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The First Thousand Days of Life: Obesity and Global Health Policy in South Africa

Author
Michelle Pentecost
Institute of Social and Cultural Anthropology
University of Oxford

michelle.pentecost@gtc.ox.ac.uk

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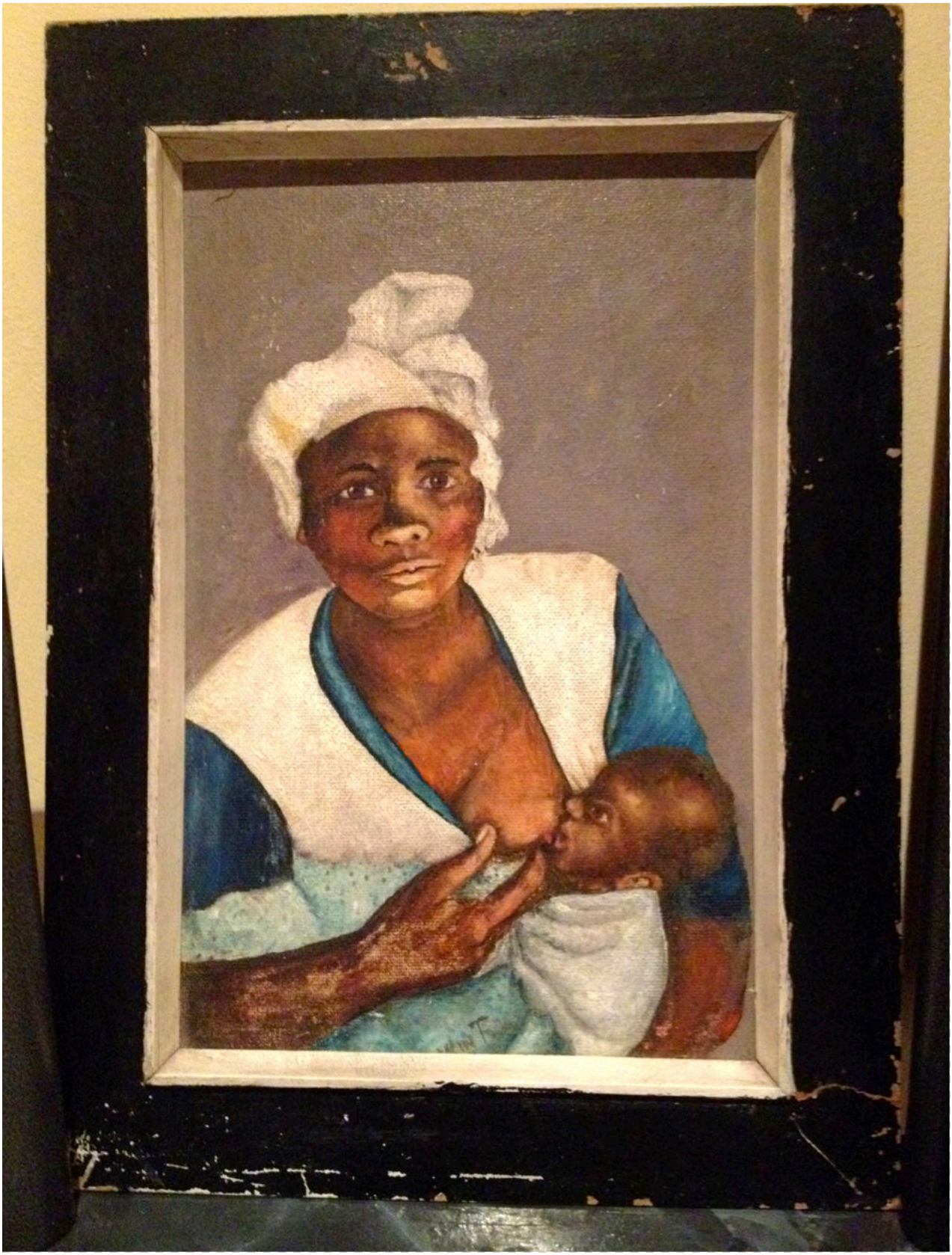

Her nipple is in full view, not artfully covered as in so many other Madonna-and-child images. The direct gaze, the exposed breast, the grimacing infant: the whole effect is one of quiet reproach. Reproach, but not surprise. This woman, with her distinct features, and her piercing gaze, asks why the viewer is intruding on this moment, and has asked that question many times before. I assume she is 'the woman from Dambaza.' At least, this is what is scribbled on the back of the hardboard. The signature of the artist is less easy to discern. Dambaza is a tiny town in rural Nigeria. The painting was found in a heap of rubbish in Site B section of Khayelitsha, one of South Africa's largest informal settlements, some thirty kilometres from central Cape Town. I can only speculate on the painting's origins, on the identity of the artist, and on that of his subjects - a nameless African woman and her suckling child.

This painting was displayed in the living room of a house in Khayelitsha where I lived for some time during 14 months of fieldwork in 2014-2015. The oil on hardboard, in an old black wooden frame, lived adjacent to the plasma screen television, such that the woman from Dambaza would continually distract me from the screen whenever we watched the evening news. I was in Khayelitsha to conduct my doctoral research. My object of study: the new global health policy focus on 'the first thousand days of life', the period between conception and a child's second birthday, presented in contemporary epidemiology as a critical period that will determine future health and potential. Shaped by new knowledge in epigenetics and Developmental Origins of Health and Disease research, global health policy frames the first thousand days as 'the priority window for impact' for nutrition interventions to target undernutrition and stunting, promote future human capital, and to prevent a potential future burden of adult non-communicable disease. The 'first thousand days' concept is especially focused on developing settings like South Africa, given the understanding that cycles of intergenerational metabolic disease are linked to the nutrition transitions that are thought to be playing out in these settings (Popkin et al 2011). My fieldwork comprised a multi-sited ethnographic study across policy, clinic and community levels. Primary care antenatal services in Khayelitsha are provided by two Midwife and Obstetric Units and three Basic Antenatal Care (BANC) facilities, where I focused my attention. I divided my time between clinic ethnography and hanging out with my informants in their homes, taking part in the daily rhythms of life in this place.

Khayelitsha is a large township that was established in 1983 by the then apartheid state. Since its beginnings it has been a landing spot for people moving from rural locations in South Africa, and from further north on the continent. An accelerated process of urbanisation has taken place since the democratic elections in 1994, such that Khayelitsha is today one of South Africa's largest urban settlements. It is comprised of an older formal centre, and a sprawling informal periphery, with at least half of residents living in informal dwellings. The latest census indicates that Khayelitsha has a population of about 400 000, but many consider this to be a gross underestimation, and place this figure closer to 1 million people. Khayelitsha's health profile typifies the 'first thousand days' focus: high rates of child undernutrition co-exist with an obesity prevalence higher than the national average: 50% of women and nearly 20% of men are classified as obese, and there is an overall trend to an increase in rates in childhood obesity over the past two decades (Shisana et al 2013). Consequently, the global health policy of prioritising interventions in 'the first thousand days of life' has been readily taken up in the South African

context, such that a strong feature of national nutrition policy is the integration of nutrition interventions into Maternal and Child Health services. One of the key questions of my research is why this global health focus has been so readily adopted by South Africa and many other states. In the context of the 'first thousand days', what are the values and assumptions that inform what or who is prioritised?

An emphasis on pregnancy and early life nutrition in international health and global health settings is not new. The public health focus on nutrition in early life has taken on different forms shaped by historical and political context since the first public health programs in the late 19th century, and there has been a historical convergence of international approaches to nutrition and food security, and maternal and child health. This has some merits, except that it is most often accompanied by a naturalisation of mothers as the primary responsible caregivers and facilitators of healthcare interventions. The most naturalised of mothering practices is undoubtedly feeding, which encompasses the feeding of children and families, breastfeeding and its alternatives, and the feeding of the fetus in utero. The tropes of the 'ignorant mother' and the 'innocent child' in nutrition interventions date back to early public health policies on maternal and child health (Kuh and Smith 1993, Baird 2008). In the mid-80s, nutritionist Erica Wheeler observed that 'the stereotype of malnutrition is the marasmic child in its mother's arms. Widespread in nutritional and medical literature is the concept of "vulnerable groups": that is, children under five years of age, and pregnant and lactating women' (1985: 133). Wheeler concurred that these are periods of physiological vulnerability, but disagreed with the policy emphasis on maternal nutrition education, which translated into a model where 'access to a good diet is limited by the woman's knowledge and skills and where the "vulnerable" young child is the first to suffer'. Ahead of her time, Wheeler criticised nutrition programs for their sole focus on maternal education, which translated into maternal blame given that 'a mother whose child is malnourished, if she has been subjected to health or nutrition education, must have refused to practice what she has learnt' (1985: 139). Nearly thirty years later, policy still employs the same definition for 'vulnerable groups' (Zarowsky et al. 2013).

Anthropological critiques of the 'international ideologies of mothering and infant feeding' (Zhang Gottschang 2000: 269) show how this discourse frames understandings of risk and responsibility for health outcomes, and confirm that infant care and feeding practices are structured by a range of factors beyond maternal control (Scheper-Hughes 1984, Pottier 1999, Sridhar 2008). As Audrey Richards' work with the Bemba showed, child malnutrition in this setting was a product of social and economic circumstances, rather than the prevailing notion at the time that this was due to the ignorance of African women (Richards 1939, Vaughan 1988). Anthropological work on food and eating makes plain that food is not just a clinical exposure or intervention, as epidemiology would frame it, but is simultaneously symbol, commodity, and cultural object.

Food practices are inflected by gender (Counihan 1999), class (Bourdieu 1984), history, and political economy (Goody 1982, Mintz 1985). As Arjun Appadurai describes it, food is a central semiotic device in a complex 'gastro-politics' (1981). For pregnant women, this includes household and individual characteristics, such as relationship dynamics, household size,

maternal status, and parity (Agarwal 1997, Van Esterik 1999). Maternal food practices are also subject to global gastro-politics: globalisation facilitates migration, the commodification of food, and the consolidation of a transnational food network, with inevitable impacts on local diets (Hartini et al. 2005, Phillips 2006). Yet policy inadequately accounts for the interconnectedness of the global food system (Pottier 1999, Hawkes 2006). It is telling that, some 20 years after Wheeler's critique, Devi Sridhar's ethnography of a World Bank nutrition program reveals that the same assumptions underlie the contemporary international focus on maternal nutrition education: mothers are the sole caregivers, they have decision-making power, and child undernutrition can be alleviated through educational correction of 'feminised, ignorant and backward' beliefs (2008: 78).

Such models operate on what Didier Fassin calls 'the moral economy of childhood' (2013). He defines moral economies as 'the production, distribution, circulation, and utilisation of moral sentiments, emotions and values, norms and obligations in the social space', and places the focus on childhood within the contemporary moral project of humanitarianism (2009: 1255, 2011). His work in South Africa shows that a powerful rhetoric of 'children as victims' operates in this context, where mother-to-child transmission of HIV, child abuse, and children orphaned by AIDS are disturbing realities. While no one would dispute that such issues warrant serious attention, Fassin highlights that the injudicious application of the notion that 'children come first' has its own side effects (2013). Mothers, in particular, become blameworthy targets of a moralising discourse that often has religious undertones in the South African context (Fassin 2013, quoting Comaroff and Comaroff 1991). This responsibility is further magnified by the post-apartheid image of children not just as the 'future of the population', but also as the 'future of the nation' (Fassin 2013: 128).

In the epigenetic era, life course epidemiology employs a rhetoric of potential that further alters these configurations to span generations, and positions maternal food practices as a central predictor of future health. This takes on a particular flavour in contemporary South Africa, where the investment in the future that the ideology of 'the first thousand days' nutrition policy promotes resonates heavily with the democratic dispensation's nation-building project. While it would be simplistic to argue that we should not be allocating resources to pregnant women and children, it is always important to consider what or who is overlooked in this instance, and the implications of such positioning of women in the South African setting as not only responsible for the health of their children, now and well into adulthood, but also for the generations of South Africans who make up the national imagined future.

I can only guess at the identity of the woman from Dambaza, and how she came to Khayelitsha.. Did this battered hardboard travel all the way from the Niger River to find its end in the wastes of this informal settlement? Or was the woman from Dambaza painted in Khayelitsha, herself an immigrant from the north? Her portrait points to invisible circulations - an alternative economy of images. Her gaze provokes uncertainty - she seems simultaneously solemn, resigned, innocent, sad, and defiant. Is she flushed from the heat, or blushing at a taboo transgressed - a naked nipple not meant for the viewer's intruding stare? Her directness disrupts the stylised, subservient Madonna motif, and hints at the complexity overlooked in current

global assemblages of mother-and-child. My own tracking of a global health programme in the local context of Khayelitsha follows the contemporary circulation of this assemblage - a trope closely tied to the invention of Africa (Mudimbe 1988), and a travelling technology that configures contemporary global health policy. In the pamphlets that now circulate through the waiting rooms in the antenatal clinics of Khayelitsha, that trope reinvents itself again, in the form of a stylised image of a mother and baby, and the message that "The first 1000 days of a child's life is a very important time for shaping a child's ability to grow and develop".

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