

5. VILLAGE WEANING PRACTICES AND BELIEFS

5.1. The Weaning Procedure and the Role of Sibling Caretakers

Weaning in Kinanbwa is generally done in an abrupt fashion. But there are two ways of carrying out the process. The most frequently used one is for the mother to absent herself physically from the village and to resume her itinerant trading activities. The other procedure is for the woman to remain at home but to take special measures to break the dependence of the child on the breast.

When the first option is chosen, the mother will give one final breastfeeding to the child in the predawn hours of the appointed day. She will then ramasé afé-l (gather up her belongings), join her trading companions, and for the first time since delivery make her way to Port-au-Prince to resume marketing activities. By that time her child will ideally already have begun eating from the family cooking pot. When the mother returns to the village some two or three weeks later, and all has gone well back home, the child will already have bliyé tété-a (forgotten about the breast) and will no longer cry after the woman's breast.

Some women, however, prefer the second weaning option and will remain at home. The day for weaning is chosen and the process begins. Most women in this situation, rather than simply denying their breast to the child, will instead apply to their nipples the extremely bitter jelly-like substance found in the leaves of the local aloe tree (laloua) to assist in extinguishing the child's attraction to the breast. Each time the child gets access to the breast, he will be repelled by the bitter aloe. Children who have already begun eating manjé sel and manjé chodyé will soon cease demanding the breast. At the same time sleeping arrangements also change. During the nursing period the child will have slept on the same bed or mat as both parents. Now the child

is put to sleep far away from the mother.

The days following weaning can, of course, be traumatic for the child. In the words of the village, ti-moun-nan chagrine, the child feels chagrin. The chagrin may be combatted with a number of special teas prepared for the child. Village belief also attributes weaning-crisis mollification to certain local leaves (boua kabrit or Cassia emarginata). These leaves will be placed either under the child's pillow or under the mattress where it sleeps. These leaves are believed to reduce the severity of the post-weaning chagrin.

However, there is another village practice which appears to be the most important buffering mechanism to help ease the toddler through the weaning period, especially in that majority of cases where the woman has physically absented herself from the village. This practice consists in the use of child caretakers.

In societies where the mother has been the sole or major caretaker, an abrupt break in the bond established brings about great distress for the infant. This is more severe if, a) separation is sudden; and b) if it occurs between 6 to 24 months of age. Separation stress may bring about weeping, temper tantrums, insomnia, anorexia, weight loss, susceptibility to infection, etc.

In the village of Kinanbwa, these reactions appear to be buffered and minimized by the practice of using a child caretaker who is responsible for the child from birth. Even before a child is born, the caretaker is selected from among young pre-teen or early teen girls in the immediate or extended family. We have even seen cases where girl caretakers were purchased in Port-au-Prince and brought to the village in preparation for the birth of an infant.

This child-caretaker will eventually take on full responsibility for most matters that involve the infant, such as cooking its labouyi and manjé sel, and washing and caring for its clothing. When the child reaches an age when he can spend time outside of the house, the caretaker will be there holding it, playing with it, supervising it. It is a full time task for the young girl and she is expected to assume full responsibility for that infant. Before weaning, of course, the mother will be there to breastfeed the child on demand. During the first two months the mother will generally be the one to bathe and clothe the child as well. But after this time, even the bathing and clothing of the child will be the responsibility of the caretaker. This practice, which strikes outsiders as especially demanding on (and even unfair to) a young pre-teen girl thus saddled with ceaseless responsibility, is with little question advantageous for the infant. Not only does it receive constant attention. But the close relationship which it has built up with the caretaker will constitute a psychically important buffer when the mother suddenly absents herself in the pre-dawn hours of the day chosen for weaning.

5.2. Traditional Criteria for the Timing of Weaning

The preceding section discusses only the procedures for weaning. But of great nutritional importance is the age at which mothers wean their children. Traditional village norms in Kinabwa provide a great deal of flexibility with respect to the age of weaning. Villagers will talk about children being weaned at 12, 14, 15, 21, and 23 months, finding such interhousehold and interchild variability quite acceptable. Traditional norms view an 18-month period of breastfeeding as the most suitable general practice, but village opinion also recognizes that there are other factors which can justify either an early termination of breastfeeding or a prolonging of breastfeeding beyond the normal period. (as will be seen, the former exception has become much more frequent than the latter.)

But the use of "months" as a terminological context for discussing weaning is more an outsider's practice than one of the villagers, who use other criteria to judge whether it is now "safe" to wean the child.

By far the most important criterion for the weaning of the child is its feeding habits. A child that has left the sweet-food labouyi period and successfully passes through the salt food "crisis" to begin eating directly from the family cooking pot is a child that village women will wean with no reservations. This willing consumption of cooking-pot foods is the most important behavioral indicator of readiness for weaning.

But other maturational and developmental criteria are also observed. Dentition is an important criterion in this regard. Children who are weaned before teething are felt to be more vulnerable to the diarrhea and loss of appetite that normally accompanies weaning. Children who have begun to teeth are believed to suffer these conditions less. Likewise, children are also believed to be more vulnerable to cold while teething if they have already been weaned when teething begins. In contrast, breastmilk is believed to have a warming effect that will help ease the child through a safer cold-free dentition period.

Walking is another important criterion which is taken as a further sign that it is "safe" to wean the child. Children who are still a tè ("on the ground") will be more likely to get sick if they are weaned. Language constitutes yet a third signal for weaning. The onset of speaking — the calling of mamma and papa — is an important traditional signal that phase-out of breastfeeding may be considered. Some informants, infact, joked about people who prolonged breastfeeding to the point where the child would tell the mother "Mother, come sit down and feed me." The joke itself indicates that linguistic competence and breastfeeding are felt to be somewhat incompatible.

A fourth-important weaning criterion is the general health of the child. If the child manifests good health in addition to a good appetite for other foods, it is believed that he can be weaned with fewer risks.

5.3. Drop in the Average Age at Weaning

The above-mentioned criteria are the traditional ideals which served as guidelines for weaning. But the eight years that had passed between the time our first research was carried out and the present research were enough to make visible a number of impressive tendencies that were undoubtedly already in operation when we first lived in the village but which had since gained impetus. The most impressive of these is the tendency to wean children much earlier than the traditional and mandated dizyuit mwa konsa (18 months or so).

Table 1 gives some quantitative evidence for the pattern whose existence we suspected from simple observation and questioning of neighbors. There are 124 village children under the age of 15 for whom information was gathered on the age at which they were weaned. Table 1 breaks children into 3 groups: those who were born in the last two years, those who were born from two to seven years ago, and those who were born more than seven years ago. The figures show a clear decrease in the average age at weaning. Caution should be used in interpreting the average of 9.8 months in the case of the children under two. The figures include only children already weaned. In this first group there are still children being breastfed beyond the age of 10 months. When this "cohort" is totally weaned it is likely that the average weaning age will be close to a year, rather than 9.8 months. But even with this increased mean age, the tendency remains dramatic: village women are weaning their children much more rapidly than they used to. And it is not at all unlikely that the mean age will continue to drop.

TABLE 1Diachronic Decrease in Mean Age at Weaning

Years since Birth	Mean weaning age (months)	(N)
0 - 1.9	9.8	(18)
2.0 - 7.9	14.7	(52)
8.0 - 15	16.2	(54)
	(P .001)	

5.4. Economic Underpinnings of the Drop in Weaning Age

The reasons that women give for early weaning of children frequently involve elements of a cross-culturally unusual belief system (the "spoiled milk complex") that will be discussed below. But this belief systems is not the ultimate cause of the drop in age at weaning. It is best viewed, rather, as an intervening cognitive mechanism to justify possibly detrimental behaviors whose ultimate cause is to be found in a worsening of the general economic situation of village households.

The women of Kinanbwa have now, and have traditionally had, an unusually heavy degree of involvement in long-distance marketing activities that keep them away from the village weeks at a time in some cases. Just before the birth of a child, the woman would return to the village. She would deliver there with the assistance of a village midwife and — most importantly — she would remain at home in the village during the entire 18 month period of breastfeeding. During this time, some women reinvested their capital in livestock and found alternative sources to generate a little income for themselves while nursing their infant in the village: making straw mats, making sisal rope (kodé pit), selling fried foods, bonbons, biscuits, at different social and recreational occasions, buying and

reselling items or foodstuffs, etc.

But this situation is rapidly changing. During the past eight years a series of rapidly increasing economic pressures has triggered off a shift in the domestic economy of many village households.

Comparing 1980 with 1972, several patterns stand out:

1. Families continue in absolute dependence on purchase of food during much of the year;
2. The price of food staples has risen dramatically over the past eight years.
3. Many families are now more dependent on the purchase of cooking fuel as well — a rare occurrence eight years ago — and the price of this commodity is also rising.

These changes affect the well-being of children, not only in terms of the availability of food and fuel in the household, but also in terms of the increased opportunity costs now associated with stable village breastfeeding. Stated simply, women can no longer afford to remain economically inactive for extended periods of time. The increased cash-flow crisis constitutes a major deterrent against the use of the traditional 18 month withdrawal period which village women formerly enjoyed.

There are several responses to this pressure. Thus, it is not uncommon now for a woman to remain in the village the first 3 or 4 months, and then to take her baby with her to PAP, where she may have to wean it a few later because of the difficulties inherent in carrying out full business activities at the same time that she nurses her child.

When a woman leaves the market to feed her baby, she is not selling, and is therefore not making any money. This in turn makes the baby a burdensome economic liability, not only because of how much money the woman has to invest in it, but because of the money it prevents her from making.

Options available to women in other societies are not part of the Haitian marketwoman's repertoire. For instance, in some societies where women engage in similar trading activities babies accompany mothers to market. While one sees many things in a Haitian market, the sight of nursing babies is not one of them. Mothers remark how rough, dirty, and dangerous this environment can be for a baby and they would rather leave the market to nurse the baby rather than bring the baby with them. Another option used by working mothers in other societies, especially with babies that have reached a certain age, say 2, 3 months, is to nurse the infant before departing to work and to resume nursing after coming back. Relatives will use bottle feeding or other supplements while the mother is away. But this sort of partial breastfeeding is again not part of the Haitian woman's repertoire. Either a woman is breastfeeding or she is not.

The adaptiveness of this traditional insistence on full-time dedication to breastfeeding should be obvious. In addition to the advantages to the child, it provided a long period of rest to the village mother, an 18-month period in which she could remain free from the physically exhausting, rough-and-dirty itinerant urban marketing activities that had become part of the traditional repertoire of village women.

But this arrangement, adaptive as it was, has proven to be extremely fragile in the face of worsening economic conditions. Under the traditional arrangement breastfeeding itself entails an opportunity cost in a way that is not true, for example, of the African mother who simply takes the child to market. But as this local opportunity cost has become less and less tolerable, the Kinanbwa woman has been faced with the choice of either taking the nursing child to market with her or of simply accelerating the weaning process. Those familiar with the squalid, inferno-like conditions of the Kwa-Bosal streets where these women sell will recognize that, in opting for the drop in weaning age, the village mothers have probably chosen the lesser of the two evils.

5.5. The Role of Powdered Milk

The effectiveness of the above-mentioned cognitive mechanism has been made possible only because of the simultaneous availability of a substitute for breastmilk. Long before our original research in 1972, village mothers had already begun to give powdered milk as a supplement to breastfed children. But at that time powdered milk had the status of simply one among many supplements which mothers fed their children in order to vary their diet. It was a functional equivalent to the various paps and liquids that were and are part of the village food supplement inventory.

But the increasingly early weaning of village infants had led to a simultaneous evolution of the position of powdered milk in the behavioral repertoire and cognitive mind-set of village mothers. Powdered milk is now no longer one among many supplements. It is now treated as an absolutely necessary staple. And even mothers who are fully committed to breastfeeding will feel obliged to provide the baby with powdered milk as well. This supplementation with powdered milk will begin no later than the second month of life, and generally begins even earlier.

The rapid emergence of powdered milk is dramatically exemplified in changes that have come over the typical village trousseau. The impending arrival of a child has, in Haiti as in most cultures, traditionally been accompanied by the preparation of a trousseau. Eight years ago, a bottle was hardly ever a part of the expectant mother's trousseau. She would get the little bonnets, waistbands for dress, castor oil to massage the head, soap for washing, matches and kerosene for keeping the house well lit, and other such necessities. Few babies owned bottles and most of the non-breast feeding was done with a small spoon. If anything, after a couple of months, a bottle was bought, for teas, sugared water, cow's milk, and some occasional "lét pharmacie". Today, however, a bottle (at least one) is an essential part of the baby's trousseau. Women who have no bottle

will be looked down upon; and better-off women will have two or more bottles which they display to their neighbors. This intrusion of the bottle into the contents of the village trousseau is merely the material manifestation of the successful "capture" by powdered milk of a new and privileged position in the childfeeding habits of the village.

Why has powdered milk achieved this new position? There are a number of contributing factors, including the simple need for a milk-supplement at a time when the continuation of lengthy breastfeeding has become unfeasible for many women. But it would be a mistake to attribute the recent predominance of powdered milk over other supplements to these simple "demand" factors. A very powerful process has been unleashed in another quarter as well. First births are increasingly taking place in the government run maternity ward in Port-au-Prince; and at least some women are having all of their children there. Informants have repeatedly told us that women are obliged by the hospital to include a bottle as part of the packet which they bring with them to the hospital. It would seem that the bottle is used in the hospital, not for formula, but for the preparation of boiled sugar water for the child until the mother can breastfeed him. But in the cognitive scheme of village women, the bottle is associated with powdered milk. And the inclusion of a bottle by the representatives of Modern Medicine as an essential item in the childcare equipment of the expectant mother serves as an important additional support of powdered milk. There has been a recent surge of publicly funded billboards in Port-au-Prince praising mothers' milk as the best food for children. But few village women see these signs, and even fewer can read them. Much more impressive to them is the insistence by Doctors and Nurses that they bring with them a bottle to the hospital where they will deliver, creating a paradoxical and perhaps unintended situation in which medical personnel transmit conflicting messages. It is clearly the pro-powder message which is coming through more strongly to the village women.

Despite the growing attachment to powdered milk, however, the village women are aware of certain practical problems which it creates. It is, first of all, increasingly expensive. It now costs about 10 g a week to feed an infant with powder milk, and this does not include the other foods that are simultaneously given the child. Secondly, it makes more demands of cleanliness than the usual tools. Keeping a bottle and nipple clean are much harder goals than keeping a spoon clean, or keeping the breast clean. Thirdly, it increases the risk of infection. More quantities of boiled water are required to prepare the bottles, which means more firewood is consumed and spent by the family.

But these practical difficulties will not suffice to turn back the increasing reliance on powdered milk. In this sense the village of Kinanbwa is traversing the same path that communities in other world regions are traversing, impelled by similar economic dynamics.

5.6. The "spoiled milk syndrome" and other cognitive mechanisms

Traditional norms placed a great deal of emphasis on protecting children. Women would wean children only when it was safe. Worsening economic conditions have placed village mothers in a double bind situation. Traditional beliefs have told them that, other things being equal, they would be harming their children if they weaned them before they had achieved the various physical developments mentioned above that were completed near 18 months of age. But economic conditions now impel them into behaviors (early weaning) which by their own cultural standards are physically detrimental to their offspring.

Anthropologists have long since learned that, when faced with such dilemmas, communities will find cognitive escape hatches which, without challenging traditional premises, nonetheless permit capitulation to new economic realities. In this case the major cognitive escape-

hatch mechanism has been the florescence of a formerly minor belief complex by which, under certain circumstances, it was now dangerous for the woman not to wean her child. This minor complex, consists principally of a belief in an illness called let gate ("spoiled milk").

Villagers believed that it is possible for the milk of a lactating woman to gate, to spoil and turn into a poisonous substance that may, instead of nourish the child, harm or even kill it. The most frequent cause for this transformation is the onset of a violent negative emotional state in the female. Even a mild emotional upset, triggered off by an argument or a disagreement with one's spouse, can disturb the woman's milk sufficiently to prevent her from feeding her child immediately. The milk will be given time to simmer back to normal.

But if the emotional reaction reaches a certain intensity, then it is believed that the woman's milk is irreversibly harmed. It would appear that marital conflicts are themselves the major context in which this milk spoiling occurs. Following a violent argument involving a lactating woman, two things can happen to her milk. On the one hand, the milk can "go up into her head" (vinn monte nan tet-li), a serious turn of events which can lead to permanent mental illness on the part of the woman. On the other hand, the altercation may simply turn her milk into move let or let gate (bad milk or spoiled milk). The milk then becomes harmful to the child, causing eruptions of boils all over his body or other illnesses which in some cases may prove fatal. Once this happens to the mother's milk, the process is generally irreversible, and the only responsible course of action is for the woman (reluctantly, of course) to immediately wean her child, even though he or she may be only a few months old.

Beliefs such as this arise and are sustained because they serve some function or functions in the group which entertains them. One is impressed at the manner in which this traditional belief in the ability

of breastmilk to get spoiled forms part of the above-mentioned complex aimed at protecting the lactating woman. That is, not only is the woman freed from the obligation to generate income in the marketplace. At the same time, she is defined as being in a vulnerable state where neighbors and other family members must accord her special treatment -- above all by avoiding any words or actions which will excite her -- to prevent her milk either from entering her own head and causing insanity or from spoiling and causing problems to the young infant. This "spoiled milk" complex then can be seen as one element in a traditional complex whose principal effect was to protect the lactating woman from the physical and emotional stresses of ordinary village life.

During our initial research in the early 70's, we had been exposed to the belief in spoiled milk. But by the time our follow-up research began, this originally minor belief had turned into a frequent topic of conversation in the village. It was as though this formerly infrequent illness had rapidly come to take on epidemic proportions, one outcome being the empirically impressive plunge in mean age at weaning documented in an earlier section.

The "illness" itself would appear to have little or no basis in biological fact. The "epidemic" must therefore stem from other factors. The belief itself was already present in the population, and even in traditional times a small degree of early weaning was probably done in conjunction with the belief. Perhaps the most productive formulation of the question is the following: what factors have caused people to invoke with increasing frequency a belief that in former times was of minor importance?

It takes little imagination to perceive the manner in which this "illness" provides precisely the cognitive rationale for turning to the increasingly early weaning that the worsening economic conditions

in the village make practically desirable. The belief complex itself makes possible a behaviorally convenient symbolic metamorphosis of the meaning of early weaning. Traditionally, early weaning was seen as an injustice to the child. But when a woman has let gate, her early weaning is interpreted as a service to the child. In this case, early weaning is not cruelty to the child; it is instead cruel not to wean the child.

We suspect thus that the epidemic of let gate which appears to have come over the village cannot be understood apart from the economic pressures which make early weaning desirable and from the concomitant need for a cognitive rationale within which this formerly criticized practice becomes personally and socially acceptable. But in positing this function, two errors must be avoided. In the first place, this factor does not explain the origin of the belief in spoiled milk. This belief antedated the early weaning patterns and must be explained on the basis of factors which fall outside the scope of this report. All that is being explained here is the increased use which villagers make of this pre-existing belief.

Secondly it would be a serious misinterpretation to assume that the use of this early-weaning rationale is being done consciously and intentionally by women looking for an excuse to stop breastfeeding their children. It is our impression that the women involved are genuinely convinced that their milk is spoiled. What appears to be operating is an anthropologically common pattern by which beliefs emerge that make possible the turn to formerly unacceptable but now necessary behaviors. These cognitive mechanisms operate on the whole without any awareness on the part of the actors involved that they are engaging in collective make-believe, and there would be no justification--either empirical or theoretical--for positing conscious trickery on the part of the Haitian woman whose milk gets thus spoiled. What has occurred has been a shift in the function of a traditional behavior/belief complex. The spoiled-milk folk-theory which formerly was used to justify special

concern for and treatment of lactating women is now invoked to rationalize the early weaning of children. The belief itself has remained untouched; what has shifted is the behavior complex into whose service it is called.