DISCOURSES AND PRACTICES OF GOOD MOTHERHOOD IN CENTRAL MALAWI

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ABSTRACT

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Discourses and practices of good motherhood are continuously produced at international, national, and local levels. As women bear the onus for practicing good motherhood, these discourses charge women with caring for themselves and their children in specific ways. However, in Central Malawi, the achievement of good motherhood is inhibited by a variety of social and economic barriers including extreme poverty and marked gender inequalities. In this context good motherhood discourses have the potential to produce expectations that are unattainable for mothers in difficult socioeconomic environments. In light of these challenges, this dissertation examines how women in Malawi understand and practice good motherhood.

This dissertation presents the findings of a qualitative study of motherhood in Central Malawi conducted from January to October 2013. My study explores the ways that women in one location in Central Malawi defined and understood good motherhood and then examines how these local ideas intersected with constructions of good motherhood touted by public health programs, in particular those promoted at pediatric health clinics called "Under-Five Clinics." I show that the specific vulnerabilities mothers faced in their daily lives—poverty, food insecurity, and domestic abuse, for example—challenged the ways women were able to enact the specific mothering practices advised by the Under-Five Clinics as well as by their own communities. To deal with these challenges I suggest that women employed the concept of "trying," producing a rhetoric of trying to be a good mother in spite of a scarcity of resources, regardless of actual success. By shifting the metric of good motherhood away from successful outcomes, "trying"

allowed women to maintain the appearance of being a good mother within their community despite dealing with severe socioeconomic barriers. I argue that in this way emphasizing "trying" may constitute a means through which women are able to actively reframe good motherhood to incorporate and respond to socioeconomic environments that are at odds with ideal expectations of good motherhood.

By examining women's own definitions of motherhood and their responses to public health programming that attempts to define good motherhood, this study provides a critical look at the impacts of public health agendas in local contexts, and especially how these programs affect the women who are often the program's targets. In particular, I suggest that the current Under-Five Clinics' use of discourses of responsibility and blame, which hold women solely accountable for the health and well-being of their children, are ineffective public health strategies that ignore both the extensive social aspects of good motherhood present in Central Malawi and the scarce resources available to women to enact good motherhood practices.

This dissertation is dedicated to my family and to Page and Maple, always.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

General Overview:

Good motherhood is socially and historically specific: "The good mother is reinvented as each age or society defines her anew" (Thurer 1994:xv). Thus, how good mothers are defined and who is able to obtain the identity of good mother varies greatly depending on specific context. The social category of good mother has important effects, influencing a woman's standing in her community as well as her access to various social and economic resources. As May (2008:473) argues, "there exist strong expectations to be a 'good' mother (however this is defined in a particular society or culture) and that consequently mothers tend to try to present themselves as fulfilling the necessary requirements." Moreover, good motherhood is also a dynamic social institution inextricably linked to larger social, political, and economic systems, and the specific ways that good mothers are socially constructed provide a glimpse into these changing contexts. Subsequently, this dissertation broadly explores how women define and practice good motherhood and what these definitions tell us about the social realities within which women live.

Specifically, in this dissertation I ask, what behaviors and practices identify a woman as a good mother and how is her success within this role judged? Further, and perhaps more importantly, I consider the consequences of successfully fulfilling or failing to fulfill the role of good mother. The answers to these questions help provide an illustration of the various structural influences that facilitate or constrain women's mothering practices, and also begin to demonstrate how women respond to these structures. Here I focus particularly on the social and medical structures that shape how women understand and practice good motherhood. These

structures employ discourses of good motherhood, defined as the "norms, values, and ideas about 'the Good Mother'" (Walker 1995:424), which produce particular versions of "good mother" along with resultant expectations for fulfilling this role.

Women in Central Malawi interact with multiple versions of "good mother" during their daily lives, and fulfilling the expectations set forth by these constructions have real consequences. Within the local community, for example, achieving good motherhood represents a woman's transition to full adult status and presents a woman as a moral person (Davison 1997; Yeatman and Trinitapoli 2013; May 2008). In contrast, during encounters with the biomedical health care system, women face a different set of expectations that may be at odds with local understandings of good motherhood. These medical discourses construct women as individuals responsible for their own and their children's health and wellbeing, ignoring the vast social component of motherhood present in community constructions of good mothers. In this dissertation I focus particularly on the ways that good motherhood is constructed in Under-Five Clinics. The discourses employed in these clinics continue a longstanding history of biomedicine working to construct good motherhood. In particular, I show that rhetoric of responsibility and blame for children's health have been used to define how women should mother and to shame women into complying with specific mothering practices recommended by biomedical institutions.

These ideas have also been explored in other current contexts as well, for example, modern prenatal clinics. As Howes-Mischel (2012:123) shows, messages at these clinics, "remind women that they are responsible for their children's healthy futures…and suggest that this responsibility involves specific forms of care practices learned at the clinic and, implicitly, that failure to follow these biomedical dictates leaves women open to external blame and

censure." I similarly look at Under-Five Clinics as sites where "good motherhood" is produced, especially through health education discourses disseminated by health workers during health talks. I ask, what particular aspects of these clinics, including the attitudes of health workers responsible for carrying out clinic activities, function to construct a model of good motherhood? Further, how does this model interact with local mothering concepts that are also a major component of this present study? Finally, how do mothers interpret and internalize clinic mandated mothering practices and the accompanying blame when environmental factors such as poverty negate women's abilities to do so?

In Central Malawi, the achievement of good motherhood is inhibited by a variety of social and economic barriers including extreme poverty and marked gender inequalities. The specific vulnerabilities mothers face in their daily lives—poverty, food insecurity, and spousal abuse, for example—challenge the ways women are able to enact the specific mothering practices advised by both the Under-Five Clinic as well as by their own communities. In light of these challenges, the last part of this dissertation asks, how do women who are unable to fulfill good motherhood practices due to a variety of socioeconomic barriers reconcile their inability to practice good motherhood with their sense of themselves and other women as good mothers? My study begins in this context of multiple health discourses focused on mothers—from ideas promoted by health care services and from the community—and explores the ways that women in one location in Central Malawi defined and understood good motherhood. I then examine how these local ideas intersected with constructions of good motherhood touted by public health programs, in particular those promoted at Under-Five Clinics. I suggest that Malawian women, living in an extremely resource-poor setting with high rates of fertility and a long history of interventions surrounding motherhood, are impacted by these discourses in ways that fall outside

of their stated health promoting goals. By examining women's own definitions of motherhood and their responses to these types of public health programming, this study provides a critical look at the impacts of public health agendas in local contexts, and in particular how these programs affect the women who are often the program's targets.

Chapter Outline:

Chapter 2: Managing Motherhood:

In this chapter I explore various discourses of motherhood. I begin by examining the ways that motherhood has been represented in literature on Southern Africa. This review demonstrates that being a mother encompasses both the biological act of childbearing and also the social practices of childrearing. I then trace how African motherhood has been constructed historically through interventions, both social and biomedical, beginning with colonial programs focused on domesticity and continuing onward to current international health and development programs. I also provide a review of the development of biomedicine in Southern Africa to situate the child health clinics that are the focus of this present study. This review also provides a background for discussions of various health messages disseminated at Under-Five Clinics, including the current public health discourses that attempt to influence the ways in which women define and enact good motherhood in Malawi.

Chapter 3: Settings and Methods:

This chapter describes the research sites and methodology used in this study. The research took place in Dedza District, Central Malawi at two hospitals (one peri-urban and one

rural), and in one community bordering the rural hospital site between January and October 2013. Employing qualitative research methods, I conducted semi-structured interviews with mothers and observed health talks taking place at Under-Five Clinics which were targeted at educating mothers. Additionally, I conducted semi-structured interviews with the health care providers who presented the observed health talks. This chapter also addresses rationales for specific site selection and sampling strategies for participants, and provides an explanation of the research methodologies used to collect that data for this study. Finally, I discuss research challenges and limitations that I encountered during the course of this research and address my research positionality.

Chapter 4: Local Women's Constructions of Good Motherhood:

In this chapter I explore various motherhood ideas and the concepts underlying the construction of the identities of mother and good mother in one community setting, in Dedza, Central Malawi. I begin by exploring some historical literature on motherhood in Central Malawi; in particular, I explore how family and residence patterns impact women's mothering practices. I then examine how women in my research site defined "good mother," as well as examine how these definitions applied to women's own behaviors and perceptions of others. Here I ask what specific behaviors and practices identified a woman as a mother or good mother, and how her success within those roles was judged. Further, I ask, how are women's ideas about good motherhood influenced by social, economic, and medical structures? I find that for women in Central Malawi good motherhood is an intensely social act, based on practices that include but also far exceed the act of childbearing. Achieving the status of good mother, as defined locally, may serve as a way to access social resources within the local community. This chapter sets out

the contextual background for a discussion of the ways that local understandings of good

motherhood intersect with ideas about motherhood disseminated at health clinics.

Chapter 5: Constructing "Good Motherhood" at the Under-Five Clinic:

This chapter explores Under-Five Clinics as sites where "good motherhood" is

constructed. Using observations from health talks at Under-Five Clinics, as well as interviews

with the health care personnel responsible for giving these lectures, I show that health discourses

construct a narrative of blame that place the burden of child health and well-being on mothers.

These discourses ignore both the extensive social component of good motherhood that emerges

from local women's responses as well as the socioeconomic and environmental factors that

constrain women's ability to achieve clinically defined good motherhood. I suggest that both the

health messages provided to women by health workers during these clinics, as well as the

attitudes of those health workers, promoted a "correct" form of good motherhood. Here I ask,

what specific aspects of these health education talks constructed a model of good motherhood?

Further, I explore how this model interacted with local mothering concepts. Finally, I ask how

mothers interpreted and internalized clinic mandated mothering practices and the accompanying

blame when environmental factors such as poverty negate women's abilities to do so.

Chapter 6: Challenges to Good Motherhood:

This chapter explores the challenges that women face in enacting the expectations of

good motherhood set out by local and biomedical standards. The main challenges women

identified with relation to performing good motherhood were recurring illness (ranging from

general aches and pains to tuberculosis, malaria, and HIV), poverty, lack of male support, and

domestic abuse. These conditions prevented women from adequately providing material resources for their families, maintaining household and bodily hygiene, and accessing health care services for their children. To deal with these challenges women first identified various tactics focused on increased physical labor, for example additional farming or temporary work, in order to earn extra income to support their families. However, these tactics were not always successful and many women emphasized that even with additional work they were not being able to provide their children with adequate nutritional and material needs on a daily basis. In response, the theme of "trying" to be a good mother in spite of a scarcity of resources regardless of actual success emerged as an important theme for women who faced substantial daily challenges in practicing good motherhood. By shifting the metric of good motherhood away from successful outcomes, "trying" allowed women to maintain the appearance of being a good mother within their community despite dealing with severe socioeconomic barriers. However, the idea of "trying" was unable to help women maintain good motherhood in the clinic setting.

Chapter 7: Conclusions:

This chapter presents the study's conclusions. I suggest that the two good motherhood discourses described in this dissertation—the first coming from the local community, and the second disseminated during health education talks given at Under-Five Clinics—construct two particular models of good mothers that have real implications for women in Kachule. Achieving good motherhood as defined by the community helps women present themselves as moral actors, while the effects of achieving good mother status at the Under-Five Clinic are less clear. I suggest, though, that being seen as a "good mother" in both the community and clinic contexts facilitates access to various resources, as well as puts women in a favorable position to receive

resources in the future. However, women continue to face significant challenges in their practice of good motherhood and in this chapter I also consider some of the changing social, economic, political, and medical structures that have impacted the contexts in which motherhood is defined and practiced in Kachule. I argue that one of the ways that women responded to dealing with difficulties achieving good motherhood, "trying," may demonstrate a means of reframing good motherhood to incorporate and respond to socioeconomic environments that are at odds with ideal expectations of good motherhood in community or clinical settings. Lastly, I revisit some of the study's limitations and provide some suggestions for future research.

CHAPTER 2: MANAGING MOTHERHOOD[1]

Introduction:

Discourses of motherhood, the "norms, values, and ideas about 'the Good Mother' that operate in any one society or sub-group" represent ideal forms of motherhood (Walker 1995:424). These discourses inform various mothering practices and influence the ways that the identity of mother is constructed and performed (Walker 1995). However, motherhood discourses are not static or universal and vary greatly depending on specific contexts (Thurer 1994). Stephens (2013) for example, demonstrates that ideal forms of motherhood adapt to social and economic changes especially those related to productive systems and gender roles. Further, these forms do not exist in isolation. Walker (1995:425) argues that, "at any one time there may be a number of different overlapping or quite separate discourses operating alongside the dominant discourse, including oppositional and marginal ones."

Who controls the dominant discourse and what impacts does this control have on women's mothering practices and lives? Health institutions, in particular, have a long history of working to manage the ways that motherhood is practiced, employing health discourses that use responsibility and blame to enforce specific behaviors (c.f Jolly 1998; Kukla 2005; Davin 1978). Smith-Oka (2013), similarly, shows an example of state imposed notions of good motherhood and the ramifications of this discourse on women's lives in rural Mexico. She suggests that the authority invested in these ideal forms of motherhood by the state create a context in which women are judged based on their compliance with state-mandated norms and practices. Women who practice state endorsed behaviors are constructed as "good" mothers, while those who do

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[1] This title is drawn from Denise Roth Allen's (2004) work "Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania."

not are labeled "bad." These authoritative discourses typically promote an idealized Western model of motherhood that is difficult for mothers to perform due to socioeconomic constraints (Smith-Oka 2013).

Moreover, the ways that these discourses are presented to women is important. Smith-Oka (2013) and Wetterburg (2004) suggest that behaviors promoted by various authoritative discourses presented to mothers, frame behaviors as "choices." Women are responsible for enacting the correct choice as well as the outcomes of these choices. For example, Smith-Oka (2013) argues that development discourses promoting smaller family sizes present women who use family planning and have fewer children as "modern" and good citizens, while mothers who continue bearing children are constructed as poor and backward. These discourses fail to acknowledge the social and economic contexts that support or inhibit the enactment of family planning standards, instead blaming women for not "choosing" to use family planning according to state imposed standards. Further, Wetterburg (2004) shows that the rhetoric of choice in pregnancy and breastfeeding discourses in the United States obscures the authoritative roots of discourses, reinforcing dominant medical discourses by rebranding them as choices made by empowered individuals.

Some of the health discourses that impact women's ideas about mothering in Malawi are the subject of Chapter 5. In this chapter I first provide a background on the multitude of discourses that have historically targeted mothers in Southern Africa. I start with an exploration of the ways motherhood and mothering have been constructed in various contexts throughout the Southern Africa region before moving on to a discussion of attempts throughout history to influence the experience and practice of motherhood. To do this, I look at the specific ways that different actors have historically attempted to manage motherhood through interventions, both

social and biomedical, beginning with colonial programs focused on health and domesticity and continuing into the present to public health initiatives representing global health agendas. In particular, I trace the ways that the themes of responsibility and blame have been used to police mothers' behaviors and to construct versions of motherhood that mirror European ideals. I then explore the development of the current biomedical health care system in Malawi that has developed in the aftermath of these colonial programs and which provides the context for the public health interventions described in this dissertation. I also explore the current context of maternal and child health in Malawi which profoundly impacts the ways that motherhood is understood and practiced. Finally, I situate my research within this historical context and literature on discourses and practices of motherhood in Southern Africa.

Being a Good Mother in Southern Africa:

Achieving good motherhood is based on enacting socially prescribed and expected behaviors and attaining the status of good mother has important social implications. In many contexts in Southern Africa, historically as well as in the present, the first step to motherhood is bearing a child. Here, bearing a child represents a woman's entrance into full adulthood and subsequently, full personhood (Davison 1997; Yeatman and Trinitapoli 2013). Stephens (2013:1) further argues that becoming a mother may be more important than other life events, such as marriage, in determining a woman's social status and identity. In fact, as Yeatman and Trinitapoli (2013:96) argue, bearing a child is so important throughout various African contexts that failing to do so, "violates shared standards and expectations for what it means to be a 'person.'" As such, becoming a mother represents a moral imperative, and is a crucial part of

successfully performing female gender roles, including being a good wife, sister, daughter, and kin member in addition to motherhood.

Women are also responsible for social reproduction as demonstrated by literature on Central Africa which note that women are charged with the responsibility of bearing children for the continuation of their lineages, in matrilineal societies, or the lineages of their husbands, in patrilineal ones (Richards 1950; Stephens 2013). Moreover, as children are often believed to belong to a mother or father's lineage (depending on the way descent is reckoned), rather than belonging to an individual mother (or father), caring properly for the child represents a woman's duty toward a larger network of kin relationships (Richards 1950; Gluckman 1950; Stephens 2013). Similarly, more current studies from Zambia and Zimbabwe demonstrate that bearing children and raising them "properly" can represent fulfillment of responsibility to living kin and ancestors, in addition to a continuation of family lineage (Pritchett 2001; Werbner 1991). Succeeding in child bearing and proper childcare thus has important implications for a mother's relationships with her kin, as well as for her social position in general (Reisman 1986; Davison 1997). Children may also denote prestige to their mothers, with number of children included as a criterion for the determination of a woman's social status (Pritchett 2001).

However, Johnson-Hanks (2006:2) argues for a distinction between "the social category of 'mother'" and the "biological event of giving birth." Using Johnson-Hanks (2006) distinction, Stephens (2013:39) argues that, "to be a mother a woman should do more than conceive and give birth: she should do these in a specified and socially recognized context." This argument suggests that becoming a mother, and particularly a good mother, extends beyond the biological process of bearing children to social practices, such as nurturing and protecting (Walker 1995; Stephens 2013). For example, Livingston (2005:175) demonstrates that the ability to care for

children and family members is the fundamental basis of motherhood for the Tswana in Botswana, beyond the act of childbearing alone. Other literature also demonstrates this notion of caring as an important component of good motherhood, such as in making decisions about treating childhood illnesses and ensuring adequate nutrition (Foley 2008; Mandala 2005). In addition to promoting children's health and providing them with sustenance, good motherhood may also be judged in terms of a child's behavior and appearance. In other situations, it is not just how many children a woman bears but which children that is important in the construction of a good mother in some contexts. Depending on the context, for example, boys or girls may be favored, with the birth of a child of preferred sex conferring prestige on the mother (Bozzoli 1991:129). Timing of birth may also be important to the fulfillment of good motherhood, especially the birth of a woman's first child (Johnson-Hanks 2006).

Lastly, despite the fundamental role of mothers as caregivers, kin networks may also hold significant power over decision-making processes. For example, in contexts where children belong to the lineage and not to the parents, the input of kin may be particularly important in terms of decisions related to childcare (Richards 1950; Bozzoli 1991). Stephens (2013), similarly, highlights influences of kin on childrearing, showing that children in precolonial Uganda were surrounded by dense webs of responsibilities and interests coming from both maternal and paternal kin networks. Additionally, she emphasizes the importance of the social context in which motherhood occurs, in this case the importance of childbirth occurring within a socially accepted marriage. Stephens (2013:42) suggests that in this context the material gifts exchanged during marriage created, "the ideal context for motherhood because it created a physical connection between all those with an interest in the children who should ensue" (Stephens 2013:42). Moreover, these multitudes of interests and responsibilities surrounding

children manifest in other ways; for example, in many Southern African contexts children do not live with their parents for the entirety of their childhood. Instead children may live with different kin members at various points in time and subsequently receive childcare from caregivers other than their biological parents (Pritchett 2001; Turner 1957; Read 1960). Kin decision-making related to childcare is especially highlighted in times of illness (Janzen 1978). In these types of situations mothers may have little say in treatment decisions for their children in spite of underlying social conceptions that mothers are responsible for child health. Additionally, in many Southern African societies women have limited access to economic resources and therefore may have to depend on husbands and family networks to garner the resources needed to access medical care, further constraining their decision-making capacity in childhood illness episodes (Janzen 1978; Kerr 2005; Foley 2008).

This literature demonstrates that although childbearing is a highly significant component of becoming a mother, motherhood is also highly social in nature and extends beyond birth. Responsibility for the health and well-being of children plays an important role according to this literature, but relations with others may also be an important part of practicing motherhood. These studies agree with Barlow's (2004:516) call for a "relational view of mothering" which acknowledges that mothers are defined by relationships outside of the mother-child dyad. However, as the next section of this chapter shows, this social component of motherhood has been ignored in motherhood interventions that focus on mothers as primarily the centers of a nuclear family and not as social actors enmeshed in networks of community and kin. In the next section of this chapter I explore some of these interventions, and in particular the historical roots of current public health discourses, tracing the various attempts by missionary and colonial

institutions to impact mothering practices and to impose "correct" forms of motherhood onto local contexts based on European ideals.

Christian Missionaries, Colonial Domesticity, and Mothers:

Colonial penetration of Southern Africa began with missionaries in the late 1800s (Gifford 2004). Along with religion, missionaries brought with them new ways of conceptualizing families and gender roles. Christian missionaries focused on transforming African family structures, positioning women as responsible for the making of Christian households in the image of Christian families back in the metropole. To enact these changes, churches set up education and health programs to inculcate a sense of domesticity and British Victorian style femininity into African women. These programs were intended to change gender relations between men and women, support nuclear, male-headed families advocated by Christian ideology, and to assert control over African populations through controlling reproduction (Gaitskell 1983; Mate 2002; Comaroff and Comaroff 1992).

Christian religious tenets characterized motherhood as women's most fundamental role, with bearing and raising children representing "God's" work (Mate 2002:559). Mothering practices were of particular interest to Christian missionary programs due, in part, to an obsessive desire for "social and moral control" over African populations (Vaughan 1991:66). Missionaries identified pregnancy, childbirth, and mothering as key sites of cultural knowledge reproduction, and missionary efforts focused on appropriating these sites and replacing cultural knowledge with church controlled discourses (Vaughan 1991; Hunt 1999). For example, Vaughan (1991) shows that missionary hospitals championed the cause of maternal and child health through the development of welfare clinics. She states that these clinics, "helped rear

contented, but disciplined babies, its effects being as much moral as physical" (Vaughan 1991:67). These welfare clinics represent a precursor to current child health clinics, such as the Under-Five Clinics discussed in Chapter 5.

Missionary hospital programs, which focused on pregnancy through early childhood years, mirror a similar concern with controlling mothers' bodies related to anxieties about the maternal body and morality back in the European metropole. Kukla (2005:66) suggests that during this time, popular scientific discourses mandated that the maternal body, as responsible for the generation and shaping of the next generation, needed to be closely managed by biomedical authorities. Moreover, she contends that these discourses argued that in order to control mothers, "The spaces of her body and home must be relocated to the public domain and rendered panoptic so as to make them manageable by responsible, more stable social and scientific institutions" (Kukla 2005:84). Further, as Davin (1978) shows, motherhood interventions during this time period reified the notion that mothers were responsible for the healthy futures of their children and the survival of the nation. She suggests that, "if the survival of infants and the health of children was in question, it must be the fault of the mothers, and if the nation needed healthy future citizens (and soldiers and workers) then mothers must improve" (Davin 1978:12). This focus on managing motherhood is also explicated by Foucault who discusses the role of 18th century public health programs in policing the behaviors of mothers related to domestic and child care (Foucault 1984). These programs were also strongly focused on domestic hygiene which was a major component of missionary education programs in Africa (Foucualt 1984; Comaroff and Comaroff 1992). As Comaroff and Comaroff (1992:54) state, through the missionary world purview, "Cleanliness was taken to be a sociomoral condition." Mothers were held responsible for the enactment of these domestic ideals.

Despite relatively ignoring maternal and child health in favor of public health interventions relevant to male labor, by 1940 colonial governments had picked up this health topic. One of the reasons for this shift was the significant increase in infant mortality seen during the first decades of the colonial program (Vaughan 1991:67). High rates of infant mortality sparked interest from Europe and calls for attention to maternal and child health from colonial governments (Blacklock 1936; Vaughan 1991). This focus on maternal and child health again related to the colonial project's interest in a stable and controlled African labor force. To that end, women as the gatekeepers of reproduction represented a first step in managing African populations and the construction of the "right" kind of labor pool (Allen 2004:13). Mothers could ensure this type of population by practicing colonial mandated domestic and childcare practices, including home and family hygiene. Furthermore, as the focus of these interventions, mothers were held responsible for the fulfillment of these directives, and also blamed for their perceived failings by colonial authorities, including those in biomedical facilities (Allen 2004; Vaughan 1991).

Biomedicine, which entered into the colonial scene with a limited set of services provided by medical doctors at missionary clinics, was first primarily interested in the health of white settlers. However, in time the biomedical institution refocused its interest on the health of the African labor pool, and as mentioned previously, part of this initiative centered on the modification of mothers' "unhygienic" behaviors mothers through education programs. However, maternal and child health in and of itself was never a colonial priority. After independence, hopeful visions of comprehensive public health services never fully materialized, and although some African states expanded maternal and child health services, including large-scale immunization programs, public health service related to maternal and child health remained

weak and poorly executed (Prince 2013:3). Structural Adjustment Programs implemented in the 1980s continued to erode health care for women and children (Turshen 1999). In the following section I examine the history of biomedicine in the Southern African region to provide a context for the current health care system where women receive care for themselves and their children, and which as I will show, continue historical attempts to manage motherhood through discourses of responsibility and blame.

Development of Biomedicine in Southern Africa:

During the early colonial period in Southern Africa, Christian missionaries and colonial physicians were the primary sources of biomedical care for both Africans and European colonizers (Vaughan 2001; Hunt 1999). Initially, the biomedical health care system was singularly concerned with the health of white settlers, and was focused on new and "exotic" African diseases, such as malaria, to which the colonists proved especially susceptible (Baer, Singer, and Susser 2003). These health services were generally centralized in hospitals (Turshen 1999). Although early missionaries also offered biomedical services, they were more interested in evangelization than in providing general health care (save for the maternal and child health welfare clinics described previously) and used healing as a means of attracting converts (Lock and Nguyen 2010; Vaughan 1991). However, as the colonial mission developed, biomedical practitioners quickly expanded their purview to include broader populations of Africans within the health care system, especially in the colonial industrial sector (Lock and Nguyen 2010; Turshen 1999).

These early biomedical providers utilized popular colonial beliefs about the inherent characteristics of African bodies as the basis of biomedical interventions (Comaroff 1993;

18

Vaughan 1991). For example, colonial anxieties over a healthy work force were paramount, and certain diseases associated with beliefs in African moral laxity, uncontrolled impulses, and unhygienic behavioral practices became the focus of colonial health campaigns (Chirwa 1999; Callahan and Bond 1999; McCulloch 1999). Sexually transmitted diseases such as syphilis were subject to expansive colonial medical attention and surveillance, even in low prevalence areas (McCulloch 1999). High morbidity rates in urban areas, due mainly to issues such as overcrowding, poor sanitation, and poverty, were instead blamed on the constitution of African bodies themselves, on "African inexperience with the conditions of urban industrial life and their difficult transition from a rural to an urban existence" (Packard 1989:687). Packard (1989) suggests that the image of "the dressed native," urban Africans dressed in European clothing, often ill-fitting or of poor quality, exemplified European conceptions of Africans as unfit for urban living and prone to diseases of urban existence, of African bodies as inherently inferior. These types of widely held biomedical beliefs and myths about African bodies served to enforce colonial policies of geographical segregation and control of African mobility, especially in the construction of reserves, impoverished rural areas where African populations were forced to reside (Packard 1989; Coovadia et al. 2009). Moreover, these ideas supported the notion that Africans were responsible for their own health problems, precluding the necessity of the colonial government to produce any type of comprehensive public health structure.

Thus, the legacies of colonial biomedical services set the stage for increasing privatization of health care in Africa and the inability of postcolonial African governments to establish strong public health systems to adequately address the needs of their populations (Turshen 1999). The sources of biomedical care available to Africans under colonial rule created what is widely considered a dysfunctional health system that was inaccessible to most of the

population (Prince 2013). For example, the majority of these services were located in urban areas, away from the vast majority of African populations who lived in rural areas. Further, these urban services were disproportionately available to men who encountered this health system while engaging in migrant labor. The focus of these services was also curative in nature and centered primarily on labor and industrial growth. In doing so, colonial health services neglected the social and environmental causes of poor health conditions, such as the overcrowding and unsanitary living conditions of urban areas, which facilitated the spread of infectious diseases such as tuberculosis (Turshen 1999). As Packard (1997) shows, up until the end of World War II, colonial medical services dedicated their attention to health as it related to development and the economic productivity of the colonies, with little interest in health infrastructure or public health systems. Post World War II biomedicine continued this narrow focus on health as a component of economic development, but new medical technologies, such as antibiotics, allowed for a dramatic scale-up of health interventions. These programs, however, continued to emphasize economic productivity at the expense of recognizing the social, economic, and political sources of poor health in the African colonies (Packard 1997).

After independence, postcolonial states were forced to confront the legacies of hugely inadequate and repressive colonial health systems modeled on the narrow interests of European powers (Packard 1997). To combat widespread poor health and poverty, many states adopted the primary care model of public health advocated by the World Health Organization and the United Nations Children's Fund at the 1978 Alma Alta International Conference on Primary Health Care (Turshen 1999). This model advocated restructuring health systems to focus on primary care services at the local level, including strengthening community-based health services, referral systems, and overall local capacity to deal health conditions. However, severe economic decline

during the 1980's led to imposition of Structural Adjustment Programs (SAPs) by international financial institutions. These programs required drastic government restructuring, incorporating neoliberal ideologies of free market, privatization, economic deregulation, and decreased spending on social welfare programs, including health care (Pfeiffer and Chapman 2010). Studies have suggested that these neoliberal policies effectively destroyed any gains made in African public health systems, and resulted in severe impacts on the overall health of populations throughout the region. Moreover, neoliberal reforms advocated the privatization of medical services, which, rather than support widespread health improvements, furthered the narrow curative focus of colonial medicine at the expense of broader public health initiatives. One aspect of these reforms was the introduction of fee for service care in government clinics where services had previously been accessible for free (Wendland 2010; Turshen 1999). Further, these reforms were embedded with neoliberal rhetoric stressing individuals' responsibility for their own health and well-being, ignoring the extreme structural barriers to health care services caused by failing public health systems.

In the wake of this "decay of government-controlled health services," other health care modalities, non-governmental organizations (NGOs), humanitarian and faith-based organizations, and various other private ventures, entered into the gap left by weak or non-existent public health systems (Prince 2013:1; Turshen 1999; Manji and O'Coill 2002; Iliffe 2006). These types of organizations are typically funded by international sources and provide specialized services focused on specific health issues, for example, HIV/AIDS and other "health emergencies" rather than mundane health needs (Prince 2013:8; Manji and O'Coill 2002). Moreover, these organizations are often temporary and do not strengthen the systems that would be needed to continue the services they provide in the long run, after the NGO has left the

country or reduced its budget (Turshen 1999). Further, as Manji and O'Coill (2002) argue,

NGOs, rather than empowering African populations, propagate colonial agendas of subjugation

and control, and reinforce colonial-based social hierarchies between Africans and Westerners.

They suggest that the discourses of development played out in the NGO arena are paternalistic,

define African populations as failing to maintain cultural standards of the West, and effectively

create Africans as objects in need of development in the form of assistance from international

organizations, and responsible, at least in part, for their own health predicaments (Manji and

O'Coill 2002).

Health and Health Care in Malawi:

Malawi's health care system has been profoundly influenced by these missionary,

colonial, and biomedical legacies. The current health system is characterized by low government

spending on primary care services (including public health), insufficient health facilities, and

frequent resource shortages (MoH 2014; GoM 2002). For example, in 2013 when I was

conducting research for this dissertation the entire country was facing a shortage of syringes,

impeding the ability of clinics to administer basic vaccines to children. In addition to issues with

resources, Malawi faces an extreme shortage of health workers and challenges with worker

retention (Manafa et al. 2009; Palmer 2006). Despite these challenges the public health sector in

Malawi continues to play a major role in health care delivery. According to Malawi's Ministry of

Health (2012), the government provides approximately 60 percent of all health care services,

with the remainder covered by the Christian Health Association of Malawi (CHAM) (39 percent)

and private health care providers (1 percent). Public health services are available at three levels:

primary, secondary, and tertiary. The primary level consists of "community initiatives, health

posts, dispensaries, maternity facilities, health centres, and community/rural hospitals" (MoH 2014:3). These primary services are mainly carried out by Health Surveillance Assistants (low level health care providers who I discuss further in Chapter 5). Secondary and tertiary public health services include district and central hospitals, respectively (MoH 2014).

The Under-Five Clinics that are the focus of Chapter 5 exist at the primary level within this weakened health infrastructure and are an important public health resource. Under-Five Clinics provide basic health care services for children, including vaccinations, growth monitoring, and treatment for common childhood illnesses such as diarrhea (Morley 1973; Cole-King 1975; Rosenthal 2015). These clinics provide much needed health care in the current Malawian context where entrenched poverty and structural inequalities have led to poor health statistics and present huge barriers for accessing health care services (Wendland 2010). However, these services are not devoid of ideological tenets. As I show in Chapter 5, the health discourses utilized in these clinics, as well as the attitudes of the health care providers disseminating those discourses, continue a rhetoric of responsibility and blame in attempts to govern women's mothering practices, mirroring some of the colonial interventions highlighted here.

Under-Five Clinics also fit into a broader context of Malawi's efforts to reduce high rates of maternal and child mortality. In the past three decades Malawi has markedly decreased its rate of child mortality. Cole-King (1975) estimates that in the early 1970s under-five child mortality (deaths of children under five-years of age) was 375 deaths/1000 live births. Malawi's high child mortality rate continued into the 1990s. In 1992, a Demographics and Health Survey found that Malawi had the highest child mortality rate in the East and Southern Africa region reporting approximately 234 deaths/1000 live births (NSO 1994). The current under-five child mortality

rate in Malawi as reported by the UN Inter-Agency Group for Child Mortality Estimation in 2015 fell to 64 deaths/1000 live births. This rate is now below the average in the Sub-Saharan Africa region which is 83 deaths/1000 live births (UN IGME 2015). The World Health Organization (WHO) (2014) attributes Malawi's success in reducing child mortality to government investment in essential public health services including immunization, malaria control, promotion of prevention of mother-to-child transmission of HIV, management of childhood diarrhea, promotion of exclusive breastfeeding for six months, vitamin A supplementation, and deworming interventions.

Maternal mortality, in comparison, has remained high throughout the country despite the implementation of various Safe Motherhood interventions during the past two decades. The World Health Organization et al. (2015) show that although maternal mortality decreased between 1990 and 2015 from 957 deaths/100,000 live births to 634 deaths/100,000 live births, this number remains substantially higher than the average maternal mortality rate for Eastern and Southern African Countries, reported at 417 deaths/100,000 live births. An analysis of health trends presented by the WHO (2014) suggests that maternal mortality in Malawi is exacerbated by high rates of HIV/AIDS as well as inadequate investment in health care systems. To reduce its high maternal mortality rate, Malawi has emphasized the need for women to give birth with skilled birth attendants (SBAs), blaming traditional birth attendants (TBAs) and non-medical facility births for contributing to the country's high number of maternal deaths. To that end, the government of Malawi passed a law in 2007 that banned TBAs from practicing as well as penalized women who delivered outside of a hospital facility, fining both new mother and TBA either a monetary penalty or livestock. This law effectively drove TBAs to practice in secret but failed to significantly reduce maternal deaths (Sarelin 2014; NYT 2013).

In 2012, upon assuming presidency, Joyce Banda refocused efforts on reducing maternal mortality through the Presidential Initiative on Maternal Health and Safe Motherhood. This initiative again focused especially on providing women with safe hospital deliveries attended by a skilled health care provider, but also reemphasized the imposition of harsh penalties on TBAs and women giving birth outside of medical facilities (MoH 2016; NYT 2013). These measures created state-mandated models of good pregnancy and delivery practices intended to motivate women to deliver "properly," and set up mechanisms for enforcing these standards. Themes of responsibility and blame are strongly evident here. The implementation of a monetary fine for not complying with state mandated birthing standards is a particularly illustrative. Women's social and economic conditions that often preclude hospital delivery regardless of a mother's intention, for example lack of funds to travel to a hospital or lack of family support, are ignored in these discourses.

Situating this Dissertation:

My dissertation research begins within the context of Malawi's efforts to reduce maternal and child morbidity and mortality, a situation in which multiple discourses exist that promote standards of behavior mothers are expected to fulfill in order to protect themselves and their children. By fulfilling these expectations women are considered "good mothers" from the standpoint of the medical institution. The version of good motherhood constructed by these medical discourses intersects with other versions of good motherhood, for example those coming from local communities. My research supports literature demonstrating the existence of multiple discourses of motherhood existing simultaneously, and showing the ways that these discourses both construct standards of behavior and police their enactment. I add to the literature by

providing an example of the specific intersection of two forms of good motherhood discourses, in this case, the discourses disseminated at Under-Five Clinics with local women's discourses of motherhood. I now turn, in the following chapters, to an exploration of the ways that women in one location in Central Malawi defined and practiced good motherhood and the medical discourses they encountered in the course of performing mothering. As I have shown in this chapter, achieving the status and identity of "good mother" has important implications in terms of fulfilling expected social roles, and in facilitating interactions with health care systems historically, and as I will show in the following chapters, currently as well. Thus, I suggest that the enactment of good motherhood is a strategy of managing motherhood, by mothers themselves. However, as the literature suggests, practices of good motherhood are also constrained by socioeconomic contexts, and therefore framing mothering practices as a choice is inherently problematic. In the following chapter I discuss the specific settings and research methods employed in this study before moving on to a discussion of women's understandings and practices of good motherhood.

CHAPTER 3: SETTINGS AND METHODS

<u>Introduction</u>:

As demonstrated in the literature review presented in the previous chapter, Malawian women are currently and have historically been faced with a proliferation of discourses about motherhood. Public health discourses in particular have a long history of focusing on mothers and employing biomedical authority in an attempt to shape various mothering practices and construct healthy individuals. Current public health discourses are also embedded with neoliberal ideals surrounding responsibility for one's own health, and in keeping with historical focuses of public health interventions, mothers are often disproportionately affected by these discourses.

The dissertation explores local women's definitions and perceptions of good motherhood and how these local constructions intersect with constructions of motherhood touted by public health programs, in particular those promoted at Under-Five Clinics. To answer these research questions, I carried out qualitative research in Dedza District, Central Malawi at two hospitals (one peri-urban and one rural), and in one community bordering the rural hospital site. Both of the hospital sites held regular Under-Five Clinics. Specifically, I conducted semi-structured interviews with mothers and observed health talks taking place at Under-Five Clinics which were targeted at educating mothers. Additionally, I conducted semi-structured interviews with the health care providers who presented the observed health talks.

In this chapter I first discuss the research objectives and questions guiding this study, and then describe the study setting and rationale for selecting my specific research sites. Next I discuss the research methods that I used, including the characteristics of my research participants, my selection criteria, and my data collection. I then describe my data analysis

process. Finally, I address research challenges and limitations, and end with a note on my researcher positionality.

<u>Research Objectives and Questions</u>:

My dissertation topic developed gradually through several phases. Initially my research intended to focus on women's experiences with HIV/AIDS and one specific mothering practice, infant feeding. To that end, I conducted two months of exploratory research in Lilongwe District, Malawi, exploring understandings of prevention of mother-to-child transmission of HIV and breastfeeding in light of recent World Health Organization HIV and infant feeding guideline changes. I interviewed health care providers, HIV project managers, policymakers in the Malawian Ministry of Health, staff at non-governmental organizations, and both HIV-positive and HIV-negative breastfeeding women living in communities surrounding Lilongwe. My preliminary data suggested that protecting children from HIV infection was a primary concern for mothers, but the specific means for accomplishing this goal was not always known. For example, although almost all women stated that breastfeeding was crucial for a child's health, many women also asserted that HIV infection precluded breastfeeding. Moreover, although the majority of women interviewed stated that their primary source of information about HIV and childcare was the hospital, interviews with health care providers working at these hospitals suggested that many health professionals treating HIV-positive mothers were unclear about the information they were providing to these mothers due to constantly changing treatment protocols. Further, despite challenges with stigma and morbidity related to HIV/AIDS, socioeconomic concerns, in particular poverty and food insecurity, played a dominant role in these preliminary interviews with mothers.

Drawing from these preliminary results, I expanded my dissertation research focus to explore broader conceptions of good motherhood—not limited to infant feeding—held by Malawian mothers and to elucidate the ways these concepts were transformed by intersections with HIV/AIDS, biomedicine, and socioeconomic barriers. Specifically, I chose to look at local concepts of "good motherhood" and how these concepts intersect with ideas about motherhood disseminated at Under-Five Clinics, where women receive health education lectures targeted at mothering practices. These questions were best addressed through qualitative methods which allowed for an exploration of the meanings that individuals attribute to phenomena and processes (Creswell 2007). I will discuss the specific methods used later in this chapter. The present study was conducted between January and October 2013 in Dedza District, Central Malawi and was approved by the Michigan State's Institutional Review Board as well as the Malawi's College of Medicine Research and Ethics Committee.

Study Settings:

Study Setting Overview:

Dedza District is adjacent to Lilongwe District, and also borders Mozambique. In 2008 the population of the district was estimated at approximately 625,000 with over half of the population made up of women (NSO 2011). Within Dedza women typically start giving birth at a relatively young age and maintain high fertility rates throughout their childbearing years. By 20 years of age 65 percent of women have given birth to at least one child. As such, the total fertility rate (TFR) of Dedza District is relatively high at 5.8 children per woman, comparable to the TFR of Malawi as a whole which falls at 5.7 children/woman (NSO 2011).

Mothers' interaction with health services for their children is fairly high as demonstrated by the most recent Demographic and Health Survey which shows that 85 percent of children in Dedza between the ages of 12 and 23 months had received all basic vaccines, higher than the country average of 78 percent. As Under-Five Clinics are a major source of vaccinations for children, this statistic suggests that these clinics are frequently used and serves as a proxy measure for interaction between health care providers and mothers. However, women throughout Dedza District also reported substantial problems in accessing health care. For example, 56 percent of women included in the survey reported difficulty obtaining money for treatment, 59 percent with distance to the health facility as a serious problem, 60 percent with problems having to take transportation in order to receive care, and 65 percent with concern that no drugs would be available (NSO 2011). These issues may substantially impact the type and quality of care available to children as well.

The district has also been hard hit by the HIV/AIDS epidemic, as has the country of Malawi in general. District data reports that in 2005, 19 percent of women who received voluntary counseling and testing (VCT) at Dedza District Hospital were HIV-positive in comparison to 11 percent of men (DTA n.d.). This number is higher than the estimated 13 percent of women living with HIV/AIDS throughout the country in general (NSO 2011). As part of my research goal was to explore the intersections of HIV/AIDS with motherhood, this high prevalence of HIV in women presented an appropriate site to address this issue.

Study Site Selection:

I chose to conduct my research in Dedza based on the characteristics of a high fertility rate (and thus, large population of women with children of various ages), a relatively high level

of interaction between mothers and basic health services (especially those provided at Under-Five Clinics as demonstrated by the high percentage of vaccinated children), and a high prevalence of HIV/AIDS in women. Proximity to the city of Lilongwe was also helpful for various logistical and research purposes. I also selected Dedza on the advice of Dr. Address Malata, the Principal of Kamuzu Nursing College in Lilongwe who served as my Research Collaborator within Malawi and provided invaluable advice throughout the duration of this study.

Once I identified Dedza as my study site, I started off my research in Dedza town (the largest urban center in the district) living with the Catholic Presentation Sisters where the Mother Superior, Sister Blandina Kamba, generously allowed me to rent one of the empty rooms in the convent. For the next several weeks I lived with the nuns in Dedza town, eating meals with them, and participating in aspects of their daily lives as well as beginning to explore the Under-Five Clinics at Dedza District Hospital, finding a research assistant, and selecting a community site. During that time, various nuns from other convents throughout Dedza District would come to the Presentation Sister's central house in town and stay for anywhere from a few days to several months. I was introduced to many nuns and novices visiting from Mtendere, the novitiate house, located approximately 30 miles away. Mtendere, fortuitously, was also located nearby to Mtendere Community Hospital, as well as approximately three miles away from a fairly large community, Kachule. In the following section I describe the specific study sites and provide a rationale for their selection.

Hospital Study Sites:

Dedza District Hospital:

Dedza District Hospital is a public government run hospital located in the center of Dedza town, a peri-urban center with a population of 20,375, on the main paved road that bisects the town (NSO 2011). As the largest and most comprehensive facility in the district, Dedza District Hospital is the referral hospital for the 17 other health centers throughout Dedza (MoH 2011). According to hospital records, as of June 2013 the hospital employed 22 clinical officers, 1 doctor, 40 health surveillance assistants (HSAs), and 34 nurses. Dedza District Hospital was the starting point for exploring Under-Five Clinics as it serves a large population, employs a large number of HSAs (who typically conduct the health education talks at the Under-Five Clinics as I will discuss in more detail in the following chapter), and holds clinics (including an education talk) every weekday morning. I received approval to conduct research within Dedza District Hospital by the Hospital Director prior to observations or interviews.

Mtendere Community Hospital:

Mtendere Community Hospital is located approximately ten miles off Malawi's main North/South highway on a fairly well maintained dirt road. The hospital makes up part of a Catholic teaching campus that has training centers for priests, a novitiate house for nuns, two private Catholic boarding schools for children, and two churches. Mtendere Community Hospital was founded in 1958 by the White Sisters (Catholic missionaries from Europe). The facility is now under the umbrella organization of the Catholic Hospital Association of Malawi (CHAM) and is run by the Terezian sisters under the Dedza Dioceses. The hospital employs one chief

clinical officer, two clinical officers, two medical assistants, one registered nurse midwife, two community nurses, seven nurse midwives, and one lab technician. There are also 83 additional staff including twenty health surveillance assistants (HSAs) (low-level government employed health workers) and three home craft workers (HCWs). I selected Mtendere as the second hospital site for this study because women from Kachule identified Mtendere Community Hospital as one of the primary locations where they attended Under-Five Clinics as well as one of the most important sites for obtaining health care for their children. I received approval to conduct research within Mtendere Community Hospital from the Hospital Director prior to any observations or interviews.

Community Setting:

Kachule is a large village approximately nine miles off of Malawi's main north/south highway on a dirt road that runs from Malawi into Mozambique. According to the village headman Kachule was founded in 1897 by Ngoni fleeing over the border from Mozambique due to armed conflicts with white settlers. Through intermarriages Kachule grew until reaching its current population of approximately 4,600 individuals and 773 households. Residents of Kachule predominantly identified as Ngoni, an ethnic group with historical roots in South Africa who migrated north into present day Malawi during the 1800s (Omer-Cooper 1994). Ngoni traditionally practice patrilineal descent and patrilocal residence patterns. However, as Ngoni groups settled in what is now Malawi, intermarrying and interacting with other ethnic groups living in the area, especially the matrilineal Chewa, they adopted various matrilineal practices (Mair 1951). Thus, throughout Central Malawi although many individuals identify as Ngoni, residents typically practice matrilineal descent and reside matrilocally (Read 1970). As a result,

many of my research participants had family who had been living in Kachule for generations, and lived close by or even on the same compound as their own maternal family members. However, I still found some evidence of a continued tradition of patrilocal residence. For example, a few Ngoni women I interviewed stated that they had moved to Kachule to live with their husband and his family members. Other residents of Kachule had migrated to the area more recently for work opportunities and had little or no family members, maternal or paternal, living in the area. The varying family structures and location of family members inherent in different descent and residence patterns have important implications for networks of social and economic support available to women as I will demonstrate later in this dissertation.

I selected Kachule as the community setting for this study for several reasons. Women from Kachule frequently attend the Under-Five Clinic at Mtendere Community Hospital which was useful in exploring the ways health messages were understood and used by women in the community. Secondly, Kachule was a large enough community that it was possible to recruit and interview a large number of women. Finally, the prevalence of HIV/AIDS within the community made this setting a useful place to explore the intersection of motherhood and HIV/AIDS. Prior to starting interviews and participant observation with mothers, I received permission from Kachule's headman to conduct research within the community.

Homes in Kachule are typically constructed of brick with mud facades and thatched roofs, and only a few homes are constructed of brick with roofs of corrugated steel. No homes have electricity or running water. Water is available via one pump and smaller boreholes located throughout the village. Residents predominantly work with rain-fed agriculture in fields surrounding the village, or look for temporary wage labor (ganyu). Some women have small stands selling vegetables, fried doughnuts, or dried fish outside of their homes. Another

livelihood source for women is the sale of beer and distilled liquor. Additionally, some residents have livestock, primarily goats, pigs, cows, and chickens. Lastly, a few women I interviewed suggested that prostitution was common in Kachule, explaining that some women from Kachule left the village to work in prostitution in other communities, even going over the border to Mozambique.

Immediately outside the village area is a large dilapidated greenhouse that had been used to grow flowers for commercial export until the mid 1990s. I was told that this flower production business had employed a substantial number of individuals living in the village, and who were now out of work. Kachule also borders a medium-sized trading area, Thete, where maize and other agricultural products are bought and sold. Thete has several stores and roadside kiosks where products such as cooking oil, soap, eggs, bread, clothing, etc. are sold, one bank that opens only on Saturdays (although I never actually saw the bank open), and some smaller commercial enterprises (tailoring, bike taxis, fruit and vegetable stands, meat stands). Thete also holds a weekly market each Saturday.

The closest health facilities to Kachule are Mtendere Community Hospital (approximately 3 miles away) and a public government run health clinic in the nearby town of Lobi (approximately 10 miles away). Transportation to either of these hospitals was available via bicycle or motorbike taxi for around between one and three US dollars at the time of this study. There was also a well-traveled foot path from Kachule to Mtendere Community Hospital, approximately two miles cutting across agricultural fields and homesteads. Access to Dedza District Hospital was more difficult and first required transport to the main highway (approximately seven miles away) via bicycle or motorbike taxi (or walking) where a small

trading center Chimbiya was a stop for minibus taxis which could be taken the additional 20 miles or so to Dedza town for an additional price of approximately two US dollars.

<u>Data Collection and Methods</u>:

Between January and October 2013 I conducted 63 semi-structured interviews with HIV-positive and HIV-negative mothers, six semi-structured interviews with health care providers, participant observation with mothers in a community setting, and observed ten Under-Five Clinics at two hospital sites and one community site in Dedza District. In the following sections I will first describe the observational data that I collected at Mtendere Community Hospital and Dedza District Hospital. I then present the semi-structured interviews and participant observations conducted with mothers as well as the semi-structured interviews with health care providers. Participant selection criteria and characteristics are included in this discussion.

Observations at Under-Five Clinics:

Throughout the course of this study I observed health education talks at ten Under-Five Clinics. Because all of the talks were conducted in Chichewa I employed a native Chichewa speaking research assistant to accompany me to each talk. My research assistant simultaneously translated the content of each talk into English and recorded her translation in a notebook. I also audio-recorded all of the clinic talks with participant permission, and these were transcribed into both Chichewa and English by two of the three native Chichewa speaking research assistants that I hired to help with various aspects of this study. I will discuss specific details about the research assistants I employed and their roles in my research later in this chapter. For each Under-Five Clinic my research assistant and I typically arrived at each clinic site prior to the education talk

and tried to sit in an unobtrusive location among the audience of patients attending the clinic, for example, in a back corner. However, there was no way for me to be truly unobtrusive as a childless white woman in a room full of mothers, babies, and small children, and so, as I will address later in my discussion of research positionality, my presence alone at the health talks may have influenced the ways that women or health care providers acted during the clinics. During the health talks I was especially interested in observing the ways that health workers interacted with the mothers attending the clinics, for example, their general demeanor and tone of voice, in addition to the specific health messaging contained in the talks themselves.

Semi-Structured Interviews with Health Care Providers:

I also conducted five interviews with various levels of health care providers regarding their work at the Under-Five Clinics as well as their how they evaluate women's mothering practices. I selected providers whose health education talks I had observed and recorded for this study. Prior to the interview I collected informed consent from all of the participants. Four of the five providers I interviewed were female and participants' average age was 45 years. Overall, I interviewed one senior community health nurse, three HSAs, and one HCW. A complete list of interview questions is available in Appendix A. All interviews were conducted in English by me and were audio-recorded with participant permission and later transcribed verbatim by me. Interviews typically lasted around 30 minutes depending on how each participant chose to answer the questions. The interview for health providers was purposefully kept short due to the extremely busy schedule of these individuals and the short amounts of time they were typically able to allot to being interviewed.

Semi-Structured Interviews with Mothers:

The main data I draw on in this dissertation come from 63 interviews with mothers. During this study I conducted interviews with 18 HIV-positive mothers and 45 HIV-negative mothers. All participants were selected through purposive sampling (Johnson 1990). I used two very broad selection criteria to choose participants: 1) having at least one child (this included women who had given birth to a child, women who were caring for a non-biological child, or women who had given birth to a child who was no longer living), and 2) being over 18 years of age. I intended to interview 20-30 HIV-positive mothers and 20-30 HIV-negative mothers based on Weller and Romney's (1988) suggestion of 20-30 participants to effectively explore a coherent domain. However, due to a large number of women interested in being interviewed, I ended up with more interviews than anticipated. I used a native Chichewa speaking research assistant who lived in Kachule, Elizabeth (who I will describe in more detail later in this chapter) to assist in all interviews with mothers. I have a working knowledge of Chichewa but women's discussions during the interviews often surpassed my knowledge of the language. In order to recruit women for interviews, I asked Elizabeth to inform community members about the study and have women who were interested in participating contact her to set up a time for an interview. Because my research questions explored issues surrounding HIV/AIDS, I had Elizabeth explain upfront to interested participants that: 1) I was not a doctor or a health professional just a student interested in learning more about motherhood, and 2) that although some questions would address HIV/AIDS this study was not about HIV/AIDS and we would be talking to all women regardless of HIV status. On Elizabeth's advice, I provided a small incentive of laundry soap to each woman interviewed.

My interview questions were intended to capture the parts of motherhood that were most relevant to my participants. To do so, I constructed a broad set of questions that asked about women's daily lives, transition into motherhood, perceptions of good motherhood, and challenges related to motherhood that women faced in their daily lives. My interview questions asked women both about their own lives as well as their perceptions of other women in their community, including characteristics and practices of a good mothers, as well as specific vocabulary, categories, and concepts that women use when discussing good motherhood and mothering practices. The specific questions used in the interviews were developed in the early stages of the study. I revised each interview question as needed in an iterative process throughout the study based on data analysis of early interviews in order to ensure that questions were clear and obtaining the intended information. Items were added, reworded, refocused, or deleted as appropriate in order to ensure that the research instrument was capturing the best possible data. A complete list of interview questions is available in Appendix B.

Interviews typically occurred outside of a woman's home or the home of her close neighbors who shared a communal courtyard. Only a few women invited me inside of their homes. Interviews were typically between 30 minutes and 1.5 hours depending on how each woman chose to answer the interview questions and all interviews were conducted jointly by both me and my research assistant, Elizabeth. Prior to the interview informed consent was collected from all participants. In particular, we emphasized the voluntary nature of participation in this study, including the option to not answer any question or to stop the interview at any time. All interviews were audio-recorded with participant permission and transcribed into both Chichewa and English by a native Chichewa speaking research assistant. Elizabeth also provided

simultaneous translation for me, Chichewa to English, throughout the interviews and I recorded these translations in a notebook.

Participant Observation with Mothers:

Participant observation allows the researcher to become immersed in the daily life of participants so that they are more likely to behave in the manner in which they would if the researcher were not present (Dewalt and Dewalt 2002). I conducted informal participant observation, which included following women as they completed their daily household routines, with six mothers in the community who I had become acquainted with during the semi-structured interview part of this study. The semi-structured interview had allowed mothers to better understand the study objectives, and in general mothers who had been interviewed before being asked to allow me to observe them were less skeptical as to why I wanted to observe and participate in their daily activities. During participant observation I helped women to shuck dried corn husks to remove kernels before being taken to the grinding mill to be made into flour, helped to prepare porridge for an infant's breakfast, and generally observed as women socialized while doing daily tasks such as laundry, home maintenance, or cooking. During these sessions I jotted notes about relevant details. My research assistant Elizabeth helped me with these observations, translating when the content of women's discussions surpassed my knowledge of Chichewa.

Participant Characteristics:

Of the 63 women I interviewed who described their ethnicity, 58 identified as Ngoni, one as Chewa, one as Lomwe, and three did not identify their ethnicity. The average age of the

women was 34 years and the average parity was 4 children. Almost all of the women interviewed had received at least some education, however, only six participants had received any education at a secondary (high school) level, and no participants had graduated secondary school. Nine participants had never received any type of formal education. Fifty-four women were married at the time of the study. Of those women who were not married, reasons included spouse deceased (5 women), never married (1 woman), divorced (2 women), and separated (1 woman). Sixty percent of women identified farming as their primary occupation. Other commonly identified occupations included: small business selling vegetables, doughnuts, brewing beer or distilled liquor (22 women), and temporary labor (8 women). Eighteen women identified as HIV-positive, while 45 identified themselves as HIV-negative.

TABLE 1: Selected Characteristics of 63 Mothers Interviewed

	n	%
Age		
18-19	1	2%
20-29	19	30%
30-39	23	37%
40-49	11	17%
50+	5	8%
No answer	4	6%
Parity		
1-4	44	70%
5+	18	29%
No answer	1	2%
Marital Status		
Married	54	86%
Divorced	2	3%
Separated	1	2%
Widowed	5	8%
Never married	1	2%
Education		
Some primary	44	70%
Some secondary	6	10%
Post-secondary	0	0%
No formal education	9	14%

TABLE 1: (cont'd)

No answer	4	6%
Occupation		
Farming	42	68%
Small business	23	37%
Temporary labor	10	16%
No answer	2	3%
HIV-Status		
Positive	18	29%
Negative	45	71%

* Note: Percentages are rounded and may not always add to 100%

HIV-Positive and HIV-Negative Participants:

During this study I interviewed both HIV-positive and HIV-negative women. Women who disclosed their status did so completely voluntarily. My research assistant, Elizabeth, who I introduce later in this chapter and who was from Kachule, knew all of the women participating in this study, and so it is fairly certain that the women who identified themselves as HIV-positive were in fact HIV-positive as revealing a false positive status to the community would have no real benefits and could lead to stigmatization. Women who identified themselves as HIV-negative may have been hiding their status to prevent HIV-related stigma, a serious issue discussed by women in this study. In terms of basic demographics, HIV-positive mothers tended to be older than HIV-negative participants (average age 39-years vs. 31-years), and have slightly more children (4.5 vs. 4). Other than these minor distinctions, I noted no substantial differences between the two groups of women in terms of characteristics such as education, occupation, or marital status.

Research Assistants:

Throughout the course of this study I employed three research assistants. My first research assistant Dmitra was a 24-year-old recent college graduate living in Lilongwe. She

assisted with observations of Under-Five Clinics at both research sites. Specifically, she accompanied me to the majority of the talks, simultaneously translated the talks from Chichewa to English in writing and recorded her translations in a notebook in case of audio-recording malfunction, and later transcribed and translated audio-recording of the education talks into both Chichewa and English. Dmitra accepted another full-time position three months into our work together but continued to help with transcription and translation for the duration of the study. My second research assistant Elizabeth was a 20-year-old resident of Kachule who was waiting to be assigned a teaching position and was looking for temporary work in the meantime. Elizabeth told me that she was pregnant with her second child (her first child had died shortly after birth several years prior and so she was not taking care of any children during the time we worked together) a few weeks after we met. Most of the women we interviewed for this study knew that Elizabeth was pregnant although she had not officially announced her status, as is typical throughout Central Malawi. In some ways Elizabeth's pregnancy was helpful in facilitating discussions of motherhood, particularly in elucidating the types of advice given to new mothers. I was also able to see the preparations that Elizabeth was making prior to the birth of her child, for example, the types of baby products she was hoping to purchase. Unfortunately, my fieldwork ended before Elizabeth gave birth so I was never able to meet her baby, although I did receive notice right before leaving the country that she had given birth to a healthy baby girl. Elizabeth assisted with all aspects of interviews with mothers, including participant recruitment. She also assisted in participant observations, translating conversations when necessary. My third research assistant Lily was employed once all of the interviews with mothers were completed. Lily had recently moved back to Malawi from the U.S. after completing her undergraduate degree at the

University of Oregon. Lily assisted in transcribing and translating interviews into Chichewa and English.

Data Analysis:

I began analyzing my data during the early stages of this study as I reviewed early interviews and observations in order to refine interview questions and observational strategies. I used cross-case analysis techniques to analyze data from participant observation and in-depth interviews in order to provide an in-depth understanding of the phenomena of interest (Miles and Huberman 1994). This type of analysis involves constructing cases out of each participant's experience and then comparing the contents of each case in order to identify common themes and shared understandings of phenomena. In order to accomplish this comparison, I read data closely, and then coded for main themes. I developed codes both deductively and inductively. First I read the data looking for main themes such as motherhood, maternal identity, ideas about good mothers, and social and biomedical influences on mothering practices, that were identified as main areas of interest for this study previous to data collection. Next I examined the data again, this time identifying themes emerging directly from the various data sources, and developed a set of inductive codes based on these emerging themes. Inductive codes included local concepts of motherhood, becoming a mother, mothering practices, and definitions of good and bad mothers. I coded all transcribed data for both sets of themes, and continuously evaluated codes based on comparisons between cases (Bernard 2006). I also coded data from participant observation, but I used this data to provide context for the cases rather than making up cases in and of themselves. Finally, I continuously compared data throughout the entirety of the data

analysis process to ensure that emerging patterns and new themes were not overlooked (Bernard 2006).

I carried out data analysis on an ongoing basis throughout the study. I inputted all transcribed interviews into MAXQDA qualitative research software to facilitate coding and analysis processes. MAXQDA facilitated the coding of large quantities of text-based data, and allowed for cross-case comparisons as well as comparisons within cases.

Challenges and Limitations:

This study is limited in several important ways. First, I only interviewed women in one community in Central Malawi and therefore my results may not be generalizable to the whole of Central Malawi, or the country in general. I also observed health education talks at hospital settings only (with one exception). Under-Five Clinics in Malawi are also conducted in more rural locations at outreach clinics. I observed only one outreach clinic and although the talk was similar to those I observed at both hospital research sites, it is possible that other outreach clinics may differ in significant ways. Further, Mtendere Community Hospital was a private hospital with fees charged for health care services other than Antenatal Clinics and monthly Under-Five Clinics. In resource-poor settings such as Kachule, individuals often could not afford to purchase these services and thus had to travel to the nearest public hospital (Lobi, about 10 miles away). Due to time constraints I was unable to explore the Under-Five Clinics or health services provided at Lobi.

In terms of conducting research, interview participants were often confused as to my occupation and reasons for asking questions about motherhood. Individuals often thought that I was a doctor or some kind of health care provider especially due to the interview questions

related to prenatal care and HIV/AIDS. This confusion was mostly likely the result of two main

reasons. First, my research assistant Elizabeth suggested that in the past the only white

individuals who had spent time in Kachule were nurses or doctors. Although Elizabeth explained

to participants that I was only a student and not a health care provider, it is likely that this idea

persisted and affected the ways that individuals chose to answer interview questions. In light of

the highly political nature of maternal health care in Malawi during the time of my research, a

result of revamped efforts at reducing the high rate of maternal mortality through the Presidential

Initiative on Safe Motherhood, as discussed in the previous chapter, my association with the

medical system likely influenced the ways participants interacted me as well as the ways they

chose to answer interview questions. For example, due to the illegality of Traditional Birth

Attendants (TBAs) (discussed in greater detail in Chapter 2), it is likely that my association with

the biomedical system precluded any discussion of TBAs as sources of knowledge for pregnancy

and postpartum care, even though TBAs have been identified in other studies as important

sources of medical care and information in Malawi (Roberts et al. 2016; Sarelin 2014; Nyirenda

and Maliwichi 2016; Bisika 2008).

Finally, using Elizabeth as my research assistant, although overall very positive also

came with some accompanying challenges. Because Elizabeth had grown up in and currently

lived in Kachule she was acquainted with everyone in the community and was able to explain

underlying relationships between residents as well as some of their relevant histories that often

did not come out in the interviews alone. Moreover, women in the community trusted her and

felt comfortable talking to her which facilitated recruitment. However, it is likely some

information that women did not want shared with the community in general was not shared

during the interviews because of Elizabeth's connectedness to other community members. As

noted in this chapter Kachule has historically been a predominantly Ngoni community, however, the nearby trading center Thete, the now closed commercial flower producing facility, and the Mtendere Catholic campus bordering Kachule have attracted a variety of individuals to the area for work. Although most of the participants interviewed in this present study were born in Kachule and had lived in the village for most of their lives, at least three women described moving to Kachule to live with their husband's families who resided in Kachule, and one woman explained that she and her husband had moved to the village to work for a grain trading and selling business in Thete. The participants recruited by Elizabeth in this study were mostly from her personal network and included mainly Ngoni women who had been born and raised in Kachule. This selection of participants likely missed many of the newer residents of the village. As a result, I did not get a true sense of how diverse the community was.

The conclusions I draw from this study are also limited by selected data collection methods. For this research I chose to employ semi-structured interviews and participant observation as my primary data collection tools. Semi-structured interviews allow the researcher to address a pre-identified set of topics in each interview, while also allowing participants the freedom to answer each question however they choose. Meanwhile, participant observation allows the researcher to become immersed in the daily life of participants and to observe the mundane aspects of life that may not be revealed in interviews alone (Bernard 2006). The use of other data collection methods may have strengthened the conclusions drawn here. In particular, focus groups might have allowed for productive group discussions illuminating consensus and diversity regarding mothering practices and meanings of good motherhood (Morgan 1996). However, due to the time and resources I had available to complete this research, as well as my competency in the local language, I felt that the semi-structured interviews, along with

participant observation, best served the purposes of this study by allowing for straightforward and focused means of obtaining data. Further, my inclusion of questions regarding HIV may have led to unintentional status disclosure in a focus group setting.

For the purposes of this study I only interviewed women about concepts and ideas about good motherhood. Including fathers would have added a more nuanced understanding of how good mothers were defined and perceived within the community. For example, my interviews showed that women had specific ideas about the roles of fathers (see Chapter 6), and interviewing men may have revealed additional components of those roles, as well as showed how men think about fatherhood and how to be good fathers.

Lastly, I did not live in Kachule during the course of this research, but rather with the Catholic sisters at the Mtendere novitiate house (located 3 miles away from Kachule). In doing so I undoubtedly missed many aspects of daily life that could only be observed through residing with participants.

Researcher Positionality:

My research was also circumscribed by my position as a white, unmarried, childless, female graduate student working in a Southern African context. The way I was viewed by the community and their understanding of the purpose of my study was often at odds with my research intentions. For example, as I discussed previously, I was immediately identified as part of some type of medical institution. However, other aspects of my positionality also influenced the ways participants interacted with me. As an unmarried, childless woman, I had not fulfilled the steps necessary to achieve full adulthood as defined traditionally in the Malawian context (I discuss these steps further in the next chapter, particularly in relation to becoming a mother). I

suspect that confusion surrounding my unmarried, childless, and thus non-adult status, led

research participants to focus on my (perceived) identity as a medical professional as a way to

better understand who I was and why I was attempting to conduct research with women in the

community. Medical professionals, especially foreigners, have privileged status in Malawian

society, and I was granted some of this (admittedly undeserved) privilege.

Although women in my study were generally open and welcoming, allowing me to

participate in various aspects of their daily lives, helping shuck corn and groundnuts, cook

porridge for their children, etc., I always felt as though my access to their lives was limited due

to my position as an outsider. Further, although I conducted this research on a graduate student

budget, my economic means far surpassed those of my research participants. I struggled to

reconcile the asymmetrical power relations that arose out of my perceived position as a medical

professional and my differential economic status by emphasizing the value of women's

experiences and my own eagerness to learn from them, but I was never completely successful in

integrating myself into the local community. My association with Elizabeth was invaluable in

mediating some of these issues and allowing me to carry out this research project. Despite these

challenges, the data that I present in this dissertation is my best attempt at representing the

experiences of the women I interviewed.

CHAPTER 4: LOCAL WOMEN'S CONSTRUCTIONS OF GOOD MOTHERHOOD

<u>Introduction</u>:

In this chapter I explore various ideas about motherhood and concepts underlying the construction of the identities of mother and good mother in Kachule. What specific behaviors and practices identify a woman as a mother or good mother, and how is her success within these roles judged? Moreover, how are women's ideas about good motherhood influenced by social, economic, and medical structures? In Kachule, women frequently explained motherhood to me in the following way: a woman marries and becomes pregnant, gives birth, nurtures and cares for her child, and gains respect in her community through her care-giving practices. But how women defined who specifically was a mother or a good mother, when she assumed this identity, and how successful she was at this role were quite varied.

This chapter begins by exploring historical perspectives on motherhood in Central Malawi in order to ground an examination of current constructions of motherhood in Kachule. This literature illustrates the dense network of relationships that circumscribe the practice of motherhood, highlighting the social as well as biological nature of childbearing. Next, I explore how women defined a "mother" in present day Kachule and examine variations that arose between definitions of motherhood based on biological fact and definitions based on social practices. I then look at women's definitions of "good mother," a concept that particularly highlights the importance of social aspects in women's underlying ideas about motherhood and what it means to be a successful in this role. Lastly, I explore some special concerns related to motherhood for women living with HIV/AIDS. The data presented in this chapter provide the necessary background for the following chapters, and especially Chapter 6 where I discuss how

current social and economic challenges are impacting culturally accepted motherhood narratives. Especially for women faced with chronic poverty and health issues such as HIV, successfully performing good motherhood had important implications in terms of social support and access to the resources necessary for maternal and child survival.

Motherhood in Kachule: An Historical Perspective:

The majority of the women in this study identified themselves as Ngoni, a group who have historically practiced patrilineal descent and patrilocal residence patterns. In Ngoni societies a woman traditionally leaves her natal community at marriage and relocates to the home of her husband and his family where she is under the authority of her mother-in-law. A woman becomes fully integrated into her husband's community only after the birth of her first child. Under patrilineal descent children belong to their fathers and their father's family line, and as such, the majority of childcare decision-making falls to a child's father and his family members, especially the child's paternal grandmother. For example, studying Ngoni communities in Malawi during the mid-1900s, Read (1960; 1970) observed that paternal grandmothers and other senior women of the paternal line were the fundamental decision-makers for various practices surrounding childbirth and childcare. The paternal grandmother, in particular, took charge of all preparations for a child's birth as well as the decisions made during the birth itself. She then continued to advise the new mother in all aspects of childcare, including weaning, and appropriate childspacing, as well as played the role of primary decision-maker during episodes of childhood illness (Read 1960; 1970).

In these communities, paternal grandmothers and other senior women also played an important role in teaching Ngoni children how to behave correctly and punishing behaviors not

conforming to these standards, although individuals in the larger community also assisted in modeling and enforcing proper behavior. In particular, children were expected to demonstrate respect and obedience towards elders, display self-control, and act generously to all community members (Read 1960). Read (1970) also observed that in the Ngoni communities she researched, the relationship between father and child was prized. She states that, "the father, as the biological parent and also the symbol of authority, was the focus of honour and respect, and the one who helped his children when they were in need" (Read 1970:134). Manifestations of these needs included school fees and financial support for medical assistance. However, although a father theoretically held authority over his children, he deferred to his own mother in terms of their care (Read 1960; 1970).

However, as I suggested in Chapter 3, as Ngoni communities settled throughout Malawi, they frequently adopted the matrilineal practices of the indigenous Chewa through joint settlement and intermarriage, impacting the roles of both maternal and paternal kin in childrearing (Read 1970; Mair 1951). In contrast to the patrilineal practices described here, in matrilineal societies women remain close to their own mothers and female relatives throughout their lives. In matrilineal communities descent is passed through the mother's line, from mother to daughter, and children belong to the maternal rather than paternal line. In these contexts, fathers traditionally have little say over their biological children and instead are more invested in their sisters' children, who will inherit land and property from their lineage. Divorce is also relatively common and women may not expect that their husbands will provide a substantial amount of support to their biological children, rather that support will come from maternal kin (Phiri 1983; Mair 1951). However, in both types of communities fathers are expected to provide their children with certain things, often material goods and school fees (Read 1960; Mair 1951).

In addition to changes related to the mixing of patrilineal and matrilineal practices, family structures have adapted over time to a multiplicity of other social and economic changes (Mair 1951; Phiri 1983; Vaughan 1983; Peters 1997). For example, missionary ideologies of a male-headed nuclear family and colonial government policies assuming male-headed households, in addition to Malawi's continued integration into a capitalist economy, have profoundly affected traditional family structures (Peters 1997; Peters 2010; Phiri 1983; Vaughan 1985; Power 1995). Decreased access to agricultural land due to rapidly increasing rural populations, and growing numbers of men seeking wage labor in urban settings, especially after World War II, have also impacted relationships between husbands and wives as well as the relationship of the conjugal unit to wider networks of kin (Power 1995). For example, men's increased access to cash altered long-standing gendered labor dynamics, especially in matrilineal agricultural communities where women typically held authority due to their control over agricultural land. Opportunities to enter this wage economy were generally restricted to men, leading to women and children's increased dependency on male providers, and further supporting the attempts of colonial institutions to enforce patriarchal norms (Vaughan 1985; Power 1995).

Motherhood in Kachule exists within this context of changing family patterns, a mixing of matrilineal and patrilineal practices, as well as some influx of new community members coming to work in Thete or the Mtendere Catholic campus (and previously for the commercial flower production site). Demonstrating some of these changes, many of the women I interviewed for this study, although identifying as Ngoni, practiced matrilocal residence patterns and some lived in close vicinity to many of their maternal kin, particularly their sisters and mother. Moreover, some women lived near both their maternal kin as well as their in-laws. Women thus had differing levels of support from a variety of relatives, as well as accompanying

responsibilities towards those kin. Practices of motherhood were circumscribed within these networks of kin relations which also mediated the resources necessary to achieve good motherhood. In the next section I turn to the specific ways that women defined mother and good mother in Kachule.

Becoming a Mother:

As discussed in Chapter 2 of this dissertation, becoming a mother in Southern Africa is a fundamental part of transitioning into adulthood and achieving full personhood, as well as a moral imperative (Davison 1997; Yeatman and Trinitapoli 2013). My data in Central Malawi support the centrality of becoming a mother to women's lives. Moreover, the distinction that Johnson-Hanks (2006) makes between social and biological motherhood is apparent in this context as well. Interviews with mothers in Kachule suggested that there were two distinct ways that the status of mother could achieved: giving birth and taking care of children. Initial definitions given by women to the question "who is a mother?" which I asked close to the beginning of the interviews overwhelmingly privileged the biological aspect of motherhood, that is, giving birth. However, later in the interviews when I asked women other questions such as, "can a woman be a mother if she does not have children?," close to 40 percent of the women modified their definitions of "mother" to include childless women participating in socially accepted mothering practices, including, most importantly, taking care of children. These responses illustrate some of the ways biological and social motherhood appeared in women's definitions of "mother" and show variability in how exactly a mother was defined. The following two sections explore the ways women discussed both giving birth and taking care of children as mechanisms for achieving the identity of mother and illustrate some of this variability.

Giving Birth:

Nearly all of the mothers I interviewed discussed bearing a child as the most straightforward way of becoming a mother. The following statement by Sarah, a 35-year-old mother of five, exemplifies a typical brief response to defining the term "mother" in a general sense: "A mother is anyone who has given birth." At the time of our interview Sarah was living apart from her husband and supporting herself and her children by selling fried doughnuts on a roadside stand outside of her home.[2] Similarly, when discussing their own personal transitions into motherhood, most women focused on the birth of their firstborn child as the point at which they considered themselves to be mothers. As Anne, a mother of four, stated: "The moment I gave birth is the moment I knew I was a mother." Anne explained that she had not been ready to be a mother, but that soon after she married she became pregnant and motherhood followed with the birth of her first child. These types of responses demonstrate the primacy of birth in assuming the identity of mother along with the physical, psychological, and social characteristics associated with motherhood.

As part of the physical changes accompanying the transition into motherhood, women especially highlighted the importance of bodily changes that occurred through delivering a child. A common theme throughout these discussions was the idea that a mother's body was profoundly different after labor and delivery than it was before birth. Some of these changes were of course natural biological mechanisms: changes in breasts due to pregnancy and breastfeeding, changes in composition of body fat, etc., changes that are universal to all pregnant and postpartum women. However, in addition to these straightforward physical changes, many women spoke about bodily change in vaguer terms, describing a general loss of physical

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[2] All participant names are pseudonyms.

strength. Some women attributed this loss of strength to the blood lost during childbirth. Rose, a 30-year-old mother of five, for example, asserted that: "Well you lose a lot of blood when you give birth. You don't look like a girl anymore. People don't look at you the same." At the time of our interview Rose was supporting her children alone as her husband was unemployed. Other women explained strength loss as a sharing of strength between a mother and her children leaving less "strength" for the mother to use, or as a diminished strength of the blood itself. Christina, a 33-year-old mother of four, explained: "I'm not as strong as I used to be before I became a mother, I was less strong each time I had children…my strength is shared between myself and my children so it's different from when I did not have them." Christina was born at Mtendere hospital and had grown up in Kachule in an extremely resource poor household where her parents were unable to afford any type of formal education for their children. She explained that she had gotten sterilized after her last child and "noticed that I am stronger."

Other women emphasized undergoing the pain of childbirth as a crucial step in the transition to the identity of mother. For example, Angelina, a 48-year-old mother of five, suggested, "Giving birth to a child is painful. The one who has felt the pain of birth is a mother." Similarly, Gertrude, a 36-year-old farmer and mother of six, explained that women who had not given birth could not be considered mothers because they had not experienced this type of pain: "She's not a mother because she hasn't experienced the pain of giving birth." Pain, in this sense, was an experience that both imparted a bodily knowledge necessary for acquiring the status of mother and was also shared amongst fellow mothers. Women explained that it was impossible for childless women to understand this kind of experience.

In addition to the transformative experience of childbirth and bodily changes initiated by delivering a child, women talked about birth as if this experience provided them with a type of

knowledge about motherhood inaccessible through other means. Several women used the word "secret" (*chinsisi*) to describe this knowledge, and emphasized that women who had yet to give birth were not privy to this information. Women explained that this type of information was shared by older women who visited them while they were pregnant for the first time, as well as by other mothers during daily interactions. However, they also stated that in every day encounters with women who had not given birth they were careful to modify their language in order to protect these secrets. "How will she be a mother if she has never had children? ... [childless women] are treated differently because they don't know the secrets of giving birth. They don't know what it's like to be in labor" Elis, a 28-year-old farmer and mother of four, explained. Elis had grown up in Kachule and said she "rushed to have children," dropping out of school to get married. At the time of our interview she was separated from her husband who was living in another village.

Similarly, a 39-year-old mother of three asserted that, "Stories about motherhood are secretive and are not just told to anyone," and that in interactions with childless women, "we watch what we say because they don't know anything about giving birth." Monica, a 31-year-old mother of three who supported her children through farming, stated that after having her first child, "I now know the secrets they used to keep from us." She continued, saying: "When a woman who has children sees a woman who doesn't have children coming her way she stops telling the story she was telling and starts telling a different one." At the time of our interview Monica was married but described experiencing abuse from her husband who would frequently leave her to be with other women and who also refused to provide financial support to Monica and her children. The type of responses presented by Monica and other women suggested that childbirth, in addition to providing the identity of mother also entitled new mothers access to a

body of knowledge that changed how they related to others within the community, especially other women.

Lastly, for many mothers I interviewed, childbearing also represented a woman's transition into full womanhood. For example, Anne, a mother of four introduced earlier, explained:

Every woman goes through different stages. There's a stage where you are very young and don't know anything. Then there's the adolescent stage. After that you get married, get pregnant and have children. That stage is when you become a woman, the stage where you have children.

Some of the women I interviewed suggested that not having children precluded a woman from attaining full womanhood as well as challenged culturally accepted life trajectories. For example, discussing the importance of bearing a child in defining a mother, Lucia a 24-year-old mother of one who moved to Kachule to live with her husband, stated: "Someone who doesn't have children can't be a mother. We don't understand why she doesn't have children. She is still a girl." Discussions during other interviews similarly revealed that women who did not have children or expressly did not want to have children were met with confusion and sometimes suspicion from other community members. Gertrude, who discussed the importance of pain in the transition to motherhood earlier in this chapter also explained that, "people are not open around this woman because she does not want to have children." Lastly, Patricia, a 27-year-old mother of two, suggested that a woman who does not have children is not respected in the community. She stated, "our society respects a woman who has at least one child." These types

of responses illustrate how a woman's position within the community is significantly impacted by childbearing.

Taking Care of Children:

More than half of the women I interviewed in this study included taking care of children as part of their definition of a mother, both in addition to childbirth and also as a distinct activity unrelated to childbearing. For example, Patricia, introduced above, defined a mother as, "anyone who has given birth and takes good care of those children," and suggested that taking care of children was important for being recognized as a mother within the community. Margaret, a 35-year-old mother of four, suggested that the term "mother," "means someone who can take care of children, even children she did not give birth to herself." Margaret had moved to Kachule to live with her husband who was employed as a carpenter and struggled to care for her children through frequent food shortages.

Further, in response to the question of whether women could be mothers if they had never given birth, nearly half of participants, regardless of previously stated definitions, said that childless women could be considered mothers if they were taking care of children. For example, in discussing the difference between a mother who has delivered and one who is a mother by virtue of childcare, Bernadetta, a 65-year old mother of six, explained, "I believe that these two kinds of mothers are the same. At the end of the day both are taking care of children. Biologically theirs or not, the aim is the same." At the time of our interview Bernadetta lived with two of her sisters and supported herself and her children through farming. A 28-year-old mother of three similarly suggested that a childless woman could be a mother if, "she is taking care of orphans or other children. Then she is still a mother because she has taken up the

responsibility meant for those children's parents." Several women explained that motherhood was something that could be learned by listening to advice from other women and observing the childcare practices of other mothers in the community. However, other mothers maintained a distinction between these two types of women. Rose, a mother of five who I introduced earlier in this chapter, said, "We can call them mothers because they are taking care of children but a *real* mother is someone who is taking care of her own children" (emphasis mine). Justine, a 28-year-old mother of five, stated, "A woman who [takes care of other people's children] is simply a caretaker. The person who gave birth to them is their mother." At the time of our interview Justine was taking care of a friend's two children, two children from her husband's first marriage, and her younger sister in addition to her own children. Several other mothers specifically noted that a woman could be considered a mother if she was taking care of her siblings' children even if she had not given birth herself.

Finally, a common theme that emerged throughout women's motherhood discussions was the idea of a new sense of responsibility and maturity that emerged once a woman assumed the identity of mother. This sense of responsibility included childcare duties as well as household maintenance and taking care of husbands. Responsibility not only contributed to the identity of mother, it was also equated with becoming an adult and taking on the types of behaviors associated with grown women. Some women identified taking on this new responsibility as the specific point at which they transitioned from girl to woman along with the physical act of giving birth. Women talked about their behavior before children as "childish" and said that girls only have to care for themselves. For example, Clara, a mother of five, explained: "My life changed because I was now mature and I stopped being childish. I wasn't a child anymore and I had to act differently." At the time of our interview Clara and her husband were supporting their family

through a variety of small businesses but she explained that she faced substantial difficulties procuring enough food to feed her family. Other women explained that "acting differently" meant an increased focus on care for others, especially children. For example, consider the following two excerpts:

My life changed for I knew I had grown up. I now had the responsibility of taking care of my children. I said play time is over let my children play around while I stay at home searching for food for my children (73-year-old mother of four).

I just knew I was now responsible for my children. I had to work so that I can afford things like soap and salt. I had to make sure my children eat and that they never go hungry (34-year-old mother of four).

Monica, who I introduced earlier in this chapter, also directly connected an increased focus on childcare with the practice of motherhood. She explained that once she became a mother:

My life changed because I now knew about caring for children. So now I had really changed because I had a life focused on motherhood with knowledge of how to run a home. I had knowledge about what my children needed in the mornings and afternoons. They need to be bathed and given food.

Although a few women stated that this new responsibility and knowledge of childcare and household maintenance was automatically acquired through giving birth, the majority of

women discussed this transition as a part of the life changes that occurred after becoming a mother, regardless of how that identity was acquired (either biologically or socially). Further, this idea of responsibility was illustrated again in women's discussions of good motherhood, where the appearance of having children and a home that were well-cared for was an indicator of mothering competency.

These interviews suggest that the status of mother can be achieved through both biological and social means. However, as I will show in the next section, the ways women defined and judged good motherhood were based on social practices and had very little if anything to do with biological motherhood or giving birth.

Becoming a Good Mother:

Throughout my interviews with women, the most prevalent themes emerging from women's definitions of a good mother related to maternal behavior and childcare. Over half of the women participating in this study mentioned a mother's individual behaviors and disposition as indicators of good motherhood while nearly 70 percent described discrete childcare practices unrelated to a mother's other activities or disposition. In my analysis of mothers' interviews, I defined "mother behavior" as the ways in which mothers treated community and family members in general (for example, a woman's own parents, in-laws, siblings, or husband) including showing love, support, kindness, respect, and generosity. These behaviors related to individuals outside of the mother-child dyad and did not include any childcare activities. Specific "mother behaviors" that I identified as associated with good mothers included: having and maintaining friendships within the community, providing advice to community members about childcare, providing advice to younger women and girls about lifestyle choices, taking part in

community development and farming, sharing resources with those in need, taking care of one's own parents, showing respect to others, and maintaining a humble and disciplined demeanor. Second, within my data analysis I chose to define "childcare" as any discrete activity directed towards child-wellbeing but not related to a mother's individual disposition or relationships with individuals outside of the mother-child dyad. Childcare activities most often related to feeding, bathing, clothing, and providing material resources needed for a child to grow well, and providing necessary life advice in order to live successfully within the community. Women also discussed a child's behavior as an indicator of successful childcare practices. In this section I first look at the ways that good motherhood was judged by women within Kachule, and then move on to the implications of this judgment in terms of women's access to material and social resources.

Childcare:

First, women's responses to the question of how a good mother could be identified that used childcare as an indicator of good motherhood tended to include a relatively uniform set of practices that denoted good mothering. In particular women emphasized adequate child nutrition, child appearance (both clean and well-dressed), and child behavior (in particular, showing respect to other community members). Ethel, a 49-year-old mother of four, explained how the appearance of successful childcare practices informed the community of a woman's mothering competency in a particularly clear way. In describing how she could tell if a woman was a good mother she stated:

It shows in the way she is with her children, her respect, her children's behavior and how well she feeds them. Things in her household show how well she takes care of her children…This woman is well-behaved. She must set good examples for her children about how life with other people needs to be, how to live a good life on a day-to-day basis and that they need to give respect to their parents if they are there, get water for them and help. It is then that people say they are being taught well, that their mother is taking good care of them and also that she is teaching them good behavior about how to live with others.

Later in her interview she went on to suggest that:

The way the child looks says a lot. The child looks well, is well clothed, and looks healthy indicating that the child is coming from a good household where they are giving that child everything needed for his/her day-to-day life. The child looks well-fed, is bathed well, and is wearing good clothes.

Ethel had lived in Kachule all of her life. At the time of our interview she was widowed and supporting herself and two of her husband's relatives through farming.

Mother Behavior:

Women's responses to questions about good motherhood that referenced mothers' behaviors outside of the mother-child dyad focused on mothers' social relationships with community members, especially other women, and did not include relationships with children (although relationships with children and childcare were often presented together with

discussions of maternal behavior in definitions of good mother and their separation in this discussion is purely for analytical purposes). In general women viewed good mother behaviors as benefitting the community as a whole and supporting community development. Good mothers also supported other community members in times of need by sharing resources. For example, Eliza, a 24-year-old mother of three, stated: "A good mother is very friendly and generous. She gives you food if she has some. She takes you to the hospital when you are sick." Women suggested that a mother who displayed these types of "good" behaviors provided an example of appropriate behavior to her own children as well as other mothers in the community and their children, and in doing so helped ensure the perpetuation of these behaviors in future generations.

The social nature of good mother behaviors was also particularly evident in women's definitions of bad mothers. In addition to the typical parallel childcare responses in good and bad mother definitions—that good mothers take good care of their children while bad mothers neglect or abuse their children, etc.—many women included a mother's social behavior in their assessment of bad motherhood. For example, Eliza stated that, "[A bad mother], her behavior is repulsive. She does not have any friends in the community…She always quarrels with people in the community." Similarly, a 35-year-old mother of four explained that, "A good mother takes good care of her children and also has a good relationship with other people in the community while a bad mother quarrels with other people." These excerpts demonstrate the social nature of the behaviors used to identify good and bad mothers.

Additionally, women described bad mothers as individuals who not only treated their own children badly, but also abused other members of the community. Bad mothers provoked arguments with others (especially other women), used foul language, drank alcohol frequently, and engaged in promiscuous behaviors. Women went as far as to assert that the behavior of bad

65

mothers affected community development because a bad mother would not farm or participate in social activities, and in doing so provided a bad example to those around her, especially her children. Bad mothers also refused to share resources with other community members or worse, were thought to actively hide resources in order to avoid sharing. In describing a bad mother, Monica, who was introduced earlier in this chapter, stated:

When she comes into your home you just think this woman has a bad attitude and behavior. When you go and ask her for things, she says she doesn't have those things when in fact she actually does have them. So you know that this woman wouldn't help you no matter what you do.

Behaviors associated with bad mothers were likely especially problematic to women like Monica who struggled to support her children without support from her husband.

Due to these types of behaviors, many women suggested that bad mothers were ignored or even treated poorly by other community members. For example, Gertrude, introduced earlier, explained that: "People don't like spending time with a bad mother. They ignore her because she curses so it's hopeless to even make an effort to chat with her." Other women similarly suggested that "bad mothers" were often simply ignored by other community members. Further, because bad mothers' behaviors were always watched, their activities were susceptible to policing through community gossip. Thus, in addition to being talked about and judged, women considered "bad mothers" faced social ostracism from other community members. Some women said that people might even be actively cruel to a bad mother, mirroring the cruel behavior she showed to both her children and to other community members. Both formal and informal mechanisms of intervention existed to reform the behaviors of the bad mother. Members of this

woman's close social network or designated older women responsible for providing advice to mothers in the community were tasked with visiting the bad mother to discuss how to change her behaviors. One of these older women explained that she would only visit a mother three times to try and advise her. If the woman chose not to listen to the advice, she would no longer receive community support and she would face the social ostracism targeted towards "bad" mothers.

Self and Home Appearance:

Other domains of good motherhood that emerged from the interviews showed the importance of social appearances and included home maintenance, mother appearance, and childspacing. Home maintenance generally included household care and creating an appearance of an orderly well-kept home. This task required frequent sweeping of the home and surrounding courtyard, repairing home exteriors with new mud or bricks, and drawing water at the local borehole. Women were also responsible for collecting dried grasses to repair thatched roofs damaged by the rainy season. Describing these types of tasks, Elis, a 28-year-old mother of four introduced earlier explained that, "[A good mother] cleans her house, sweeps, draws water, bathes her children and is always kind to them. She also takes care of her parents. That sort of woman is a good mother." Women spent the majority of their days engaged in home, family, and childcare, often waking before dawn to start their daily routines. Typical village homes were structured in such a way that the majority of household activities were performed outside in clear view of other community members. This public nature of life presented an impetus for mothers to keep a well-maintained home for social appearances.

Mother appearance was another commonly addressed topic related to good mothers. Women who identified mother appearance as an indicator of good motherhood stated that good

mothers were able to bathe frequently, dressed well, and appeared healthy. For example, Christina, a 33-year-old mother of four introduced earlier in this chapter, stated that, "A good mother looks after herself. She has a good body, smooth skin, she looks well and dresses well." Similarly, an 18-year-old mother of one explained that good mothers could be identified by the way they dressed. Moreover, she added that, "Some women have children and sometimes grandchildren but their dressing does not reflect that. They dress disgracefully or like young girls even though they have grown children." Similarly, a 42-year-old mother of four asserted that, "A good mother takes care of herself, when you're a mother who doesn't take care of herself it's telling to people that being a mother is something that you can't handle."

Success in maintaining a socially appropriate appearance indicated to others that a woman was able—physically, intellectually, and financially—to support both herself and her children. Women also frequently connected childspacing with their responses related to appearance, and both were heavily associated with hygiene practices. Improper childspacing impeded women's ability to appear in this socially appropriate way. Women who gave birth too frequently were thought to look unhealthy, lack hygienic practices, and have food insecure households. A 34-year-old mother of three explained: "People can tell by how you look if you're a good mother or not. They can tell by looking at her frail body that she doesn't practice proper childspacing and has had multiple children in a short amount of time." Moreover, these women were thought to be unable to care for their children appropriately due to lack of economic resources, reduced physical strength, and insufficient knowledge related to childcare. Some women also evaluated their own childspacing practices based on these ideas. For example, Mary, a 41-year-old mother of seven, stated: "My children are close to each other in birth like mice. I scold myself. So close to each other? That kind of spacing is not good." Mary lived with her

husband who worked as a watchman for a business in Thete. She described facing daily struggles supporting her family and was also dealing with complications from a surgery she had received during one of her pregnancies.

Compliance with Medical Advice:

Ideas about proper childspacing were also a common theme disseminated at Under-Five Clinics where women went each month to have their children weighed and to receive basic medical services as I will show in the following chapter. In women's interviews, several mothers suggested that simply attending Under-Five Clinics was an indicator of being a good mother. These women's discussions centered around the idea that going to these clinics would demonstrate that a woman was taking appropriate care of her child, and thus show her to be a good mother. Sarah, a 35-year-old mother of five introduced earlier, explained that, "Good mothers take their children to the Under-Five Clinic to have them immunized. They are also able to know and follow their child's weight." Other women addressed compliance with the various health advice obtained at these clinics (including childspacing) as ways to demonstrate good motherhood. For example, a 40-year-old mother of three used compliance with medical advice as part of her assessment of bad mothers: "Bad mothers do not do what they are told at the hospital. They do not deliver at the hospital but opt for home deliveries instead despite being told not to do that. That is how we know that someone is a bad mother." Gertrude, a mother introduced earlier in this chapter, similarly identified failure to comply with health care provider advice as sign of being a bad mother. She stated:

If a health worker comes to the community to talk about motherhood, there will be women encouraging bad mothers to go listen to what the health worker has to say, but a bad mother will not listen to them and will sometimes treat the other women badly. We know that such a woman has a problem.

However, the low frequency with which women identified clinic attendance or following advice obtained at the clinic, as important criteria of good motherhood showed that this was not as salient a marker of good motherhood as judged within the community as the other indicators discussed here.

The Impact of HIV/AIDS on Women's Constructions of Good Motherhood:

In general, the HIV-negative and HIV-positive women who I interviewed for this study were similar in terms of age, parity, occupation, and marital status. I also found few differences in women's discussions of aspects of motherhood and good motherhood based on HIV status. However, interviews with several HIV-positive women demonstrated some additional concerns for HIV-positive mothers regarding childcare. Specifically, these HIV-positive women were concerned with making sure that their children would be well-supported when they died. For example, Cecilia, a 43-year-old HIV-positive mother of seven, explained that: "[An HIV-positive mother] is aware of her life situation and wants to use all the energy she has to take care of her children before she dies." At the time of our interview Cecilia supported her family through farming and small business. Similarly, Ethel, a mother of four who was introduced earlier in this chapter and who identified herself as HIV-positive during our interview, stated:

At this time, I need to see that my life is limited, my life could be reduced and I could die at any time. I need to make a future for my children so that they should know that their mother is making a future for them.

These responses demonstrated that some HIV-positive women felt the need to increase their mothering efforts above what would typically be expected of an HIV-negative mother, especially in terms of providing resources to their families. Moreover, due to the stigma related to HIV/AIDS it was especially important that these women achieve good mother status to maintain their social standing. Three HIV-positive participants, however, also explained that HIV-positive mothers were weaker than those not affected by the disease, and thus had increased difficulties taking care of their children in addition to enacting other good mother practices.

Because of this idea of bodily weakness, HIV-positive mothers stressed the importance of antiretroviral therapy (ARVs) in order to maintain their health and strength so that they could continue to care for their children. For example, in discussing HIV and motherhood a 34-year-old HIV-positive mother of one explained that in order to take care of her children successfully an HIV-positive mother, "can start by going to the hospital where she will receive treatment that will make her strong and healthy enough to be able to take care of her children." Of the 18 HIV-positive women I interviewed during this study, seven specifically mentioned that they were stronger after being diagnosed with HIV/AIDS because of ARVs. Ethel, for example, stated: "From the time I found out that I had HIV, my life has changed because I couldn't work at that time. After I got tested I could do all types of work and I have more strength compared to before the test because of ARVs." Another 73-year-old HIV-positive mother of one explained that, "My

life is better now compared to before because of the ARV treatment. Although I'm old I am stronger now and don't get sick as often I used to before. I am able to farm."

Discussion:

Good Motherhood as a Social Resource:

With the birth of a child a woman begins to gain the identity of "mother" and is privileged with access to women's knowledge (secrets of motherhood) and women's social groups (although birth does not guarantee sustained membership within these groups). However, I argue in this chapter that although childbirth may partially bestow the identity of mother, with accompanying privileges and responsibilities, the full status of a mother is not achieved until a woman has successfully performed a set of social practices that show the community that she is a "good" mother. These social practices include childcare but also expand beyond the mother-child dyad and incorporate relationships with other community members, especially other women. This distinction supports Johnson-Hanks (2006:2) differentiation between the biological act of childbearing and the "social category of 'mother.'" The accomplishment of good motherhood represents the achievement of this social category, integrating a woman into her community and entitling her to a level of respect above that accorded to mothers through virtue of birth alone.

Achieving the status of good mother was also described as a way to facilitate access to social and material resources. In Kachule, due to the commonality of matrilineal residence patterns, mothers were theoretically able to access resources from maternal family networks. These types of resource exchanges took several forms. For example, many women mentioned providing different levels of support to family members, in particular women's own mothers,

sisters, and sister's children, including providing meals. Women also described family members providing food, water, and material goods after the birth of their children, and sometimes providing material support to deal with childhood illnesses (especially fees for hospital care). Food exchanges from wealthier relatives to less prosperous kin are an especially common form of resource exchange in matrilineal family compounds in Malawi (Vaughan 1983:277). However, women's discussions of challenges obtaining resources demonstrate that these kin networks alone were not able to alleviate the substantial socioeconomic burdens that women faced on a daily basis (as I will discuss further in Chapter 6).

Because of the inability of kin to provide significant material support to women in times of need, mothers were forced to seek out support from other social networks. Women identified good mothers, in particular, as individuals who would quickly share resources with others during these difficult times. Further, as good mothers were able to make and maintain friendships, these women had a larger network from which to seek out support when they needed additional resources for themselves. This type of support was particularly important in the current socioeconomic environment of Kachule, where extreme poverty presented a huge challenge for the practice of everyday life. For women facing additional challenges, such as HIV/AIDS, garnering social support may be especially crucial. In this way, attaining the status of "good mother" may be viewed as a survival strategy as well as an accepted part of a woman's life trajectory. Further, as a social strategy good motherhood becomes a form of social capital, defined here as: "the ability of actors to secure benefits by virtue of membership in social networks or other social structures" (Portes 1998:6).

This social capital view of good motherhood also fits with Englund's (1999:141) discussion of personhood in Central Malawi as "a composite of relationships" that situate an

individual within his or her social world, and provide structure and meaning to everyday social interactions. Any individual action makes these networks of relationships visible by demonstrating the social connectedness between specific people (Englund 1999). For example, appropriately distributing accumulated wealth and social support throughout one's social network ensures the maintenance of established social relations (Englund 1999; Pritchett 2001). In fact, Pritchett (2001:118) states that in the Southern African context, "Very little of one's identity has its own autonomous existence. One is something only in relation to someone else." In times of extensive social and economic uncertainties, drawing on this "composite of relationships" becomes a crucial survival tool (Englund 1999:141).

Through achieving the status and identity of good mother, a woman in Kachule gains respect and social standing in her community. Thus, women suggested that becoming a good mother was an extremely important part of social life in Kachule despite also acknowledging that the resources theoretically available to good mothers were less accessible due to the current socioeconomic environment (see Chapter 6). Further, although achieving good motherhood as it was defined by the local context clearly had important implications for women, this version of good motherhood was not the only construction that women faced in their daily lives. In the next chapter I explore health education discourses disseminated at Under-Five Clinics. In particular, I focus on the ways that these discourses facilitated the construction of a specific form of good motherhood as well as the ways that these clinic discourses intersected with the local concepts of good motherhood presented in this chapter.

CHAPTER 5: CONSTRUCTING "GOOD MOTHERHOOD" AT THE UNDER-FIVE CLINIC

Introduction:

Women singing: *Raising all these children, let me be the one that raises them*

You've got yourself in this situation, one baby on your back, another on your shoulder and another in your womb.

Health Surveillance Advisor:

Let's sing another one that says the mother is the one responsible for the child because they are the ones that had the child at the hospital, they should be home changing diapers because all that responsibility goes to the mother. From the day the child is born until the day they die, be it a boy or a man with a beard, even to the day they're laid to rest in their grave, the mother still clings to her child.

Women singing: *A mother is the child's mother, I suffered, I scratched myself, I crawled, I shouted, I hit myself.*

(Song, Mtendere Community Hospital)

So began the health education component of an Under-Five Clinic at Mtendere Community Hospital. The hospital frequently drew large crowds for its once per month clinic for children five-years of age and under, and women had begun to gather outside the clinic building

75

early that morning. By 8:30am at least 70 women waited outside the small brick structure, chatting with other women or nursing their babies, while several health surveillance advisors (HSAs) weighed each child and recorded his or her weight in a yellow health passport. At around 10am, once all of the children had been weighed, the HSAs ushered more than 100 mothers inside the building to sit on wooden benches or the floor for the next part of the clinic, a health education talk and the provision of some basic health services. After a short prayer, the HSAs requested that the women sing a song regarding a health topic, in this case women's responsibility to care for their children's health and well-being. At the conclusion of the song, one of the HSAs continued with a talk on preventing pediatric diarrheal disease by improving cooking and home hygiene practices.

This chapter explores Under-Five Clinics as sites where a specific version of "good motherhood" is constructed. I suggest that both the health messages provided to women by health workers during these clinics, as well as the attitudes of those health workers, promoted a "correct" form of good motherhood that women attending the clinic were expected to follow. Here I ask, what specific aspects of these health education talks construct a model of good motherhood? Further, how does this model interact with the local mothering concepts I explored in the previous chapter? Finally, how do mothers interpret clinic mandated mothering practices and the accompanying blame when environmental factors such as poverty negate women's abilities to do so?

The first part of this chapter provides some additional background on the history of Under-Five Clinics which I began to introduce in Chapter 2, and examines the role of health education as a component of these clinics. Next I briefly describe the specific Under-Five Clinics I observed during my fieldwork. I then examine some of the kinds of health education provided

to women attending the clinics, as well as the presentation of this information, and the ways that these discourses served to promote a particular form of good motherhood. In particular, I focus on themes of responsibility and blame that emerged from the health talks, and explore how these themes work through various health discourses to define and control women's mothering practices. Lastly, I discuss women's responses to the messages imparted in the clinics.

Under-Five Clinics and Health Education:

Under-Five Clinics in Malawi were developed during the early 1970s through a conjoined effort of the Ministry of Health and Christian Hospital Association of Malawi (CHAM) to combat Malawi's extremely high rate of child mortality (see Chapter 2). The majority of deaths at this time were caused by widespread undernutrition combined with common childhood infections, conditions readily addressable by low cost interventions. Thus, Malawian Under-Five Clinics were based on threefold aims of reducing malnutrition and preventable childhood diseases, improving access to quality medical services, and increasing knowledge, attitudes, and practices related to issues of child nutrition and general care (Cole-King 1975:185). The basic structure of these clinics followed concepts of comprehensive child care elaborated by Morley (1973:319), whose influential treatise on pediatric issues in developing countries called for an increase in preventive and curative services for children through, "the four corner-stones of Treatment, Immunization, Weighing, and Health Education." To meet these ends he suggested that health education, in particular, should be used to promote nutrition, immunization, and "the need for cleanliness" (Morley 1973:14).

As such, health education, and specifically health education targeted at mothers, has been a priority of Under-Five Clinics since their inception, both as a general concept carried out in

developing countries, and in Malawi in particular (Morley 1973; Cole-King 1975:188). The topics presented in current Under-Five Clinics' health education talks continue the original aims established in the 1970s and also fit within current national and international priorities for child health as set forth by Malawi's Health Sector Strategic Plan as well as multilateral public health organizations such as UNICEF (United Nations International Children's Emergency Fund) and the WHO (World Health Organization). These organizations focus on reducing child mortality through low-cost technical interventions, specifically those targeted at common childhood diseases such as pneumonia and diarrhea, nutrition, and hygiene practices (WHO 2016; MoH 2011).

Health education talks at Under-Five Clinics throughout Malawi are typically conducted by health surveillance advisors (HSAs) at government run clinics or homecraft workers (HCWs) at clinics run by CHAM. Both HSAs and HCWs are low level health care providers who receive a basic 10-week training in community health issues including nutrition, hygiene, vaccination, common illnesses, child health and growth monitoring, family planning, and antenatal care. Becoming an HSA requires only a high school level certification with no additional formal medical training (MoH 2009; Gilroy et al. 2013). HSAs, in particular, are intended to link local communities with basic health care services, and each HSA is assigned a catchment area that contains around 1000 individuals (Gilroy et al. 2013). HCWs also provide basic health services and additionally hold occupational demonstrations for women, for example in sewing and cooking. Both HSAs and HCWs receive additional health-related trainings held by the Ministry of Health in a workshop format, but these are infrequent and none of the providers I spoke to had been to a recent training.

In addition to health education talks, several other resources are available at the Under-Five Clinics: routine vaccinations, basic pediatric care, and nutritional surveillance. In cases where malnutrition is identified, children may receive some food donations or be referred to a special undernutrition clinic for additional monitoring and care. Further, Rosenthal (2015:518) suggests that mothers may also receive social support and companionship from the other women attending the clinics, adding social capital as one of the resources Under-Five Clinics provide.

The Clinics:

During my fieldwork I observed nine health education talks given at Under-Five Clinics in two hospital settings (described in greater detail in Chapter 3). Dedza District Hospital held Under-Five Clinics each weekday morning, while at Mtendere Community Hospital, Under-Five Clinics were held once per month. Clinics at both sites included an educational talk typically presented by an HSA or HCW. At Dedza District Hospital one senior nurse occasionally conducted the educational portion of the Under-Five Clinic. The format of the clinics at each site was relatively similar, however, at Dedza District Hospital the health education talks were given prior to any health care services, including growth monitoring, while at Mtendere Community Hospital, HSAs often began weighing children before the talk started. Talks at each site lasted between 15 and 45 minutes and covered similar health topics including common childhood illnesses, nutrition, family planning, the importance of vaccines, and family hygiene. Talks typically started with a prayer, after which the moderators asked the women in attendance to sing a short song addressing a health topic. These songs were widely known and a common component of both Under-Five and Antenatal Clinics.[3] Next the HSA (HCW or nurse) presented

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[3] Songs have frequently been used as tools for health promotion in populations with low literacy rates (Tembo 1995).

a lecture on one or two health topics, asking questions addressed to the women in attendance throughout the course of the talk. During interviews with the providers who gave these health talks, I was told that topics were selected by each individual HSA or HCW from a pre-set list of subjects and based on the perceived health needs of each audience. Once the lecture was complete, children were provided with routine vaccinations and other basic services.

However, in addition to providing health information regarding various health topics, health education talks also imparted notions of responsibility and blame onto mothers attending the clinics. In the next section I look at these concepts more closely, highlighting their role in both the health education information being disseminated and in the construction of a specific form of good motherhood.

Responsibility and Blame:

Throughout the health talks I observed, women were reminded over and over again about their responsibility for fulfilling child care recommendations provided at the clinic. Both health education discourses and the HSAs presenting these materials characterized women who failed to comply with these directives as uncaring and lazy, blaming them for poor child health outcomes. For example, a health song at an Under-Five Clinic health talk at Dedza District Hospital demonstrates the ways that health discourses defined bad mothers and blamed them for their children's health status:

You don't care about your child, you don't go to the Under-Five Clinic, you don't cook for your child, you just look after yourself instead. It's your fault if your child falls ill, your fault if your child becomes malnourished (Song, Dedza District Hospital).

During another health talk a nurse reiterated this theme of maternal responsibility and blame:

Why is the child malnourished? Is it because the child is sick? Or is it because the mother is lazy? Sometimes a mother's laziness can cause her child to become malnourished. She has no time to cook because she would rather gamble and play games with her friends instead of cooking porridge and exclusively breastfeeding her child (Female Nurse, Dedza District Hospital).

The song opening this chapter is also illustrative of the kinds of messages about responsibility communicated to mothers through health discourses, including the overwhelming burden placed on mothers to ensure healthy outcomes for their children. These types of messages told women that child care and child health outcomes were solely their responsibility. Subsequently, any poor outcome was also the responsibility of the mother. For example, consider the following interchange:

HSA: *As women, we forget that these babies are our responsibility. For how many months have we had our babies growing inside us?*

Women: *9 months.*

HSA: *How many months?*

Women: *9 months.*

HSA: *Does anyone keep the baby for us?*

Women: *No.*

HSA: *We forget about this and fuss and complain once the baby is born. Mothers are*

              responsible for their babies.

(Female HSA, Mtendere Community Hospital)

Furthermore, the ways that HSAs (or HCWs) who conducted the health talks treated

women during the clinics had an enormous impact on constructing blame during the clinic

encounters. For example, in some cases HSAs employed derogatory language, indicating that

mothers were lazy and irresponsible. By doing so, those HSAs used attitudes of superiority to

position themselves as health experts with the power to attribute blame to mothers who were

unable to meet the specific recommendations provided during the clinics. Women's personal

hygiene was also a common means of positioning women attending the clinics as inferior to the

health providers working at the clinic. For example, the following three excerpts illustrate some

of the ways that health workers used women's hygiene to create a power differential between

themselves and the mothers attending the clinics:

HSA: *Do you think doctors are silly to recommend that the child attends the Under-Five*

              Clinic sessions for 5 years? They have reasons for such recommendations. Am I

              making myself clear? We all know when we are going to go to the hospital. Why

              then do we smell bad? Please bathe your children when coming to the hospital.

              Wash their clothes. Change their diapers. Women please remember to wash your

              underwear. Let's be hygienic please to reduce the bad odors here. This is the

              maize and groundnut season. Let's take a look at the floors. How do they look?

Women: *They look clean and tidy.*

HSA: *Come 10am these floors are going to be very dirty. Who do you think will remove*

                these papers? Did you hire anyone to clean these floors? Please ladies, let us be

                hygienic; it all begins at home. Are there any questions?

(Male HSA, Dedza District Hospital)

Nurse: *Let us take good care of the health cards. Let us keep them clean and undamaged.*

                The doctor should not feel disgusted because of a dirty health card.

(Female Nurse, Dedza District Hospital)

HCW: *What lessons did you all learn last week?*

Women: *We need to give birth at the hospital.*

HCW: *What else?*

Women: *We need to be clean and look neat and tidy.*

(Female HCW, Mtendere Community Hospital)

Assessing Good Motherhood:

During interviews with health care providers, HSAs (and HCWs) explained that they

categorized the women they saw at the Under-Five Clinics as either good or bad mothers. In

particular, providers identified good mothers as those who regularly attended the Under-Five

Clinics, understood and remembered the educational materials provided, and complied with the

recommendations provided there. For example, one HSA stated: "I can tell a woman is a good

mother when she attends the Antenatal Clinics accordingly and then afterwards comes with the baby to the Under-Five Clinics. Yes, I see she's been taught by the HSAs." (Female HSA, Mtendere Community Hospital). Another HSA asserted: "We have to check to make sure the woman visits the Under-Five Clinic every month. Once we see that she comes to the Under-Five Clinic every month regularly we automatically know that this is a good mother and that she knows her responsibility" (Male HSA, Mtendere Community Hospital). Other HSAs described identifying a good mother by the number of children she had given birth to:

> *I try to explain to women that to be a good mother you should have a small family. If women have many children they may die during the delivery and they can't even take care of the children they already have. The children can't go to school because there is no money and there are always problems* (Female HSA, Mtendere Community Hospital).

Another female HSA at Mtendere Community Hospital expounded on the importance of childspacing and small families:

We teach women that it's good to plan with their husbands how many children they want to have, and how they will space them, in order to prevent unexpected children. If they do that they can look after their children well, school them well, and also so as a mother they can behave well and have time to farm in their lands. They will have food or money and can even lend something. When they are just bearing children they have no time. They are busy and they are not healthy (Female HSA, Mtendere Community Hospital).

However, none of the providers suggested that categorization as either a good or bad mother had anything to do with how services were provided to women attending the clinics.

<u>Women's Responses</u>:

During the clinic sessions, women did not visibly respond to the HSAs' assertions about the inadequacy of their various hygiene or other mothering practices. Rather, in most cases the women appeared to passively sit through the entirety of the health lecture waiting for the services (vaccines and basic medical care for common childhood illnesses) provided afterwards. Moreover, outside of the clinic, in interviews with mothers, women elicited respect for and a desire to comply with the advice provided at the Under-Five Clinics with no mention of disrespectful behavior on the part of the health workers. For example, Elis, a 28-year-old mother of four who I introduced in the previous chapter, stated: "A woman needs to follow what health workers advise because it benefits her in the end." Similarly, a 23-year-old mother of four asserted that health recommendations obtained at the clinic should be held to a higher standard than mothering advice learned in the community because, "most people in the community are illiterate while the health workers know everything." Following this portrayal of health care providers as experts, Patricia, a 27-year-old mother of two who was also introduced in the previous chapter, added: "What we learn from the hospital is more professional than what we learn from the community. You can't take what you learn from the community seriously."

Women's discussions of the advice they received at the Under-Five Clinic also tended to focus on issues of hygiene. In particular women identified the need to bathe both themselves and their children regularly as a common lesson promoted at the clinic. Stella, a twenty-year-old mother of one child, demonstrated this focus particularly clearly in her description of clinic-

based hygiene advice: "They tell us to bathe before we go to the Under-Five Clinic. They also tell us to bathe our children every morning, afternoon, and evening." At the time of our interview Stella was unmarried and supporting her young child through farming. These types of responses echo the emphasis on hygiene that health workers inserted into the health education talks they presented at the Under-Five Clinics.

Hygiene was also a major component of women's ideas about good motherhood practices outside of the discussions of specific clinic advice, as shown in the previous chapter. Women who spoke about hygiene practices in relation to good motherhood indicated that good mothers looked healthy and clean, as well as had clean children and homes. Further, women often connected hygiene with childspacing, another topic that was frequently presented at Under-Five Clinic health talks. Mothers associated improper childspacing practices with unhygienic behaviors and poor mothering skills, suggesting that women with many children close in age were unable to practice appropriate childcare due to lack of economic resources and reduced physical strength.

In addition to the ideas about hygiene and childspacing that emerged in women's discussions of good motherhood and that mirrored the advice given at the Under-Five Clinics, during interviews a little over half of the women also stated that they had learned how to take care of their children at Under-Five and Antenatal Clinics. For example, a 28-year-old mother of three said: "I learned what I know from the Under-Five Clinic. We learn a lot from there... I make sure I cook for my baby in the morning, afternoon, and evening. Every time my child goes out to play I make sure I bathe her afterwards. I also take her to the Under-Five Clinic each and every month. I never miss any clinics." A 27-year-old mother of three similarly explained: "We

are told how to take care of our children at the Under-Five Clinic and how to make sure that they are strong and healthy."

As well as identifying the clinics as a major source of advice related to childcare, forty percent of women who talked about receiving motherhood recommendations stated that other community members were their main source of advice. Women who suggested that they had also received childcare advice within the community often said that this advice was the same as what they had received at the Under-Five Clinic, although as I showed earlier some women disregarded community advice as less official. The community advice that women identified had a variety of sources, for example from family members, friends, and older women. Further, advice was also provided in a more official capacity, by a specific set of older women selected by the village headman to serve as advisors for pregnant and postpartum women. At the time of my research there were 18 women throughout Kachule who had been selected to be advisors. These women received some basic training at Mtendere Community Hospital regarding care for pregnant women and newborns and then visited pregnant women and new mothers to provide advice and support. When I asked women what advice about motherhood they had received in the community it is likely that they referred to the advice given by these advisors, advice which followed that given by the Antenatal and Under-Five Clinics.

When mothers described different types of advice given within the community and at the clinic, the clinic's advice was privileged. For example, Cecilia, a 43-year-old mother of seven children who was introduced in the last chapter, explained that when she gave birth she was given childcare advice from individuals within the community as well as at the clinic: "The village gave me advice but I believed the advice from the hospital." Gertrude, a 36-year-old mother of six children who also appeared in the previous chapter, similarly stated: "The advice

we are given in the village is different because it's old fashioned. We are not told exactly what happens when you're pregnant. They aren't as open as the doctors at the hospital so we know it's better to go to the hospital instead." Few women went into any detail about this type of "old fashioned" advice during their interviews. However, in the limited instances when these types of beliefs were addressed, women mainly discussed proscriptions on the resumption of sexual relations between husband and wife after the birth of a child until after a certain number of months (typically 4-6) had passed due to a belief that sexual relations before that time could cause a man to become ill. Women suggested that these types of beliefs were no longer held by community members, rather, mothers in the community now followed the advice provided at the Antenatal and Under-Five Clinics.

Lastly, my data suggest that women from all age groups privileged standard clinic discourses over other types of recommendations and further, were well-versed in those discourses. Presumably, older women would have been more exposed to different recommendations than younger women who gave birth after Malawi's political climate shifted towards increased maternal and child health interventions, in addition to attempts at eliminating traditional forms of knowledge (for example, banning Traditional Birth Attendants). However, my data do not show substantial differences between knowledge of clinic discourses or the privileging of these discourses over other sources of advice between older and younger women.

Discussion:

Returning to the specific questions posited in the introduction to this chapter, I argue here that through a focus on women's responsibility for the health and well-being of their children, and blame for failing to enact specific practices, health discourses and the providers who

disseminate them constructed a "correct" form of good motherhood that mothers attending Under-Five Clinics were expected to perform. This version of motherhood depended on compliance with childcare advice provided during the Under-Five Clinics and included both health information on topics defined by national and international health agendas: nutrition, hygiene, immunization, etc., as well as the less official messages communicated by health providers throughout the clinic sessions: the idea that mothers attending the clinics were unhygienic or that malnutrition was caused by mothers' laziness. These discourses unapologetically increased women's daily burden of responsibility to their children and families and reflected a reality discordant with women's actual lives.

The model of good motherhood constructed at the clinic was enforced by a rhetoric of blame. Mothers who did not fulfill specific practices advocated during Under-Five Clinics faced being labeled as deviant or "bad" by health care providers. This type of blame implied a moral failing on the part of mothers. Hygiene in particular, was a theme that conferred a strong sense of morality. The use of hygiene as a tool of subjugation and power has a long history in public health messaging as well as colonial discourses intended to construct and control African bodies. For example, as shown in Chapter 2, colonial authorities and missionaries constructed and reified racial and social difference through discourses surrounding hygiene, cleanliness, dirt, and odor (Burke 1996).

Some of the ways that HSAs used hygiene as a mechanism of blame during health talks mirrored colonial and historical public health uses of hygiene discourses. The HSAs' focus on women's personal hygiene, for example, went beyond general health education—hygiene promoted in the context of health topics such as hand washing, preventing tetanus, or avoiding common skin maladies such as scabies. This focus on hygiene in the context of women's

appearance had the potential to be particularly insulting as hygiene was a common indicator of good motherhood as demonstrated in the last chapter. Further, most women who I observed attending various Under-Five Clinics, both at Dedza District Hospital and Mtendere Community Hospital, had clearly dedicated substantial time and effort into their clothing and general appearance. For example, women often dressed their children in special occasion clothing, not typical of daily wear. Moreover, health provider assertions that women attending the clinic smelled offensive, or that their appearance or belongings, including their children's health passports, would be "disgusting" to the clinicians, illustrated how hygiene served as a power tool to distance HSAs socially from patients. Dirt, here, was also associated with moral failing, and poor mothering practices. In this way hygiene was one of the ways used by health providers to position women attending the clinics as inferior and in need of health education in order to claim the identity of good mother, an identity that could only be conferred by clinicians.

However, despite these clear displays of disrespect, women's identification of health information obtained at the Under-Five Clinics as important sources of parenting advice showed that women welcomed the health knowledge disseminated at the clinics, privileging this knowledge over advice obtained from other sources. Increased social distance between HSAs and the women attending the clinics, established through the use of discourses such as those related to hygiene, perhaps made this health information seem more official due to the positioning of the HSAs as superior experts. None of the women I interviewed described being categorized as a good or bad mother by the HSAs (although as I showed in the previous chapter, several women directly connected attendance at the Under-Five Clinic with good motherhood). That women incorporated a strong focus on hygiene into their own definitions of good motherhood, outside of discussions of clinics, also suggests that despite the ways that

information is disseminated, women accepted and internalized provider definitions of good motherhood, including ideas about appearance and domestic hygiene.

These types of responses are consistent with what Rosenthal (2015) terms "security-seeking behaviour." She suggests that mothers she observed in Southern Malawi actively sought out services at Under-Five Clinics, attempting to utilize all available means for increasing security. As one such security-increasing mechanism, participation in Under-Five Clinics had multiple goals: acquiring health care resources for children (albeit often limited), building social networks through comradery with other mothers attending the clinic, and receiving the occasional provision of additional materials, primarily food and cooking items (Rosenthal 2015:518). Here I emphasize the inclusion of health information as a part of the various care resources that women sought at the clinics. Rosenthal (2015) also shows the high value that women placed on Under-Five Clinic attendance as evidenced by time lost in agricultural work and other wage-earning labor, and the often long distances women travelled to reach the clinics. As such, Rosenthal (2015:516) argues that for women in Malawi, "attending the Under-Five Clinics is anything but passive."

However, despite women's acceptance and even active seeking out of health information provided at the Under-Five Clinics, health education themes of nutrition, hygiene, and childspacing, especially, communicated standards of practice that were challenging to achieve in socioeconomically disadvantaged contexts. These health education topics reflected broad national and international health agendas, and promoted a generic version of good parenting based on standards often at odds with local realities. Perhaps most significantly the health discourses observed in this study expected a level of agency that simply was not available to most women using the clinics. Thus, I argue that health education alone did not impact women's

91

capacity to enact new behaviors. In the Under-Five Clinic for example, even though women readily accepted the health information being provided, the health discourses utilized made no attempt to incorporate the underlying social or economic barriers that substantially impacted mothers' ability to carry out these practices. Nor did the HSAs conducting the lectures address socioeconomic barriers during the clinics that I observed, although they were all well aware of the specific challenges that women faced, most having worked in the community for a substantial period of time. Moreover, one HSA had actually grown up in Kachule and currently resided in the village, and so was intimately familiar with the concerns of mothers in the community. The reasons that HSAs chose to ignore the real life circumstances of women attending the clinics, relying instead on generic discourses at odds with local contexts, was not discussed in my interviews.

Further, rather than addressing women's life challenges, some HSAs expressed the sentiment that if women followed what was advised at the clinic, especially advice related to childspacing, these daily problems would simply go away. In particular, HSAs suggested that having fewer children would leave women more time to farm and participate in other money making ventures. However, although HSAs talked about childspacing as an important means of alleviating poverty, as well as indicator of good motherhood, none of the health talks I observed or the interviews I conducted with health providers indicated an ideal number of children or time between births.[4] This advice therefore failed to provide any real solutions to some of the substantial socioeconomic issues women were dealing with, and additionally led to women being blamed for their own socioeconomic condition.

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[4] The World Health Organization currently recommends that after a live birth a woman should wait at least 24 months before beginning her next pregnancy, and it is likely that this was the recommendation HSAs were using although this is unclear from my data (WHO 2007).

This was not always the case. During Antenatal Clinics I frequently witnessed HSAs trying to get men involved in their wives' health care practices. Institutional structures were also in place that facilitated the incorporation of men in these clinics that did not exist in the Under-Five Clinics. For example, if a woman brought her husband or male partner to the Antenatal Clinic, she would receive her health services first, in front of women who came alone. In some clinics couples were even given priority seating up near the front of the room close to where the HSA was lecturing. HSAs emphasized throughout these clinics that it was the responsibility of men to purchase the materials that their partners needed during the birth of their child, and further, that men should ensure that their wives were not overworked by shouldering some of the household and agricultural labor typically left completely to women. These types of messages acknowledged the power men held over a family's finances and attempted to normalize male involvement in women's pregnancy care to target this type of socioeconomic barrier.

On the other hand, during the Under-Five Clinics, HSAs frequently called for women to feed their children foods from multiple food groups (e.g. fruits, vegetable, proteins, etc.). These types of foods would be considered *ndiwo* (a term used to describe a side-dish of meat, fish, or vegetables) as opposed to the main staple of the meal, *nsima* (a thick porridge made of corn meal). Women in Kachule frequently stated in our interviews that they expected their husbands to provide the foods that would make up the *ndiwo* portion of the meal, and that often these expectations were not met. I discuss this more in the next chapter, but here simply use this example to show that calls for food variety at the Under-Five Clinic failed to take into account power and gender dynamics related to acquiring foods in the local context. Further, many women interviewed in this study faced chronic food insecurity, describing difficulties providing sufficient food for their children each day. Thus, the recommendation that women should feed

their children six food groups, while ostensibly providing valuable information about nutrition, seems to be an inadvisable approach to improving child health outcomes as it fails to acknowledge the serious and real challenges women faced in acquiring food. Similarly, health topics related to childspacing and family planning neglected the pressure that male partners place on women to bear children, as well as the importance of bearing children in achieving the status and identity of woman and mother. There is no doubt that the HSAs were aware of this context, but continued to use the generic messaging taken from Ministry of Health education protocols, themselves a reflection of global health agendas, and which did not reflect local realities.

Thus, although the health discourses employed in Under-Five Clinics sought to improve women's own health and the health of their children through education, in this context building a knowledge base was insufficient to affect real changes in women's lives. Rather, health education talks attributed an unrealistic level of responsibility onto women to comply with health recommendations, but simultaneously ignored the context-specific constraints that made fulfilling these recommendations difficult or impossible. Ignoring these external factors facilitated blaming women for various health issues.

Blaming mothers for child care is not new. As Smith-Oka states, "mother are easy to blame." Public health discourses have a long history of focusing on mothers as sites of intervention, discussed in greater detail in Chapter 2. Foucault (1984), for example, shows that during the 18th century public health initiatives increasingly focused on role of families in ensuring the health of children. These initiative attempted to define and police the types of care children received, including practices of domestic hygiene, bodily appearance and cleanliness, and health status (Foucault 1984:280). Mothers as the locus of the domestic sphere bore the majority of responsibility for enacting these mandates (Foucault 1984:280; Peterson and Lupton

1996:73). Foucault (1984) also suggested that public health initiatives centered around child health were characterized by moralistic undertones, leading to forms of "correct" care and consequent blame for failing to enact these practices. These types of moral underpinnings persist in a variety of current public health initiatives, especially those related to the health of children. For example, Bell, McNaughton, and Salmon (2009) show that public health discourses surrounding child health issues such as fetal exposure to alcohol, childhood exposure to tobacco smoke, and childhood obesity are wrought with "punitive and value-laden language" that blames mothers for their children's poor health. Similarly, Cleeton (2015:45) demonstrates that African American women have been blamed for high infant mortality rates in the United States, with public health discourses focusing on these women as "ignorant and irresponsible" mothers, rather than the high rates of poverty and low access to quality health services that significantly affect both maternal and child health outcomes.

In these examples, blaming mothers for their children's health is supported by the neoliberal assumption that individuals are freely choosing subjects who have the power to affect their own health outcomes by actively selecting to engage in various health promoting behaviors (Ayo 2102). I argue in this chapter that this assumption ignores the structural factors that limit women's agency. Moreover, this idea of a freely choosing subject is also discordant with the ways that people in Central Malawi think about themselves and others. As part of a set of relationships, individuals are inextricably linked to social and kin networks that profoundly influence their actions rather than autonomous decision-making units (Englund 1999; 1996). Further, as Englund (1999; 1996) shows, the type of individualism inherent in neoliberal ideologies may actually be dangerous in Central Malawian's conceptions of reality. Here

individualistic behaviors demonstrate a failure to fulfill moral standards of society based on appropriately managing social relations and can lead to witchcraft accusations.

Public health discourses utilizing individual health decision-making narratives fail to acknowledge the social component of health care decisions. For example, in traditional Ngoni communities, paternal grandmothers play a crucial role in making decisions about children's health care, while maternal kin play a significant role in these decisions in matrilineal areas, as I showed in Chapter 4. In Kachule, women I interviewed described consulting with other family members, including their husbands or their children's grandmothers (both maternal and paternal) in times of child illness, asking for advice or monetary assistance. In this way decisions related to child health were frequently circumscribed by a variety of social relations. It is therefore unsurprising that health discourses that blame mothers had little effect on actual child health outcomes when larger structural factors precluded the enactment of various health promoting behaviors regardless of a mother's desire to employ those specific practices (Bell, Naughton, and Salmon 2009; Cleeton 2015). Some of the main challenges that women faced in their daily lives is the subject of the next chapter.

In the present study, women did not mention being blamed for their children's health by the clinic or being identified as a bad mother by clinic staff. This does not bar the possibility that mothers internalized blame or provider categorization as good or bad mothers. In a study of mother-blaming in Australia, Jackson and Mannix (2004) demonstrated that mothers frequently internalized blame from others, especially from health care providers, and consequently blamed themselves for various issues over which they held little control. Moreover, "Individuals are created through their categorization by those in power," in this case categorization as good or bad mothers (Smith-Oka 2013:126). These categories, constructed at the Under-Five Clinic, have

the capacity to be perpetuated outside of the clinic in the surveillance of women's behaviors by other mothers. For example, women's associations between bad mothers and poor hygiene may demonstrate an incorporation of provider defined good motherhood into local definitions. A further investigation into the impact of blame in the construction of maternal subjectivity is beyond the scope of this research. I suggest, though, that the explicit blame (and shaming) that occurred during the Under-Five Clinic health talks was not an effective health promoting tool.

Finally, the inclusion of clinic discourses in women's discussions of good motherhood may be a product of the medical/political agenda at the time of this study, where aggressive interventions intended to reduce maternal mortality have forced other types of cultural discourses (such as advice and practices disseminated by Traditional Birth Attendants) underground, and less a reflection of women's true ideas about good motherhood. My association with the medical system, described in more detail in Chapter 3, likely had a substantial impact on the importance women gave clinic discourses in their interviews as well as the devaluation of community advice related to mothering practices. For example, my interview data reveal no instances in which women displayed resistance to clinic messages, even though literature on childbirth practices in Malawi demonstrate that TBAs are important sources of both information and health care (c.f. Sarelin 2014; Nyirenda and Maliwichi 2016; Bisika 2008). However, the large number of women who discussed Under-Five Clinics as a component of good motherhood suggests that these clinics play an important role in women's lives regardless of whether the specific advice disseminated there is followed.

In the next chapter I discuss in more detail the specific socioeconomic constraints that inhibited women from enacting good motherhood as defined by local and clinic standards and the ways that these barriers impacted ideas and practices surrounding good motherhood.

CHAPTER 6: CHALLENGES TO GOOD MOTHERHOOD

Introduction:

Women are responsible for their own and their children's lives. When we say 'mother' we mean someone who has had been through the whole experience of giving birth and taking care of children. A mother will not let her children suffer while she is alive. However, she faces a lot of challenges in taking care of her children. Take me for example, I do not have a husband and I am not running any business. I solely depend on farming which is very unpredictable; sometimes my harvest is good and other times I harvest very little. How can I take care of my children? I have to feed them, buy soap, clothes and I have to buy them the little I can to make them happy. How am I going to do this? It's very hard. Because of that I am stressed half the time (46-year-old mother of five).

Women in Kachule bear the onus for practicing good motherhood as well as the repercussions for failing to fulfill good motherhood expectations. As discussed in the previous chapters, women who do not meet community and clinic expectations of good motherhood may potentially lose access to social resources, and are looked down upon by health care providers. Health clinics, in particular, place unattainable standards on women who utilize these services for their prenatal and childcare needs while simultaneously ignoring the underlying social and economic vulnerabilities that prevent women from achieving these expectations. However, despite difficulties meeting the standards of good motherhood as defined locally and clinically, none of the women in this study identified themselves as bad mothers. How then do women reconcile their inability to practice good motherhood with their sense of themselves and other

women as good mothers?

Throughout my interviews women identified serious challenges that inhibited or made impossible various good motherhood practices. To deal with these challenges women first identified multiple tactics focused on increased physical labor, for example additional farming or temporary work, in order to earn extra income to support their families. However, these tactics were not always successful and many women emphasized that even with additional work they were not able to provide their children with adequate nutritional and material needs on a daily basis. Faced with few recourses, what then do women do to maintain their status as good mothers? As women discussed their life challenges, an additional tactic began to emerge, one centered around the idea of "trying" to accomplish good motherhood practices regardless of ultimate success. By shifting the metric of good motherhood away from successful outcomes, "trying" allowed women to maintain the appearance of being a good mother within their community despite dealing with severe socioeconomic barriers. However, the idea of "trying" was unable to help women maintain good motherhood in the clinic setting.

This chapter first details the main challenges women identified with regards to practicing good motherhood and includes some of the strategies women took to mitigate these challenges. Next, I explore the concept of "trying," which, I argue, moved women's actions from the concrete to the "subjunctive," a condition "trafficking in human possibilities rather than in settled certainties" (Bruner 1986 cited in Good 1994:153). "Trying," in this way is inherently focused on possibilities; here the possibility of success rather than its actual achievement. Moreover, "trying" represents an attempt to transform discourses of good motherhood. Finally, I discuss the ways that public health discourses are not set up to incorporate "trying" as a good motherhood practice. Although "trying" may allow a woman to be viewed as a good mother by the

community, these same practices do not fulfill clinical expectations of good motherhood.

Main Challenges:

Despite their best efforts, fulfilling all of the expectations of good motherhood set forth by community and clinical standards proved extremely challenging for most of the women in this study. During my interviews I used two questions to elicit a discussion of these problems. The first question asked women about the specific challenges they personally faced on a day-to-day basis, while the second focused on the challenges they believed were most seriously affecting Malawian women in general. For mothers who discussed their current personal life challenges, the most common problems identified were poverty, illnesses (ranging from general aches and pains to tuberculosis, malaria, and HIV), and problems with spouses which ranged from financial neglect to physical abuse. All of these challenges directly and substantially impacted the ways that women were able to care for themselves and their children. Women's responses to the most pressing challenges for Malawian women in general reflected similar issues, but more frequently identified spousal problems as the most significant challenge rather than poverty. For the purpose of this analysis I defined "poverty" as any mention of economic hardship or lack of resources, including food insecurity; "spousal problems" as any mention of physical abuse, spousal financial neglect, infidelity, or male alcohol abuse that negatively affected either women or their children; and "illness" as any mention of either personal experience with illnesses or dealing with children's illnesses (none of the mothers interviewed for this study discussed spousal illness or illness of extended family members as a significant daily challenge). Only four women said that they were not personally facing any life challenges at the time of the interview.

Poverty:

Poverty was one of the most pervasive topics throughout women's interviews and was highly connected to the other challenges women identified. Aspects of poverty that appeared most frequently in women's responses included food insecurity, difficulties finding work (both agricultural and temporary labor (*ganyu*)), and general childcare problems stemming from lack of material resources (such as difficulties clothing and bathing children properly, inability to send children to school, and problems obtaining medical care). For example, Beatrice, a 30-year-old mother of four, discussed a relatively typical situation for many mothers in Kachule:

My life is a struggle these days. I [farm] but it is no longer farming season. When it is we find some work to do but there is no work at the moment because it is no longer farming season… There are so many problems. Sometimes when my child falls ill I have to look for money on my own. When there is no food I have to do it on my own too. I have to find school supplies like books, pens and sometimes school uniforms too.

To mitigate some of these issues, women spoke about searching for *ganyu*, attempting to start small businesses (usually selling local produce, prepared foods, or beer), and selling off stored agricultural products, generally maize or peanuts, in order to earn some immediate income. However, women struggled to find temporary work and selling agricultural products, understandably, was saved for urgent needs only. Rosemary, a 36-year-old mother of five, stated:

The biggest problem is that we lack start-up capital for a small business. If you have an income generating activity you will be able to take care of your children, at least you can do something

about the problems you face. But because we don't have that money to start small businesses it's hard and we can only depend on farming for livelihood. If your husband doesn't do anything about it then things get even tougher. All those are problems women are facing…Ganyu keeps me going. Without it then things will get unbearable. But at least when you find something to do here and there your problems become lighter… [Right now] I don't have anything serious to do because I'm in the village. All I do is cook for the children in the afternoon. There usually isn't enough food in the house for breakfast so they don't eat in the morning. Then I'll try to look for food so that they can eat at lunch. If we're lucky then they will eat in the evening too but if not, then they don't.

Many other women described similarly precarious economic situations, where finding work proved a significant challenge and food insecurity was a real daily threat.

In addition to procuring foodstuffs, some women who discussed poverty as a main life challenge also focused on the inability to purchase specific material goods as indicators of economic duress. Soap, lotion, clothing, school supplies, and salt were the most talked about material items and not having these products was used as an indicator of poverty.[5] Perhaps significantly, many women who identified lack of material goods indicated that ideally fathers would be responsible for providing these types of goods for their families. Men who were either unwilling or unable to provide material goods were perceived as neglectful or even abusive and were frequently identified as bad fathers. These responses also illustrated women's perceptions that they were left solely responsible for the care of their children and family without male support. In matrilineal communities the expectations for male support are lower than in

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[5] Soap in Southern Africa has a long history of being associated with material wealth and social prestige (Burke 1996).

patrilineal ones, however, despite many of the women included in this study practicing matrilineal residence patterns, they still expected a variety of material and food goods from their husbands (see Chapter 4 and the discussion of *ndiwo* in Chapter 5).

Spousal Problems:

Problems with spouses took several forms but the most commonly discussed type of problem was spousal financial neglect as highlighted above. Women described their male partners failing to provide for their families either by not sharing wages or squandering earnings on alcohol or other unknown expenses and thereby leaving them with full responsibility for supporting their children. Abigail, a 32-year-old mother of six who I introduced in the previous chapter, highlighted the serious effects of spousal financial neglect on the family's economic situation:

I try my best to find money through brewing beer. I do everything alone. I don't know what my husband does with his money. He does a lot of ganyu, builds houses and fences, but doesn't give me anything. I don't even have a chitenje [cloth wrap] or good clothes. Even when I find money and buy maize, I'll come back home and found that he has sold the maize.

In addition to her six children, Abigail was also taking care of one of her husband's nephews. Anne, a mother of four who I introduced in Chapter 4, highlighted the connection between financial neglect and ideas surrounding bad fathers:

Bad fathers do not show interest in their children. Even when they have the money they choose to

drink alcohol instead of buying food for their children. All they do is drink and yet there is no food or anything else at home.

Ruth, a 36-year-old mother of five, added:

Bad fathers do not think about their children. They leave the entire responsibility of childcare to the mother. They expect you to buy clothes for the children, to feed them, to buy soap for them, to do everything. This is abuse because you expect them to help you because they are the father.

Although only three women mentioned personally experiencing domestic violence, general physical violence at the hands of male partners was identified as a significant challenge for Malawian women in general.[6] Ruth, who described financial neglect as a form of abuse, was one of the three women experiencing physical abuse at the time of my interviews. She stated:

Sometimes my husband gets very abusive. There are times when he doesn't do much for the family…Sometimes he gets like that after drinking alcohol. He comes home and hits me for no apparent reason…To protect myself, if he comes at night I go to sleep at someone's house just to avoid certain things. If he comes home drunk in the afternoon, then I go over to a friend's house to chat…Sometimes the problems are so big that I can't do anything about them. I actually think about what to do but there's never a solution.

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[6] The most recent Malawi Demographic and Health Surveys for which data are available indicate that 31 percent of all women in Malawi aged 15-49 have at one time experienced physical and/or sexual violence perpetrated by a husband or male partner (NSO 2011).

Finally, infidelity was a form of abuse that women identified in their discussions of spousal problems. Several women mentioned their husbands leaving them for other women or suspected that their husbands had other girlfriends. The term "girlfriend" had several meanings in this context. Some women used the term to describe a long-term extramarital relationship sometimes accompanied by a second family, while others used the terms as a euphemism for prostitute. These extramarital affairs often led to men's resources being directed away from their primary families, exacerbating women's burden of responsibility for childcare and their perceptions of financial neglect. Moreover, in addition reducing family resources, women acknowledged that men's affairs could lead to a very real possibility of HIV. In fact, the issue of male fidelity was most especially mentioned in women's responses regarding HIV testing. During the interviews women were asked if they had ever been tested for HIV and if so why they had sought the testing. Clara, a mother of five who I introduced in Chapter 4, illustrated a typical response to this question: "I went for testing because I wasn't sure of my status. I don't really know what my husband does out there." Other women were more explicit in their discussions of their husbands' behavior. For example, Sarah, a 35-year-old mother of five who I introduced in Chapter 4 and who identified herself as HIV-positive during our interview, explained:

I used to get sick very frequently. I was also very suspicious of my husband's behavior. I suspected that he was sleeping around and that made me decide to go for testing… Every time he went out drinking he used to come back the next day or he never even came home at all. Whenever I confronted him about it he used to say he was too drunk and slept at his friend's house. After I noticed he was sleeping out a lot I decided to go for testing.

Illness:

Illnesses such as HIV also intensified the experience of poverty. Women discussed both

their own and their children's illnesses as serious problems. Women's own illnesses presented an

especially substantial barrier to finding temporary labor or participating in agricultural activities,

while children's illnesses represented a huge financial drain on family resources. A 46-year old

mother of two stated:

If a woman is sick then household are mostly left undone, there is not enough food around the

house, school fees are scarce, and during the planting season there are problems like lack of

fertilizer.

For children's illnesses, the most pressing concern was in procuring funds for treatment at

the hospital or health clinic. When finding additional work was impossible, or acute illness

necessitated immediate access to monetary funds, women resorted to selling agricultural surplus

products. Requesting funds from family members and friends in the community was identified as

a possible means of obtaining funds for hospital care but women acknowledged that other

community members also lacked resources. "Who are you going to ask? If your own family

doesn't have resources you'll suffer," explained one woman in an informal interview at her

home.

Women dealing with chronic illnesses such as HIV, tuberculosis, and frequent malaria,

faced additional problems. For example, HIV-positive women frequently described lacking the

strength needed to work enough to adequately support their children, a concern that also

appeared in HIV-positive women's discussions of good motherhood (see Chapter 4). A 32-year-

old mother of six who learned she was HIV-positive three years previously explained:

When a woman is HIV- positive she usually is not as strong as she would be without it. Therefore, it's hard for her to take care of her children. She'll still try to look for ganyu, sometimes she'll be able to work and other times she will not have the strength.

Trying:

As a result of these significant barriers to enacting good motherhood practices some women expressed the idea of "trying" to fulfill certain expectations regardless of their ultimate success. Although only a few women used the actual Chichewa term for "trying" (*kuyesela* or *kuyesetsa*) in these explanations, the sense of "trying" as an attempt to accomplish something began to emerge in several ways throughout the interviews. First, mothers described attempting to care for their children and households despite lacking the appropriate means to do so. For example, Justine, a 28-year-old mother of five introduced in Chapter 4, explained:

A good mother takes good care of her children. Even though she cannot afford some things it's easy to know that she has tried. Some women can afford to take care of their children but they choose not to. She doesn't bathe them or wash their clothes. Sometimes the children will go days without taking a bath and yet she can afford these things. But sometimes even though there is no body lotion, you can still tell that the child's mother has tried to bathe the child.

In this way women began to distance the status of good mother with the specific resources necessary to enact local expectations of good motherhood.

107

Second, "trying" also appeared in descriptions of women's continuous search for work in order to care for their children. Angelina, a 48-year-old mother of five introduced in Chapter 4, detailed an exhausting effort to obtain wage-labor, connecting this attempt with the practice of good motherhood:

I try to work because I see that if I become lazy it means my children will not go to school and they won't find soap. But I should force myself to work. Even if I want to or not, I need to work in order to help myself. But if I just stay, the problems will pile up. It means I'm failing at motherhood because I swore I would take care of the children God gave me.

The types of responses given by Justine and Angelina demonstrate the focus on possibility that "trying" engenders, emphasizing attempts to achieve various good motherhood practices rather than the actual fulfillment of those practices. The first example highlights attempts to enact good motherhood practices despite lacking the resources to do so, while the second illustrates continuous efforts to find work despite an overwhelming lack of available labor opportunities. Trying, in this sense, is telling a story about oneself, a way for a woman to claim good mother status by emphasizing the positive practices of good motherhood that she is engaging in, and downplaying those that do not fit with expectations of good mothers.

Finally, some women used the concept of "trying" in their definitions of bad mothers. For example, Stella, a 20-year old mother of one who was introduced in the previous chapter, explained that bad mothers both lack resources and neglect their childcare duties, leaving their children to fend for themselves. She added that even though these children have parents they are "like orphans," and may end up participating in prostitution or leaving home in search of work.

This response suggests that it is not just lack of resources that defines a bad mother, but rather a combination of lacking resources and not "trying" to either attain necessary resources or fulfill good motherhood practices without them.

However, like labor-based tactics that women employed to alleviate some of their life challenges, "trying" was not a highly successful or long-term solution. Several women stated that regardless of a mother's efforts, if she lacked necessary resources she would not be able to achieve good motherhood. These women blamed male partners for creating this situation. For example, Christina, a 33-year-old mother of four who I introduced in Chapter 4, asserted: "Bad mothers become such because their husbands have failed to look after them. She might have children but can't take care of them because she does not have the basic resources to do so." Other women, in the face of insurmountable difficulties enacting good motherhood described placing their faith in God and trusting that through faith and prayer some of their problems would be alleviated. For example, a 31-year-old mother of seven stated: "We pray and put those problems in God's hands so that he may help us, what can we do? We put it in God's hands asking for guidance, we have nowhere to run." Similarly, a 34-year-old mother of four explained:

When I face challenges taking care of my children all I do is kneel down and pray to God. I know they are my children. I gave birth to them and they are my responsibility. They have no father. I am on my own so there's nothing else to do except kneel down and pray and I know that God will see me through which He does.

Women's explanations of "trying" demonstrate both the possibility of using this concept for reframing good motherhood discourses, and also how this concept remains delimited by lack of access to necessary resources. This discussion first addresses the qualities of "trying" that allow for women to work in the "subjunctive" and to focus on future possibilities of success for various actions. In this sense, "trying" is a flexible concept, one that allows for various contingencies: success or failure are both equally plausible. The act of "trying" in the way used here cannot be judged based on outcomes then, because outcomes do not yet exist.

The uses of the concept of "trying" employed by women in Kachule in some ways mirrors Whyte's (1997) concept of "questioning" elucidated in her study of how the Bunyole of Uganda deal with uncertainty. Whyte (1997:21) suggests that Bunyole accept and live within a "reality of misfortune" which is dealt with through the use of the "subjunctive," a mode focused on possibility rather than certainty. The subjunctive opens a space for experimentation, where the Bunyole can utilize various strategies to alleviate suffering, as well as understand and explain misfortune by evaluating the outcomes of those experiments (Bruner 1986 cited in Good 1994:153; Whyte 1997). This type of experimentation parallels the ways women in Kachule enact "trying" to practice good motherhood. By "trying" women are also working in the subjunctive mode, focusing on possibilities, and experimenting with various means for achieving good motherhood goals.

Lastly, the social component of "trying" shares similarities to Whyte's "questioning" and experimentation. Whyte (1993:3) suggests that for the Bunyole, "The process of questioning, doubting, and trying out is about social relationships." Similarly, the way that mothers utilized "trying" in this study was intended to be a public act, one that could be viewed and judged by

other community members. For the Bunyole, the process of questioning was intended to reveal problematic social ties leading to disease and affliction, pacify these threatening social relationships, and reinforce an individual's position within his or her social world. While "trying" in the context of good motherhood was not about disease, the social nature of "trying" was intended to continuously position women as good mothers within their social networks, allowing women to obtain the social benefits of good mother status without enacting the full set of practices associated with good motherhood. Ultimately, by continuously positioning women as good mothers, "trying" represents a way of reframing discourses surrounding good motherhood to reflect women's current reality.

By actively "trying" and reframing good motherhood discourses women may take some measure of control over their precarious socioeconomic environment. However, I argue here that this tactic provided a superficial measure of control at best. "Trying," in the way used by the women of Kachule failed to challenge the social and economic structures that necessitated the employment of this tactic in the first place (c.f. Hunt 2000). Here, despite women's use of "trying" as a tactic to retain good motherhood status, "trying" ultimately increased women's daily responsibilities to include continuously showing attempts at practicing good motherhood, an exhausting prospect to say the least. Moreover, women's responses to their daily life challenges clearly illustrate that women were not always fully in control of their socioeconomic situations, and many had little recourse for obtaining necessary material resources and food.

Further, although local women's constructions of good motherhood demonstrated that good mothers theoretically had increased access to social resources, few women mentioned social means as a way to alleviate their daily burdens, acknowledging that other community members also faced similar socioeconomic challenges. Subsequently, the majority of women in

111

this study described dealing with life challenges alone without the support of spouses, extended kin networks, or various social groups, increasing their already significant level of responsibility for child care and well-being. Although, as I show in Chapter 4, women described offering and receiving some support from family members, these types of support were not discussed in terms of women's life challenges or means of alleviating these challenges. Part of the reason for this omission may lie in women's desires to support (and receive support from) family members without engendering expectations of reciprocity that may be unable to be met. For example, the food transfers from wealthier to poorer family members, that Vaughan (1983:277) shows are an important part of supporting matrilineal relatives, are also "disguised as much as possible," and are differentiated from gifts of food products which necessitate future reciprocity.

Additionally, other types of social networks available to women in the community, such as church groups, were also not mentioned as means of alleviating women's main daily challenges. Almost all of the women I interviewed identified themselves as Catholic and stated that they attended the local Catholic church located on the Mtendere Catholic training center (described in Chapter 3). Catholic churches often have a women's group who meet regularly and which provide a significant means of social support to the women in attendance. For example, the Catholic church in the town of Dedza had a designated women's group composed of about 20-30 women who met weekly and supported various church causes. However, the women I interviewed did not address these types of groups or describe being members of them.

Thus, women in Kachule faced a variety of substantial socioeconomic challenges and both individual actions and support from social networks were either unavailable or incapable of ameliorating these problems. Therefore, while the concept of "trying" may serve to reframe good motherhood and provide a way to help achieve the status of good mother in resource-poor

settings it is important to delimit the actual agency that women have over changing their circumstances. Because of these limitations, "trying" as it is used here, should be viewed as a tactic rather than a strategy. Here I use the term tactic in the sense taken from de Certeau (1984:37) and elaborated upon by Scheper-Hughes (1992:472), as actions "defined in the absence of real power," which "do not challenge the definition of the political-economic situation." Although tactics have the potential to "temporarily divert" larger power structures, they are ultimately unable to significantly transform them (Scheper-Hughes 1992:472).

"Trying" and Clinic Discourses of Good Motherhood:

The characteristic of "trying" as a tactic helps explain why this type of action fails to confer good mother status to women during the clinical encounter. As discussed in Chapter 5, good motherhood, as constructed through Under-Five Clinics focuses on women complying with a set of specific childcare practices mandated during health education talks. Incomplete compliance with these directives, regardless of effort, is considered a failure on the part of the mother. As Waitzkin (1991:11) has suggested, "medical encounters are 'micro-level' processes" that "occur in a social context, which is shaped by 'macro-level' structures in society." As such, the tactic of "trying" is unable to substantially change larger power structures expressed by public health discourses disseminated at clinics. Medical discourses are hegemonic, make no room for other knowledge, and in fact render invisible other competing discourses, including, in this present study, local discourses of good motherhood (Waitzkin 1991; Bourdieu 1991). In doing so, these medical discourses negate the power, however small, that allows mothers to reframe good motherhood to incorporate actions of "trying" in the community setting.

The public health discourses disseminated at Under-Five Clinics position women as the

locus of intervention, ignoring the social contexts in which women perform motherhood. Ignoring this context is problematic, because, for example, as demonstrated in this chapter, the environment in which women practice mothering in Kachule is fraught with entrenched poverty, gender inequalities, and frequent illness, and is also intimately linked to family and kin structures. Public health discourses blame mothers for not being able to meet good motherhood expectations without providing actionable solutions to the serious contextual problems which impede successful fulfillment of public health mandates. Moreover, the standards providers use to assess good motherhood are inconsistent, further complicating women's ability to fulfill clinic expectations associated with good mothers. For example, throughout my study health care providers asserted that they defined good motherhood based on clinic attendance, maintenance of hygiene for both mother and child, use of six food groups for child nutrition, and seeking hospital services for sick children. However, my data suggest that the actual assessment of whether good motherhood expectations had been met was based almost solely on Under-Five Clinic attendance and the appearance of the mother and child, which provides an incomplete picture of women's actual mothering practices. Finally, clinics work in binary terms in assessing good motherhood. That is, a woman is either a good mother or a bad mother: a woman can either meet clinic standards for achieving good motherhood or not. As Smith-Oka (2013:5) suggests, binary categories such as good/bad or compliant/non-compliant have "very real social, political, and economic implications." This binary standard was upheld despite providers being well aware of the socioeconomic limitations preventing women from fulfilling clinic directives.

Public health programs intervene at specific points in a woman's life. Intending to maximize effectiveness by focusing on critical junctures, these programs necessarily ignore women's full life experiences. On the one hand these programs have made great strides in

women's lives, such as reducing maternal and child mortality, however, they fail to account for the larger structural issues and socioeconomic vulnerabilities that women face on a daily basis. Moreover, as I have shown here, these discourses leave no room for competing ideas about good motherhood that better reflect women's actual experiences mothering.

CHAPTER 7: CONCLUSIONS

<u>Overview</u>:

Motherhood is a dynamic social institution which, as Bowers (1996) has argued, "is a moving plurality of potential behaviors always undergoing supervision, revision, and contest, constructed in particularity" (Bowers 1996 cited in Stephens 2013:5). As such, conceptions of good motherhood continuously adapt to new contexts as they interact with changing social, economic, and other environmental conditions (Stephens 2013; Thurer 1994). Consequently, all mothers are faced with historically specific configurations of social structures that impact how motherhood in general, and "good motherhood" in particular, is understood and practiced. The present study has examined the ways that these concepts and ideas about "good motherhood" are conceptualized and practiced in Kachule, Central Malawi as well as the particular structures that influence women's ideas and behaviors associated with good motherhood.

Beliefs and practices surrounding good motherhood are informed by various discourses, which Walker (1995:424) defines as the "norms, values, and ideas about 'the Good Mother' that operate in any one society or sub-group." Just as the institution of motherhood is a continuously changing entity, so too are the discourses that both inform and are themselves informed by the ideas and practices that make up this institution (Allen 2004). In this dissertation I have explored two forms of good motherhood discourses, the first coming from the local community, and the second disseminated during health education talks given at Under-Five Clinics. In particular, I have examined the expectations set forth by each source, the implications of achieving good motherhood as defined locally and by clinic standards, and the ways these two sets of discourses intersected in women's conceptions of good motherhood. I have suggested that overall these two

116

types of discourses constructed two very real versions of "good mothers" with real implications for women's lives. However, as I also argue, the model of good motherhood promoted at the clinic perpetuates a long history of blaming mothers for health outcomes, a product of colonial biomedical programs distant from the daily realities of the local women they serve.

In this final chapter I review the ways that mothers in Kachule and Under-Five Clinics constructed good motherhood and contrast these perspectives in terms of both their expectations and the implications of fulfilling good motherhood as prescribed by local and clinic standards. I also consider some of the contextual factors that frame these various perspectives, and especially the ways these factors constrain women's mothering practices. Lastly, I revisit some of the study's limitations and provide some suggestions for future research.

Good Mothers and Moral Careers:

In Kachule, being a good mother has important social implications. In particular, as Englund (1999:141) has shown, in this area of Central Malawi personhood is considered to be "a composite of relationships" that places an individual within his or her social world, and provides structure and meaning to everyday social interactions. The ways individuals behave and their interactions with others demonstrates the social connectedness between specific people, for example, in the distribution of wealth, gifts, favors, and food. To present oneself as a moral person, an individual must cultivate and maintain specific relationships and follow a socially approved life trajectory. These relationships and behaviors are informed by a "moral order" which Livingston (2005:20) defines as, "a shared set of values held by society that guides its members in expected conduct and provides a way to judge or interpret the actions of others." For many women I spoke to in Kachule, the first step to becoming a moral person was in bearing a

117

child, fulfilling an expected life milestone that entitled a woman to adulthood status and in doing so, full personhood (Davison 1997; Yeatman and Trinitapoli 2013). In this way becoming a mother represented a moral imperative, and was a crucial part of successfully performing female gender roles, including being a good wife, sister, daughter, and kin member in addition to motherhood. Beyond this transition to "mother," success in achieving the status of "good mother" represented another important step in presenting oneself as a moral person (May 2008:471).

Being seen as a moral person facilitates building social relationships, social and material exchanges, and maintaining social status. Alternatively, failing to construct oneself as a moral person opens up an individual to a variety of negative social outcomes. A particularly clear example of this failure of moral personhood lies in the accumulation of wealth without appropriate (or expected) redistribution throughout an individual's social network. This type of accumulation represents dysfunctional social behavior, a display of individualism at odds with behaviors expected by a shared moral order and leading to suspicion, jealousy, and distrust; such behaviors are associated with witchcraft (Ashforth 2005; Englund 1996). As Englund (1996:473) argues, "witchcraft constitutes an argument about moral personhood and represents individualism as an inversion of morality." Although I did not encounter any accusations of witchcraft, many of the women in Kachule I interviewed described bad mothers as displaying some of this dysfunctional accumulation. These women refused to share resources with other community members or worse, were thought to actively hide resources in order to avoid sharing. Participants' concepts of good motherhood, on the other hand, incorporated aspects of social exchange and reciprocity and facilitated access to social and material resources.

Nonetheless, for the women I spoke with during this study, poverty rather than wealth was the norm for day-to-day life. As a result, distributing resources in a socially prescribed manner was problematic or even impossible. Women identified substantial problems with poverty, food insecurity, domestic abuse, and health as the main issues that constrained their abilities to enact practices associated with socially prescribed good motherhood, both those related to aspects of exchange as well as other main good motherhood domains—childcare, mother behaviors, self and home appearance and compliance with medical advice. In light of these challenges, women reinterpreted alternate behaviors to fit within a framework of good motherhood. I have argued in this dissertation that women displayed this reinterpretation in expressions of "trying" to be a good mother, that is, in attempting to fulfill expectations of good motherhood regardless of the ultimate success of those attempts. In "trying," women were able to acknowledge both the networks of exchange and reciprocity in which they were enmeshed, as well as their responsibilities for caring for children and other dependents, without the concomitant expectation that all of these obligations would be met. As May (2008:472) argues, "If an individual's adherence to social norms is less than perfect they may attempt to repair their potentially 'spoiled' identity by employing narratives that align their behaviour with cultural expectations." In this case, "trying" was a tool used by women to reconstruct a narrative of good motherhood focused on possibility rather than the actual fulfillment of mothering practices and to maintain standing in the community as a moral person.

The social nature of "trying" permitted women to continuously reposition themselves as good mothers within their social networks, allowing them to obtain the social benefits of good mother status without completing the full enactment of good motherhood practices as defined by the local community. "Trying," in this sense, takes advantage of the "subjunctive," a mode

focused on possibilities rather than "settled certainties" (Bruner 1986 cited in Good 1994:153). By "trying" women in Kachule worked in this subjunctive mode, focusing on the possibility of achieving good motherhood goals and experimenting with various means for doing so. The nature of motherhood itself, as a dynamic social institution, allowed for this type of creative redefinition and focus on possibility.

Nevertheless, I also argue that despite these attempts at reframing good motherhood, "trying" did not represent a highly successful or long-term strategy for dealing with women's daily challenges. Most importantly, "trying," in the way used by the women of Kachule, failed to challenge the social and economic structures that necessitated the employment of this tactic in the first place (c.f. Hunt 2000). Moreover, women's efforts to reframe good motherhood through "trying" were unable to fully alleviate their socioeconomic burdens and so were themselves ultimately limited by a lack of access to necessary resources.

Constructing Mothers and Individual Clients at the Under-Five Clinic:

"Trying," as a way to achieve good motherhood also failed to confer good mother status to women during the clinical encounter. Good motherhood, as constructed through Under-Five Clinics, focused on women complying with a set of specific childcare practices mandated during health education talks. For example, HSAs advised mothers to feed their children a diet composed of multiple food groups and to bathe them frequently, in addition to regularly taking them to Under-Five Clinics for growth monitoring and vaccinations. Incomplete compliance with these directives was considered a failure on the part of the mother (c.f. Smith-Oka 2013). In addition to this rigid assessment of good motherhood, I suggest here that these health promotion attempts had limited effectiveness for several other reasons. First, the discourses utilized during

120

the health talks were embedded with the neoliberal assumption of individual agency and the subsequent assumption that individuals have the power to affect their own health outcomes by engaging in various health promoting behaviors (Ayo 2102). However, as I have shown throughout this dissertation, the idea of a complete individual agency is discordant with the ways that people in Central Malawi think about themselves and others, as socially connected beings rather than individuals alone (Englund 1999; 1996). Further, these discourses failed to account for women's socioeconomic realities which severely limited their abilities to practice motherhood as advised by the clinic. Lastly, as I illustrated in Chapter 5, HSAs delivered much of this health education in a derogatory manner, employing rhetoric of blame and responsibility and shaming mothers for failing to fulfill clinic mandated mothering practices. This type of presentation also supported the biomedical model in which patients are expected to passively absorb authoritative health information without questioning its implications (Waitzkins 1991).

Because of the negative aspects of these health education talks, both in content as well as delivery, one would expect negative outcomes for the women receiving this information, as seen in other literature evaluating the impacts of public health messaging that utilizes shaming tactics (Jackson and Mannix 2004). But these expected negative outcomes were not supported by my data. Rather, women in my study identified health information obtained at the Under-Five Clinics as important sources of parenting advice, privileged this knowledge over advice obtained from other sources. The acceptance of the health promotion provided at the Under-Five Clinics in spite of the negative manner of its dissemination makes sense when understood within a model of clientelism, such as that posited by Kaler and Watkins (2001). In their study of provider-patient relationships in family planning clinics in Kenya, Kaler and Watkins (2001) showed that providers strategically utilized their positions to garner respect and prestige amongst

their clients. In doing so, these providers attempted to cultivate a patron-client relationship between themselves and the individuals they served. The authors suggest that, "In such a relationship, the patron provides the client with individualized access to resources in exchange for the commitment of the client's support at some point in the future, should the patron require it" (Kaler and Watkins 2001:255-256).

In Under-Five Clinics in Malawi, HSAs similarly situated themselves as health experts who merited respect, prestige, and authority based on their positions, and as patrons, gatekeepers to medical knowledge and services. This authoritative position was supported in several ways. First, the education and training HSAs received in addition to their government employment status distanced them significantly from the women they treated; in my study none of the latter had completed high school level (post-secondary) schooling, and only 6 who had received any type of secondary schooling at all. HSAs also worked to increase this social and power differential between themselves and the women attending the clinic through their interactions with mothers and especially through the ways they disseminated health information during health talks, for example, using insulting and derogatory language.

Despite these displays of disrespect, women's identification of health information obtained at the Under-Five Clinics as important sources of parenting advice showed that women welcomed the health knowledge provided at the clinics. In keeping with the notion of clientelism, I suggest that mothers accepted derogatory messaging from HSAs because by going to the Under-Five Clinic they received various resources, for example, health information and (limited) medical care for their children. This idea similarly fits with the interdependence of wealthy and poor that is characteristic of many areas of Southern Africa, including Malawi, as I show earlier in this chapter (see also Chapters 4 and 6) (Englund 1999; Ashforth 2005). In this

122

context, individuals expect to form "ties of dependence" on others who are better off socially and materially (Swidler and Watkins 2007:150). As such, the ways women were treated at the clinics becomes less important than the potential resources obtained there, including the establishment of a patron-client relationship with HSAs, fitting with Rosenthal's (2015) assertion that women in Malawi attend Under-Five Clinics as a "security-seeking behaviour." In this way the health discourses and the providers disseminating them constructed mothers as individual clients in addition to constructing a "correct" form of good motherhood that women were expected to perform.

Good Motherhood in Changing Contexts:

Finally, as I show throughout this dissertation, changing social, economic, political, and medical structures have profoundly impacted the contexts in which motherhood is defined and practiced in Central Malawi. Specifically, in this dissertation I focus on the social and medical influences that have attempted to shape women's understandings of good motherhood as well as specific mothering practices. These types of attempts to manage motherhood are not new. For example, family and kin networks have historically held significant bearing on how mothering is practiced (Read 1960; Janzen 1978; Kerr 2005; Foley 2008). Moreover, with regards to health, biomedical programs from the colonial period and onward to current public health initiatives have focused on maternal and child health issues, targeting mothers as responsible for health outcomes for themselves and their children. These programs utilize rhetoric of responsibility and blame to control mothers' behaviors and construct versions of good motherhood that fit with Western ideals often at odds with the social realities of local women, as I have demonstrated with regards to the Under-Five Clinics in Malawi (Allen 2004; Vaughan 1991). Themes of

responsibility and blame were also characterized by moralistic undertones, not only blaming mothers for poor health outcomes but also constructing them as "bad" mothers, conflating failure to practice biomedically mandated good motherhood with moral failings (c.f. Foucault 1984; Bell, McNaughton, and Salmon 2009; Cleeton 2015). In this current study, responsibility and blame appeared in both the health education discourses used at the Under-Five Clinics and in the presentation of these discourses. For example, I showed in Chapter 5 that some HSAs employed derogatory language indicating that mothers were lazy, uncaring, and irresponsible, at fault for a variety of poor child health outcomes including malnutrition.

Further, new issues continue to impact the context of mothering. In recent decades the HIV/AIDS epidemic, which has hit Southern Africa particularly hard, has had a marked influence on the daily lives of individuals living in this region (Iliffe 2006). My research found that HIV had a significant impact on some participants included in this study. These women felt the need to increase their mothering efforts above what would typically be expected of an HIV-negative mother, especially in terms of providing resources to their families. For example, HIV-positive women expressed the need to focus their efforts on farming or small business endeavors to make sure their children would be supported after their deaths. Moreover, some of the HIV-positive women I interviewed highlighted the importance of taking antiretroviral medications to maintain their physical strength in order to care for their children. Other literature similarly suggests that HIV/AIDS has had significant impacts on women's mothering practices. For example, HIV-related mortalities have dramatically changed family structures and ideas about motherhood, responsibility, and childcare in the Southern Africa region (Magwanza 2010). Illustrating one of these impacts, Magwanza (2010) shows that there has been a marked increase in child-headed households and orphans due to HIV-related deaths in South Africa (Magwanza

2010). Long (2009) additionally demonstrates that important mothering practices such as breastfeeding have been challenged by HIV and the possibility of mother-to-child transmission of HIV through breastmilk.

Similarly, Malawi's renewed commitment towards reducing maternal mortality, as evidenced by Joyce Banda's Presidential Initiative on Maternal Health and Safe Motherhood (see Chapter 2), has continued and exacerbated a medical/political context in which traditional means of maternal health care have been driven underground, and various mothering practices, particularly those related to pregnancy and delivery, have become highly policed (Sarelin 2014). Understanding, negotiating, and in some cases surviving these changing contexts while simultaneously performing the role of good mother entails the strategic use of social and economic resources, mobilization of kin networks, navigation of biomedical institutions, and creative reinterpretation of social realities.

Limitations:

This study had several limitations which I discuss in greater detail in Chapter 3. With regards to the research methodology, I only interviewed women in one community and therefore my results may not represent the ways good motherhood is understood or practiced in other areas of Malawi. I also observed health education talks in only hospital settings although these talks are also given in outreach clinics in more rural areas of the country. Including fathers in this study would also have provided a more nuanced look at mothering practices and perceptions of good mothers, however, this was not possible due to time and resource constraints. Finally, adding focus group discussions to the data collection may have provided an expanded view of mothering and good motherhood through group discussion and group consensus building.

During this study I also relied on the support of my research assistant Elizabeth who was a Ngoni woman who had lived in Kachule all of her life. Elizabeth's familiarity with the community was invaluable to recruiting participants and obtaining access to the community. However, it is likely that some information that women did not want shared with the community was not shared during the interviews because of Elizabeth's connectedness to other community members. Further, the participants recruited for this study were mostly Ngoni women from Elizabeth's social network, thus my participant selection likely missed newer residents of Kachule or women outside of this Ngoni network.

Lastly, interview participants often thought I was affiliated with the biomedical health care system. Due to the highly political nature of maternal and child health care in Malawi during the time I was conducting research, this affiliation likely influenced the ways that participants interacted with me as well as the ways they chose to answer interview questions.

Suggestions for Future Research:

Multiple Roles of Women:

My research demonstrates the centrality of motherhood to women's lives. However, "mother" is not the only role held by women in Kachule. Some of the other roles women played, for example, as entrepreneurs, farmers, wives, and family members, are not represented well in my research. These multiple roles, though, may have important implications for how women practice mothering as well as their ability to achieve good motherhood. As Liamputtong (2006:28) argues, "women are not simply only mothers. Rather, women have other interpersonal identities that are also salient to them and impact on their mothering roles." Women's roles as

126

kin members may be especially important as women living in matriarchal societies have historically used these networks as safety nets during times of scarcity (c.f. Vaughan 1983; 1985). Additionally, women in my study faced serious challenges with regards to procuring food, and so the ability to farm or conduct small business may have significant bearing on the success of various mothering practices. Additional qualitative research using similar methods to the current study would be effective in capturing and elucidating some of these multiple roles as well as the ways these roles impact motherhood.

Fathers:

Further, my interview questions although asking about women's perceptions of good and bad fathers, did not include fathers themselves. The ways that fathers' behaviors impact mothering practices and the ways that fathers view and judge good motherhood would further enhance an understanding of good motherhood in Kachule. For example, mothers identified specific roles they expected fathers to play but my research does not answer what fathers themselves thought about those roles. A study that mirrors the present research but focuses on fathers and good fatherhood rather than mothers would provide some of this missing information and present a more nuanced model of parenting in Kachule.

Health Surveillance Advisors:

Finally, as I discuss in Chapter 5, the reasons that HSAs chose to ignore the real life circumstances of women attending the clinics, relying instead on generic discourses at odds with local contexts, was not discussed in my interviews. It is possible that HSAs chose to deliberately disregard this knowledge in attempts to establish and grow a substantial social and power

differential between themselves and their clients. For example, in another context, Kaler and Watkins (2001:262) suggest that family planning providers attempt to accumulate "reserves of prestige and status" with the goals of upward mobility, especially in the form of promotion and increased wages. It is possible that the HSAs in my study emphasized global child health priorities in ways at odds with local needs and priorities to support their goal of upward mobility, increasing the social distance between themselves and their clients by ignoring their socioeconomic environments. Further qualitative research with HSAs would elucidate these specific motivations and provide a better understanding of how HSAs view their roles as health care providers.

Good Motherhood in Kachule:

In this dissertation I have explored the ways that good motherhood is constructed by women living in Kachule and through health discourses and health care providers at Under-Five Clinics. I have shown the various ways that the success of good motherhood is judged in these two settings, as well as the consequences, both positive and negative, of achieving good motherhood in these contexts. I suggest that while achieving the status of good mother has important social outcomes within the community setting, in terms of presenting oneself as a moral person, the consequences of achieving good motherhood as defined by the Under-Five Clinics are less clear. Discourses used at the clinics continue a history of interventions focused on maternal and child health that blame (and shame) mothers for their children's health outcomes. These discourses focus on women as individual subjects rather than social beings as well as ignore the substantial socioeconomic challenges women face in their daily lives.

However, despite the differences in good motherhood as defined in local and clinic settings, achieving the status of good mother in both of these contexts represents a contingency plan. Within the community, achieving good motherhood provides access to social and material resources when they are available, both in the present and the future. In the Under-Five Clinic, being seen as a good mother may also similarly facilitate access to social, material, and medical resources held by HSAs. Women in this study described a serious lack of resources that constrained their mothering practices, and so any strategy for garnering resources, including the possibility of resources in the future, represents a logical step for hedging against uncertainty. As Johnson-Hanks (2005:377) argues:

Under extreme uncertainty, when all the rules are changing, what works is not the best strategy but the most flexible one—the one that takes every present in the subjective, that keeps every alternative open as long as possible, and that permits the actor to act rapidly and flexibly to take advantage of whatever opportunities arise.

"Trying" to be a good mother, in this sense, represents a "flexible" strategy, allowing mothers to negotiate challenging socioeconomic environments, maintain social standing as moral actors, and focus on a better future for themselves and their children.

APPENDICES

APPENDIX A

HEALTH CARE PROVIDER INTERVIEW GUIDE

1.1   Name
1.2   Age
1.3   Where are you from?
1.4   Occupation/Position:
1.5   How long have you been in that position?
1.6   What is your catchment area?
1.7   What kind of training did you have for that position?
        Where was the training? How long? Held by which organization?
2.1   What kind of things do you teach women at the Under-Five Clinics?
2.2   When you are giving these health education talks how can you tell if a woman is a good mother?
2.3   What are the biggest challenges that the women you see have with following your advice?
2.4   What kinds of questions do women aske you about the things you teach at the clinic?
2.5   How has Malawi's recent emphasis on Safe Motherhood impacted your work?
2.6   When you talk to women what kinds of things do you teach them about Safe Motherhood? [if relevant]

WOMEN'S INTERVIEW GUIDE

INTRODUCTION
We want to know more about your life and the things you think are important. We're especially interested in your ideas about motherhood. We want to emphasize that there are no right or wrong answers to these questions. What we really want to know is what you think. Let me assure you that everything you tell me will be completely anonymous. Also, please feel free to not answer any questions you don't feel comfortable with, or to stop the interview if you no longer care to participate. Any questions before we get started? **(Mwaswela bwanji? Ife timafuna ticheze nanu makamaka nkhani za unakubala. Inu mukhale omasuka kucheza nafe ndipo ngati pali mafunso amene inu simungathe kuyankha masukani ndithu palibe vuto lililonse. Zimene inu ndi ife titakambilane ndi zachinsinsi ndipo sitikaulula kwina kuli konse. Chonde khalani omasuka. Ndinu olola kucheza nafe?)**

6.1   Age **(Inu muli ndi zaka zingati?)**
6.2   Ethnicity **(Nanga ndinu a mtundu wanji? Nchewa? Ngoni? Etc?)**
6.3   Where are you from, where do you live now? **(Mumakhalila kuti?)**
6.4   Where were you born? **(Inu munabadwila kuti?)**
6.5   Are you married? **(Muli pa banja?)**
6.6   How much schooling have you had? **(Sukulu munalekezela kalasi yanji?**)
6.7   What is your occupation? **(Mumapanga chiyani kuti mupeze chakudya pakhomo panu?)**
6.8   Are you supporting any of your relatives? Who? Where do they live? **(Mumathandiza achibale anu ena? Amakhala kuti? Ndani?)**
6.9   Where you do you go to church? **(Mumapemphela kuti?)**

[QUESTIONS ABOUT EARLY LIFE]
0.1   What was your life like when you were a child? What did you do? **(Mungandiwuzeko za moyo wanu muli mwana Kapena muli wan'gono? Mumapanga chiyani?**

0.2   Who took care of you and what kind of things did they do? Do you think you were well taken care of? Why? **(Amakusamalani ndani? Amapanga zinthu monga ngati zanji? Mene mumawonela, ankakusamalani bwino? Chifukwa chiyani?)**

0.3   When did you feel you transitioned from a child to a woman? **(Nanga inu munadziwa bwanji kuti mwachoka pa utsikana ndipo mwafika pa umayi?)**

0.4   How did your life change when you became a woman? What happened? **(Moyo wanu unasintha motani inu mutakhala nzimayi? Chinachitika ndi chiyani?)**

[QUESTIONS ABOUT MOTHERHOOD—GENERAL]
Now I want to talk about being a mother in Malawi **(Pano ndikufuna ndicheze nanu za Unakubala wa M'malawi)**

1.1   When you hear the word motherhood what does that mean to you? **(Mukamva mawu okuti nakubala kapena utchembele, zimatanthauza chani?)**

1.2   How would you define a mother? **(Kodi mayi kapena kuti nakubala ndi ndani?)**

1.3   How does a woman become a mother? **(Chimachitika ndi chiyani kuti nzimayi akhale nakubala?)**
          PROBE: Does she have to be certain age to become a mother? **(Pali zaka zimene mayi amayeneleka kufika kuti akhale nakubala?)** What age? **(Zaka zingati?)** Are there certain steps a girl or woman needs to take before she can become a mother? (**Pali ndondomeko zina zimene zimatsatilidwa pachikhalidwe chathu kuti mayi akhale nakubala?)**

1.4   What kinds of things does a woman have to do to be recognized as a mother by her community? **(Kodi nanga mayi amapanga zinthu monga ziti kuti aziwike kuti ndi nakubala?)**

1.5   If a woman does not do those things [list things] what happens? **(Chimatika ndi chiyani ngati mayi sakupanga zimene mwanditchulilazi?)**

1.6   Can any woman become a mother? **(Nanga nzimayi wina aliyense akhoza kukhala nakubala?)**

1.7   What happens if a woman does not want to become a mother? **(Nanga chimachitika ndi chiyani ngati mayi sakufuna kukhala nakubala?)**

1.8   Can a woman be a mother if she doesn't have any children? How? **(Nanga mayi angakhale nakubala ngati sanabelekepo?)**

          PROBE: If a woman has a baby and it dies, is she still a mother? **(Monga ngati mayi atafeledwa. Mwana wake anamusiya, iyeyu tinganene kuti ndi nakubala?)**

1.9   How do people in the community treat women who don't have any children? (**Kodi anthu a m'mudzi amakhala bwanji ndi amayi safuna kukhala ndi ana?)**

1.10   How do you know if a woman in your community is a bad mother? (**Mumadziwa bwanji nzimayi si nakubala wabwino?**)

          PROBE: What kind of things do bad mothers do?

1.11   If a woman is a good mother, how do people in the community treat her? (**Ngati mayi ali nakubala wabwino kodi anthu ammudzi amakhala naye motani?)**

1.12   If a woman is a bad mother, how do people in the community treat her? (**Ngati mayi Sali nakubala wabwino anthu am'mudzi amakhala naye bwanji?)**

[QUESTIONS ABOUT MOTHERHOOD—SPECIFIC]

1.13   When did you feel like you first became a mother? **(Inu munadziwa bwanji kuti mwasanduka nakubala?)**

1.14   How did you know you were ready to become a mother or how did you know you were ready to have children?
(Nanga inu munadziwa bwanji kuti muli okonzeka kukhala nakubala kapena kuti munadziwa bwanji kuti munali okonzeka kukhala ndi ana? Zinangochitika?)

1.15   Once you became a mother, in what ways did your life change? **(Nanga inu moyo wanu unasintha motani pamene munabeleka koyamba kapena pamene inu munasanduka kholo?)**

1.16   What is your life like now? For example, what kinds of things you do you do every day?
(Moyo wanu wa tsiku ndi tsiku umayenda motani? Mumatani pamene kwacha mpaka dzuwa ndikulowa?)

1.17   Did anyone give you advice about how to be a mother? Who? What did they tell you?
(Alipo amene anakupatsani malangizo a unakubala? Ndani anakulangizani? Anakuuzani zinthu zonga zanji?)

1.18   Do you give other women advice about being a mother? What do you tell them? **(Nanga mumapeleka malangizo a unakubala kwa amayi kapena anthu ena? Malangizo onga ngati anji?)**

[QUESTIONS ABOUT CHILDREN]
Next I want to learn about your children and how you take care of them. **(Pano ndimafuna ticheze za ana anu ndi m'mene inu mumawasamalila).**

2.1   How many children do you have? **(Inu muli ndi ana angati?)**
What are their ages?
Do you have grandchildren (if applicable)? **(Muli ndi zidzukulu?)** How many?

2.2   Are all of your children with the same father? **(Anawa bambo awo ndi amodzi?)** Do they all live with you? **(Amakhala kuti?)**

Are you taking care of anyone else's children? (If so, whose children?)

2.3   Where did you give birth to your children? **(Ana anu anabadwila kuti?)**

2.4   How old were you when you gave birth for the first time? **(Munali ndi zaka zingati mutabeleka koyamba?)**

[QUESTIONS ABOUT FATHERS]

Now I want to talk to you a bit about fathers and how they care for children (**pano ndimafuna ticheze za m'mene bambo amasamalila ana ake)**

3.1   How do you know if a man is a good father? **(Mumadziwa bwanji kuti bambo ndi kholo labwino?)**

3.2   How do you know if a man is a bad father? **(Mumadziwa bwanji kuti bamboyu sikholo labwino?)**

[QUESTIONS ABOUT HIV-POSITIVE MOTHERS]
5.1   If a mother has HIV are there any special things she needs to do in order to take care of her children? What are they? **(Ngati mayi ali ndi kachilombo ka HIV,pali zina zimene amachita kuti asamale ana ake?)**

5.2   If a mother is very sick, how should she take care of her children? **(Nanga mayi amasamala bwanji ana ake ngati wadwalika kwambiri?)**

5.3   Have you ever gone to HIV testing? **(Inu muyazetsapo ngati muli ndi kachilombo ka HIV)**
       If yes, would you mind sharing the results with us? **(Mungatiwuzeko zotsatila zake?)**

[QUESTIONS FOR HIV-POSITIVE MOTHERS]
5.1   When did you first find out you had HIV? **(Munadziwa liti kuti muli ndi kachilombo ka HIV)**
       Who did you tell? (**Munawuza ndani?)**

5.2   In what ways did this change your daily life and relationships? **(Moyo wanu wa tsiku ndi tsiku unasintha motani mutazindikila kuti muli ndi kachilomboka?)**
           PROBE: What kind of challenges did you face because of your diagnosis? **(Munakumana ndi zovuta zanji?)**

5.3   Did you already have children when you found out you were HIV-positive? **(Munali ndi ana kale mutazindikila kuti muli ndi kachilomboka?)**

5.4   If yes: Were there any special things you did in order to take care of them? **(Panali njira zina zapadela zimene inu mumawasamalila ana anu?)**

       If no: Were there any special things you did during pregnancy? **(Nanga muli oyembekezela?)**
       What kinds of things did you do to take care of them after they were born? **(Nanga atabadwa mumawasamala bwanji?)**

5.5   Where did you learn how to do those things? **(Zimenezi munazidziwila kuti?)**

5.6   What kinds of things do you do to take care of yourself? **(Nanga inu mumazisamalila bwanji?)**

5.7   Where do you go to get your treatments? (**Mankhwala anu mumawatenga kuti?**)

5.8   Besides this group, do you have any other types of support? **(Kupatula supoti gulupu iyi palinsi zithandizo zina zimene mumalandila?)**

5.9   What do you think are the biggest challenges facing HIV-positive mothers in Malawi? **(Inu mumawona ngati mavuto amene azimayi amene ali ndi kachilombo ka HIV ndi onga ati?)**

Thank you so much for sharing your experiences with us, is there anything else you think we should know about being a mother in Malawi?

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