’ (1994, p.5) as they were valued more for their cheap labour (especially as domestic workers) than for their mothering abilities. Historically, for the black mother, part of her job as ‘good mother’ is to contribute to the economic survival of her family (Phoenix & Woollett, 1991). Although the experience of marginalised mothers are deemed different to what is perceived to be universal attributes, they are still researched and judged based on universal theories and perceptions. For instance, there is an over-representation of white middle-class mothers and children when normal processes of development and motherhood is studied. Phoenix and Woollett (1991) point out, ‘‘The converse of this omission from psychological studies when ‘the normal’ is being studied is an over-representation of black and working class families when the pathological is being studied’’ (1991, p. 21). In order to escape this ‘‘normalised absence/pathological presence’’ (Phoenix & Woollett, 1991, p. 21) they cite Newson and Newson’s (1968) research as an example of how attitudes to mothering tasks were inextricably linked to social class and the resources that were available to mothers. The researchers looked specifically at toilet training and found that mothers who had no access to washing machines, and were burdened with hand-washing nappies, were more concerned to toilet train their child as this would ease their burden. However, women who did use washing machines perceived toilet training to be less of an issue (Phoenix & Woollett, 1991). Apart from few researchers like Newson & Newson, the general trend in research has perceived universal (ideal) representations of ‘good’ mothering as the norm and have tended to obscure and pathologise alternative ways of mothering. (Dally, 1982). Hence, a space is created for ‘bad’ mothering.

Feminist writers acknowledge that motherhood is a ‘‘contested terrain’’ (Glenn, 1994, p.2) and attempt to link perceptions of motherhood to the social context. Parker (1995) comments that mothering is influenced by both psychical and external factors. Race, social class, marital status, sexuality and illness affect what it means for women to mother. She draws on Phoenix et al (1991) who go one step further by pointing out that even within a particular class, race or social context, maternal experience should not be homogenized as each person’s experiences are unique.

Feminist perspectives arguing that motherhood is socially and historically located put forward that motherhood changes when the social and historical contexts change. As such, normative definitions that construe motherhood to be a natural, static, inborn ability are challenged. This is not to say that motherhood is not valued. ‘‘Feminist texts...have theorised motherhood as a crucial part of women’s lives, affecting women’s position in the social structure and the ways in which the next generation’s gendered identities develop’’ (Phoenix & Woollett, 1991). Feminists argue that essentialised notions of motherhood constrain mothering in particular ways. Taken for granted mothering practices come to be viewed as universal and ideal and this marginalises other mothering practices that do not conform to this ideal. As a result, a dichotomy is created where certain practices are deemed to be good and others viewed as bad. In this way, society tends to draw attention to those ways of mothering that do not conform to the ideal by policing ‘bad’ motherhood.

‘Good’ and ‘Bad’ Mothering

The above discussion suggests the feminist critique challenges notions of ‘ideal’ motherhood as a universal category. The assumption is that in depicting white middle class motherhood as desirable, it comes to be labelled as ‘good’ motherhood. Motherhood that does not conform comes to be viewed as ‘bad’ motherhood. The following discussion looks briefly at the effect that ‘good’ and ‘bad’ depictions have on individual identity when marginalised mothers both reproduce and resist these ‘good’ ways of mothering.

The designation of objects and subjects in the social world as ‘good’ and ‘bad’ is linked to the issue of morality. ‘‘The connection between our sense of morality and sense of self, according to Taylor (1989), means that one of our basic assumptions is the need to feel connected with what we see as ‘‘good’’(Crossley, 2000 p. 16). In terms of identity, Crossely (2000) draws on Taylor’s (1989) theory which states that people have a sense of who they are through a sense of where they stand in relation to the ‘good.’ It is this tension that is negotiated by marginalised mothers when they are subjected to dominant ‘ideal’ assumptions of motherhood.

Social and psychological representations of the ‘good’ (normal and ideal) mother run counter to the reality of motherhood for many mothers (Glenn, 1994). These representations are drawn

upon by many women who are then required to negotiate their personal experiences with this ideal. According to Parker,

> cultural and public representations of good and bad mothering interact with the unique, personal, private and emotional meanings motherhood has for a woman. Mothers both reproduce and resist assumptions of what it means to mother - but those assumptions cannot be escaped. (1995, p. x)

Parker (1995) draws on the tension that all mothers (especially black, working–class mothers) negotiate in their practice of mothering. Although motherhood is an invention, in a particular culture, certain assumptions of motherhood are held to be dominant and 'good' and individual experiences are made sense of in relation to these standards and ideals.

Parker (1995) draws on the concept of maternal ambivalence to illustrate that this tension does not exist solely within the private experiences of mothers, but is also mirrored within society. Maternal ambivalence (that is, simultaneous, contradictory feelings of love and hate towards the child), brings about the experience of maternal guilt (Parker, 1995). The coexistence of love and hate is productive of motherhood, hence this experience is viewed to be a normal, inherent part of motherhood. Parker's (1995) point is that cultural representations mirror these ambivalent feelings and renders them unacceptable and unpalatable. By separating 'good' and 'bad' mothering, the ability of mothers to acknowledge maternal ambivalence is limited because public and cultural representations cannot tolerate these contradictory feelings existing simultaneously within the mother. In this way the cultural ideal transforms normal maternal guilt into something that is invested with badness.

The cultural influences of ambivalence (outside of the experiences of mothers themselves) is illustrated in Long's study (2005) on the experiences of the HIV positive mother. She says, ''there was a constant split between good, idyllic mothers and bad, uncaring, irresponsible mothers, echoing similar splits in the literature and in dominant constructions of motherhood'' (2005, p. 119).

One of the ways in which mothers deal with the anxiety of maternal guilt (brought about by maternal ambivalence) is by looking to other mothers to confirm their own experiences. Parker (1995, p. 1) explains this process succinctly when she says,

> Some mothers use other mothers as mirrors. Each mother scrutinizes the other in pursuit of a reflection of her own mothering. They look for differences from their own style of mothering and they look for sameness. But above all that they look for confirmation that they are getting it right, in the face of fears that they are getting it hopelessly wrong.

Sometimes though, this 'mirroring' as Parker (1995) calls it, becomes a source of insecurity when the mother projects her own capacity of 'good' mothering (care, attention, competence) onto other mothers and ''finds herself depleted, hateful and hating.'' (1995, p. 6). At other times, perhaps, when the 'mirror' is the HIV positive mother, mothers project 'bad' mothering onto these 'other' mothers and experience themselves as nurturing, protecting and 'good.' It appears that mothers' perceptions of other mothers help make meaning of their own experience.

Psychological theories and common sense

Feminist criticism points to psychological theories as one of the main sources through which current conceptualisations of motherhood have emerged, and which have been absorbed into common sense understandings of the mother-child relationship. This is not to say that current conceptualisations are not contradictory. Glenn (1994, p.11), in talking about the ways in which mothers are portrayed in psychological theory says that,

> Mothers are romanticized as all-giving, self-sacrificing and forgiving and demonised as smothering, overly-involved and destructive. They are seen as all-powerful - holding the fate of their children and ultimately the future of society in their hands - and as powerless, subordinated to the dictates of nature, instinct and social forces beyond their ken.

Although universal perceptions and representations remain dominant, these assumptions are contradictory and contested and mothers within the dominant paradigm will hold a variation of meanings and beliefs about how to be a 'good' mother. This variation can be attributed to the extensive and contradictory sources of knowledge that women find in self-help books or through popular media, that have been filtered down from various 'scientific' studies that render this advice to be authoritative (Burman, 1994). Richardson (1993) attributes psychological knowledge as the reason that women depend more on the advice of professional 'experts' who tell them how to be 'good mothers'.

According to Burman (1994), developmental psychology's impact on popular culture is seen in the representations of both professionals and parents in their view of motherhood. Through research that typically looks at 'normal' mothering styles (of white middle class mothers), developmental psychology emphasises that the mother-child dyad is the primary unit in which children develop (and where the mother is seen as the primary caregiver). Mothering that deviates from this norm (single mothers, mothers in the workplace, working-class mothers, black mothers, depressed mothers, HIV positive mothers) is seen as opposite to the ideal of the 'good' mother and hence is represented and perceived as the 'deviant' mother (Phoenix et al., 1991).

The focus of developmental psychology is the child as the unit of study. Burman (1994) outlines the research that emerged which viewed the mother as merely the 'environment' in which the child was raised. Research on 'maternal environment' focused on maternal styles, mothers' attitudes to parenting and observations of mother-infant interactions that focused on 'responsiveness' and 'sensitivity' (Phoenix, et al., 1991). In line with the child-centred approach, 'good' mothering is defined by the needs of the child. The key feature of mothering assumed by research is sensitivity and responsiveness because this is what they say the child needs. It is useful to note that their definition of sensitivity includes, ''the practice to listen and to hold their own feelings in check, endurance, energy and good health to cope with the physically exhausting demands of parenting'' (Phoenix et al., 1991, p.36). It is against this background that much of the scientific research on HIV positive mothering is conducted. Although research has shown that children do require an attentive parent who can cater for their needs, this particular definition favours a mother who is particularly energetic and healthy and implies that this must be the case all the time. The research does not account for the mother's personal and particular experiences that affect the ways in which she relates to her child. Kruger explains that by essentialising mothers in this way, by measuring her child's happiness in relation to her own happiness ''which she is supposed to experience in response to the child's response to her'' (2006, p. 187), the ideal of the 'good' mother is created where every mother is measured against this standard. This type of research thus locates the mother as the primary caregiver and fails to acknowledge other family structures where children are raised by many 'mothers'. In this way, this type of research is biased.

Burman (1994) locates developmental psychology's interest in prescribing mothering styles within the broader socio-historical context. She explains that in England during World War II, with men away at war, women were needed in factories. Federal funds were provided to day-care centres so that women were free to take over the jobs of the men at war. The working mother, far from being perceived as neglectful, was now idealised as patriotic. Burman (1994) explains that when men began returning home from the war, women began receiving mixed messages. Women were now being told by 'experts' that their place was in the home. These emerging psychological theories (eg., Bowlby, 1970, Winnicott, 1947) provided justification for excluding women from the labour market.

Childcare experts and mothers' decreased access to public resources encouraged full-time mothering post World War II (Bortolia-Silva, 1996). Burman (1994) highlights the shift to current dominant perceptions of mothering. She says that the 1950's was ''a period which glorified motherhood (as both the bearing of and caring for babies)'' (Burman, 1994, p. 78). This shift was towards a greater attendance, by mothers, to their child's psychological needs. Psychoanalytic theories were used to encourage mothers into full-time mothering by stressing that inadequate mothering would affect the child's later development into adulthood. There was a shift between these psychoanalytic theories and developmental research in that where developmental psychology's interests focused more on the child, psychoanalytic theory focused more directly on motherhood identity (Phoenix, et al., 1991; Dally, 1982). Kaplan contextualises this invention of the ideal mother when she comments that, ''the call for an exclusive bond between mother and child that becomes the mother's primary occupation and source of satisfaction supports a society in which women (white middle and upper middle class women) are expected to be full time mothers'' (1992, p. 5). This understanding comes from psychoanalytic ideas that view motherhood as instinctual and natural and as a consequence, bonding with the child is also 'natural.'

Bowlby's theory of maternal deprivation warned that mothering styles also affect the child detrimentally. Children who failed to develop a secure attachment to their mothers were likely to suffer later psychological problems. Theories of separation and lack of bonding thus ensured that mothers were ''responsible for the ills of the world.'' (Burman, 1994, p. 80). In this way the

theory created the assumption that mothers should be always available, self-sacrificing and all-giving (Kruger, 2006).

Attachment theory appealed to women's natural capacity to bear children as the basis for women's 'natural' know-how in raising children. This served to perpetuate the notion that mothers are solely responsible for childcare because it is 'natural.' Psychological theory in general suggests that motherhood is natural and maternal skills emerge naturally (Burman, 1994). In other words, women have an inborn ability that simply unfolds when they become mothers. Phoenix and Woollett (1991) looked at the impact of psychological knowledge on popular childcare information that professionals and mothers draw upon. They show that the ability to mother is not a natural unfolding but a learning experience fraught with insecurity as knowledge about how mothers should mother 'right' is dominated by 'experts' who are often men and doctors. This version of motherhood that is presented by 'experts' is seen to be more valid than advice from other mothers, which is dismissed as 'old wives tales' (Marshall, 1991). Although mothering is perceived to be 'natural' in scientific thinking, the devaluation of mothers' knowledge renders this contradictory when mothers are told to rely on science rather than their own intuition. Psychological knowledge can be said to convey formal knowledge that mothers are expected to draw upon in order to be 'good' competent mothers. In all this, motherhood has been romanticized as the ultimate fulfilment (Dally, 1982).

Feminist researchers have critiqued the universal claims around motherhood made by traditional psychological theories by emphasising the context in which the research was conducted, including identifying whether the sample generalised from the mothering practices of white middle-class mothers is at the exclusion of other racial and class groups (Boonzaier & Shefer, 2006). What these critiques reflect is how concepts like motherhood are representations that are not static and value-free. In contextualising the HIV positive mother within psychological understandings (which give rise to accepted social understandings when it is filtered through to common sense), she would be perceived as deviating from the 'normal' motherhood depicted by the healthy mother who can 'sensitively' respond to her child. If this mother happens to be a black mother, she is doubly prejudiced. Greene (1990) points out that within scientific literature, black mothers are measured against the idealised representation of white mothers. In this way,

research pathologises black mothers by producing research that focuses on deficits and overlooks the strengths of marginalised ways of mothering.

Black Motherhood in South Africa

The above review demonstrates how Western understandings of motherhood come to filter into psychological theory and common sense understandings. Western understandings and perceptions also influence other non-Western societies through colonisation when these representations merge with indigenous understandings.

Walker (1995) locates black motherhood in South Africa within a social and historical context by contrasting precolonial and colonial understandings of motherhood. In precolonial times, the economy of black societies in South Africa was a subsistence economy that was agriculturally based. Within the patriarchal context of gender relations, the responsibility of child-care was met by numerous females within the homestead. Guy (1990) elaborates that the centrality of women's reproductive labour within that society ensured a considerable social status as well as authority and autonomy that was not replicated in colonial society. Colonialism and capitalism shifted and reorganised the precolonial economy and resultant social and kinship relations, such that the same set of maternal practices that women were responsible for previously had to be carried out in reconstituted kinship and family structures with the father away as a migrant labourer and in different environments, such as urban shantytowns (Walker, 1995). Over time certain mothering practices have changed as a result of the impact of colonisation and capitalism that did not replace, but recreated maternal identities as indigenous understandings and practices met with European, colonial ideas and practices. Walker (1995) cites research conducted by Preston-Whyte and Zondi of African teenage pregnancy in Durban to show that the value placed on women's fertility has not changed from precolonial times. In addition, the research shows that there is an increase in female headed households as young women are increasingly sceptical of marriage, but there is also a decline in the stigma of single motherhood as women still hold on to the value of fertility.

Meintjies (1990) attributes the change in motherhood for black women to the rise of Christianity. Walker (1995) shares this view and states that in 1946 over half the African population were church members and at this time there was a very small distinction between 'black' motherhood

and ‘white’ motherhood. The church influenced its members through its control over the school and family life (Meintjies, 1990). This is not to say that the church merely replaced traditional practices. Although the Euro-Christian notions of the ‘good’ mother overlapped with indigenous beliefs, the appeal of the church according to Walker (1995) is that it offered a way to help black people cope with the new society in which they found themselves. Both Walker (1995) and Meintjies (1990) argue that the western ideal of mothering was not imposed on black mothers, but rather, African women developed their own understanding and practices of motherhood by drawing on both cultures.

With further changes in historical, economic and social contexts, with women’s increasing economic independence, and the related rise of female headed households, the rise of women’s movements and the declining authority of the church, the meanings and practices around mothering and motherhood are shifting and class (in addition to race) is seen to determine the differences in mothering experiences. This social perspective on motherhood is expressed succinctly by Bortolia-Silva when she says ‘‘Mothering is a complex and shifting issue that involves much more than mothers and children. It encompasses ideologies, resources, labour markets, technological changes, men, law, choices and obligations’’ (1996, p. 33).

Glenn (1994), in contrasting black motherhood to universal motherhood assumptions, states that there are two problematic assumptions based on the (universal) white, middle-class mothers’ experiences. The first assumption is that mothers raise their children in a context of economic security and the second assumption, which is based on the first, is that women are not struggling for survival but are in the pursuit of individual autonomy. Her point is that ‘‘mothering is not just gendered, but also racialised.’’ (Glenn, 1994, p.7) This is illustrated in South Africa when historically black women were nannies to white, middle class children. Often, these women were mothers themselves who had to leave their own children in order to ‘mother’ their employers’ children as they lacked choices other than domestic labour. Another assumption made by the universal claims is that there exists a dichotomy between the public and private spheres where good mothers remain at home as the main source of childcare. Hill Collins (1994) calls this the ‘‘archetypal white middle-class nuclear family’’ (1994, p. 46) where the father is responsible for economic provision outside of the home and the mother is responsible for nurturing the children inside the home and supporting the father. In the nineteenth and twentieth centuries this applied

to American and European bourgeoisie. However, for both black and white working class mothers, they had to combine child care and domestic labour both in and out of the home with income earning (Glenn, 1994). Therefore family structures are reorganised differently in working-class black families. In many instances, both in South Africa and the United States, grandmothers are highly revered in black communities and function as primary caretakers of young children whose mothers leave them for work (Hill-Collins, 1994; Greene, 1990).

With regards to psychological research on motherhood in South Africa, Kruger (2006) argues that there has been very little research in general. South African psychological research, when it has focused on motherhood, has tended to mirror medical, scientific research by focusing on mothers and children at risk. Kruger says, ‘‘an analysis of how contemporary mothering and mothers are psychologically impacted upon by race, class, and culture is almost entirely missing from the South African literature’’ (2006, p. 194).

HIV Positive Motherhood

It has been reported that in developing countries like South Africa, the HIV epidemic is spreading most rapidly amongst young women of child-bearing age (Strebel, 1995). Infection of these women poses a risk for infection of children, with more than 90 percent of infection vertically transmitted from their mothers (Richter & Griesel, 1998). The relationship between maternal infection and child transmission is woven into gendered representations of HIV/AIDS, where women are seen to be the infectors of both men and children (Patton, 1993).

Gendered representations that depict the HIV positive mother in particularly negative ways can be traced to emerge from scientific representations, which are authoritative in defining this group of mothers in both scientific and lay understandings.

Joffe (1998) elaborates on the way HIV research has been represented in scientific literature. She says that although medical research presents itself as empirical and ‘objective’, ‘‘they draw upon the ‘us’ versus ‘them’ thinking that exists in the society at large.’’ (1998, p.24) For instance in the early days of the epidemic (and to a certain extent now) the epidemic was linked to ‘‘foreigners, outgroups and aberrant practices’’ (1998, p. 24). The epidemic has from the very start been linked to ‘the other’ who is viewed as ‘bad.’ As such, HIV/AIDS has been inextricably linked to death, stigma and immoral behaviour.

As an outgroup HIV positive mothers tend to be portrayed (with fear and horror) in both scientific and popular media as carriers of the HI virus (Long, 2002). As mothers, this group has been studied mostly in terms of mother-child transmission where their own personal experiences of having HIV coupled with the experiences of motherhood have been ignored. For instance, the experience of being HIV positive and a mother means that for these women, their maternal practices of self-sacrifice where they put the children's needs before their own remains unacknowledged. Demarco et al. (2002) coined this process "silencing of the self" which implies that HIV positive mothers deny their own (emotional and health-related) needs to meet the needs of their families. The function of this style is to protect the mother's self esteem and to keep her family intact, at the expense of her own health. Being the ideal 'good mother' serves to normalise family life. DeMarco et al. (2002) emphasise that HIV positive mothers have been studied mainly in relation to the impact on children's development and are often not seen as individuals in their own right. This is illustrated in studies conducted by Forehand et al. (1998) and Hough et al. (2003) who conclude that children whose mothers are HIV positive (compared to children whose mothers are not HIV positive) are extremely vulnerable and have more difficulties in psychosocial adjustment. In another study conducted by Forehand et al. (2001) HIV-infected African-American single mothers were studied to determine risk for depressive symptoms and were found to be at greater risk than non-infected single mothers. Miles et al. (2001) found a link between physical and mental health in HIV positive mothers and concluded that ''these findings have significance for the health of the mother and the parenting of her infant'' (Miles et al., 2001, p. 42). HIV positive mothers therefore, have been researched in terms of mental disorders (like depression) and have been portrayed in relation to the harm or deficit they create in their children (Parker & Aggleton, 2002). In this way, HIV positive motherhood is presented as an homogenous group that deviates from the normative, 'natural' qualities of motherhood as nurturant and responsible and are represented in literature and research as being responsible for their own and their children's infection and resultant doomed future (Sacks, 1996).

In her review of the literature on HIV positive mothering, Long (2002) comments that the HIV positive mother ''is constructed as a blameworthy object'' (2002, p.12). She goes on to review the way scientific literature represents the HIV positive mother and demonstrates how the researchers make negative inferences even in the face of positive research results. For instance,

even when the evidence pointed to mothers' resilience, maternal concern, nurturance and responsibility they were represented as damaging, absent, guilty and ashamed (Long, 2002).

Lawless et al. (1996) focus on the stigma and discrimination of HIV positive women, particularly the ways in which health care professionals perceive these women to be promiscuous and irresponsible. This, they argue, leads to the tension that exists when HIV positive women wish to seek help but are fearful of discrimination. In this way, they are stigmatised by being perceived to be deviant. Lawless et al. (1996) explain society's perception that infected women do not conform to the dominant perception of women as carers and moral guardians and are consequently perceived as vessels that could infect those that they should be caring for. They found that infected women were most discriminated against when it came to issues of sexuality and reproduction. Mothers, for instance, who discovered their HIV status when they were pregnant were perceived to be irresponsible with regards to decisions around their foetus and were encouraged to abort. This treatment, they argue, leads to self-stigmatisation when infected mothers feel guilty and blame themselves for being 'diseased'.

Not all individuals with HIV experience stigma (Taylor, 2001). Babies who have contracted HIV through maternal transmission are seen to be blameless while mothers who are perceived to be responsible for transmission are stigmatised as they are viewed to have contracted the virus through deviant means. According to Parker and Aggleton (2002) perceiving infected children as 'innocent victims' is a back-handed form of stigmatisation. In defining stigma, Taylor (2001) draws on deviance as a distinguishing trait. Similarly Parker and Aggleton (2002) draw on the work of Goffman (1963) who argued that stigma is conceptualised by society as 'difference' and 'deviance' which results in a 'spoiled identity' for the stigmatised individual. Parker and Aggleton (2002), however, argue that stigma should not be seen as static but rather as a changing social process. They argue that ''stigma plays a key role in producing and reproducing relations of power and control in all social systems. It causes some groups to be devalued and others to feel that they are superior in some way.'' (Parker & Aggleton, 2002, p. 9) In this way, stigma is socially and historically located.

With respect to HIV/AIDS, stigma has been reinforced by powerful metaphors that exist around the disease. HIV/AIDS is imbued with metaphors of death, horror, punishment, shame and otherness (Parker & Aggleton, 2002). The metaphors surrounding HIV/AIDS reinforce the fear,

avoidance and isolation of infected individuals. Stigma is one of the main reasons that people do not wish to know their HIV status (Bond et al., 2002) or disclose their status to others (Schlebusch & Cassidy1995; Campbell, 2004).

Campbell (2004) cites Joffe (1999) who outlines the process of stigmatization. She explains that people project their fears around HIV onto a clearly identifiable outgroup, who are then subjected to discrimination. By rendering this group as 'other' than them, they are able to let go of their fears and feel secure. AIDS-related stigma therefore comes about when people are afraid of contracting AIDS, which is life-threatening and associated with immoral behaviour. In this way, infection is perceived as a moral fault (promiscuity) created by the person who is now being punished for that lapse in morality (de Bruyn, 1999). Sexual stigma and HIV/AIDS are therefore inextricably linked. When heterosexual women are infected, they are perceived to have been promiscuous and 'loose' and are perceived to be responsible for the increase in prevalence.

Gender and HIV are also inextricably linked. The reproduction of structural inequality is played out when women are typically held responsible for their infection while men are excused for the behaviour that led to their infection. In developing countries, women with HIV may be abandoned by their partners who infected them and rejected by their families (Parker & Aggleton, 2002)

Societies vary in the meanings and representations that surround HIV/AIDS. In individualistic societies, an infected individual is seen to hold personal responsibility for her illness. In contrast, a more communal and collectivist society may perceive HIV/AIDS as bringing shame upon the family and community. In this way, stigma extends to all those individuals (family and friends) and is termed 'secondary stigmatisation' (Parker & Aggleton 2002). Family members are not always supportive towards the infected individual and women especially are treated worse than men and children (Bharat & Aggleton, 1999). Negative attitudes within the family lead to less disclosure as the infected individual fears rejection and alienation (Schlebusch & Cassidy, 1995).

Negative responses to HIV/AIDS mirror the negative responses of other illnesses that also evoke fear and repulsion (Taylor, 2001). Parker and Aggleton's (2002) point is put forward in the following quote.

> While negative responses to HIV and AIDS are by no means inevitable, they typically reinforce dominant ideologies of good and bad with respect not only to sexuality but also to illness - and perhaps above all with respect to what are understood as proper and improper behaviours (2002, p. 20)

Pregnancy and HIV Positive Motherhood

The recent increase in research around women and HIV/AIDS reflects the extent to which this disease impacts on women (Strebel, 1995). The chief mode of HIV transmission for women is heterosexual (deMarco, 2002) and women are more likely than men to become infected through heterosexual transmission (Strebel, 1995). Women are also more often infected at a younger age than men, this being ten years younger during their childbearing age (Richter & Griesel,1998). It is not surprising then that many women discover their HIV positive status when they fall pregnant.

Following from this, a major feature of HIV infection in women is perinatal HIV transmission from mother to infant. Strebel (1995) draws on Kanki and Coutinho (1992) to illustrate that in the absence of Nevirapine®/ART around 30% of babies of HIV positive mothers are infected. This leads to the perception that HIV positive mothers are ‘‘reservoirs of disease.’’ (Strebel, 1995). Even when women are HIV positive and not pregnant, it is not always an easy option to deny motherhood and the choice to bear children cannot always be controlled. In many cultures motherhood is revered and a woman’s ability to bear children is accorded high status and respectability (Dossier, 1990; Walker, 1995)). Given that childless women are stigmatised in many cultures, it seems that even HIV does not appear to be a factor that hinders women from being accorded the status of mother (Taylor, 2001).

Carrying the pregnancy to term is a decision that many women take for a variety of different reasons. One, is the importance of motherhood in the woman’s community. Another, is having more children than they might otherwise have had in order to increase the probability that some survive (Long & Ankrah, 1996). A further reason for this choice is antiretroviral therapy that is given during pregnancy and in the first six weeks to the baby and is shown to reduce infection rates. (Coutsoudis, 2005). Also, children represent an investment in the future (Dossier, 1990) and for many women are a motivation to staying alive.

Breastfeeding and HIV Positive Motherhood

Apart from perinatal transmission, postnatal transmission may occur through breastfeeding. With mothers who are HIV positive, breastfeeding is known to be harmful as it may transmit the HI-virus (Israel and Huber, 1999). As a result, HIV positive mothers are discouraged from breastfeeding their infants. However, in developing countries, where infants may contract diseases due to poor sanitation and malnutrition, as replacement feeding is unsafe, unaffordable and not sustainable, the World Health Organisation encourages breastfeeding as the infant is more at risk of succumbing to other infections and diseases (Coutsoudis, 2005). Where there are no alternatives to breastfeeding (in poorly resourced countries) owing to costs of formulas and access to clean water, mothers have little choice and are advised to breastfeed exclusively as exclusive breastfeeding carries a lower risk of HIV transmission than mixed breastfeeding (Coutsoudis, 2005). According to Coutsoudis, (2005) the prevalence of HIV infection per year due to breastfeeding is thought to be 300,000 while the absence of breastfeeding is responsible for 1.5 million child deaths per year.

Furthermore, the stigma attached to not breastfeeding (in certain cultures) is linked to HIV infection (Richter & Griesel 1998, Eide et al., 2006). Similarly in Long's (2005) study, a participant who decided not to breastfeed was worried that it would be a sign of being a 'bad' mother. This is because it is culturally valued in her community and she was afraid she may be exposed as HIV positive if she did not breastfeed. At the same time there was a sadness over the loss of the bonding that breastfeeding was meant to bring about. Overall, the decision not to breastfeed was regarded as an aspect of 'good' motherhood (despite being infected) while the mothers themselves regarded 'bad' motherhood as depicting those behaviours that continued to 'infect.' Therefore, observing an HIV positive mother breastfeeding or falling pregnant is viewed with horror (Long, 2005).

Cultural assumptions about maternal practices, like breastfeeding, place much pressure on mothers who choose not to breastfeed. Abstaining from breastfeeding is stigmatising as mothers are accused of being 'bad' mothers. In addition there is also the prejudice that abstinence from breastfeeding is linked to HIV infection. This brings about a double prejudice, being a 'bad' mother for not breastfeeding and being an HIV infected mother. It has been seen that cultural assumptions are not created in isolation. Further, cultural assumptions are acted out by individual

mothers who make meaning of breastfeeding in relation to their cultural beliefs. In order to locate these assumptions, the next section looks at the social and political context within which these assumptions emerge.

Gender and HIV

Having seen that cultural practices place much pressure on mothers, this section explores gendered power dynamic within heterosexual relationships and within a patriarchal society. The aim of this section is to highlight how these prejudices are set up and how women are vulnerable in their positioning as black, working-class women.

Wilton (1997) states that ‘‘women’s subjugation to men is both reflected in and reinforced by the ways in which the pandemic has been gendered’’ (1997, p. 2). The majority of women are economically dependent on male family members and material inequalities are responsible for women’s lack of power in heterosexual relationships (Wilton, 1997). Women’s discriminated access to economic resources stems from a gender identity conceptualised around patriarchal ideals that renders them more vulnerable than men (Strebel, 1995). In this way women’s position in society has been naturalised within and by whichever paradigm is hegemonic in various cultures (Wilton, 1997).

Women are more vulnerable to contracting HIV/AIDS for various reasons. On a biological level, women are more susceptible to contracting HIV (Wilton, 1997). On a social level, for black and ethnic minority women, simply accessing information on safe sexual practices is problematic because these materials may not be produced in their first language or because this type of information is restricted in their cultures (Wilton, 1997). On a psychosocial level, patriarchal power relations constrain women’s ability to negotiate safe sexual practices (Strebel & Lindegger, 1998). Strebel and Lindegger (1998) point out that the predominant heterosexual mode of HIV transmission in South Africa necessitates the study of issues concerning gender in relation to HIV infection. They argue that differential relations of power between men and women have implications for understanding women’s vulnerability to HIV infection. HIV negative mothers in this study showed an awareness of safe sexual practices and attempted to be responsible, but were also aware that as women, they have little influence within their relationships. Strebel and Lindegger’s (1998) understanding of the dynamics at play are thus

relevant to outline. Their study revealed discourses of power and responsibility that are inherent in the relationships of their black participants. There was an assumption of male power where men dictated what happened within the relationship. (A related assumption is highlighted by Shefer and Potgieter (2006) who draw on women's socialised sexual practices which constrain them to the role of passive and submissive partners.) In the Strebel and Lindegger (1998) study, a biological understanding of the male sex drive led women to understand that men require many sexual conquests. Women were thought of as powerless in this regard. Although women were aware that they had power in numbers and that they could resist male domination in relationships, they were aware that any change would be met with obstacles and would not occur overnight. It seems there exists a double standard where men are expected to have a high sex drive and to 'naturally' relieve their desires through multiple partners whilst women are seen to be sexual only in relation to the sexual needs of men. If a women is sexually active, she is viewed as promiscuous and 'unclean' (Shefer & Potgieter, 2006). The other issue that emerged in Strebel and Lindegger's (1998) study was the issue of responsibility. Although women were aware of ways of practising safe sex, their personal experiences led them to understand that men were reluctant to take responsibility, which left women to carry the burden of responsibility. However, women's responsibility is contradictory in that although they were seen as the carers of men, they could not easily protect themselves from HIV infection. Talking about sexual matters was not acceptable and romantic love and trust was not associated with condom use. Further, if a woman insisted on condom use for her protection, and her partner interpreted that as mistrust, he could easily turn to other women. Strebel and Lindegger (1998) concluded that the risks of losing one's partner and thus losing economic support constrains womens' actions with regards to safe sexual practices. Their argument is that gender and economic need are inextricably linked.

Strebel (1995) highlights that an overemphasis on gender issues for women in Africa denies the existence of racial and class differences. It is found that HIV infection is greatest amongst the very poor. Poverty brings with it malnutrition, stress and a lowered immunity, which increases the risk of HIV infection. In South Africa, black women are more vulnerable to poverty as the historical forces that have shaped their position in society include colonial culture, urbanisation and apartheid, where migration policies resulted in an increase in poverty amongst women (Walker, 1995, Shefer & Potgieter, 2006). ''With the feminisation of poverty, particularly

evident in Africa, women are made especially vulnerable to HIV infection through the intersection of economic and gender power inequalities'' (Shefer and Potgieter, 2006, p. 112). Race and gender are doubly responsible for black women's lower social and economic positions and vulnerability to HIV infection. Strebel (1995) found women who are more economically independent are better able to negotiate safe sexual practices if they stand in a more equal position in terms of access to financial resources. However, the majority of working class black women, especially if they have families to support, are economically less powerful and hence find more difficulty negotiating sexual and gender issues. Shefer and Potgiter (2006) cite South African studies of 'transactional sex' that show that it is particularly *younger* women who are more vulnerable to HIV infection as research illustrates that older men are chosen by younger women for access to money and status.

In understanding the vulnerability of black working-class women of child-bearing age, it is relevant to locate them within their social, class and racial context. The above review illustrates that it is women's disadvantaged economic, racial and cultural positions as females that constrain the roles that they may carry out. In heterosexual relationships, black, working-class women are perceived as submissive and are powerless in relation to dominant men whose needs take precedence.

Conclusion

This chapter reviewed various aspects that pertain to the conceptualisation of black, HIV positive mothers in South Africa. It has been seen that the literature on HIV positive mothers in terms of their actual experiences as well as how they perceive themselves or how others perceive them, is limited. In attempting to understand HIV positive motherhood and the metaphors that surround it, dominant perceptions of 'ideal' motherhood were discussed as this white, middle-class conceptualisation of motherhood is frequently applied to all mothers, including black, working-class mothers. The discussion illustrated the dominant (ideal) perception of mothers, in patriarchal societies, as self-sacrificing, emotionally invested and nurturing. It also highlighted that any kind of motherhood that does not meet the criteria set up by the dominant image is regarded as 'bad' motherhood.

The literature moved on to feminist critique that pointed to psychological knowledge as setting up the ideal of the 'good' mother. Developmental research was seen to normalise white, middle class mothering styles and was shown to pathologise black mothers when it produced research that focused on deficits of black mothering styles.

The review on black, South African motherhood was mostly historical as current literature is virtually non-existent. This section illustrated that motherhood is racialised. Black mothers in South Africa do not conform to the dominant ideal of motherhood as they are poor, marginalised and are more susceptible to HIV infection.

The literature then moved on to consider the ways in which the HIV positive mother is stigmatised in scientific literature. Various studies were drawn on to illustrate that the infected mother is seen as irresponsible, negligent and 'diseased.' Such studies excluded the HIV positive mother's personal experiences of having HIV coupled with the experiences of motherhood. Instead the HIV positive mother was shown to be portrayed as damaging, irresponsible and ashamed. Owing to these perceptions, the literature review suggested that infected mothers experience discrimination and stigma.

Stigma was defined and elaborated on within the literature review. AIDS-related stigma was seen to emerge when people are afraid of contracting HIV/AIDS, which is life-threatening and associated with immoral behaviour. What is of significant interest is the perception that the

infected mother is blameworthy while her child is blameless. Babies who have contracted HIV through maternal transmission are seen to be the 'innocent victims', while mothers who are perceived to be responsible for transmission are stigmatised as they are viewed to have contracted the virus through deviant means (namely promiscuity). The review on HIV infection in pregnancy and breastfeeding highlighted that HIV infection is greatest amongst women of childbearing age. Breastfeeding was examined in relation to its significance as part of maternal practice. The literature reviewed the importance of breastfeeding for HIV positive mothers in developing countries where replacement feeding is not feasible. There was also the opposing idea that HIV positive mothers that engaged in breastfeeding continued to infect. Moreover, failure to breastfeed led to stigma when others viewed the mother as infected, and by not breastfeeding, as a 'bad' mother. This highlighted the paradoxical and complex position that breastfeeding holds in relation to HIV positive motherhood.

The review concluded by contextualising black, South African motherhood within its social, economic and historical context. Gendered power dynamics were seen to be responsible for women's decreased power in heterosexual relationships where their ability to negotiate safe sexual practices is constrained. Class and race within a patriarchal society was discussed as positioning black, working-class women as more vulnerable to HIV infection.

Chapter 3: Research Method

1. Methodological Framework

Qualitative approaches to research are engaged with exploring, describing and interpreting the personal and social experiences of individuals (Smith, 2006). These approaches are best understood as a journey that is co-constructed with the research participant as opposed to a mining expedition where information is simply unearthed and uncovered (Kvale 1996). The aim of this research was to journey with HIV negative mothers in order to describe and interpret their subjective feelings and perceptions in relation to HIV positive motherhood. The research paradigm adopted the interpretive approach where ‘‘the key principle…is to stay close to the data, to interpret it from a position of empathic understanding’’ (Terre Blanch & Kelly, 1999). In this research, qualitative methods involved collecting data in the form of interviews (of HIV negative mothers) with the aim of being ‘‘interviewer as traveller’’ (Kvale, 1996, p. 4). Interpretive qualitative analysis using interviews is described as a process where

> the interviewer wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of their lived world, and converse with them in the original Latin meaning of *conversation* as ‘wandering together with.’
>
> (Kvale, 1996, p. 4).

Kvale (1996) suggests that knowledge is not located within the participants or within the interview transcripts for the researcher to uncover. Rather, in engaging with the research participants the researcher’s understandings and the participants’ understandings coincide, thereby constructing and subjectively transforming the meanings that are produced. This particular study adopted the technique of interviews and thematic analysis in order to generate and order HIV negative mothers’ perceptions in the form of themes.

Interpretive Inquiry

Qualitative methodology is concerned with ‘‘making sense of human experience from within the context and perspective of human experience in an empathic manner’’ (Kelly, 1999, p. 398). Terre Blance and Kelly (1999) draw on Dilthey’s concept of v*erstehen* (understanding) which suggests that participants’ meanings and experiences can only be ascertained in relation to the contexts in which they occur. *Verstehen* or ‘Empathy’ occurs when ‘‘the text is placed back in its context and there understood’’ (Terre Blanche & Kelly, 1999, p. 125). Within this framework, meaning is always contextually grounded. Ricoeur (1979, cited in Kelly, 1999) puts forward the idea that there are contextual and subjective limits to understanding. By viewing an experience from a distance (a process he termed *Distanciation),* the new vantage point ceases to be limited to the author’s intentions. The text becomes invested with an excess of meaning, thus the process of distanciation is productive of meaning (Kelly, 1999). Therefore in understanding a phenomenon, the researcher needs to look at the context (empathy) and also requires the process of distanciation. Kelly explains that ‘‘In distanciated interpretation, we are not only interested in understanding subjective understanding, but in revealing its contextuality. So we might say that we are interested in understanding ‘understanding’, or interested in interpreting understanding’’ (Kelly, 1999, p. 402). It is hoped therefore that this research is successful in developing an understanding of subjective experience and in providing an interpretation of the voices of respondents.

2. Participants:

Eight HIV negative mothers were interviewed for about an hour each and all interviews were conducted in English. The requirement for the sample included mothers who were able to converse adequately in English so as not to have the added component and interference of translation. The sample size was 8 mothers because comprehensive and in-depth coverage of the issues was found with 8 participants. Further, ‘‘experience has shown that 6-8 sources or sampling units will often suffice for a homogenous group’’ (Kelly, 1999, p. 381).

Since HIV infection is spreading most rapidly amongst black, working–class women of child-

bearing age (Strebel, 1995) participants were domestic workers, residing and working in the northern suburbs of Johannesburg and between the ages of 26 – 38 years. Domestic workers were selected as a homogenous sample of black, working-class mothers who were easy to access.

All women chosen for the sample were mothers. Since mothers from different socio-economic and cultural contexts will tend to hold different meanings around the concept of motherhood, mothers from one particular socio-economic and racial context were interviewed. Black, working-class mothers who were HIV negative made up the respondents as the researcher was interested in exploring perceptions about HIV positive motherhood from those mothers who were not infected in order to explore issues surrounding stigma. As mothers, the researcher hoped that HIV negative mothers' position within society (as 'mothers') allowed them to engage in a way where they were able to relate to the vignette that focused on issues around breastfeeding. Although their cultural backgrounds (e.g. Zulu, Xhosa etc.) were diverse and they were originally from different parts of the country, the sample was reasonably homogenous as it consisted of working–class, black, HIV negative mothers of child-bearing age, working in the northern suburbs of Johannesburg (particularly Killarney and neighbouring Illovo) as domestic workers. Purposive sampling was employed, where participants were selected based on particular criteria that conformed to the research requirements and to form a reasonably homogenous group. Participants were accessed through purposive snowball sampling where one domestic worker was accessed who in turn recommended her friend and the friend in turn brought another friend. This sampling strategy, although convenient, may be limiting in that only a certain section of domestic workers in the northern suburbs-who were related in some way through friendship, language, kinship ties etc. were selected. The basis of their network was not explored and this could limit the research.

Six mothers were single. One mother was married, and living with her husband and another mother was in a long-term relationship but living apart from her partner. The number of children ranged between one and three, with a mix of girls and boys, and these children were between the ages of 1 year and 15 years. Apart from one mother who was unemployed and living with her children, the rest of the mothers were employed and lived away from their children. Although this was not a requirement, all mothers in this study knew at least one person with HIV/AIDS.

3. Data Collection

a. Procedure:

Participants were informed about the study both verbally and in writing and were given a week to decide if they wished to participate. They were informed before-hand as to the type of questions that they would be asked and were told briefly about the vignette as this was possibly a sensitive topic for some individuals and would determine if they chose to participate or not. Mothers who declined to participate cited language as a barrier as they were anxious to have to converse in English for an hour. Other mothers who declined did not give a reason but the researcher speculates that they appeared confused and perhaps suspicious as to the reason that a woman (the researcher) socially positioned as an 'employer' to them would want to talk with them and not want to employ them to do any domestic chores etc.

Participants who agreed to participate were first involved in a negotiation of date and time. They were then interviewed at places of their convenience. Six participants opted to have the interview conducted at the researcher's apartment while the other two (with permission from their employers) chose to participate at their places of work. In all interviews, the interviewer offered refreshments as a way to join with and ease the participant into the interview. Participants were initially anxious but once they understood what was required of them and were able to relax, they engaged more fully and were able to disclose personal experiences with HIV infected friends and family towards the end of the interview. By the end of the interview, many participants reported that having someone to listen to them was beneficial. The interviews were then transcribed verbatim and the participants' names were changed to protect confidentiality. Analysis began during transcription when themes that emerged or issues that were highlighted from the literature were highlighted in bold in the transcript. When the first transcript was complete the interview was analysed by the researcher and research supervisor separately before it was discussed. Once all the interviews were recorded and transcribed, a separate process of analysis was engaged with, that followed the model by Terre Blanche and Kelly (1999).

b. Interviews

Data was collected through semi-structured interviews. Smith and Eatough (2006) advise that semi-structured interviews be ‘‘participant led in the fullest sense yet guided by the researcher’’ (2006, p. 330). The advantage of this approach is to allow the researcher to explore and follow up on unexpected and important issues that may come up and to treat participants as experiential experts on the subject of motherhood. The semi-structured interview was conducted (after participants signed a consent form) and with additional permission from each participant, was audio-taped. Audio-taping each session attempted to minimise interviewer bias (Breakwell, 2006). This allows the data to be a permanent record that would be open to verification by other researchers. Breakwell (2006) points out that there is no clear evidence to show that audio-taping constrains what respondents are willing to say and may be seen as non-intrusive as more people are exposed to and have access to technology.

In order to allow for a relatively focused discussion around perceptions of HIV positive motherhood, a vignette and a set of questions was drawn up that was used as a guide rather than to dictate the course of the interview. Constructing a set of questions allowed for consistency across the responses of the various participants (Breakwell, p. 2006). Participants were given a case that they were asked to discuss (with help from the researcher) and then they were led to discuss their own perceptions in relation to the case. The fictitious case included a discussion around a dilemma that an HIV positive mother faced. The vignette was the following:

> Thandi has recently given birth to a healthy baby boy. She has named him Mpho. When Thandi was pregnant she discovered she was HIV positive. Thandi thinks breastfeeding her son is very important but because of her HIV status she is not sure what she should do.

This particular scenario was created to get closer to the experience of mothering by focusing on the issue of breastfeeding. It was hoped that posing a dilemma would draw participants into a conversation which was about a fictional mother, hence allowing a distance that would be less threatening. The particular focus on breastfeeding was selected as it is, apart from a basic

maternal activity that is usually a shared experience, controversial. The literature suggests that breastfeeding is held in high esteem amongst black mothers and failure to breastfeed brings with it much stigma and suspicion that the mother is HIV positive. In this way, the dilemma was intended to bring about discussion around stigma. The vignette also neglected to present background information in order to allow mothers to make their own assumptions about Thandi. Although it is stated that baby Mpho was born healthy, the vignette also allowed mothers to make their own assumptions regarding the child of the HIV positive mother.

Questions posed in relation to the vignette included:

a. Why do you think Thandi is not sure if she must breastfeed or not?
b. What do you think she should do?
c. What do you think of Thandi? What kind of person do you think she is?
d. What do you think it will mean for the baby that his mother is HIV positive?
e. What do you think of Thandi's HIV status? How could she have contracted it?
f. What would a good mother do in this situation?
e. What does this situation mean for you? How would you compare your own experience of being a mother with Thandi's experience?

These questions were asked in no particular order and with the sole intention of guiding the conversation. The questions link to the main research questions around what the image of the HIV positive mother evokes, issues linked to the perceived causes of infection, the meaning that breastfeeding holds in both HIV positive and HIV negative motherhood, and issues around the impact of the child.

The researcher attempted to guide the interview in an empathic manner and used particular listening skills (reflections, prompting and open-ended questions) to facilitate the conversation. The ideal of being co-constructors of knowledge was highlighted as the researcher joined with the participants by answering questions posed and did not claim expertise on the matter. Although all participants were not fluent in English, they were able to express their sentiments clearly.

4. Analysis:

The discussion above infers that the interview technique was used to collect data because it focused on subjects as makers of meaning (Kaplan, 1992) and allowed an exploration of subjective representations. With this in mind, interpretative analysis was operationalised by using the techniques of thematic analysis, which emphasises the recognition of meaning. This is a form of analysis which describes the themes that emerged from the interviews.

Krippendorf (1980) as well as Terre-Blanche and Kelly (1999) highlight the importance of context in analysis. Stewart (1983) also stressed that all interpretation must be sensitive to context. This means that the analyst must construct a world in which the text makes sense and can answer the analyst's research questions (Krippendorf, 1980, Ricoeur, 1981). A context is the ‘‘conceptual environment’’ of the text (Krippendorf, 1980, p. 33) and applies all the knowledge that an analyst applies to the given text. Krippendorf (1980) suggests beginning with research questions in advance of the analysis. Joffe and Yardley (2003) explain that thematic analysis begins from a theoretical position that enables the researcher to have pre-identified themes. The first advantage is efficiency as the analyst reads the text with a purpose. Secondly, by searching through the text for answers to the research questions, it helps to ground the analysis empirically. Formulating research questions protects the analyst from getting lost in mere abstractions. (Krippendorf, 1980). Although theory is used to formulate the research questions and in this way guides the analysis, the researcher has to be open and sensitive to new themes that may not be anticipated.

Step 1 is Familiarisation and Immersion (Terre Blanch & Kelly, 1999). In this research particular themes (based on the literature) already came to mind whilst the interviews were being conducted. In transcribing the interviews, the researcher highlighted in bold the various themes that appeared relevant. For example, when the respondents talked about their perception of Thandi being discriminated against and again related their own experience of witnessing stigma, the theme was coded as ‘Stigma’. Initial themes that came through also included, ‘Dangers of breastfeeding,’ ‘Gender relations’ and ‘Personal Experiences.’ Once the material had been

transcribed, the data was read through many times until the researcher was very familiar with its content (Terre Blanche and Kelly, 1999).

Step 2 (Inducing Themes) and Step 3 (Coding) are discussed separately by Terre Blanch and Kelly (1999) but in this analysis occurred simultaneously. Once all the interviews were transcribed - with this preliminary analysis in bold type within the transcripts - the transcripts were read through and further themes were highlighted. Whole sentences and paragraphs were read with themes emerging from these texts (Burns, 1990, Weber, 1990, Smith and Eatough, 2006). In generating themes, the focus was not only on the content of the transcripts but also on the process and contradictions within the text (Terre Blanch and Kelly, 1999).

Once all the themes were generated (using coloured pens to code the different themes), they were typed up. Respondents' phrases and actual speech were recorded under each theme. Connections between the themes were made in this way and were explained briefly. At this point, the themes were not generated with only the research questions in mind but everything that appeared to follow a pattern was documented. At this point, the entire result of the coding was discussed with the research supervisor who advised that aspects pertaining to the respondents' personal experiences of motherhood be put aside as the research question focused specifically on respondents perceptions of HIV positive motherhood. The themes that were excluded related to the respondent's ambivalent experiences of leaving children behind to work in order to be 'good' mothers. Further, their personal experience of negotiating safe sex was mainly excluded unless it linked to the infected mother as unable to negotiate safe sex (which was included).

Terre Blanche and Kelly (1999) refer to Step 4 as Elaboration. This is the process where connections between the themes were made as like themes were grouped together and what, initially, were grouped under the same theme, was now seen to be different. In this step, the themes were explored more closely until there were no new insights that were generated.

At this point, the research questions were used to guide the analysis but the researcher was sensitive to unanticipated themes that emerged and were relevant. This was shown when the researcher initially anticipated that HIV negative mothers would be discriminating if the HIV

positive mother breastfed. However, what was not anticipated was that when respondents talked about HIV positive mothers as 'mothers' they were able to identify with her and were non-discriminatory but when they talked about the infected mother in relation to the child, they perceived her as the 'absent' mother who was different to them. This could not have been anticipated from the theoretical framework of the study.

Step 5 entailed Interpretation and Checking. In this step the quotes that appeared under the different themes were elaborated on and explained. The results were given meaning and were arranged thematically (Smith, 2006; Terre Blanche and Kelly, 1999). From this analysis, three main themes and further subthemes were identified:

1. *Awareness of the Social Challenges of being HIV positive*
    - 1.1 Disclosure and Stigma
    - 1.2 Vulnerability
    - 1.3 Perceptions of Blame
2. *Perceptions of Motherhood*
    - 2.1 Perceptions of the HIV Positive Mother as Similar
    - 2.2 Perceptions of the HIV Positive Mother as Different
    - 2.3 Breastfeeding
3. *Impact of Maternal HIV on the Child*
    - 3.1 Mother-Child Relationship
    - 3.2 Psychological and Social Impact on the Child

5. Validation

The researcher attempted to be reflective throughout the research process. Discussions with the supervisor and other colleagues helped to evaluate the research process and interpretation of data through other eyes. In order to get a distance from the data and review the research results, the literature review was revised after draft 1 of analysis in order to obtain a fresh perspective and to develop new ideas. According to Kelly (1999) authoritative accounts of concepts like reliability and validity are much debated and are less important in qualitative research than good qualitative practice, transferability, triangulation, communicative validity and peer review.

Good qualitative practice should keep close to the data when labeling phenomena and with this in mind analysis began with directly utilizing the quotes and phrases of the participants. Good qualitative practice should always bear in mind the impact of the researcher on the context of study as well as the way in which the participants' perceptions are interpreted. Discussions with the research supervisor considered the impact of the researcher's middle-class social positioning and as an employer of a domestic worker upon the research context. The research supervisor also read through transcripts in order to validate whether the researcher's interpretations and thematic codes were relevant. Peer review allowed the researcher to think through interpretations of the data in the presence of the research supervisor and through the critique generated by informal discussions with colleagues. In order to facilitate transferability it is hoped that this research is successful in providing rigorous qualifications for the analysis which will allow other researchers (utilising the same procedure and framework) to transfer the same meanings and interpretations to another context.

6. Ethical Considerations

In sourcing research participants, they were informed (both verbally and in writing) of the aims and outcomes of the research project prior to their agreement to participate. Participants were told that they had to be HIV negative or believed themselves to be HIV negative had they not been tested. They were not asked to disclose their HIV status but were told that they should not participate if they were HIV positive as the interview may be too close to their experience. The vignette specifically focused on a common dilemma faced by an infected mother and it was possible that should the respondent be infected, she would be able to relate to this vignette in a very personal way. As such, the interview, although empathic was not a therapeutic space in which to be counseled but was meant to probe and explore particular issues around HIV and motherhood. In order to prevent discrimination, participants were also encouraged to abstain from participating if they were not interested or if their work commitments did not allow it. In this way, possible HIV positive participants did not have to disclose their status through non-participation. Another reason that came from participants for non-participation was their anxiety at having to converse for a lengthy duration in English. This anxiety was taken seriously by the

researcher and no respondent was forced to participate. After the purpose of the interview was explained, participants were guaranteed confidentiality and were required to sign a consent form. Each interview was tape recorded (with additional permission and another consent form) and transcribed for analysis. Participants were assured that the tapes would be destroyed once the researcher graduated. None of the participants found the interviews to be particularly difficult. However, they were informed that in the event that they found the interviews emotionally difficult the researcher would set up appropriate referrals for counselling. No participant required or requested counseling and the majority found it interesting to talk about an aspect of their lives (motherhood) that they take for granted. They also found that reflecting on the experiences of their infected friends and family members was beneficial.

7. Reflexive considerations

Throughout the research process, the researcher reflected on her role in shaping the research process and decision making within the research. As a first time qualitative researcher the experience was a new one and much anxiety was generated along the process. This undoubtedly affected the research process.

There was an awareness that an Indian, middle-class female researcher who was childless occupied a very different position to Black, working-class mothers. The researcher's position as woman and her empathic interest in the mothers themselves existed alongside the differences between the interviewees and the researcher.

The researcher's educational privilege allowed for there to exist a power inequality where the researcher determined what questions to ask and what the focus must be. Engaging in supervision was helpful as the researcher was made conscious of power dynamics in the form of direct, leading questions that arose due to the researcher's anxiety. Although an attempt was made to rectify this, the researcher sometimes failed in this regard.

Another power inequality was that the researcher was better versed in English and the use of English may have marginalized the mothers, who were not all fluent in English. The decision to

use the researcher's home as the interview location also brought to the fore class inequalities. The power inequality was identified and regarded as an aspect of the research process. The researcher tried not to be seen as expert by identifying herself as co-producer of knowledge. This was done by telling the participants directly that it was their perceptions that was of interest and that were no right or wrong answers. The researcher, being interested in the perceptions of the participants, therefore aimed to be an interested and empathic co-constructor of knowledge.

Chapter 4: Analysis

Introducing the themes

The analysis begins with a general analysis of how participants understand the predicament of the HIV positive mother in relation to stigma and discrimination and will go on to discuss HIV positive motherhood, examining ways in which participants perceive what it means to be an HIV positive mother. The analysis then goes on to consider participants' perceptions of the impact of the mother's positive status on her child.

The first section, **Awareness of the Social Challenges of Being HIV Positive**, draws on the respondents' acute awareness of the social challenges that the HIV positive mother and other infected individuals experience. This section looks at 3 subthemes: *Disclosure and Stigma, Vulnerability* and *Perceptions of Blame.* The first subtheme will draw on participants' explicit understanding of the stigma and prejudice that infected individuals experience and that leads to non-disclosure. The next subtheme (*Vulnerability*) follows on from the first and discusses the perceived vulnerability that HIV negative mothers feel when thinking about HIV infection. This leads to *Perceptions of Blame*, where the participants' assumptions around how the HIV positive mother became infected are discussed.

The second section, **Perceptions of Motherhood**, deals with the ways in which the participants perceive HIV positive motherhood. This section is divided into a discussion around 3 subthemes. The first two themes, *Perceptions of the HIV positive Mother as Similar* and *Perceptions of the HIV positive Mother as Different*, explores the participants' sometimes ambiguous perception that there is no difference between themselves and the HIV positive mother. The role and practices of (black, working-class) motherhood allows participants to identify with Thandi, the HIV positive mother in the vignette. The subtheme of *Breastfeeding* looks specifically at the meanings and perceptions that breastfeeding holds for participants in general and in relation to HIV in particular.

The third section deals specifically with the **Impact of Maternal HIV on the Child**. It moves away from perceptions of the HIV positive mother to focus on the mother-child relationship. In

this section, the analysis is divided into 2 subthemes. *Mother-Child Relationship* centres around respondents' perceptions of the impact of the mother's physical and emotional well-being on her child. Analysis then shifts to explore the *Psychological and Social Impact on the Child*. This subtheme looks at participants' perceptions of the impact of the child's social world in response to the mother's HIV positive status. This analysis takes a different tone to the preceding analysis as participants' perceptions shift.

SECTION 1

1. Awareness of the Social Challenges of being HIV positive

This section deals with the respondents' awareness of the direct experiences that the HIV positive mother faces in her social interactions. The following analysis explores *Disclosure and Stigma, Vulnerability and Perceptions of Blame.*

1.1 Disclosure and Stigma

The mothers interviewed in this study all knew at least one mother with HIV/AIDS and appeared to have direct knowledge of the way in which the person they knew experienced this illness and were aware of the limitations in support, around the issue of HIV/AIDS. The following analysis deals with their awareness around issues of disclosure, stigma and shame and highlights their identification with the HIV positive mother in the vignette as well as mothers they knew in real life.

Disclosure

Respondents believed that, apart from the catharsis that disclosure brings, disclosure was beneficial for the infected individual to decrease stigma by educating others. In this way, others who know her will see that she can be just like them, ‘‘normal.’’

> *(She must disclose) so that they will learn from her that HIV doesn't mean that you dying, the way they will see how I take care of myself. I would just be a normal person to them. I won't do anything to them, so they will get knowledge through me. (Siyanda)*

Siyanda closes the gap between herself and the HIV positive mother by talking in the first person. She suggests that disclosing to others whilst one is healthy, physically illustrates to

others that HIV positive individuals are 'normal' and can live 'normally'. The HIV positive mother is thus portrayed by Siyanda as being a kind of role-model for normal and healthy living. The perception that the infected individual can cause harm or 'do something to them' implies that in the eyes of other non-infected audiences, the HIV positive individual is seen in their collective imaginations to be threatening and contagious (Lawless, et al., 1996). Siyanda's use of the word ''*normal*'' suggests that there are prevailing assumption of abnormality that is linked to the sick, infected body. By normalising the HIV positive mother, Siyanda reframes and re-constructs HIV as synonymous with not dying (''*HIV doesn't mean that you are dying*'') and as non-threatening. In this way Siyanda re-constructs the experience of being HIV positive to be 'normal.'

Disclosure as Conditional

Although respondents felt that the HIV positive mother should disclose her status in order to access support and to 'normalise' the disease, they were aware of the stigma and prejudice that comes with disclosure. As a result, respondents perceived that disclosure was useful only in certain cases. Participants were acutely aware of how stigma allowed infected mothers to appear to be deviant. This is in line with Taylor's (2001) argument that stigma serves to reinforce social norms by defining deviance. Respondents therefore perceived disclosure to be conditional and suggested that the HIV positive mother should only disclose when it became obvious that she was ill.

Gertrude suggests that in order to come across as being normal, the HIV positive mother should not disclose even if people are suspicious that she is not breastfeeding due to HIV. Gertrude's advice is that the HIV positive mother should rather lie in order to protect herself as it is difficult to trust others.

> *Sometimes she'll (Thandi) say, 'My breastfeeding is not okay, no milk' or whatever...It's not easy to tell everybody I'm HIV positive (Gertrude)*

Gertude highlights the difficulty that the HIV positive mother may experience in disclosing her status to others. The stigma attached to not breastfeeding is linked to HIV infection (Richter & Griesel, 1998; Eide et al., 2006). Therefore, lying serves to conceal her deviation from other 'normal' mothers and allows her to join with those mothers who are viewed as acceptable if they

cannot produce milk or they experience more acceptable problems with their breastmilk, in some way other than being infected. In talking about how Thandi (the HIV positive mother in the vignette) may lie to others to conceal her status (‘‘*My breastfeeding is not okay*’’), it is interesting to note how she then changes to the first person to reveal herself and not Thandi when she says, ‘‘*It’s not easy to tell everybody I’m HIV positive*.’’ This subtle shift may imply the extent to which she identifies with Thandi, that she can put herself in Thandi’s place and empathically imagine how difficult it must be to disclose one’s HIV positive status.

Stigma

The fear to disclose was linked to the issue of stigma and blame. Stigma (and the resultant shame) was perceived to be manifested in the way HIV positive mothers are treated by others, where they are laughed at and judged (blamed) and in the extent of their concern and worry around disclosure.

Respondents were aware of the stigma associated with being HIV positive and held the perception that, although family support is valuable, it is not always easy for one’s own family members to disregard their own prejudices towards the HI virus and those who are carriers of the virus. This inadequate support is linked to ‘secondary stigmatisation’ (Parker & Aggleton, 2002) and shame that a family member carries the virus. Family members’ rejection of the HIV positive individual is perceived as very isolating and devastating for her. Palesa illustrates this sense of despair and isolation when she talks about her cousin whose family is discriminatory.

> *They (the family) are helping her. (But) the other one she’s not helping, she don’t want to touch her.* In reaction to that, Palesa says her cousin wants to commit suicide.

When Palesa sees that her infected cousin’s sister ‘‘*don’t want to touch her,*’’ whilst other family members do touch her, it brings her understanding closer to the experience of her HIV positive cousin where she sees the desperation and hurt her cousin feels at this rejection. In this way Palesa is able to illustrate her own witnessing of the impact of stigma. This highlights her empathic understanding of and awareness of her cousin’s experience.

Although respondents were aware that not all members of a family will support the HIV positive family member, as mothers themselves, participants spoke with particular disapproval about the

possibility that one's own mother may not be supportive. They imagined a sense of hopelessness if one's own mother was insulting and held stigmatising beliefs.

> *Sometimes I know some mothers are not good to their children if they are HIV positive, ja, they take you eish, they separate you from the children...Hm, ja even your own mother will be insulting you. They say, 'Don't touch our things; don't touch our baby', everything like that. 'You will eat alone and don't touch everything we use', so eish, you get stressed (Andile)*

Andile speaks hesitatingly (*''hmm, ja'')* and her use of the exclamation *''eish''* reveal her shock and disbelief over the stigma that she perceives comes from their own mothers. Her repetition of *''eish''* suggests that it is hard for her to think of such lack of support for the HIV positive mother and that stigma could come from such close sources. Her disbelief that a mother could be stigmatising is linked to the maternal ideal that a mother will never abandon and forsake her child, and that she will always be available to care for that child (Hays, 1996). It can be suggested that participants perceive stigma to work by serving to isolate the HIV positive mother within her family as her own flesh-and-blood will treat her with contempt (*''her own mother will be insulting'')* and in a discriminatory way.

Apart from family, respondents perceived that HIV/AIDS is shameful for all those associated with the HIV positive mother. Cindy explains succinctly how stigma can isolate the HIV positive mother when her friends abandon her for fear of being associated with her shame.

> *She's thinking about, 'Now I've got AIDS, I'm dying'...And then the friends don't want to see her, see. Because if you've got AIDS the friends is running away... They scared because, they shy and you'll be shy because you sick. (Cindy)*

Cindy highlights self-shame *''you'll be shy because you sick''* (which is linked to the stigma of others) and the shame that others feel over the infected individual's positive status. By virtue of association, those close to the HIV positive mother will feel shame and *''don't want to see her.''* The perception is that having friends who ''run away'' for fear of being associated with the shame of HIV, leaves the HIV positive mother with less support. The understanding is that stigma has the capacity to spill over from those initially stigmatised to those who are close to them (Parker and Aggleton, 2002).

Shame

Shame emerges in relation to HIV as being linked with immorality. By introducing stigma that associates HIV positive people with immorality, they are looked upon shamefully as being deviant. Thus HIV positive mothers are shamed as they are assumed to have contracted HIV through promiscuity, as opposed to contracting the disease in a different way (de Bruyn, 1999). Participants expressed their understanding of this process.

> *Because when you got the HIV, the people they don't know, you see they are thinking maybe you sleeping around...From my side, its shame. (Palesa)*

Palesa suggests that an HIV positive status can be perceived by others to mean that the infected individual was promiscuous. Her perception is that this knowledge links HIV infection with shamefulness. This links to Cindy's perception (above) of the shame that infected individuals face due to the stigma of others.

Similarly Diketsang draws on the popular assumption of promiscuity when she says,

> *Other people just like to put their remarks, Ja man she was having a lot of boyfriend, those funny things, even though they didn't know other side of the story. Sometimes you can be HIV it doesn't mean you are having a lot of boyfriend. Maybe somebody rape you you can be affected. There are lots of things that can happen for you to be HIV (Diketsang)*

Diketsang suggests that shame is related to promiscuity. Although Diketsang is aware of popular prejudiced assumptions of infection (''*she was having a lot of boyfriend*'') the above quote implies an insistence that it could be something other than promiscuity that led to her infection. Diketsang says that ''*other people*'' automatically perceive the infected individual as being promiscuous and this becomes the only version of infection that is spoken of. The ''*other side of the story*'' is perceived by Diketsang to be disregarded, as stigma only allows one telling of the story. All other versions (however truthful) are silenced. Another version to infection could be ''*rape*'' which implies powerlessness, and is opposite to promiscuity. In this way Diketsang does not challenge the popular assumption that shame is about punishing promiscuous people. She highlights that it is not the infected woman's fault as she was not sleeping around. The unfairness

is that for Diketsang, the infected woman was not sleeping around and still became infected. In this way, shame is perceived to be linked to promiscuity.

Stigma due to Perceptions of Vulnerability

Diketsang illustrates how stigma is perceived to lead to a lack of trust in the HIV positive person. All sorts of frightful fantasies are played out in one's mind when one interacts with the HIV positive individual. Diketsang describes a tension where the person swings from being irrationally emotional to rationally aware of the extent of the actual danger.

> *You know for the first time when he (her friend) come to my place and tell me he was HIV, you know when somebody start to tell you he is HIV, you start to be scared, ooh you gonna. But since he tell me, ah, tsk, we just friends I don't have a problem...You know after he tell me ne, he used to bring some apple to me and then when he go ne I just throw in the bin. Sometimes he bring the pie from Woolworths and I would say, 'Aah this one maybe he just cut himself,' It is my mind. 'Maybe he just cut and pour in this. He want me to be affected.' But later I say, 'No man let me not take this guy like this, maybe he is not doing this. I am just imagining maybe he is doing that.' But these days I don't have a problem. (Diketsang)*

Diketsang remembers her initial reaction to her friend's disclosure. She highlights the immediate fear which is then replaced by complete acceptance when she says, ''*you start to be scared, ooh you gonna... But since he tell me, ah, tsk, we just friends I don't have a problem...*'' However her emotional reaction was not that fixed and she swayed between being irrationally fearful and doubtful (when she thought her friend may purposefully infect her) to reminding herself rationally that it is her mind (''*It is my mind... I am just imagining'')* that is creating her paranoid fears. This highlights that although respondents show much support to their HIV positive family and friends (''*we just friends, I don't have a problem'')*, there is a significant amount of fear of being vulnerable to HIV/AIDS.

Conclusion

When one reviews the responses of the participants with regards to disclosure and support, it becomes clear that the issue of stigma is inextricably linked. Participants cited the benefits of disclosing one's HIV positive status but warned that such disclosure should be conditional. HIV negative mothers were acutely aware of the reasons that the avenue of non-disclosure was taken. Predominant themes surrounding non-disclosure were linked to issues of stigma, shame and discrimination. Respondents sought to normalise the HIV positive mother by portraying her as non-promiscuous, in order to ensure that she was not seen as aberrant or deviant. They were explicitly aware of stigma and made much effort in being non-discriminatory. HIV positive mothers were viewed as ''*good*'' , as ''*a normal person*'' and not to blame for their status as there are perceived to be stories other than the story of promiscuity that led to infection. At the same time mothers interviewed were acutely aware of the forms that stigma and discrimination took in everyday behaviour and were able to link it to feelings of vulnerability. Their empathic understanding and willingness to support were very evident and came across strongly throughout the analysis.

1.2 Vulnerability

In the above analysis, HIV negative mothers were found to be supportive of the HIV positive mother. They made every effort to demonstrate that she was 'normal' and ordinary' like they were. Although respondents show much support to their HIV positive family and friends, there was evidence from Diketsang's statement (about her initial reaction to her friend's disclosure) of fear and hyper-vigilance around being vulnerable to HIV/AIDS. The following analysis focuses on HIV negative mothers' perceptions that everyone is at risk for contracting HIV/AIDS.

Respondents expressed fear that anyone is susceptible to contracting HIV/AIDS, and that one may have it but be unaware. Palesa talks about the high prevalence of HIV/AIDS and the widespread fear around the uncertainty of one's HIV status.

> *Now half the people got HIV and half is not. They talking about HIV on the radio, like me you don't know, maybe I got HIV or maybe you got HIV.....maybe you going to the doctor today to check up and you going to get it. (Palesa)*

Palesa suggests that HIV is widespread when she says, ‘‘*Now half the people got HIV.*’’ She further states that public broadcasting ensures that people are aware that they are vulnerable as there is much AIDS-talk in the media. Her feeling that everyone is at risk is emphasised as she says, ‘‘*like me you don't know, maybe I got HIV or maybe you got HIV.*’’

Cindy puts forwards a similar view of the uncertainty of one's HIV negative status. She says, *‘‘Now you see me I'm laughing and maybe I've got AIDS now...I don't know because the doctor is not checking me’’ (Cindy).* Cindy suggests that although her good humour may indicate good health, this may not be the case as she is unaware of her status. Cindy emphasises that one is vulnerable even if one is found to be in good spirits as one's good health does not mean that one is immune from the disease.

Gertrude echoes Palesa and Cindy by stating, *‘‘I don't like HIV because somebody can get it anytime’’ (Gertrude).* Here, she puts forward the prevailing perception that everyone is at risk and that no-one is immune from HIV/AIDS. HIV infection is seen to be unpredictable where people can be infected ‘‘*anytime*.’’

Unfairness of HIV Infection

HIV/AIDS-related vulnerability does not apply only to its unpredictability. Respondents perceived that vulnerability to the disease applied to all people, however unfairly. Andile puts forward the idea that even when one is ‘‘*good*’’ one is not immune from contracting the virus. She says,

> *Ja, you think of your life, because if I think that I was good, but now I've got disease. Eish! Ja, its going to kill you. (Andile)*

Andile implies that life is not always fair and that even people who are deserving of good things are also at risk. HIV-related vulnerability extends to concerns around being good versus being bad and the unfairness that HIV's lack of discrimination leads to. In considering this, Bongiwe discusses her experience of HIV/AIDS on innocent victims, which serves to illustrate the extent of perceived vulnerability. Bongiwe draws on media images that inform her belief that everyone is vulnerable to HIV/AIDS. Even when people are responsible, it is difficult to know who to

trust, as even the expert and trustworthy medical industry could infect. As a result, there is a sense of unfairness that nobody is immune to this disease.

> *That time when I was in Cape Town I heard about this nurse who was HIV positive and she's in the department of family planning and then I heard she was infecting the girls. She was injecting the girls and she put the HIV thing in that. Sometimes you can get it like that. Also I heard a story about a child from P.E. This child he needed blood and then the doctor they have to put blood in his body. I don't know I never need blood. I think if you need blood the doctor must test it first before, but this child needed this blood and the doctor pour this HIV blood in him. He was 6 months. And when they were doing this test they find he is HIV positive. And the parents were not. His father, or his mother, when he hear the news he get a stroke and they both got sick and they couldn't look after the baby and the doctor wasn't doing nothing about that. It was a sad thing and the boy end up dying. (Bongiwe)*

Bongiwe draws on the fear of being infected purposefully or through negligence. She draws on stories of ''*girls*'' and ''*a child from P.E*'' to indicate that children who are innocent and helpless are also vulnerable to HIV. The horrifying aspect of her two stories is that the victims were infected by trusted medical professionals whose job it was to protect the innocent children. In this way, she formulates the process of infection as having little protection from those entrusted to protect as even innocent children are easily infected. This highlights the unfairness of HIV infection where the innocent are equally vulnerable.

The notion that everyone is vulnerable extends not only to innocent (nameless) children but also to people who appear to be larger than life: popular celebrities. HIV/AIDS has become so common that the media portrayals of celebrities dying of HIV/AIDS have become numerous and also remind people that no amount of power and status can protect one from infection.

> *You know my mother she just hear those things from T.V. They say AIDS, AIDS, AIDS and she see a lot of people on the T.V they are dying. They say because of AIDS. Those celebrities on the T.V they die because of AIDS so she is feeling painful...Like this guy who was announcing weather. Do you know that guy on SABC1? He just died of AIDS.*

Ja he dies because of AIDS... Ja because even Brenda (Fassie). They were announcing on the TV. That she dies because of AIDS what-what (Diketsang)

Diketsang highlights the extent of AIDS-talk in the media when she says, ‘‘*They say AIDS, AIDS, AIDS.*’’ It appears that it is difficult to come to terms with the prevalence of HIV/AIDS and it becomes more pronounced when popular media images succumb to this disease, showing that anyone can be vulnerable to it. However, what is of interest is her perception that Brenda Fassie ‘‘*dies because of AIDS.*’’ The medical report showed that Brenda Fassie’s death was the result of an asthma attack which led to cardio-respiratory arrest. Diketsang’s perception of the singer’s death being due to AIDS implies the extent of her preoccupation with the disease where everyone is suspected to have died of ‘‘AIDS’’ even when medical reports and the media report otherwise.

Personal Experiences of Vulnerability

The perception that everyone is vulnerable does not just include reminders through stories of nameless innocent victims or popular media celebrities. Bongiwe brings this vulnerability closer to home when she relates her own experience of feeling vulnerable.

When Bongiwe was expecting her first child, she heard that her neighbour was HIV positive. She describes her reaction.

You know I was so frustrated and I was, I felt, I was thinking of that little one (neighbour’s child). Because she was very sick. ..I was shocked. I even cried when my sister told me this girl is HIV positive. I, you know, I feel, what if she dies and whose gonna look after this baby. What if it can be me who’s HIV positive, what would I do? So I was crying. (Bongiwe)

Bongiwe speaks hesitatingly. Her faltering speech indicates much emotion to the content of her speech. She speaks of her intense emotional reaction to the news of her neighbour’s HIV positive status. Bongiwe describes that she was ‘‘*shocked*’’ and ‘‘*frustrated*’’ and suggests that although her neighbour was ‘‘*very sick*’’ she did not expect that she was HIV positive. As a future mother, Bongiwe’s immediate concern was for the child. Having not expected this news Bongiwe

suggests that her shock at her neighbour's status made her aware of her own vulnerability when she says, ''*What if it can be me who's HIV positive, what would I do?*''

In contrast to Bongiwe's emotional reaction of immense fear and shock, which she expressed through crying, Diketsang illustrates an opposing reaction to the high prevalence of HIV/AIDS and one's vulnerability to it. Diketsang appears to defend against feeling vulnerable. She highlights that people are vulnerable to death in general and that she has come to terms with it**.** She says,

> *You know if mine, this thing can happen I won't have a problem. If that thing can happen to me I won't have a problem... Because I just tell myself one day, nobody is gonna stay in this world for permanent. We are all going to die but with different ways. Maybe others there will be a car accident, others they just fall down. It is gonna be lot of different but I won't have a problem. (Diketsang)*

Diketsang explains that since it is inevitable that people must die, she is not afraid of HIV/AIDS as it will merely lead to death the way a car accident will. Her repetition of ''*I won't have a problem*'' suggests that she feels the need to reassure (either herself or the researcher) and make clear that she will not be affected if she contracted HIV. Her complete lack of emotion suggests that she deals with the vulnerability of contracting HIV/AIDS in a different way to Bongiwe's emotion-filled reaction.

Bongiwe and Diketsang discussed their personal reaction to their feelings of vulnerability. Below, Palesa also discusses her personal experience but through a different perspective, through the lens of stigma and social vigilance.

> *Like some people, if you got T.B, if you got asthma, if you lose weight, they think its HIV you see...Like sometimes me I was fat, sometimes I was thin. When I was fat they say I was pregnant. When I was thin they say maybe I'm sick....Ay, I don't care....I know myself....I don't sleep around....and I don't trust my boyfriend. (Palesa)*

Palesa illustrates that everyone looks to everyone else for signs of the disease. There is thus a fear of association through common physical indicators like weight loss or other illness like T.B. Her reaction ''*Ay, I don't care*'' suggests that she feels immune from the stigma of others

concerning her HIV status as she trusts that her own actions make her less vulnerable. This is illustrated when she says, ‘‘*....I know myself....I don't sleep around...*’’ However, her vulnerability is shown when she states that she does not trust her boyfriend, indicating that she is not in complete control of her health and safety. Although she ‘‘*doesn't care*’’ as she feels she is less likely to contract HIV/AIDS, she had to admit to herself that she was still vulnerable.

Vulnerability and Gendered Action

Respondents' fear of being vulnerable to HIV/AIDS led them to take action to counteract their fear. Palesa demonstrates this when she says,

> *Every week I'm going there to see my boyfriend. I tell him every month we must go to the doctor to check up. If we get sick we gonna get treatment immediately... He said 'Yes'. He's scared. (Palesa)*

Palesa suggests that the issue of feeling vulnerable did not extend only to women. She recognised that men also feel vulnerable to HIV/AIDS. However, it was women who were perceived as bearing the responsibility for safety, and to inform their partners about potential risks and ways of protecting each other. In this way, the respondents' vulnerability allowed them to be proactive in their sexual health.

Similarly, Siyanda explains the woman's role in aiding in them being less vulnerable to HIV/AIDS.

> *No, especially black people, we don't easily understand, our men, they don't understand if you say they must use condoms, they don't easily understand. But if you teach your men to be like that in the beginning, they will advise both of us to take care of ourselves....Ja, my man he understand... Most of the time I talk to him that we must use condoms, we must prevent, maybe until we can go and do the blood test. (Siyanda)*

Siyanda suggests that black men ‘‘*don't understand*’’ safe sexual practices so it becomes the responsibility of the woman to ‘‘*teach your man*’’ and ‘‘*talk to him*’’. By talking to her partner and giving him advice she implies that men can learn to be responsible. In this way, she suggests that it is up to the woman to ensure a decreased vulnerability to HIV. However, she goes on to say ‘‘*I'm just scared (to get tested for HIV)...because my children's father...has died so I don't*

remember what killed him but I am afraid to go and test'' (Siyanda). Here, Siyanda reveals that although she is responsible for her and her partner being protected from HIV/AIDS, there is fear that comes with being responsible. Her fear is linked to her ex-partner's death where the cause of his death is unclear. Although she ''*can't remember what killed him*'' she is ''*afraid to go and test*'' possibly for fear that she may be vulnerable.

Conclusion

The mothers in this study felt vulnerable to HIV infection when they considered the uncertainty and unpredictability of the disease that was non-discriminatory in its target. There was a sense that anyone (however undeserving and innocent) could be infected at any time, and through various unpredictable means where even health care professionals cannot serve as protection. Media images are perceived as spreading the fear of vulnerability through reports of AIDS-related deaths of well-known personalities. Respondents reacted to the perceived hyper-vigilance surrounding HIV infection by becoming intensely emotional or by showing very little emotion. There were attempts to control feelings of vulnerability by attempting to carry out protective measures like HIV testing and educating partners. However much responsibility the mothers in this study attempt to carry within their relationships, the fear that everyone is at risk for HIV infection is predominant.

1.3 Perceptions of Blame

Having discussed the vulnerability that is felt by the respondents in this study in terms of contracting HIV, this section looks at the ways in which respondents perceive infection to occur. This section is based on the research question that sought to determine how respondents perceived Thandi to have become infected. The vignette presented in interviews does not specify how Thandi became infected. Participants' often spontaneous speculations regarding how this happened are therefore informative of perceptions of blame.

Reluctance to blame the HIV positive mother

Respondents were eager to put forward that the HIV positive mother is not to be blamed for contracting the virus. They perceived her infection to be a ''*mistake*'' which was ''*not her fault*''.

She must see, your mother it's not her fault she got HIV positive. It was a mistake (Cindy)

Cindy suggests that the child of the HIV positive mother ''*must see*'' that her mother is not to blame for having contracted the HI virus. It is an appeal to ''*see*'' or to bear witness and thus validate her mother's innocence. This is implied in Cindy's insistence that ''*it's not her fault, it was a mistake*'' and suggests that the HIV positive mother did not choose to contract the virus.

In a similar manner, Gertrude calls into existence an audience that bears witness to the virus and to the fact that infection happens by accident. Here she suggests that not only should people ''*see*'' but they ''*must listen*'' in order to understand the seriousness of the disease.

The people they understand when you tell the truth, (they) must listen. HIV is not a ball to play. Somebody gives it to you, by mistake (Gertrude)

Not only does Gertrude appeal to the senses *(''must listen'')* to bear witness but she also appeals to the audience to ''*understand.*'' Both Cindy and Gertrude suggest that it was a ''*mistake*'' but Gertrude goes further to suggest that ''*somebody gives it to you*''. In this sense it is implied that the HIV positive mother is the victim, who had no control over contracting the virus. Her comment that ''*HIV is not a ball to play*'' highlights the seriousness of the diagnosis of HIV/AIDS and suggests that people do not behave irresponsibly. In this way, her line of thinking shows that because being infected with HIV/AIDS is so serious it had to have been a ''*mistake*'' and not something that one chooses for oneself hence ''*somebody gives it to you.*''

Like Cindy and Gertude, Thobeka also perceives that the HIV positive mother contracted the virus without intending to.

They must support her because she didn't know that she got the HIV. She didn't know (Thobeka)

Her repetition of ''*she didn't know*'', suggests that she is not to be blamed as she was unaware. Thobeka suggests that people should not only acknowledge and understand that the HIV positive mother is not responsible for having contracted the disease, but because she is the victim, she should be supported.

Added to their perception of the HIV positive mother as a blameless victim in need of understanding and support, the mothers in this study highlighted her similarity to them. Siyanda talks about her HIV positive neighbour.

> *I think she is like all other mothers. It is not that if you get HIV you're a loose person… Ja, it's not that you're loose, because you can get HIV through other things, it's not just having sex with many people. So I don't think she's bad. She's like all other people She's an ordinary person, she is like all other people… She is not different. She is not different… She is an ordinary person, she is like all other people. We must treat her like all other people, no changes. If she's my friend, she'll stay my friend. It won't change anything...Yes she's like all other mothers. (Siyanda)*

Siyanda shows a strong need to emphasise that the HIV positive mother is ‘‘*like all other mothers,*’’ ‘‘*like all other people*’’. She repeats these lines many times, suggesting an insistence that the HIV positive mother is ‘normal’ and ‘‘*ordinary*’’. This means that nothing can be drawn upon to distinguish her from uninfected mothers. The HIV positive mother cannot be said to be ‘‘*loose*’’ or ‘‘*bad*’’ or ‘‘*different*’’. She is rather the opposite, that is, good and faithful and ‘‘*no changes*’’ to how she was when she was not infected. In this way Siyanda makes a case for not labelling the HIV positive mother in a negative way by asserting that she could have contracted the disease in other ways, ‘‘*it's not just having sex with many people.*’’ Siyanda's suggestion to perceive her to be ‘‘*like all other people*’’ allows her to make a case for not discriminating against the HIV positive mother as she is perceived to be non-promiscuous.

Promiscuity and issues of Blame

As discussed above, participants perceived that the HIV positive mother was not to blame for her infection as she contracted the virus ‘‘*by mistake*.’’ This served to take away responsibility from her, and place it elsewhere by suggesting that ‘‘*somebody gives it to you*’’. However, when it came to actually identifying who that someone was who infected the HIV positive mother, respondents were ambiguous. Respondents tried to remain neutral in terms of blame. The following analysis illustrates that blame is perceived to be a vexing issue.

When asked how she thought Thandi became infected, Gertrude said, *''I'm not thinking because sometimes your boyfriend is not straight and sometimes you are not straight either. I don't know who's straight and who's not.'' (Gertrude)*

Gertrude was reluctant to blame either partner and her desire not to make a suggestion is shown when she says, ''*I'm not thinking*''. It appears she feels uncomfortable having to be placed in a position where she must make a choice.

Although the mothers in the study were reluctant to blame either partner, Siyanda shows how the reluctance to blame can slip and shift. She began by considering that both partners could be equally responsible for infection as either partner could have been promiscuous.

> *She can have got the disease through his (her) man because sometimes your man can go and get the disease outside and bring it to you... Sometimes maybe she was a loose person. (Siyanda)*

However, it became difficult for her to remain completely neutral with regards to issues of blame. This is illustrated when Siyanda settles on who to blame. Siyanda soon says :

> *I think we get it through our men because there are some loose men here who sleep around and carry the disease. Maybe Thandi got the disease from her (pause) her man brought the disease… Most of the times, because we mothers, most of the times we don't go sleeping around, because if you are married you just wait for your man. (Siyanda)*

Siyanda reframes how she speaks and identifies herself as part of the group of women that she speaks about when she says, ''*we mothers*''. When she places blame on ''*our men*'' she joins with Thandi as ''*we mothers*''. In this way, she links her own experience of being a mother with Thandi's experience when she says, ''*because we mothers, most of the times we don't go sleeping around, because if you are married you just wait for your man''*. This illustrates that she perceives mothers to be faithful, and not promiscuous, and hence more responsible than men. Her perception is that women contract the virus from their partners.

Safe sex, Power and Gendered Relationships

In order to fully understand how respondents in this study came to identify with the HIV positive mother (as shown in Siyanda's speech above) and did not perceive the HIV positive mother as blameworthy, it is necessary to consider gendered, heterosexual relationships. Diketsang highlights negotiation of safe sex in heterosexual relationships. She outlines various reasons for the mother's HIV infection, but none of the reasons point to the mother herself.

> *According to Thandi's story ne, she sounds like maybe she is very quiet.. .like you can have one boyfriend ne only to find out that the guy maybe had HIV and most of the people who doesn't go for testing, they don't know their status... because if you meet a partner and the partner tell you, 'You know my status is this' it means you are going to keep on using condom for life… So, but according to Thandi it means she just meet the partner and he didn't use condoms so that is why she was affected... Like some condoms they are not 100 percent. You can use it and the condom can show you their true colours. (Diketsang)*

Diketsang's reading of the vignette suggests that she sees Thandi as someone who is ''*very quiet*'' and in a sense impotent. She perceives Thandi to be quite powerless in negotiating safe sexual practices when she says, ''*it means she just meet the partner and he didn't use condoms so that is why she was affected...*'' Diketsang perceives safe sex to be the partner's responsibility and although she plays down his role (''*don't know their status*'') by drawing on ignorance, she subtly rests blame and responsibility upon him solely. When Diketsang places blame on the defective condom which is not always ''*100 percent*'' she implies that even if the partner is not to blame, the woman is still blameless.

Similarly Cindy perceived that the HIV positive mother was not to blame as she is powerless in a heterosexual relationship. If the woman suggests the use of a condom, and the man refuses as he wants to ''*sleep meat by meat*'' she has no power to negotiate around her own health.

> *I'm not blaming Thandi. Cos Thandi don't know nothing. If I'm finding a boyfriend outside and he says, 'Cindy I love you', I'm not a doctor. I will love him (make love to him) because I love him neh. I don't know if he's sick, or what. Me, I say, 'Lets use a condom'. He say, 'No I don't want to use a condom. Must sleep meat by meat' (laughs)*

> *So what must I do? Maybe I get pregnant. I go to the doctor the doctor says, 'Cindy you got AIDS,' what must I do? It's not my fault. (Cindy)*

Cindy states explicitly that she does not blame Thandi. She draws on her own experience of the delicacy of negotiating safe sex to show that women in general have less power than men. With regards negotiating sex (''*If I'm finding a boyfriend outside and he says, 'Cindy I love you', I'm not a doctor. I will love him*'') and to negotiating condom use (''*He say 'No I don't want to use a condom.'')*, she highlights how the man's desire is more important. Cindy also illustrates very clearly her understanding that her actions can very easily lead to her being infected when she says, ''*So what must I do? Maybe I get pregnant. I go to the doctor the doctor says, 'Cindy you got AIDS,' what must I do? It's not my fault.''* This quote also shows her perception that she has no choice and that should she become infected it will not be her fault as she was helpless *(''what must I do?''*)

Siyanda concurs with Cindy and Diketsang and goes further by contextualising the predicament of women in general. Siyanda draws on the power dynamics between men and women, where in her culture men are regarded as the ''*head of the house*'' and as such must be obeyed without question.

> *Especially in our culture, we blacks, the men say, 'I'm the head of the house, so the woman can't tell me what to do.' They say, 'I'm the head of the house, you can't tell me anything…' Ja the women must be under the men (Siyanda)*

Siyanda places in context the perceptions of respondents. She emphasises that in her culture, men are considered the leaders and decision makers. As such the role of women is to follow the decisions made by the head of the household. She repeats, ''*so the woman can't tell me what to do,'' ''you can't tell me anything''* and *''the women must be under the men''* to highlight the inability of women to speak (''*you can't tell me'')* and make decisions. It is suggested that women's voices are not legitimate and have to therefore be suppressed. This possibly explains Cindy's remarks that although she understands she could be easily affected, the decision for condom use is not for her to make.

Conclusion

Respondents were initially reluctant to place blame for HIV infection on either partner. The discussion then opened up to issues around gendered power relations. The perception was that mothers were more responsible and faithful in relationships, and were therefore victims when they became infected. Positioning infected women as mothers allowed the respondents to get close to the experience of the HIV positive mother and allowed them to identify with her around issues of power and responsibility. The perception was that the infected mother contracted the virus ‘‘*by mistake*’’ Although they were aware of their own role in bearing responsibility for safe sexual practices they were also aware of gendered power dynamics that made negotiating safe sex a delicate issue. Cultural attitudes to gender were also highlighted as allowing for women to be vulnerable to infection. Respondents were explicit in holding men responsible for infection and also placed blame on condoms that were not ‘‘100 percent’’ thus avoiding placing blame on the mother.

SECTION 2

2. Perceptions of Motherhood

The following section looks at the ways in which the mothers in the study perceive the HIV positive mother in terms of her role as mother. The section begins with an analysis of the ambiguous ways in which they perceive the HIV positive mother. The analysis then explores issues around the practice of breastfeeding in order to explore how the infected mother's status renders her both similar and different to the mothers in this study.

2.1 Perceptions of the HIV positive mother as similar

Respondents made an attempt to identify with the HIV positive mother. ''*If that situation in me, hey, I don't know how I'm going to handle it....If I think about her... eish*'' *(Andile)*. Their empathic responses and attempts to understand what she may be going through made them think about themselves in her place. They tried to identify with the HIV positive mother and found it hard to imagine how they would cope. ''*Hmm, I just feel that if I was Thandi what I was going to do*'' *(Diketsang).*

Respondents' identification and empathy with the HIV positive mother allowed them to see her as both similar and different to themselves. Their perceptions and identification with the HIV positive mother were not always clear and the slight ambiguities and contradictions in the mothers' speech will be highlighted.

Participants' explicit perception was that the HIV positive mother was normal and healthy like the respondents were. A closer reading of their speech, however, shows contradictory perceptions exist simultaneously. Thobeka's quote below illustrates this clearly.

She's (Thandi's) just like normal children normal girls. (Thobeka)

Although Thobeka wishes to show that there is not much of a difference between her and Thandi (in that she is ''*normal*''), the absence of herself in that comparison is telling. She does not compare herself with Thandi but with other ''*normal children, normal girls.*'' By likening Thandi to that of ''*normal children*'' it is suggestive that she sees Thandi as naive, immature and inexperienced as children in general may be. However, when one considers her perception of

young girls from her interview, her perception of ‘‘*normal children’’* and ‘‘*normal girls’’* does not include innocence. In the interview with Thobeka, she emphasised that her perception of young girls in these times (compared to when she herself was younger) is that they are far more promiscuous ‘‘*And the girls got 2, 3 boyfriends*’’ and that they have children at a much younger age ‘‘*the young girls now, 13 years, 14 years, they got a baby now*’’. In this way it can be suggested that she perceives Thandi to be ‘normal’ much like the girls she disapproves of, and implies that for Thobeka ‘normal’ means that Thandi conforms to the ways in which young girls are in general. Mothers in this study were not told Thandi’s age in the vignette and Thobeka’s response shows that she perceives Thandi to be young and reckless much like her experience of the young girls she knows of who she perceives as being promiscuous. Although Thobeka insists that Thandi be portrayed as ‘‘*normal*’’, Thobeka highlights that ‘normal’ is a relative concept and refers to the young girls of this generation and does not imply that ‘normal’ is necessarily what she respects and agrees with.

Siyanda, however, does include herself in the comparison when she says that she and Thandi are the same. Siyanda, below, perceives herself to be the same as the HIV positive mother in that she has to still be cautious and behave as if she is HIV positive as everyone is vulnerable. In this way she identifies with the HIV positive mother. She says,

> *I think we are the same. I think we are the same... Well when I was pregnant I had no status, I was negative....(but) I was supposed to be careful because even when I gave birth, I wasn’t, I was negative, but it can happen that when I am giving birth I can contract the disease, so even if I was negative, I was supposed to take much care...we are both mothers, there is no difference (between her and Thandi). (Siyanda)*

A closer analysis suggests that Siyanda stresses her sameness with the HIV positive mother. This is implied in her emphasis of ‘‘*I think we are the same, I think we are the same.’’* She draws on them both being mothers at the end to link them within the experience of mothering. ‘‘*we are both mothers, there is no difference’’* as an attempt to highlight that the HIV positive mother is ‘normal’ like her and that as mothers they have to ‘‘*take much care*’’ to protect their children. Although she identifies her sameness with the infected mother as a mother like her, it is motherhood that is suggested to bring about HIV infection. The idea that HIV comes with motherhood is illustrated when she says, ‘‘*when I am giving birth I can contract the disease*.’’

Andile also makes a link between herself and Thandi in the case study by identifying with her as a 'good' mother who suffers the way she does.

> *Ja, eh, I think Thandi is a good lady. Ja, who understands, Ja. Because in this world if you understand, problems come to you. I know that...I know. Sometimes you are suffering if you are good. You suffer if you are good Ja. So I think Thandi is a good mother, so that is why things are going like that. Because I know some people are doing bad things and like too much husbands, but they don't get, but if you are steady to your partner you will surprise that if you go to the clinic they will say you are HIV positive while you are still good. (Andile)*

Andile portrays the HIV positive mother as ''*a good lady*'' and ''*a good mother*'' and holds onto the belief that bad things happen to good people. This is indicated when she says, ''*You suffer if you are good*''. The implication is that the world is unfair when ''bad'' mothers who are promiscuous do not contract HIV/AIDS and that ''good'' mothers are victims of an unfair world. In this way, Andile is able to normalise the HIV positive mother by making her similar in terms of shared suffering in an unfair world.

Suffering was not just confined to contracting the virus if one was 'good'. Suffering was also linked to everyday financial hardships. Working-class mothers in this study all expressed finance as a central concern. Being mostly single mothers, they found it difficult to cope with the demands of providing for their children. They perceived the HIV positive mother to be like them as their suffering was the same.

> *Only different is I'm not HIV positive. That's only different. The other thing, I'm suffering. She's suffering you know. So nothing different exactly but its only one thing, I'm not HIV positive. It's a small difference because I'm suffering and she's suffering. (Thobeka)*

Thobeka suggests that her HIV status is a ''*small difference*.'' The fact that both mothers are suffering allows them to have a similar experience of survival in the world.

2.2 Perceptions of the HIV positive mother as Different

Not all mothers were keen to perceive the HIV positive mother as someone ordinary like them who joined with them in motherhood and suffering and not all thought the difference in HIV status to be ‘‘*small*’’. Diketsang perceived the infected mother's experience to be outside the range of normal experience.

> *Because my life and Thandi's life, mine it was normally (normal) but for Thandi's life it was just abnormal… Ja, because of that problem (HIV)…. The difference is gonna be the happiness. My happiness and Thandi's happiness they are not gonna be the same. Mine, it was excellent...(with Thandi) it's not gonna be excellent. Even she can be happy but sometimes she will think 'oh that thing' you know trauma, sometimes it come. Trauma is not always, but once you started to think about that it's just coming. (Diketsang)*

Diketsang suggests that being HIV positive throws one outside the experience of a 'normal' life. She says, ‘‘*Thandi's life it was just abnormal, Ja, because of that problem (HIV*).’’ However by virtue of being HIV negative, she perceives herself as 'normal' compared to Thandi. She suggests that HIV/AIDS is not just a virus that resides in and affects the body. It also has a psychological and social component. The effects of HIV/AIDS are perceived to extend to one's internal psychological state when she says ‘‘*The difference is gonna be the happiness*’’. While Diketsang's life experiences have allowed her to feel happiness, she is aware that the experience of being HIV positive can be traumatic. In this way Diketsang draws upon a psychological understanding where she utilises psychological concepts of trauma and intrusive memories ‘‘*sometimes she will think 'oh that thing' you know trauma, sometimes it come.*’’ This psychological understanding serves to define the HIV positive mother's experience as being 'abnormal'.

HIV/AIDS therefore, is perceived by some mothers to be a major difference which affects quality of life. Apart from a difference in happiness, a consideration of internal psychological states was drawn upon by Andile when she talked about the difference in perceptions about the future amongst infected and non-infected mothers.

> *Like I know me I am thinking like that disease, I think there's no life. If you are not working I can't even go and look for a job, or (because) I think anytime I will die. So you*

tell yourself, 'I better stay like that, because I am used to this, anytime I will die. So even, eish! It is very painful, Ja...Ja because I am not thinking that even, God knows I am going to die next week but I have got a hope that I will stay more than 20 years because I don't have that disease. So if you have diseases anytime you will die, but like me, I am telling myself that I will grow up until 100 years because I don't have that disease. That is my belief. I believe that Ja I will die late. But if you have got that disease and the doctors say you must come to the clinic, these days it stays long, long, long life but you don't believe...I know if the doctor said, I don't believe it. You think you will die anytime and leave your child alone...So you don't have power to do something for tomorrow. (Andile)

Andile suggests that there exists a difference in outlook on one's life that is determined by one's HIV status. She imagines herself in the shoes of a mother who is HIV positive and believes that her HIV status will be so devastating that she will become incapacitated, where she will think ''*there's no life*'' and ''*anytime I will die* ''. Her consumed worry about her impending death will mean that she ''*can't even go and look for a job''*. Her perception is that she is different to the infected mother as her health allows her a sense of a long future ahead. She is aware that she cannot be certain of a long life (''*God knows I am going to die next week'')* as nobody can foresee the future. However, her HIV negative status gives her ''*hope''* that she still has time to live a long life. Her perception is that once a person is HIV positive, their self-talk (''*you tell yourself,...anytime I will die*'') combined with the virus itself *(''if you have diseases anytime you will die'')* will mean a shortened future with no hope (''*you don't believe*'') as the fear and vigilance of death will mean that ''*you don't have power to do something for tomorrow.''* Her illness transforms her into an impotent mother who lacks motivation and who has lost all hope, in contrast to the non-infected mother, who, although she cannot ever be certain as to the time of her death, can feel secure that her health allows her a longer life filled with hope. In this way, she paints a powerless and gloomy picture of an HIV positive mother.

Only two mothers in the sample had partners while the rest were single mothers. Although the vignette did not include Thandi's relationship history, it was found that mothers in this study perceived her to be single and without support, much like they were.

> *Its hard for her. You said she was confused ne. I think she's alone. Maybe she needs help. And in that case your parents, we not married but we have kids so at least if your mother is there or a boyfriend its better. (Bongiwe)*

Bongiwe empathises with the HIV positive mother when she considers how hard it must be for her. She perceives her as being ''*alone*'' and without the support of a mother or boyfriend who could advise her and alleviate her confusion. She identifies with the HIV positive mother when she makes a reference to them both not being married. Although she implies that she and the HIV positive mother are the same, as single mother, it must be highlighted that Bongiwe herself, although a single mother, has extensive support. Her firstborn lives with his paternal grandmother and his father contributes (together with Bongiwe) to the child's maintenance. Her second child is cared for by her mother and his father is also there to help Bongiwe financially. Although she mentions that ''*at least if your mother is there or a boyfriend its better''*, it should be borne in mind that she says this in reference to herself. This is not suggestive of the way she perceives the HIV positive mother: ''*I think she's alone*.''

The phrase ''*She's alone*'' was repeated across interviews and suggests that participants assume that the HIV positive mother is alone and abandoned because of her status. As a result participants perceive her as having limited or no support. This is captured by Diketsang when she says, ''*She sounds like she is lonely. Because it sound like she doesn't have support.''*

Bongiwe also perceives the HIV positive mother to be alone and abandoned.

> *I think maybe the boyfriend ran away from her because knowing of her status. He ran away so she's alone with her baby now...I think most of the time the boyfriends run away because of the maintenance part and they don't want to accept that you positive.(Bongiwe)*

Unlike the experience of the single, HIV negative mother, Bongiwe suggests that the HIV positive mother only became single when ''*the boyfriend ran away from her*'' after she disclosed her status. She perceives that ''*because of the maintenance part*'' the HIV positive mother becomes burdensome and is therefore abandoned. Another reason she puts forward is that the boyfriend cannot accept her status and this makes it harder for him to support her.

Similarly, Thobeka perceives that the partner abandons the HIV positive mother once he knows her status.

> *He not around. He won't help her. If somebody give you a disease he can't accept 'I gave you the disease'. He just run away. (Thobeka)*

She gives a different reason to Bongiwe. Thobeka perceives that his retreat is because ''*he can't accept*'' or take responsibility for infecting her.

Conclusion

In this subsection respondents drew on the similarities between themselves and the HIV positive mother, that they were '*normal*', they were '*mothers*' and that they '*suffered*' in the same way. The role of being a mother allowed them to identify with the infected mother. At the same time, they could not deny the differences. Only Diketsang and Andile, amongst all the respondents, explicitly pointed out the difference between themselves and the HIV positive mother by drawing on how her HIV status affects her psychological state where she will feel traumatised and have a sense of hopelessness. When it came to considering social aspects, however, respondents stressed that her difference (in being alone for example) was not due to her own doing, but rather the reaction and stigma of others in her environment. In this way, much effort was made not to blame her for any lapse in her mothering role and not to discriminate against her.

2.3 Breastfeeding

Since breastfeeding amongst HIV positive mothers is a complex and contested issue (Richter & Griesel, 1998) participants were asked specifically about feeding an infant when the mother is HIV positive. The question was posed to elicit where stigma was located within HIV positive motherhood. This section begins by briefly outlining respondents' perceptions of breastfeeding and HIV positive motherhood. It then goes on to explore the meaning that participants hold around the issue of breastfeeding in general in order to locate respondents' perceptions of breastfeeding amongst infected mothers. The discussion then concludes with a consideration of conditional breastfeeding where respondents explore instances when breastfeeding is not beneficial.

In the context of the practice of mothering, breastfeeding was important in being a 'good' mother. Breastfeeding was perceived to be part of the 'natural' activities of mothering. However, when the mother was HIV positive, breastfeeding was perceived to take on complex significations.

Respondents perceived that it was 'normal' to breastfeed a child as breastfeeding had many benefits. However, if the mother was ill, breastfeeding would harm her baby and she should abstain. This is illustrated when Palesa considers whether Thandi should breastfeed or not,

> *She mustn't breastfeed...(otherwise) baby gonna get sick more more more, she (baby) gonna die. (Palesa)*

Palesa's advice to Thandi would be that she abstain from breastfeeding as she will potentially make her baby very sick, thereby killing him. With regards to the HIV positive mother, respondents viewed the infected mother's breasts as dangerous and her milk to be unsafe and a carrier of disease and illness. Bongiwe illustrates the perception that the breastmilk is a carrier of disease when she says, ''*I think she mustn't give the breast, to keep the child safe from getting HIV.'' (Bongiwe) (p.1).* With regards to Thandi, and other HIV positive mothers, then, the respondents suggested that breastfeeding would be harmful to the child.

Although respondents perceived that the HIV positive mother's breastmilk was not ''*safe*'' for the child, they did perceive breastfeeding in general to be 'normal' and 'natural' and the best form of feeding a child. The following discussion looks at HIV negative mothers' perceptions of the benefits of breastfeeding in general in order to locate the perspective from which their advice to Thandi comes.

Respondents viewed breastfeeding as the work of a 'good mother.'

> *Good mothers they breastfeed. (Siyanda)*

Siyanda voiced the opinion of the other respondents when she suggested that it was the job of a 'good' mother to breastfeed. What makes breastfeeding part of 'good' mothering practices is the belief that breastfeeding is the best form of feeding an infant if the mother was healthy.

Andile concurs that breastfeeding is the first choice when she said,

What I know is that if you read that in the (formula) milk tin they will tell you that breastfeeding is better (than formula feeding). (Andile)

Here Andile suggests that she is not biased in her belief that breastfeeding is the first choice of nutrition. She draws on the authority of information that even the formula-makers agree that breastfeeding is better and healthier for the child.

Furthermore breastfeeding was thought to be **'**natural' and 'normal' as it facilitates a connection with the child and is an activity that makes one 'feel' like a mother

It is not normal (not to breastfeed). Ja, ja, ja, you feel like you are working for that child, even, you don't have connection with that baby. I think breastfeeding is connecting you to the baby...you feel like a mother if you are breasting the child. (Andile)

Andile articulates quite clearly her view that ''*it is not normal*'' not to breastfeed. She suggests that breastfeeding serves as a connection for mother and baby and by not breastfeeding it appears she is saying that there is no natural connection. She also draws on the maternal ideal that a mother's job is not 'work' as it is 'normal' (when she says, ''*you feel like you are working for the child''*). Thus it is perceived that in the absence of any 'natural' connection, child-care becomes 'work'. The assumption, that ''*you feel like a mother if you are breasting,*'' suggests that the mother's role is a normal and natural one where the exclusion of breastfeeding makes it artificial to the experience of being a mother and impacts not only her own feeling of being like a 'normal' mother but also her connection with her child.

The dominant perception that breastfeeding is 'normal' and 'natural' appears to stem from respondents' common mothering practices within their families and communities. The belief that breastfeeding was the right way to nurture a baby arose due to the predominance of breastfeeding in their culture and because it was taught to them by their own mothers who advised that it was the best way to raise healthy children.

Um, like our culture we do that (laughs) so if we give the baby breastfeeding it is growing stronger and that I was taught by my mother. (Andile)

Andile attributes her belief that breastfeeding is beneficial to the child to her culture. Cultural knowledge is passed along to her through her own mother.

Andile elaborates on the knowledge that breastfeeding is beneficial to the child. With regards to raising healthy children by breastfeeding, the perception was that breast-milk safeguards the baby from illness and helps the baby be more resilient.

> *Ja, if you breast your child, even like small diseases, if you breast your child, your child will survive the small diseases like flu, what-what for children, but if you breast them it is good for that, but if you don't breast the child everytime you go somewhere – flu; if you go somewhere-stomach, what-what, ja. (Andile)*

Andile explains that breast-milk is important to allow the child to ''*survive the small diseases*''.

Apart from health benefits, breastfeeding was believed to be beneficial as it not only provided nutrition but also nurturance and love.

> *Okay the time I was pregnant they always telling us breastfeeding is important because when you breastfeed your child you give him or her love, rather than when you put him on the bed and you give bottle and you leave him alone. I mean when you breastfeeding it's very important because you give him love and I mean as you keep him on (the breast) you just watching him, how he drinks, you just love each other. (Bongiwe)*

Bongiwe draws on the perception that breastfeeding (as opposed to bottle-feeding) helps foster love and affection between mother and child. Breastfeeding ensures a physical closeness between mother and child, as opposed to bottle feeding where she says the child is put ''*on the bed*'' and ''*you leave him alone*''. She suggests that it is the physical closeness that fosters an emotional closeness with the breastfed child. By holding the child to her breast, the 'good' mother focuses all her attention onto the child (''*you just watching him*''). In this way, the ideal of maternal attentiveness is fostered and an emotional connection is formed.

For the mothers in this study who were all working-class, a further important benefit of breastfeeding was its practicality as it was cheaper than formula milk.

> *It's better because you not buying the milk. Maybe sometimes you are poor, you see...especially for the poor people. (Palesa)*

Palesa considers that ‘‘*especially for the poor people*’’ it becomes easier to breastfeed the child as it is an affordable choice.

The above discussion outlined the various ways in which the mothers in this study perceived breastfeeding as important because it is natural, less expensive and allows the mother to ‘feel’ like a mother. The following discussion shows how the respondents considered breastfeeding in relation to conditions that were perceived to be legitimate reasons to abstain from breastfeeding. It is important to bear in mind that the respondents, although opposed to the HIV positive mother breastfeeding, do not always portray the HIV positive mother as a distinguishable group in considering the reasons that women abstain from breastfeeding. The following is a discussion on the conditional aspects of breastfeeding.

Respondents suggest that if the mother is sick (in line with their advice to Thandi) or herself unhygienic, then she must not breastfeed. Palesa shows how this idea is generalised to all mothers, not just to HIV positive mothers. She says,

> *You know breastfeeding, the others is healthy, the others...like the others is not healthy, the others is drinking and after that they coming to give their babies breast you see. Better, if you stay in a dirty place, better you must buy the milk for your baby. (Palesa)*

Palesa considers the practicality of bottle-feeding when she considers the mother’s health and hygiene. If the mother is not in a position to be clean, ‘‘*if you stay in a dirty place*’’ or if the mother drinks alcohol and then breastfeeds her baby, then it is better if she abstains from breastfeeding. This is in line with the advice that the mothers in this study gave to Thandi, and illustrates that they view the breast-milk of certain mothers to be unsafe and dangerous to the baby. These would include drunken and sick mothers.

The perception that ‘dirty’ mothers should not breastfeed does not only apply to drunk mothers who live in dirty places. ‘Dirty’ mothers are also perceived to be those mothers who resume sexual contact with their partners whilst they are breastfeeding. Below Cindy shows how breastfeeding is conditional on the mother’s sexuality and hygiene.

> *The people give the baby the bottle because they want to still laugh outside you see...because....the baby gets the sickness if you feed the baby and then you sleep with the*

father for the baby....the dirty for the father for my baby came with me and me I feed my baby and baby get sickness. That's why if you got the baby you can't sleep with your husband. (Cindy)

Cindy suggests that mothers who are still interested in a sexual relationship after giving birth should abstain from breastfeeding in order not to spread their germs to their children.

Cindy explains that abstaining from breastfeeding in order to resume sexual contact with one's partner is not an easy choice to make. She explains the predicament between breastfeeding and abstaining from sexual practices.

If you have sex you spoil your daughter because your daughter is still young. So the people say, 'If I don't sleep with my husband, my husband is gonna run away. (Cindy)

It would appear that although the benefits of breastfeeding are perceived to be many, Cindy suggests that if she chooses breastfeeding over a sexual relationship, ''*my husband is gonna run away.*'' In this way, the fear of losing one's partner is the condition whereby mothers will choose to abstain from breastfeeding. This points to power dynamics between the mother and her male partner that makes her more willing to comply with sexual demands over demands to breastfeed.

Apart from hygiene (the mother being 'dirty') there are legitimate health reasons for not breastfeeding, as Andile explains below.

Um, like our culture we do that (laughs) so if we give the baby breastfeeding it is growing stronger and that I was taught by my mother. Unless someone has got breast cancer like my cousin was not giving milk to the baby. We know she's got a disease, she's got cancer so that is why she is not feeding... Ja these days people are surprised, why don't we breastfeed children these days, ja, everybody is surprised and talk and I know I am not okay. I have a problem of breast. But people don't understand that ja...they think you are HIV. Yes because its a common disease. (Andile)

Andile suggests that although culture dictate that breastfeeding is beneficial for the child's health (''*so if we give the baby breastfeeding it is growing stronger*''), this belief is not rigid or static. Breastfeeding is conditional. If the mother has an illness like cancer, it is acceptable for her to inform the community (''*we know she's got a disease*'') and abstain from breastfeeding.

However, if she abstains, without a reason, she is suspected of having HIV/AIDS (‘‘*they think you are HIV’’*). This implies that for respondents, breastfeeding is normative. Any option other than breastfeeding serves well only in certain cases like illness.

Above, Andile highlights that if a mother does not breastfeed – without a legitimate reason – her community assumes that her abstinence is linked to her being HIV positive. Below, Siyanda suggests that if the reasons for breastfeeding are not made public, this is not only an indicator of disease, but is seen as disregarding one’s culture in favour of a western value system. In this way mothers are quickly judged.

> *Ja my neighbour wasn’t breastfeeding. She didn’t breastfeed her baby because she was positive...In our culture breastfeeding is common, in our culture, so especially the in-laws, they wonder when you don’t breastfeed and they ask many questions why you are not breastfeeding the baby. They would want to know why...it is just that breastfeeding is among our culture so they think its funny for the baby not to be breastfeeded. They don’t understand if you say you mustn’t breastfeed it. They just think you are talking white...They would say you are jumping to other people’s culture so that is why they demand we breastfeed our babies. They don’t understand...They easily judge you. Cos they now understand that there is HIV. So they will go out and say ‘Do you see that one? She is infected, that’s why she is not breastfeeding.’ Like that. (Siyanda)*

It appears that Siyanda suggests that the dominant perception was that failure to breastfeed went against the cultural norm when she says, ‘‘*They just think you are talking white...They would say you are jumping to other people’s culture so that is why they demand we breastfeed our babies*.’’ Siyanda understands the dynamics of the overt stigma that HIV positive mothers experience if they refuse to breastfeed. The above quote also highlights how Siyanda places both infected and uninfected mothers in the same category when she explains how all mothers can be easily judged as being HIV positive.

Apart from the advice of their culture, the majority of mothers relied on the advice of medical experts when it came to issues of breastfeeding. Although all the mothers in this study breastfed at least one child (if they abstained it was due to resuming school or work after the birth), as it is

common to do so in their families and communities, they disregarded traditional advice when it conflicted with medical advice.

> *Ja, I mean for the culture. But if the doctor says, like if the doctor says we are HIV positive so you can't follow your mother because you have that disease so you can't breastfeed a child. (Andile)*

Andile suggests that medical advice over-rides traditional advice as mothers learn to value scientific advice over that of their own mothers when it comes to issues around HIV/AIDS. This perception, that it is acceptable to abstain from breastfeeding, is only made possible when the mothers located themselves within a more scientific framework. In this way, a voice was allowed that rendered abstaining from breastfeeding to be acceptable.

Conclusion

The vignette included breastfeeding as part of the maternal role when it asked of respondents whether they thought Thandi, the HIV positive mother, should breastfeed. All mothers in this study perceived Thandi's breast-milk to be unsafe for her child. In understanding how they came to this conclusion, this section dealt with their perceptions of breastfeeding in general. Respondents perceived breastfeeding to have many benefits, and believed that it was a 'natural' and 'normal' part of being a 'good' mother. Breastmilk was seen to be convenient and healthy as it safeguards the baby from illness. However, respondents also believed that breastfeeding was conditional and should be avoided if the mother was unhygienic or sick, or if power dynamics ensured that she may lose her partner if she follows her cultural advice and abstains from sexual practices. Although this condition was put in place, mothers in this study were aware of the stigma attached to not breastfeeding, and warned that choosing not to breastfeed went against cultural advice. They implied that should the reasons for not breastfeeding be hidden, the mother would be perceived as being HIV positive. Although they were aware of the stigma of their community, their own attitude was not to portray conditional breastfeeding to be unnatural. Rather, they suggest that the HIV positive mother is not alone in this predicament.

SECTION 3

3. Impact of maternal HIV on the child

This section deals specifically with the child of the HIV positive mother. The following analysis therefore looks at HIV positive motherhood from the perspective of the child. The first part of this section, *The mother-child relationship,* explores the impact that the infected mother's physical and emotional health has on her ability to care for her child. The next section, *Psychological and Social Impact on the Child,* looks at respondents' perceptions of the impact of the social world on the child, when they presume the mother to be dead.

3.3 The Mother-Child relationship

Healthy Living with HIV infection

Respondents suggested that with treatment the infected mother could live a normal life and mother normally. Siyanda highlights that the mother-child relationship should not be affected by the mother's HIV status when she says,

> *HIV doesn't change you if you take care of yourself, HIV is not like other diseases, it is now different, you can take care of your baby. (Siyanda)*

Siyanda suggests that with investing in one's health, one can remain unchanged and remain healthy. When she says, ''*HIV is not like other diseases*'' she means that now there is a way to treat the mother so that she remains healthy for longer and can, as a result, care for her child. Palesa concurs with Siyanda that the HIV positive mother can ''*still live*'' if she takes her treatment and suggests that the individual is able to live life as she did before.

HIV-related Worry

Compared to Siyanda, Palesa (below) shows a more personal understanding of the experience of the HIV positive mother with regards to issues around health. Although she suggests that there is hope with treatment and the infected mother can live a somewhat long and normal life, she also highlights that HIV cannot be ruled out of the equation. Palesa perceives much HIV related worry to coexist with 'normal' living. She says,

> *Can I give you an example. She's worried my cousin, she's worried. She's worried because she say, 'When I'm die whose gonna look after my daughter.' I said, 'No don't worry, we are here. We gonna take her to the clinic, don't worry, to the doctor. She gonna grow up.' She's worried too much. Maybe Thandi is worried (also), I don't know... (Palesa)*

'Worry' is much emphasised in the above quote. Palesa makes an easy link between Thandi and her cousin around HIV-related worry, at having contracted the disease, but more particularly, worry around the implications that having HIV/AIDS means for the child. Manapaiboon et al., (1998 cited in Long 2002) found that HIV positive women placed worrying about their family and children before worry about themselves. Likewise, Palesa's cousin appears to be overwhelmingly concerned about who will care for her child as she does not appear to believe that she will live a long life. This is implied when Palesa says, ''*She's worried my cousin, she's worried. She's worried because she say, 'When I'm die whose gonna look after my daughter'.*'' This illustrates that when thinking about the child, Palesa is aware that her HIV positive cousin perceives that she will not be alive to raise her child. It seems that in the context of thinking of the direct experience of her infected cousin, Palesa also perceives that her cousin will not live a long life.

Although the mothers in this study were hopeful about treatment aiding in a long healthy life, they were aware that HIV/AIDS brought much worry and concern to the HIV positive mother, as shown in Palesa's experience of her cousin. In particular, respondents believed that maternal concern is greater if the mother is HIV positive. Maternal concern is illustrated when Palesa says,

> *If Thandi is good she gonna worry too much, more more more worried. If she's a good mother. If she's not a good mother she won't worry she won't care. (Palesa)*

Palesa highlights the idea that a ''*good mother*'' worries about her child. She speaks these words as she talks about the impact that her cousin's HIV positive status has on her baby. In the interview Palesa compared her concern for her own child to that of her cousin's to suggest that being HIV positive creates greater concern for the mother. She then makes the link between her cousin and Thandi when she says that Thandi's ''*worry*'' will be extensive as she will be ''*more*

more more worried.'' This is the requirement of a 'good' HIV positive mother, whereas a 'bad mother' will not worry. Here Palesa highlights the maternal ideal of concern when she perceives that a good mother will invest herself in thinking about her child.

Diketsang also talks about maternal concern where the HIV positive mother ''*thinks too much*''.

> *She will think that maybe my child should not be born because of this disease. She will think too much about that (Diketsang)*

Diketsang suggests that the HIV status of the mother will create such a significant impact upon the child that she will consider not bringing her child into the world (''*my child should not be born*'')

For Palesa and Diketsang, the HIV positive mother is thought to invest ''*too much*'' in her ''*thinking*'' and ''*worry*'', unlike a non-infected mother. Below Andile and Thobeka elaborate on what it is they perceive the HIV positive mother to be worried about. Respondents tended to view the HIV positive mother as soon-to-be-absent whenever they thought about her concern for her child specifically. In thinking about the child, the mothers perceived the HIV positive mother to be in a bad and deteriorated condition. The child's future becomes precarious as it is seen as being in the absence of the mother.

> *So I know if you have HIV/AIDS it's, eish! It's very painful so I know, eish! She's in trouble because if she's thinking about it...too much...Like I'm going to die and leave my baby. Eish! That thing is very painful. Hey! Who is going to be with my child when I'm dead, ja. And who is going to stay. My baby is going to grow up? Or is he going to die? And if he's going to grow up who is going to live with him? Ay! (Andile)*

Andile imagines the content of the HIV positive mother's concern. She suggests that much of her concern will relate to the child's uncertain fate after the mother dies. There is an explicit assumption that for the HIV positive mother this *is* the end of the road for her. Andile also perceives her concern and worry to be excessive when she says, ''*she's thinking about it...too much*''

Thobeka also draws on the perceived content of the infected mother's thoughts.

> *She's thinking to die because HIV, the HIV becomes AIDS. Now already you die. She's thinking about the child, 'I'm sick. I'm dying what about my child.' She's thinking about the child, 'What must I do about the child?' Because she's HIV. She's positive. 'What must I give the child? I must breastfeed him or I must give something?' She's confused now. (Thobeka)*

Thobeka highlights the idea that HIV is linked with death when she says, ''*Now already you die.*'' She suggests that the child is foremost in the mother's thoughts and her concern is only regarding him, ''*She's thinking about the child, 'I'm sick. I'm dying what about my child.' She's thinking about the child, 'What must I do about the child?' ...'What must I give the child?''* It appears that the HIV positive mother is perceived to be on her deathbed and her confusion as to how to care for him highlights the ideal of maternal sacrifice and concern where the mother will put the child before herself (Hays, 1996).

Andile, in thinking about a mother's role in caring for her children, talks about her own experience of mothering and then goes on to compare it with that of a mother who is HIV positive.

> *Ja I work for them, I teach them laws, I teach them something to do tomorrow. Ja, if you got a good, if you have a mother, your mother teach, taught you good things for tomorrow. Ja, everything that is good. Ja if you have a good mother it's good. They tell you everything, Ja, 'If you are grown up like me we do this, do this, do this and do that,' so...but if you don't have mother nobody is going to tell you all these things (Andile)*

Andile highlights the idea of the absent mother in her perception of the HIV positive mother. She suggests that a ''*good mother*'' will make the time to teach the child lessons for his future. However, her perception is that an HIV positive mother will be unable to fulfil this role as she is ''*useless*''. This ties in with Richardson's (1993) argument that assumptions about maternal responsibility ensure that mothers worry about whether they are bringing up children ''the right way.''

Andile continues,

> *Eh ja...Because you tell yourself, 'There is nothing I can teach my children' because you are useless. Ja, anytime you can die so it's useless to teach. You tell yourself that is not important. So if you have got disease I know, you can't think of everything. You can't think of good thing but you stay thinking of your day to die. (Andile)*

Andile perceives the infected mother's endeavours to be hopeless and futile as she cannot put her child first. Her perception is that she worries about her own fate ''*you stay thinking of your day to die*'' and this preoccupation impedes her ability to be the 'good mother' who is able to hold her child in mind. As such, she is ''*useless*'' and her wisdom ''*is not important*.'' Andile perceives the infected mother to be unable to live up to the ideal of maternal sacrifice as she ''*can't think of everything*'', unlike a 'normal' and healthy mother. It is the infected mother's self-concern that does not make her a ''good mother''. Like the other mothers mentioned above Andile describes the content of the mother's thoughts and worries and feels that her concerns are markedly different and more excessive to that of the non-infected mother.

Mother's Emotional World Affects the Child's Health

Respondents perceived all mothers as responsible for the health of their children. It was also perceived that in the case of mothers, the ill-effects of worry could be passed along to her baby: if a mother worries and makes herself sick with worry, it was believed that the baby will be affected by virtue of the breastmilk, carrying the mother's emotional state to the baby, causing damage and harm should she not be in an ideal emotional state.

> *She must stop worrying. If you don't stop worrying, you get more sick and you can't take care of the baby...then she will affect the baby, if she worries too much....If you breastfeed the baby, the baby will get sick because you worried. (Cindy)*

Cindy suggests that the mother is responsible for her own as well as her child's health. ''*She must stop worrying*'' implies that it is within the mother's control to be responsible for her and her child's health. A mother's inability to ''*stop worrying*'' will mean that ''*she will affect the baby*'', thus bearing the blame for the child's ill-health. It was perceived that the child's health will be affected when the child consumes the mother's milk. Although breast-milk is meant to be nutritious Cindy believes that it also carries the mother's emotional state and her worry in turn

will be passed on to her child. In this instance, the HIV positive mother's milk is a conduit for illness.

Mother's Health Determines Baby's Health

When participants talked about Thandi, they were able to draw on their own understanding of a mother's health in relation to raising a healthy child. Respondents perceived that mothers who were healthy had healthy offspring. However, in relation to the HIV positive mother who is perceived as ill, her child is seen to be at a disadvantage, not only after he is born but also whilst in utero.

> *Thandi's baby is gonna grow up slowly because his mother is sick (Palesa)*

Palesa links the baby's health with that of the mother's. She perceives there to be a correlation where the child's health will suffer as the mother's health becomes worse. As the child is still developing, his development will be ''slow'' and Palesa links this directly to the mother's ill health.

Diketsang makes a similar link between the mother's and child's health.

> *You know I was happy because my son he didn't get ill...Maybe it's because I didn't have any illness when I was pregnant. Like let's say for example, if I were asthmatic it was going to affect the child and then if I was sinus, even other children they be affected by the sinus. So I didn't have those illness, so he was lucky. (Diketsang)*

Diketsang describes being ''*happy*'' and perhaps relieved that her son ''*didn't get ill*.'' She links his good health to her own good health, when she says, ''*Maybe it's because I didn't have any illness when I was pregnant.*'' Here Diketsang implies that whilst in utero the child may be affected by the mother's health. She feels that it was chance that gave her, and consequently her child, good health: ''*he was lucky*''. Although it has been suggested earlier by Cindy that the mother is responsible for her child's health, it seems that Diketsang is suggesting that it is luck that determines whether the mother will be in good health. This serves to take away some of the responsibility from the mother as the child is ''*lucky*'' to have a healthy mother.

Investment in Health Care/Expert Medical Advice

In order to ensure that she and her child are in good health, a 'good' mother is perceived by respondents to be someone who invests time and effort in her child's health and well-being and checks with doctors regularly.

> *You know what, the baby is growing up because when she is taking this baby to the clinic to give the...the doctor must give the treatment, maybe she (the baby) gonna grow up If Thandi is serious with the baby, if she's a good mother you see....(Palesa)*

Palesa highlights that if Thandi is a ''*good mother*'' she will be ''*serious*'' about her child's health. Being ''*serious*'' means to take the baby to the clinic for treatment and advice. In this way, she perceives that the baby's health will be fine only if the mother seriously invests in the child's health.

Investing in the child's health requires regular monitoring. In monitoring her child's health, respondents felt HIV positive mothers should be hyper-vigilant. It was thought that infected mothers must constantly check and monitor their babies if they were good, invested mothers.

> *She must take him to the clinic to the doctors to check him every time he is sick. My cousin got this kind, HIV, and she got a baby. Every month she must go check and they give the baby treatment. The baby is treating and the mother is treating. She never gave him the breastfeeding, she buying the milk for him, you see, she's sick like this baby. (Palesa)*

Palesa explains the extent to which the HIV positive mother must be vigilant and constantly checking her child, but not by herself. Palesa perceives that the child needs constant monitoring from medical experts as opposed to the mother. The mother's role therefore is to ''*take him to the clinic to the doctors to check him*''. It is ''*they*'' the medical experts that ''*give the baby treatment*'' and it is implied that the medical experts advised the mother to abstain from breastfeeding as ''*the mother is treating also.*'' Palesa perceives that the mother's role in healthcare is to ensure that she take the child ''*to the clinic to the doctor''* and herself comply with treatment and advice.

Palesa draws on her own experience to demonstrate that she, as a ‘good mother’ sought medical advice from before she gave birth.

> *When I was pregnant, they checking me at the hospital they checking me. Doctor said she’s checking my blood and it’s all right and I can give my baby the breast...at the hospital they are checking the milk. If you not right they say you mustn’t give the breast. (Palesa)*

Palesa draws on the legitimacy of medical authority as being the experts in helping her raise her child healthily. Prior to giving birth she was checked routinely at the hospital. Her repetition of ‘‘*they checking me*’’ possibly implies that she was vigilant and very invested in being monitored by the doctors in order to ensure her good health (‘‘*it’s all right*’’). She emphasises that both her blood and her breast-milk were screened and ‘‘checked’’ and only after her blood and breast-milk were deemed to be ‘‘*all right*’’ was she told that she could breastfeed her baby. Palesa perceives the hospital checks to be thorough and the advice based on the check-ups are perceived to be reliable.

Conclusion

This section focused specifically on the impact of the mother’s physical and emotional health on her infant. Respondents perceived that compared to uninfected mothers, HIV positive mothers experienced great maternal concern towards their child. This HIV-related worry was thought to be passed on to the child. The infected mother’s ill-health was also perceived to affect the child’s health. In order to protect her child, the ‘good’ HIV positive mother was seen to be invested in the child’s health by consulting medical authorities and being constantly monitored and checked.

HIV-relate worry was linked to the ideal of maternal concern where (for the ‘good’ HIV positive mother) concern for the child preceded concern for the self. At the same time, the ‘bad’ and ‘useless’ HIV positive mother was perceived to be preoccupied with her own ill-health and impending death. Much of the content of the ‘good’ HIV positive mother’s worry was related to the child’s fate after her death. In this way, the infected mother was perceived as the ‘soon-to-be-absent’ mother who does not fulfil her maternal responsibility in ensuring that she prepares her

child for the future. Respondents' overall perception, therefore, was that HIV was synonymous with death and that the infected mother would soon die.

3.2 Psychological and Social Impact on the Child

This section highlights respondents' perceptions of the impact that the mother's HIV positive status has on the child and will explore issues around stigma and prejudice.

HIV-related Worry

Participants perceived the child of the HIV positive mother to be unlike other 'normal' children as they were perceived to be plagued with worry and to experience emotional difficulty to a greater extent than would children whose mothers were not HIV positive. Below Getrude begins the analysis with a consideration of the kinds of issues that face the child of the HIV positive mother. She considers that this child has much to think about.

> *I think Mpho is gonna think about, 'My mother is going to die. My mother is not straight because she is HIV positive.' (Gertrude)*

Gertrude perceives that the child will question and think about the uncertainty surrounding his mother having contracted the virus when she says, ''*My mother is not straight*'' She perceives that the child will also contemplate his mother's death and highlights her own perception that the HIV positive mother is soon to die.

Further, Cindy suggests that the child's thoughts ought to be monitored as the child may be ''*thinking too much.*'' If the child is not helped to deal with the mother's HIV positive status it will mean a bad outcome for him. She says, ''*He's gonna become a criminal because he's thinking too much. Thandi must take (him) for counselling*'' (Cindy)

Cindy draws on a psychological understanding to suggest that if the child thinks too much, without talking about his thoughts, he will be unable to process his experience and will in turn have a bad future. In particular, she perceives that he will not just be naughty but rather that he will be a ''*criminal*.'' She suggests that he be sent for ''*counselling*'' in order to help him adapt to the experience of having an HIV positive mother.

Although the majority of mothers perceived the child's future to be bleak, only one mother graphically described the impact of the loss of a mother from HIV/AIDS. Andile explained that no matter how much care and love the child may get from other family members, he will not be open to receiving it and will use his mother's death and HIV status to prove that he is alone in the world. As a result, her assumption was that he would rather run away than be reminded that he has lost his mother.

> *Eish that thing has confused the child. Hm, that is why you see the other children from the street, ja they are thinking that they got problem of that, they have got problems like that, like we are saying, Ja, so the children...Because I saw some children sleeping in the street because of the same problem. Ja. Because the family can't live with that children good like his mother. Ja. Even though you tell your children the truth he thought that, 'She don't love me because my mother dies'...even though you tell them the truth to advise him, she thought, 'Ah, my mother is not here that is why they are treating me like that, so I better go and stay in the street'. Like if you say, 'My baby, go to school, something like that go to school', yes, and so she or he refuses to go to school, something like that... Even though he is doing stout (naughty) things, (you say) 'Leave this' she thinks, 'No that is why they are saying that, because I'm alone.' So the child goes (Andile)*

Andile talks about the mother as if she is not present in the child's life. She suggests that the child will be ''*confused*'' and unable to comprehend the mother's HIV status. She repeats that knowledge of the mother's positive status will lead to ''*problems*''. Andile perceives that the child will be raised without his mother and will not be taken care of the way his mother would have cared for him. She perceives that in instances where the caretaking is sufficient, the child will not have the capacity to receive it as such. The child will see any criticism as an attack for not having a mother, no matter how good the intentions of the caregiver are. As a result, life without the real mother leaves them feeling isolated and lonely and she perceives that to be the reason they run away. Her assumption is that many of the street-children are living away from home for that particular reason. It is interesting to note that she perceives the HIV positive child to be the street-child, who is alone and abandoned. This perception is very bleak and leaves little hope for a better kind of a life.

Social Impact of Stigma

Respondents perceived that the child of the HIV positive mother will be teased and ostracised by his peers as children can be cruel and also ignorant about the spread of the disease. One of the reasons for the child feeling alone and that he does not belong, is the response by others to his experience.

> *The other children sometimes they tell (Mpho), 'Your mother is HIV positive' then they don't want to play with him or her. They just ignore and she's a child so she needs to, she needs other child...sometimes she (Mpho) cry. Sometimes she shout at them. Sometime she just ignore them. (Bongiwe)*

Bongiwe highlights the prejudice that children can face from other children. The HIV positive child not only feels abandoned by his mother and family but also rejected by his peers as the stigma of his mother' disease is attached to him also. Bongiwe points out that children ''*need other child(ren)*'' in order for certain kinds of development to be negotiated successfully. The blatant discrimination leads to emotional reactions in the child as he attempts various ways of coping with being discriminated against.

Above, Bongiwe imagines the child's difficulty in interacting with his peers if his mother's status is disclosed. Siyanda considers whether it would be in his best interest to disclose his mother's status.

> *I think it's safe to let him know, but it will be difficult for him especially at school. Most of the children will laugh at her and mock him, 'Your mother is HIV positive'. Ja sometimes it can be hard, and at times he'll refuse to go to school. And the children are running away from him. They won't like playing with him just because the mother is positive, 'We will get disease from you because your mother is positive.' (Siyanda)*

She suggests that it may be ''*safe*'' to disclose but she is very aware of the cruelty he will suffer as a result of the disclosure when she says, ''*it will be difficult*''. She perceives that other children will ''*laugh*'' and ''*mock*'' him. Siyanda considers the reality of the impact this will have on him where he may ''*refuse to go to school*''. However, she suggests that he will only

experience difficulty ‘‘*sometimes*’’. Although she is very explicit about ‘‘*children...running away from him*’’, she does not make clear why it will only affect him ‘‘*sometimes.*’’

Like Siyanda, Thobeka is also explicit in the way stigma plays out in the child’s life.

> *The child, he will cry (when Thandi tells him her status). He will cry, nothing else. He will feel bad that ‘my mother is HIV positive and also that I am HIV positive’. He will feel badly. The other children, if your mother is HIV positive and you are HIV positive, they don’t want to share with you their things. They know that you give the disease. The other children they don’t know how you get the HIV, they know that if I’m HIV positive, if I talk to you I give you the disease. (Thobeka)*

Thobeka highlights that the discrimination that the child feels will make him, ‘‘*cry, nothing else*’’. Like Siyanda, Thobeka also gives an elaborate account of how the child will be ostracized when children won’t share with him, but Thobeka appears to explain their behaviour away, ‘‘*The other children they don’t know how you get the HIV*’’ by pointing to their ignorance. It is interesting to note that respondents were not told whether Mpho, the child in the vignette, was HIV positive. Thobeka’s assumption of him as HIV positive indicates her implicit assumption is that he is not protected from the virus.

Children’s Prejudice and Lack of Education

Above, Thobeka cites ignorance as the reason for discrimination. The following analysis explores respondents’ perceptions of the impact that lack of education has on discrimination and stigma as well as their perceptions that HIV/AIDS education may mean that the child will be less affected.

Although Siyanda, above, was quite explicit in imagining the kinds of abuse the child will suffer, she says,

> *He can be a nice person though, if he gets, how can I say, if he has been taught about the disease. Even though now it’s better, our children are taught about HIV at schools so they now understand about HIV. They now understand so it’s not a problem to them because they’re taught at school. (Siyanda)*

Siyanda suggests that ‘‘*he can be a nice person*,’’ if he is educated. It can be suggested that ‘‘*a nice person*’’ means a child who is not affected much by his mother’s status. Although earlier she highlighted how horrific his experience may be, she now dismisses it entirely by saying, ‘‘*They now understand so it’s not a problem*’’.

Like Siyanda (above), Diketsang is aware that ignorance and lack of HIV/AIDS education means a difficult childhood for the child of the HIV positive mother. She believes that continued HIV/AIDS education at schools will make it easier for children to understand the transmission of the disease as well as prejudices that surround it. In this way, the child will be better accepted amongst his peers. She says,

> *Like Mpho, once she started to attend the school they are gonna teach them about those HIV what-what because children for now ne, those who are attending school, they teach them HIV at school. They understand what is happening and they know they have to use the condom (Diketsang)*

However, Diketsang is also aware that HIV/AIDS education, although helpful, will not change the way the child develops

> *With Mpho, concerned to the life of the mother, she is not gonna grow like other children... (Diketsang)*

Diketsang perceives that the child has the odds stacked against him. ‘‘*She’s not gonna grow like other children*’’ implies that for all the education he receives, he will still be different to other children, and a sense that he will not ‘‘*grow*’’ implies a doomed future.

Conclusion

By looking at the mother-infant relationship and then exploring respondents' perceptions of the psychological and social impact on the child, a different image of the infected mother comes through. In relation to the mother-child relationship, the infected mother is seen to carry out her role in a limited capacity where she continues to harm the child (though excessive worry or breastfeeding). When respondents considered the psychological and social impact of the mother's HIV positive status on the child, they focus on the infected mother's death. Respondents' perception that her ill-health will mean her early demise is reflected in her complete absence when they talk about the child. Respondents were quite explicit in their descriptions of the stigma and discrimination the child will face owing to his mother's HIV status and absence and perceived the child to be developmentally and morally disadvantaged.

Chapter 5: Discussion and Conclusion

This research was interested in exploring social perceptions around HIV and motherhood. The relevance of this study emerges from the widespread stigma that is linked to perceptions around HIV positive motherhood (Long, 2005). The sample consisted of HIV negative mothers because their similarity in their identification as mothers allowed them to engage more personally with that social category. By having an insider perspective to motherhood, the category of HIV infection amongst mothers was easily highlighted as respondents were able to clearly explore social perceptions of HIV from an outsider perspective.

Three broad themes were explored:

1. *Social Perceptions of HIV* explored respondents' perceptions of the social challenges of being HIV positive. HIV negative mothers showed awareness and empathy to the stigma and prejudice faced by the HIV positive mother. The infected mother was portrayed in a non-stigmatising way and as being 'normal' and 'ordinary'. Although stigma occasionally and subtly came through, respondents spoke in ways that were not stigmatising or discriminatory.
2. *Perceptions of Motherhood* explored respondents' perceptions of the similarities and differences between themselves and the infected mother. The analysis highlighted their identification with the infected mother. Where differences were perceived, they were perceived as the reaction and stigma of others in her environment.
3. *The mother-child relationship* viewed HIV positive motherhood from the perspective of the child. It was in talking about the infected mother in relation to her child that stigma emerged more blatantly.

The following discussion brings together the three main strands of analysis. It begins by considering HIV positive motherhood from the perspective of black, working-class woman as mothers. As such, the first part of the discussion is 'mother-focused'. The discussion then moves on to explore respondents' perceptions of HIV positive motherhood from the perspective of considering the child and is therefore 'child-focused'.

Respondents, in viewing HIV positive motherhood from the perspective of the mother, were non-discriminatory and identified with her as a black, working-class mother. By virtue of being a mother, she was seen to be responsible and as placing her needs secondary to that of her child's, the way a 'good' mother ought to. Black, working-class mothers in this study all had finance as a primary concern. Being mostly single mothers, they found it difficult to cope with the demands of providing for their children. Respondents perceived the HIV positive mother to be suffering financially the way they were, and this aspect of being poor, working-class mothers allowed them to identify with the woman in the vignette.

There was an understanding that being a poor, working-class black mother makes one more vulnerable to HIV infection. This is in line with recent statistics that show that the group most vulnerable to HIV infection are poor, black women of childbearing age (Strebel, 1995). In this way, HIV positive motherhood is perceived to be part of poor black motherhood. The analysis illustrated the extent to which mothers in this study felt vulnerable as there was the fear that anyone could be infected at any time. The unpredictable and non-discriminatory way in which their personal acquaintances (people 'just like them') became infected brought their fears closer to home. There was a fear that they could contract HIV at any time and there was an awareness that seeming good health was not an indication of being HIV negative. The perception that 'good' people also become infected illustrated the unfairness of infection where bad things happen to good people in an unfair world. Respondents perceived that being 'good' and responsible was not enough to safeguard one from the virus as black women were vulnerable in relation to 'untrustworthy' male partners. Extensive AIDS-talk in the media was also perceived to be responsible for the way that people are always looking to others for signs of the disease. One respondent illustrated the preoccupation with HIV when she wrongly attributed Brenda Fassie's death as being HIV/AIDS related. In this way, vulnerability to HIV infection is felt as ever-present, producing fear.

It is the quality and extent of fear that prompts people to be stigmatising towards those infected with HIV/AIDS. This is supported by Campbell (2004) who states that HIV/AIDS-related stigma comes about when people are afraid of contracting the disease. HIV negative mothers fall into this category of being afraid that they are vulnerable. However the analysis shows that they are not stigmatising. This discrepancy can be understood if we consider the process of

stigmatisation. According to Joffe (1999 in Campbell, 2004) stigmatisation occurs when people project their fears around HIV onto a clearly identifiable out-group, who are then subjected to discrimination. It may be suggested that because mothers in this study identify with HIV positive mothers, infected mothers cannot be regarded as an out-group. Although non-infected mothers do fear being vulnerable to HIV infection, they do not project their fears onto other working-class black mothers, perhaps because they are black, working-class mothers themselves. Respondents perceived that there is no clear distinction between themselves and infected black, working-class mothers. The perceived vulnerability that infected mothers were, prior to infection, 'just like them', allows them to be regarded as part of the in-group. Apart from their identification through financial insecurity, there was also an awareness of gendered power dynamics that united black, working-class women whether infected or not.

Respondents did not hold the HIV positive mother responsible for her infection. The perception was that HIV positive mothers were like ''*all other mothers*'', and as mothers were more responsible and faithful in their relationships. Respondents viewed motherhood and promiscuity to be conflicting and diametrically opposite categories and therefore perceived that the infected mother did not become infected due to her own promiscuity. This links to Woodward's discussion around perceptions of the 'ideal' mother who is imbued with morality and ''unsullied by sexuality'' (1997, p. 250). From this perspective HIV positive mothers were, as a consequence, perceived to be victims when they became infected. This goes against the perception in scientific literature where mothers who are perceived to be responsible for transmission are stigmatised as ''blameworthy objects'' (Long, 2002, p. 12). Although they were aware of their own role in bearing responsibility for safe sexual practices, respondents were also aware of gendered power dynamics that made negotiating safe sex a delicate issue. They perceived that, like themselves, the HIV positive mother has less power in her relationship and if she does not give in to the demands of her partner, he will leave her. There was also the belief that culturally, men are regarded as the head of the household and as such are the decision makers. In this way women's input is not required. This ties in with the research conducted by Strebel and Lindegger (1998) who argue that patriarchal power relations constrain women's ability to negotiate safe sexual practices. In addition to gender, race (being black) and class status (working-class) increase women's vulnerability to HIV infection (Kiguwa, 2004).

In identifying with the HIV positive mother, respondents had acute awareness of and explicit knowledge of the stigma and discrimination that infected mothers are subjected to. Respondents perceived the fear of discrimination and stigmatisation to lead to less support for the HIV positive mother. Lawless et al. (1996) also argues that the portrayal of HIV positive women as promiscuous and irresponsible leads to their decreased access to support structures due to fears of discrimination. The mothers in this study were aware of the reasons that HIV positive mothers may not disclose and made links to issues around shame, stigma and discrimination from drawing on the personal experiences of their acquaintances. They expressed non-discriminatory sentiments and sought to normalise the infected mother in order to ensure that she was not seen as aberrant or deviant.

From the mother-focused perspective, the non-stigmatising portrayal of the HIV positive mother does not correspond entirely with the depiction in scientific and popular literature of HIV positive mothers as vessels that could infect those they should be caring for (Lawless, et al., 1996). As conduits of disease (Strebel, 1995) infected mothers are seen, in scientific and popular literature, to be infecting men and children (Lawless, et al., 1996) through irresponsible and deviant behaviour. In defining stigma, Taylor (2001) draws on deviance as a defining trait. When it came to issues of blame, HIV negative mothers perceived the infected mother to be ‘‘*like other mothers*’’ (non-promiscuous) and not deviant. One of the ways in which HIV negative mothers perceived the infected mother as non-deviant was when they talked about the issue of breastfeeding. On a biological level, all mothers were aware that breastmilk may be infected and, as a result, infected mothers should abstain from breastfeeding. Respondents were also aware that, culturally and within their communities, abstaining from breastfeeding was stigmatising. In their own talk, however, respondents did not portray conditional breastfeeding to be unnatural or deviant. They did not exclude the infected mother as one group that should avoid breastfeeding. Instead they drew on other instances of illness (cancer) and poverty (with regards to hygiene) that ‘normalised’ decisions to replacement feed.

Stigma was present occasionally when the infected mother was viewed from the perspective of the mother. It was particularly blatant, however, when her HIV positive status was viewed from the perspective of the child. The following discussion moves away from considering motherhood from the perspective of the black, working-class woman as mother to focus on motherhood from

the perspective of the child. This shift will illustrate how motherhood is seen differently when HIV is fore-grounded in a child-centred perspective. When considering the child, HIV negative mothers, in talking about their perceptions of motherhood, felt that there were differences between themselves and HIV positive mothers in the manner in which they were able to 'mother' their children. Respondents perceived that HIV infection impacted psychologically on the mother when she feels hopeless about her future. As an infected mother, her illness is assumed to transform her into an impotent mother who lacks motivation. The 'bad' and 'useless' HIV positive mother is seen as having lost all hope as she is preoccupied with her impending death. The preoccupation with her death is assumed by respondents to mean that she cannot put her child first. Her preoccupation is viewed to impede her ability to be the 'good mother' who is able to hold her child in mind. As such, she is ''*useless*'' and unable to live up to the ideal of maternal sacrifice unlike a 'normal' and healthy mother. It is the infected mother's self-concern that does not make her a ''good mother''.

Much of the content of the 'good' HIV positive mother's worry is related to the child's fate after her death. In this way, the infected mother is perceived as the dying mother who does not fulfil her maternal responsibility in ensuring that she prepares her child for the future. From a child-centred perspective, the perception of the infected mother, as unable to live a healthy and normal life and as unavailable or deceased, goes against the ideal of the mother as always available (Glenn, 1994; Hays, 1996). This is in line with Long's (2002) argument that the HIV positive mother is portrayed as damaging and absent. The analysis highlights that this is the case when motherhood is viewed from the perspective of the child.

In relation to the infant, the infected mother is seen to carry out her role in a limited capacity where she continues to harm the child (though excessive worry or breastfeeding). It is from this perspective, in considering the child, that the HIV positive mother is perceived as continuing to infect those they should be caring for (Lawless et al., 1996). When respondents' considered the infant grown up into a child, the mother is perceived as already deceased. Respondents were quite explicit in their descriptions of the stigma and discrimination the child will face owing to the mother's HIV status and absence. The child is viewed as developing slowly, disadvantaged, deprived, socially isolated and a criminal. It appears that the mother's HIV positive status stigmatises her child. Secondary stigmatisation (Parker & Aggleton, 2002) occurs when stigma

extends to family members who are associated with the HIV positive mother. Motherhood from the perspective of the child, views mothers as appendages to children (Burman, 1994). Hence the child is stigmatised for being in such close proximity to the mother where even her emotional state is perceived to impact on her child.

The result mirrors Burman's (1994) argument that mothers are poorly represented and blamed when they are seen as appendages to their children. Scientific literature, especially psychological literature, is child-centred and mothers are researched in relation to the child (Burman, 1994). When this is the case, where mothers are not seen as individuals in their own right, and the focus is on the mother in relation to the child, the mother becomes marginalised. If the mother's characteristics go against the dominant, western ideal of white, middle-class motherhood, she is studied in relation to deviance (Phoenix & Woollett, 1991). In this way much scientific research of (black, single, working-class) HIV positive mothers focus on deviation from 'normal' mothers who are white, married middle-class, and healthy (Phoenix et al., 1991) by researching infected mothers in relation to mental illness and as having failed in their role as mothers (Parker & Aggleton, 2002; Forehand et al., 2001, Miles et al.,2001).

The themes that emerged in analysis and the way in which the interviewees expressed themselves prompt us to rethink the way stigma is expressed in the general public. It is clear that motherhood is perceived differently when respondents talk about HIV and only think about the black, working-class woman as mother compared to when the child comes into focus. From the perspective of the mother, non-infected mothers are able to identify with the infected mother as black, working-class mothers. In this way, they are non-stigmatising and non-discriminatory, and insist that she is ''normal.'' Respondents perceive her role in infection as the innocent victim who is blameless. They are aware that within their communities and within society at large, HIV-related stigma is linked with promiscuity and irresponsibility. However, their perception of infection does not link stigma to sexuality as they have an acute awareness of gendered power relations. When stigma does emerge within their talk it is around issues of motherhood, particularly in relation to the needs of the child.

Respondents express stigma in relation to HIV-related motherhood where the infected mother's status means that she deviates from her role in ensuring her child 'turns out right'. This is suggestive that the ideal of maternal responsibility operates here (Fineman, 1999). From a child-

centred perspective, motherhood is revered, and mothers are perceived to be 'useful' in ensuring that children are cared for and are prepared for their futures. Infected mothers are perceived as being absent and unavailable and as a result are unable to fulfil their maternal duties when their children become 'criminal.' HIV positive motherhood, from the perspective of the child, is the failure of living up to the ideal of the all-responsible, all-powerful mother who is ever-present.

Respondents' perceptions of the HIV positive mother differ when the infected mother is viewed from the perspective of the black, working-class woman as mother than from a child-centred perspective. Although stigma emerges when the child is talked about, from a mother-focused perspective, respondents are not unreflexively stigmatising. When considering the HIV positive mother from the perspective of the black, working-class woman as mother, the interviewees are empathic and this goes against popular perceptions that people hold negative, fantasised beliefs about HIV positive mothers. This is unusual as so much research is based on the assumption that stigma and discrimination is rife (which is true). The stigma that emerged when the child came into focus prompts us to consider the circumstances around which stigma arises. This research suggests that perhaps stigma and discrimination may not be blatant for some people because perhaps their identification on another social category (black, working-class mothers and women in heterosexual relationships) allows them to be less discriminating. A question that comes out of this research is whether fostering an identification on another social category would lead to less stigma.

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