

Karen Marie Moland

Mother's Milk, An Ambiguous Blessing in the Era of AIDS: The Case of the Chagga in Kilimanjaro

Abstract

HIV/AIDS has renewed the need for a critical interpretation of breastfeeding in social and cultural terms. The issue that this study addresses is how medically informed knowledge of HIV transmission through breastfeeding is interpreted and transformed in a local rural community in Kilimanjaro Region in northern Tanzania. The paper explores the articulation between a medical discourse on risk and a local discourse on motherhood which informs the choice of infant feeding method. It discusses the complexities involved in making an appropriate decision on breastfeeding, and argues that breastfeeding must be understood as closely tied to the cultural elaboration of the female body and of motherhood. It shows that the body of the mother and the body of the newborn child are subject to close scrutiny and local diagnostic processes. Not breastfeeding is not only perceived as a significant failure of motherhood, but also raises suspicion of a likely HIV positive status on the part of the mother.

Introduction

For the last few decades, the influence of feminism in the social sciences has put issues related to fertility, reproduction and childbirth on the agenda of anthropological inquiry (see e.g. Jordan 1993; Handwerker 1990; Lindenbaum and Lock 1993; Davis-Floyd and Sargent 1997; Lock and Kaufert 1998). The absence of breastfeeding in the literature produced in this field of research is however remarkable. It is quite clear that breastfeeding, as an aspect of human reproduction, has not attracted much research interest compared to, for instance, pregnancy and birth. An important exception is *The anthropology of breastfeeding: Natural law or social construct*, a selection of studies edited by Vanessa Maher in 1992. Maher holds that the reason for the neglect of breastfeeding in social science research is related to the fact that breastfeeding has been bound up with the concept of nature (Maher 1992). The act of breastfeeding has been defined as a matter of natural law rather than as a matter of choice and subject to social and cultural pressures. Research efforts accordingly have primarily been geared towards understanding the nutritional and immunological secrets of mother's milk. But clearly, breastfeeding involves more than

biology and human nutrition. Situated in the field of fertility and reproduction, breastfeeding is subject to considerable cultural elaboration, and to paraphrase Maher, more complex cultural conditioning and social relationships are at stake if breastfeeding is threatened (1992). In view of the current knowledge of the risk of HIV transmission through breastfeeding, the HIV epidemic may represent such a threat.

HIV/AIDS has put breastfeeding on the agenda of social science research and has renewed the need for a critical interpretation of breastfeeding in social and cultural rather than merely medical terms. This paper deals with breastfeeding as an issue of increasing concern and uncertainty in Kilimanjaro Region where the HIV prevalence in the general population is among the highest in Tanzania (Ministry of Health 1999). It discusses the articulation between two opposing discourses on breastfeeding. One discourse focuses on *risk* and emanates from medical research on HIV transmission through breastfeeding. The other focuses on *motherhood* and is local in origin, and closely tied to the gendered discourse on parenthood and the general conditions of life in the area. These two discourses propel their proponents into different directions, causing the women to make a choice that might result in further risk and uncertainty.

In her discussion of uncertainty among the Nyole in Uganda, Susan Whyte (1997) argues that: 'uncertainty and response are linked to broader social and moral concerns that shape and are shaped by them' (Whyte 1997:3). It is these broader social and moral concerns that are examined here.

The current attempt to approach the problem of breastfeeding in the context of HIV/AIDS is based on long-term fieldwork on maternity, birth and birth care in Kilimanjaro Region during 1997 and 1998 and subsequent yearly follow-up visits from 1999 to 2003. The data presented here have been collected through participant observation of daily life in a low-income rural community on the slopes of Mount Kilimanjaro and through interviews with men and women of different ages. Key informants were women who were pregnant or breastfeeding at the time of the fieldwork, and grandmothers and local experts on birth and reproductive health including Traditional Birth Attendants. Most women in the community are involved in farming combined with petty trade. The area used to supply labour to a large coffee plantation that is no longer operational. Many of the men are unemployed; others commute to town for work. The common residence pattern in the community is virilocal involving a relationship of interdependence between a married woman and her affinal kin, especially her mother-in-law. The people living in the area identify themselves as Chagga. Although the local vernacular, Chagga, is used in domestic settings, Swahili, the national language, is the unifying tongue and is commonly known and widely used.

Kilimanjaro Region has been badly hit by HIV/AIDS. The prevalence rate rises above the national average of 7.8 percent among adult men and woman

(Ministry of Health 1999; UNAIDS/UNICEF/WHO 2002). According to the National AIDS Control Programme (NACP) in Tanzania, 13.5 percent of the pregnant women attending antenatal clinics in Moshi in 2000 were HIV positive (Ministry of Health 2000).¹ Moshi is the regional capital and the largest town with a population of 150,000. The town partly owes its recent development and pace of modernisation to the Kilimanjaro Christian Medical Centre (KCMC), the national referral hospital for the northern zone which is situated in the vicinity of Moshi town. Within Tanzania, Kilimanjaro Region is known for its educated and development-oriented population. The coffee and banana cultivating Chagga farmers who inhabit the slopes of Mount Kilimanjaro constitute the dominant ethnic group both in terms of numbers and in terms of economic and political power (Klepp, Biswalo, and Talle 1995). The Christian Church is strong in the area, especially among the Chagga. The particular area where the data for this paper were collected is often described by other Chagga as backward in terms of education and economic development. The interpretation and the management of the problem of HIV and breastfeeding in this area must therefore be understood in the context of poverty.

In the following section I introduce the concept of prevention of mother-to-child transmission (pMTCT) and the discourse on risk that surrounds it.

Mother-to-child Transmission of HIV and the Risk of Breastfeeding

Vertical transmission of HIV from mother to child during pregnancy, delivery and breastfeeding is an urgent problem in sub-Saharan Africa and is the main cause of HIV positive status in children below 15 years of age (UNAIDS 1998). With an increasing population of HIV positive pregnant women, and an estimated overall risk in populations who breastfeed of between 30 and 45 percent if no preventive measures are taken (WHO 2001), we are talking about a problem of dramatic proportions. It is estimated that breastfeeding causes between one third and one half of the cases of HIV transmission from mother to child. The risk of HIV transmission through breastfeeding varies with viral load and maternal health, as well as with the breastfeeding pattern and duration (see e.g. Chopra et al. 2002).

Mother-to-child transmission of HIV is an issue that has raised concerns about human rights and the protection of the unborn child as an urgent matter. The social, demographic and ethical implications of mother-to-child transmission (MTCT) have encouraged the establishment of projects of prevention (pMTCT).

Prevention Efforts

In Tanzania, intervention projects to reduce the risk of transmission have been established in many regions of the country, including Kilimanjaro, and the risk

of transmitting HIV through breastfeeding is an issue that is receiving growing attention. Since 1999 KCMC has been one of five pilot sites in Tanzania for a UNICEF funded VCT (voluntary counselling and testing) and pMTCT programme. The pilot phase ended in 2003 and the Ministry of Health is now in the process of expanding VCT and pMTCT services to all regional hospitals in the country. The social and legal consequences as well as the policy implications of the complex issues involved in vertical transmission of HIV are also vigorously debated locally by women's organisations working with legal rights issues and with HIV/AIDS NGOs like KIWAKKUKI (Women against AIDS in Kilimanjaro Region) and KWIECO (Kilimanjaro Women Information Exchange and Consultancy Organisation). The subject is also raised in newspapers and radio broadcasts. Mama Terry, a popular local health educator broadcasting information on HIV/AIDS on the radio every Thursday morning, represents an important source of information on MTCT, particularly to women living in rural areas who have limited access to other sources of information. Although medical knowledge about mother-to-child HIV transmission and prevention remains low in the general population in Kilimanjaro Region, the idea of breastfeeding as potentially dangerous to the child of an HIV positive mother has become widespread even in rural areas.

The prevention of mother-to-child transmission projects involve voluntary counselling and testing (VCT) of pregnant women attending antenatal clinics and the administering of antiretroviral drugs to the HIV positive mothers as prophylaxis during pregnancy and/or during labour and delivery.² Short-course antiretroviral prophylaxis reduces the risk of transmission in late pregnancy, during birth and through early breastfeeding postnatally to about one third.³ The drug treatment does not change the HIV status of the mother. The infant feeding advice given is based on the international guidelines on breastfeeding and HIV suggested by UNAIDS, WHO and UNICEF from 1998, and promotes a so-called fully informed and free choice of infant feeding method for HIV positive mothers. The guidelines recommend that counselling for HIV positive women should include the best available information on the benefits of breastfeeding, the risk of HIV transmission through breastfeeding and the risks and possible advantages of alternative methods of infant feeding (UNAIDS/WHO/UNICEF 1998). Guidelines for safe infant feeding methods developed specifically for Tanzania recommend either exclusive breastfeeding for six months or replacement feeding from day one (Ministry of Health 2003). Exclusive breastfeeding means giving no supplement of any kind and should be followed by abrupt weaning after six months. Replacement feeding such as commercial infant formula or home prepared formula from cow's or goat's milk should be introduced immediately after birth, as breastfeeding should be avoided altogether. Expressed and heat-treated breastmilk has been added as another safe option in the new draft guidelines of 2003, but has previously been

found not applicable to the Tanzanian context, and is not presented to parents as an option on a routine basis during counselling at KCMC.

The concept of prevention of mother-to-child transmission (pMTCT) is based on medical knowledge and discourse defining breastfeeding in terms of nutrition, disease prevention and, at best, mother-child attachment. It follows that when breastfeeding becomes a risk to the health of the baby, it should be replaced by other feeding methods. Although replacement feeding is promoted as the safest option in terms of HIV transmission, the guidelines recognise the medical and nutritional superiority of breastfeeding and the potential risks involved in other feeding methods in terms of hygiene, knowledge, access to money to buy replacement foods, and convenience. At the same time exclusive breastfeeding and abrupt weaning is an alien concept in an area where prolonged breastfeeding, usually extending into the second year of life, and early introduction of supplements have been common practice (de Paoli et al. 2002). Hence, neither of the options promoted are easily implemented. Both methods involve major dilemmas particularly for poor women, and according to de Paoli et al. (2002), the best infant feeding method for economically disadvantaged women is still being debated internationally as well as locally in Tanzania.

The Social and Cultural Context of Choice

The current national and international policy guidelines on infant feeding in HIV positive women do not fully recognise that breastfeeding is a practice that involves much more than a physical and psychological relationship between two individuals. Neither do the guidelines sufficiently reflect the fact that infant feeding choices are never made in a social and cultural vacuum. The social relationships surrounding and conditioning breastfeeding involve much more than the relationship between mother and child. Breastfeeding is embedded in a social system involving relationships of control, power and authority. It is integrated into a universe of symbols about the female body, about sexuality and reproduction, about motherhood, and about belonging.

In the following sections I discuss how the information or medical knowledge on HIV transmission through breastfeeding is interpreted and transformed within the social and cultural context of the Chagga of Kilimanjaro. This involves an examination of the cultural significance of breastfeeding and an inquiry into the kind of choice that women are faced with in deciding on infant feeding. It also involves a discussion of the tension between customary practice and culturally informed ideas about breastfeeding and motherhood on the one hand, and the knowledge transmitted through the intervention project on the other. International and national agencies involved in pMTCT have agreed on the concept of free and informed choice as a standard expression and as an ethical ideal (see e.g. Chopra et al. 2002). Informed choice implies that it remains the mother's right to choose the most appropriate feeding method. The

relevance of the concept in the particular social and cultural context of the Chagga and the application of the mother's right to choose is questioned here.

The Cultural Significance of Breastfeeding

Fertility and the Power of the Milk

The cultural importance of fertility in defining women's status in Kilimanjaro is well documented (see e.g. Raum 1996/1940; Moore 1986; Howard and Millard 1997; Setel 1999; Moland 2002). Fertility refers both to the ability to create and to sustain life, to give birth and to nurture the child. Bodily fluids in general represent a rich source of symbol production, and breastmilk is no different. Sally Falk Moore (1986), who has conducted extensive fieldwork among the Chagga, holds that the local concepts of sexuality and reproduction emphasise semen and mother's milk as life-giving forces. While semen is necessary to create life, breastmilk is necessary to sustain it. But as all-powerful substances, mother's milk and semen were also considered able to transmit evil and sickness (Moore 1986; Raum 1996/1940). While the proper combination of male and female created life, improper combination and timing could result in death and sickness (Moore and Puritt 1977).

A woman's milk is seen as her own blood, her own life-sustaining fluid. The same blood that feeds the foetus in the womb runs from the breasts as milk after birth so that the mother can continue to nourish the baby. The positive attitude towards mother's milk contrasts sharply with the negative connotations given to menstrual blood. Menstrual blood and mother's milk, according to Moore, represent opposite aspects of the female in Chagga cosmology. While menstrual blood is associated with pollution, death and danger, mother's milk is associated with feeding, life-bringing and maternal qualities (Moore 1986). According to O.F. Raum (1996/1940), a German missionary who worked in Kilimanjaro Region in the early twentieth century, and who later wrote a Chagga ethnography, the image of mother's milk as powerful is represented in a number of sayings and practices. He mentions that when a mother offered her breast to an unrelated child, it could be accepted into the family. The relationship among brothers and sisters was, and still is, recognised by the phrase 'they were suckled by the same breast'. Being breastfed by the same woman is seen to create a sense of belonging and solidarity that may be described in terms of milk kinship (for a discussion on milk kinship in Islam, see e.g. Khatib-Chahidi 1992). The relevance of the term in this context has, however, not been fully explored and the rights and obligations involved are not well known. More important in understanding the role that mother's milk plays in the ideology of reproduction is perhaps the concept that the lineage draws its strength not only from a common descent, i.e. from common ancestors in the patriline, but also from mother's milk (Raum 1996/1940). The implications of these ideas about

the importance and the power of mother's milk in a patrilineal kinship system go beyond the topic of the current paper and require further research.

Although the context of the local conceptions and ideas about breastfeeding and mother's milk have changed dramatically in the post-colonial era, there is no doubt that mother's milk is still seen as vital for lineage continuity. But at the same time, the AIDS epidemic has attacked the two major life-giving substances represented in Chagga ideology of sexuality and reproduction. Both semen and mother's milk have become potentially life threatening.

The issue that I now turn to is how the powerful role of breastfeeding in human reproduction in general, and in the reproduction of the patriline in particular, is expressed in social institutions and in the gendered division of labour and responsibility.

Motherhood and Post-Partum Confinement

In most societies women's sexuality and reproductive capacity are subject to control mediated by the political and the symbolic systems (see e.g. Lock and Kaufert 1998; Maher 1992). In the case of the Chagga, patrilineal descent and a virilocal marriage pattern represent important conditions for the way that fertility is controlled and represented in general, and for the way in which breastfeeding is interpreted and infant feeding decisions are made.

A major theme in Chagga cosmology is the continuation of the patriline through the chain of ancestors and descendants. In the gendered division of labour among the Chagga, women may be said to have done the *necessary* work that sustains life. A woman's work is closely tied to the reproduction of the patriline. It is her responsibility to bear and nurture children. A woman who bears six children may spend about twenty years either pregnant or breastfeeding. According to the Health Statistics Abstract for 1997, the fertility rate of Kilimanjaro region is 5.8 children per woman (Ministry of Health 1997). As Marylynn Salmon (1994) comments in her historical study of breastfeeding, these very physical realities of childbearing place motherhood in the very centre of women's lives.

The power of the breastmilk as a life-sustaining fluid is still strongly emphasised in concepts of infant feeding and is clearly expressed in the respect for women's physical powers and role in infant feeding. Respect as a mother is earned not only through giving birth, but is significantly produced and reinforced through breastfeeding and nurturing the child. The mother receives credit if her baby flourishes. The good health of the child enhances her status. The respect for women's power in nurturing and rearing a child finds concrete expression in the privileges granted to the breastfeeding woman during the period of confinement. Today, childbirth is the one event that exempts a woman from her normal duties and places her in a position requiring special care and attention from her husband and her mother-in-law. Similar practices in

connection with circumcision and marriage have largely been discontinued due to competing demands on time and lack of economic means.

Pregnancy, birth and confinement have traditionally been the province of the mother-in-law and as a senior woman she had considerable power over her daughter-in-law. In contrast to pregnancy and childbirth which have been subject to increasing medicalisation and to a large extent been moved to the domain of nurses in hospitals, confinement has remained the concern of the lineage and primarily the mother-in-law (Moland 2002). The major purpose of the confinement period is to establish motherhood through breastfeeding and to secure the fertility and reproduction of the lineage. The woman eats and rests in order to be able to feed the child. At the same time the body of the woman ending her confinement mirrors the love and the economic power of the household. The woman's body should be firm and fat and her skin should be shiny. It brings shame over the family if a woman leaves her confinement thin and unhappy. This will tarnish the reputation of her husband and her mother-in-law (Moland 2002). Today it will also create some suspicion that she may have AIDS.

The period of confinement, ideally extending over three months, has been highly appreciated as a time of rest, recognition from kin and good food. Although women today rarely enjoy the customary three months of postpartum confinement, birth continues to bring attention and assistance to Chagga women albeit in a changing fashion (Howard and Millard 1997).

Failure to Breastfeed: A Failure of Reproduction and Motherhood

According to Howard and Millard's important study of malnutrition among the Chagga in the 1970s and 1980s (1997), failing to breastfeed was a significant failure. People saw the absence of breastfeeding, whether as a conscious choice or not, as an act against the lineage, against the values of cooperation and commensality and against ideas about mother's milk as an essential link in the life cycle (Howard and Millard 1997). Women who did not breastfeed could fall victim to witchcraft accusations and were said to actively refuse to breastfeed their children. The strong influence of Christianity in Kilimanjaro Region from the end of the nineteenth century may have strengthened the sanctions against non-breastfeeding mothers. Breastfeeding, according to the Bible, is a woman's sacred duty and should take precedence over all other obligations (Baumslag and Michels 1995). Failing to breastfeed is not less important and not less sanctioned today. People say that for a mother to deny her infant her breast is an evil act that may cause the death of the child. The cultural imperative to breastfeed in Chagga is still so strong that it hardly allows for an alternative. When presented with the possibility of a child not being breastfed, a common reaction from both men and women is astonishment and disdain, and they question whether the baby will live if it is not breastfed. Breastfeeding is experienced as vital to child survival. A common phrase is: 'mother is life' (in

Swahili: 'mama ni uhai'). Conversely, the absence of a mother means insecurity, illness and even death. Mothering implies breastfeeding. The two issues are intertwined and interdependent, and the one cannot be seen in isolation from the other. The failure to breastfeed is a failure of reproduction and motherhood. The context and the interpretation and social consequences of *not* breastfeeding, have, however, changed in the course of the AIDS epidemic.

Childbearing Women as the Core Narrative of AIDS

To be able to understand the social dynamic of choice of infant feeding method, we need to investigate how people talk about and make sense of the link between breastfeeding, mother's milk and HIV/AIDS. In view of the concept of mother's milk and blood as one, people do not find it hard to understand that breastfeeding may transmit HIV. As explained by a grandmother and a local expert in birth care: 'Milk is blood, the virus is in the blood. Hence, the milk also carries the virus'. She explains that while the child is fed by the mother's blood in the womb, it is fed by the mother's milk after birth. Hence a woman who is infected with HIV cannot have a healthy child. The child will already be infected at birth or it will be infected through the milk of the mother. The common concept, which derives from this understanding, is that women infected with HIV/AIDS should not breastfeed. The issue of exclusive breastfeeding is rarely raised as an alternative.

Not breastfeeding a newborn child, however, is taken as a sign of AIDS, and as illustrated in the following narratives, it causes fear on the part of others, and isolation of mother and child:

Mary, a 38-year-old educated woman living in Moshi town, has a friend who recently gave birth in the referral hospital. Mary tells me that: 'I went to see Rose in the hospital to congratulate her on the child. I asked her how she was doing and she told me that the doctor had advised her not to breastfeed her child. She started to cry and asked: 'What am I going to give this child?' I was shocked. I understood that she was infected. I said she had to do what she was advised to do by the doctor. I tried to comfort her by talking about other things. Since that time I have not been to visit her again. I don't know what happened to our relationship. I don't feel like going. The love is not there. She reminds me that death is near. I think they will both die.

Rose and her baby died a few months later. Mary attended the funeral, but she never went to see Rose before she died.

Elisabeth is in her early twenties, married, and staying with her husband and her parents-in-law in a rural area not far from Moshi town. She recently lost a baby in childbirth and has previously miscarried twice. She has no live baby. Elisabeth is still confined to the house and is very worried about her future and her health. She tells us that the neighbour's daughter gave birth at the referral hospital. She is divorced and came back home to stay with her mother. Elisabeth further explains:

She has got problems. She was told not to breastfeed her child. She is sick. Her mother takes care of the child. People around here say it is AIDS. It is only AIDS that makes a woman not breastfeed her child. I have not been to see her. I fear. Nobody from here goes to that house any more. We think she might bite.

People often express fear of being bitten by an HIV positive person and are uncertain about the risk involved in terms of HIV transmission.

The stigma of HIV/AIDS finds new expression in the mother who does not breastfeed her child. Breastfeeding, the quality of the mother's milk, and the development of the child, have become a topic of increasing interest, suspicion and gossip. It is well documented that stigmatisation in the AIDS epidemic in Tanzania as elsewhere has built on pre-existing prejudices (see e.g. Lie 1996). The idea of the female body as dangerous and polluting has been nourished by the AIDS epidemic, particularly through the construction of risk and risk groups in the early phase when female prostitutes were defined as the prime targets of intervention. The focus remains the female body, but the attention is drawn not only towards defined risk groups, but also towards women in child-bearing. This marks a significant change in the common interpretation of AIDS and of risk. The change is not unique to Kilimanjaro or to Tanzania. In their study of stigma and pMTCT in Zambia, Bond et al. (2002) argue that women with HIV have become the *core narrative* of HIV infection in the particular community of the study. According to the findings, mothers are commonly suspected and blamed for infecting their babies and people talk about how visible AIDS has become through pregnant women and new-born babies falling sick and dying.

We need to recognise that in a situation of an unknown or HIV positive status, childbearing women have to live with two kinds of fear, the fear of infecting the baby, and the fear of social sanctions both from close kin and from the community at large. The fear of being ousted from the social network of respectable people involves not only loss of economic security, but also loss of belonging and recognition as a social person.

'Food for What, Money for What?': The Uselessness of the Infected Mother

A woman earns a place in her husband's family through proper wifely behaviour, motherhood and obedience to her mother-in-law (Howard and Millard 1997:144).

Anna has been worried about her own health for several years. Her husband is a driver in Dar es Salaam, the largest city in Tanzania, roughly a one-day bus-ride from Kilimanjaro, and he only comes home once or twice a year. Now she only worries when she or her last-born child, who is still being breastfed, gets sick. About the idea of not breastfeeding her infant, she says:

I would have felt very bad if I had not been able to breastfeed my newborn child. I would not be fulfilling my responsibilities and I would start thinking about the death of the child. If I could not breastfeed, the child would die very fast. People would think I am *useless*.

Neighbours and relatives, who would otherwise bring confinement food like bananas, or money, would not bring anything. People would think food for what, money for what? I would not get assistance from anybody but mother-in-law and I would not get the rich confinement food meant for a mother who is feeding her newborn. I would not fit into life here any more (emphasis added).

It is not only Anna who reasons about breastfeeding and confinement in these terms. The confinement period is seen as a benefit that a woman is granted to pay respect to her role in reproduction and to enable her to fulfil her obligations to feed the infant. Unless a woman breastfeeds, she cannot complete her role in reproduction and she will have no need for the rest and the feeding that the husband and the in-laws customarily provide. Neither is a woman who does not breastfeed worthy of respect as a mother, according to Anna. Not only would failing to breastfeed seriously downgrade her respect vis-à-vis her in-laws and in the local community, it would also critically reduce her self-esteem.

Complying with the feeding advice issued by the doctors and nurses in the PMTCT project is, no doubt, a huge burden to carry particularly in a situation where a mother's respectability and belonging hinge on her fulfilling the obligations to 'feed the child from her own blood' as Mama Neema, a local expert on birth care put it. This is not only so in relation to the mother-in-law. As the cases above illustrate, it also involves rejection and distrust on the part of neighbours and friends. The significance of keeping the HIV positive status of the mother a personal or a family secret must be understood in a context where the non-breastfeeding mother is stamped as being useless to the child, to the patriline and to her social network in general.

The efforts to hide the problem of not breastfeeding involve avoiding arenas where women normally gather and not taking part in activities that are expected by a woman after the end of the confinement period, like going to the *shamba* (Swahili for agricultural plot), to the market or to church. The common expectation that a mother should carry her child on her back while attending to her normal duties, and at the same time be very responsive to the child's needs for comfort and feeding at her breast, adds to the burden of the non-breastfeeding mother. As one of the key informants commented: 'What will she do when the child cries and people start commenting that she should respond to the needs of her child?'

The close and symbiotic relationship between the body of the mother and the body of the child, otherwise celebrated in the ideology of fertility and reproduction, is for the non-breastfeeding mother turned into a barrier, which hinders her from taking part in social life.

'The Child Will Reveal the Secret of the Milk'

Considering the perceived close association between failing to breastfeed and HIV/AIDS that has developed, it may be very hard for a woman to convince her

mother-in-law that she should not breastfeed her child without at the same time revealing that she is HIV infected. As Anna, to whom I refer above, puts it:

If the mother-in-law sees milk running from the breasts while the mother refuses to breast-feed her crying child, the mother-in-law will know it is AIDS. Most women will keep quiet and just breastfeed.

But even if an HIV positive mother breastfeeds her child, her secret will be revealed in due course. The local birth expert, Mama Neema, who regularly counsels women on issues related to maternal and child health in her community, explains that an infant's development is seen as directly linked to the quality of the mother's milk. Thus, people are able to judge the milk of the mother on the basis of the health condition of her child. Mama Neema elaborates further:

Nowadays we judge the woman's health through the development of her child. If you get a child, the child itself will reveal the secret of the milk. Breastfeeding has become an issue not only to women. These days also men know that if you have AIDS it is also in the milk. People will pay attention to women who breastfeed and ask if the milk is good, saying: 'Let us see how the child will grow up'. And they will watch carefully.

The common concept then, is that a mother will not be able to keep her secret of being HIV infected whether she breastfeeds or she fails to breastfeed. Paulina, a local family planning counsellor and local expert in birth care, comments on the predicament of the HIV positive mother, saying that:

The health authorities advise HIV positive women not to breastfeed. If you don't breast-feed, people will know. If you breastfeed and the child does not develop well, people will suspect that you have AIDS. They will start whispering and gossiping. The only way to keep your secret is not to get pregnant.

The link between the health of the mother and the health of the child is the milk. This is not a new idea in Chagga. The quality of the milk reflects not only the health condition of the mother in a narrow sense, but also her *tabia*, i.e. her moral character (see e.g. Haram 1999; Setel 1999). Today women talk about two conditions in addition to AIDS that can harm the baby through breastfeeding. One is a new pregnancy and the other is illegitimate sexual relations. Being a good mother means not exposing the milk to pollution of any kind, and in particular to avoid the damaging effect of semen from a man other than the father. Hence, violations of these moral codes are evidenced through the development of the child. According to the elders, however, no disease or condition before AIDS has been understood to epitomise the link between the health of the mother, including her moral character, and the health of the child, so unambiguously.

Decision-making and the Predicament of the HIV Positive Mother

To understand the HIV positive mother trying to cope with the infant feeding dilemma, we need to understand the context of choice and we need to ask what

is at stake. We need to consider her understanding of risk and child survival, and we need to understand the cultural significance of breastfeeding as well as the social implications of not breastfeeding.

In the choice of infant feeding method, there are two issues at stake, child survival and motherhood – two sides of the same coin. Women with HIV/AIDS have to consider the message from the medical doctors that breastfeeding implies a risk of HIV transmission. As I mentioned earlier, the popular understanding of this message is that HIV positive women should not breastfeed; breastfeeding may kill the child. At the same time the body of a woman who does not breastfeed her newborn carries the imprint of HIV. Susan Whyte (1997) groups misfortune among the Nyole in Uganda into four categories, including failure of health, failure of prosperity, failure of gender and failure of personal safety. In Chagga society, where breastfeeding is a cultural imperative, not breastfeeding is considered a failure of motherhood and of reproduction. When, in the same context, reproduction and motherhood are so central to the expectations about being a woman, not breastfeeding may even be seen as a failure of gender, a failure of fulfilling the purpose of being a woman.

By addressing only the issue of child survival, focusing on infant feeding and ignoring how this is linked to motherhood, pMTCT projects introduce a distinction between motherhood and breastfeeding that is alien to the Chagga concept of reproduction. The two issues cannot be addressed separately. The issue of breastfeeding can only be understood in the context of women's wider roles as mothers. Therefore questions of *motherhood* must be addressed alongside questions of breastfeeding.

Medicalisation of life events in general and of sickness in particular has often been associated with the imposition of power over the bodies of individuals (Lock 2001). In Ivan Illich's (1976) famous terms, the medical rationality colonises people's consciousness and causes dependence on medical expertise. A recurrent topic in the early feminist literature was women's resistance to medicalisation and thus to the power of medical knowledge and technology (see e.g. Martin 1989). It would be tempting to see HIV positive women's choice to practise customary breastfeeding, with early introduction of supplements, contrary to counsellors' advice as an example of resistance to medical knowledge and power.⁴ I do not think however, that such an approach would bring us much further in understanding women's choice of infant feeding method, nor women's responses to medicalisation. To many women the pMTCT project, that works to medicalise not only childbearing, but also breastfeeding, is experienced as *enabling*. It potentially provides the woman and her family with a choice. The prospect of saving the child is greatly appreciated and replacement feeding is appropriate in many cases, particularly among urban, educated and employed HIV positive women. The response to medicalisation shows great variation within Kilimanjaro Region too, and it is

closely related to the individual woman's economic and social position, and hence to her agency.

I would argue that it is the rural, economically poor and socially disadvantaged women that are least likely to practise what, by the health authorities, have been defined as safe feeding options, including replacement feeding of animal milk or infant formula, or exclusive breastfeeding. But this effect cannot be explained in terms of disbelief or distrust of medical knowledge and expertise. HIV positive women who breastfeed tend to do so because the alternative is worse and involves a great risk of losing status as a social person. Breastfeeding despite HIV positive status I argue, is a function of social pressure from close kin and neighbours, and is connected to individual women's lack of agency. Living in an extended family setting may expose a woman to the close monitoring and control of the mother-in-law and severely limits her opportunity to make a so-called free and informed choice of infant feeding method.

As Margareth Lock puts it, 'the responses of individuals, families and communities to medicalisation are complex and perhaps best described as pragmatic' (Lock 2001:81). In Kilimanjaro the choice to breastfeed in spite of medical personnel urging caution, I argue, is an expression of pragmatism in a situation of uncertainty and doubt as to the management of HIV/AIDS on the one hand, and of a deep fear of being ousted from social life on the other. Thus the articulation of the medical discourse on breastfeeding which focuses on risk and risk reduction, and the local discourse focusing on motherhood, produces patterns of infant feeding that vary across social and economic groups within Chagga society.

In closing, I return very briefly to the issue that I started out with – the possibility that the AIDS epidemic represents a threat to breastfeeding and hence to the social relationships that surround and condition breastfeeding. My initial assumption was that people's ideas about breastfeeding would change as a result of the negative publicity that breastfeeding is getting through the pMTCT project and the way this information is interpreted locally. I was concerned about the public health effect of the pMTCT project. From seeing mother's milk and breastfeeding as a blessing, I anticipated a change towards an attitude to mother's milk and breastfeeding characterised by ambiguity. To some extent I believe that this is also the case. People do talk about the milk of HIV positive mothers as poison (*sumu*). But even so, this very uncertainty of breastfeeding and AIDS may have a quite unexpected impact on practice. Interestingly, there are some signs that the cultural significance of breastfeeding in the AIDS epidemic has been not only reinterpreted, but also reinforced. The woman who does not breastfeed has become the subject of negative attention, suspicion and blame for not fulfilling the obligations of motherhood. Breastfeeding has become an important sign in lay diagnostic processes of HIV/AIDS. In the context of HIV/AIDS, breastfeeding, no doubt, has been

given new attention and acquired new meaning, not only in the research community, but also in local Chagga communities where breastfeeding continues to be widely practised and collectively praised.

Acknowledgements

The study is part of a research project on reproductive health, a collaboration between The Kilimanjaro Christian Medical Centre (KCMC) and The Centre for International Health at the University of Bergen, that has been funded by grants from the Norwegian Research Council and NUFU (The Norwegian Council for Higher Education's Programme for Development Research and Education). I am particularly grateful to the key informants for their willingness to participate in the study, and to Agnes Ngowi, my local collaborator. I would also like to thank the Nordic Africa Institute and especially Liv Haram for inviting me to take part in the conference on 'Uncertainty in Contemporary African Lives', for which this paper was prepared.

Notes

1. Figures vary a great deal between reports. The latest updates from UNAIDS/UNICEF/WHO for Moshi town in Kilimanjaro Region are based on data collected through the National AIDS Control Programme in 1998, not on the data from 2000 referred to in NACP 2000. It is therefore hard to establish an accurate figure on HIV prevalence. For comparison, the median of HIV positive women attending antenatal clinics countrywide was found to be 17 percent in 2001 (UNAIDS/UNICEF/WHO 2002).
2. There are different antiretroviral regimens used in pMTCT projects. While the UNICEF pilot projects used AZT as prophylaxis from the thirty-fourth week of pregnancy and throughout delivery, the drug of choice, as stated by the Ministry of Health in Tanzania in 2003, is Nevirapine, which is administered by the mother herself at the onset of labour before she reaches the hospital. The baby is given a dose of Nevirapine syrup after birth (Ministry of Health 2003). Externally funded intervention research projects providing full HAART (highly active antiretroviral drug treatment) to HIV positive pregnant mothers and their partners are also being set up in a few hospitals in Tanzania, but because of the small scale of these projects, the impact will probably be limited – population wise – in the initial trial phase.
3. The figures on the risk of MTCT vary quite a lot both with regard to the risk of transmission if no preventive measures are taken, and the risk of transmission when antiretroviral prophylaxis has been administered to the mother.
4. Research on infant feeding has shown that mixed feeding (breastfeeding combined with supplementary feeding) increases the risk of transmission of HIV because it reduces the resistance to microorganisms in the intestinal tract.

References

- Bond, V., Chase, E., and Aggleton, P. 2002. 'Stigma, HIV/AIDS and Prevention of Mother-to-Child Transmission in Zambia', *Evaluation and Programme Planning*, vol. 25, pp. 347-356.
- Baumslag, N., and Michels D.L. 1995. *Milk, Money and Madness. The Culture and Politics of Breastfeeding*, London, Bergin and Garvey.
- Chopra, M., Piwoz, E., Sengwana, J., Schaay, N., Dunnett, I., and Sanders, D. 2002. 'Effect of a Mother-to-Child HIV Prevention Programme on Infant Feeding and Caring Practices in South Africa', *South African Medical Journal*, Vol. 92, pp. 298-302.
- Davis-Floyd, R.E., and Sargent, C.F. (eds.) 1997. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, London, University of California Press.
- Handwerker, W.P. (ed.) 1990. *Birth and Power: Social Change and the Politics of Reproduction*, Boulder, Westview Press.
- Haram, L. 1999. "'Women out of Sight": Modern Women in Gendered Worlds. The Case of the Meru of Northern Tanzania', Unpublished Doctoral Dissertation, University of Bergen.
- Howard, M., and Millard, A. 1997. *Hunger and Shame: Poverty and Malnutrition on Mount Kilimanjaro*, New York and London, Routledge.
- Illich, I. 1976. *Medical Nemesis: The Expropriation of Health*, New York, Pantheon.
- Jordan, B. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*, Prospect Heights, Waveland Press. First published in 1978.
- Khatib-Chahidi, J. 1992. 'Milk Kinship in Shi'ite Islamic Iran', in Maher, V., *The Anthropology of Breastfeeding: Natural Law or Social Construct*, Oxford, Berg Publishers Ltd.
- Klepp, K.I., Biswalo, P.M., Talle, A. (eds.), 1995. *Young People at Risk: Fighting AIDS in Northern Tanzania*, Oslo, Scandinavian University Press.
- Lie, G.T. 1996. *The Disease That Dares Not Speak Its Name: Studies on Factors of Importance for Coping with HIV/AIDS in Northern Tanzania*, Research Centre for Health Promotion, Faculty of Psychology, University of Bergen.
- Lindenbaum, S., and Lock, M. (eds.) 1993. *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, Berkeley, University of California Press.
- Lock, M. 2001. 'The Tempering of Medical Anthropology: Troubling Natural Categories', *Medical Anthropology Quarterly*, vol 15, no. 4, pp. 478-492.
- Lock, M., and Kaufert, P.A. (eds.) 1998. *Pragmatic Women and Body Politics*, London, Cambridge University Press.
- Maher, V. (ed.) 1992. *The Anthropology of Breastfeeding: Natural Law or Social Construct*, Oxford, Berg Publishers Ltd.
- Martin, E. 1989. *The Woman in the Body: A Cultural Analysis of Reproduction*, Boston, Beacon Press.

- Ministry of Health. 1997. *Health Statistics Abstract 1997*, Dar es Salaam, Health Information, Research and Statistics Section, Planning Department, Ministry of Health.
- Ministry of Health. 1999. *National AIDS Control Programme – HIV/AIDS/STD Surveillance*, Report No. 14, December 1999, Epidemiological Unit, NACP.
- Ministry of Health. 2000. *National AIDS Control Programme – HIV/AIDS/STD Surveillance*, Report No. 15, January-December 2000, Epidemiological Unit, NACP.
- Ministry of Health. 2003. *Draft PMTCT National Guidelines*, Unpublished.
- Moland, K.M. 2002. 'Giving Birth in Kilimanjaro: The Politics of Knowledge in Moral Contexts', Doctoral Dissertation, University of Bergen.
- Moore, S.F. 1986. *Social Facts and Fabrications: 'Customary' Law on Kilimanjaro 1880-1980*, Cambridge, Cambridge University Press.
- Moore, S.F. and Puritt, P. 1977. *The Chagga and the Meru of Tanzania*, London, International African Institute.
- de Paoli, M., et al. 2002. 'Counsellors Perspectives on Antenatal HIV Testing and Infant Feeding Dilemmas Facing Women with HIV in Northern Tanzania', *Reproductive Health Matters*, vol. 10, no. 20, pp. 144-156.
- Raum, O.F. 1996. *Chaga Childhood: A Description of Indigenous Education in an East African Tribe*, Hamburg, LIT Verlag. Published 1940 by the Oxford University Press.
- Setel, P. 1999. *A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania*, Chicago, The University of Chicago Press.
- Salmon, M. 1994. 'The Cultural Significance of Breastfeeding and Infant Care in Early Modern England and America', *Journal of Social History*, vol 28, no. 2, pp. 247-269.
- UNAIDS. 1998. *Report on the Global HIV/AIDS Epidemic*, Geneva, UNAIDS.
- UNAIDS/WHO/UNICEF. 1998. *HIV and Infant Feeding: Guidelines for Decision-Makers*, Geneva, UNAIDS.
- UNAIDS/UNICEF/WHO. 2002. *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections*, United Republic of Tanzania.
- WHO. 2001. *Prevention of Mother to Child Transmission of HIV: Selection and Use of Nevirapine. Technical Notes*, Geneva, World Health Organisation.
- Whyte, S.R. 1997. *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda*, Cambridge, Cambridge University Press.

Karen Marie Moland
Faculty of Health and Social Science
Bergen University College
Bergen
Norway.