

From Global Policies to Local Practices: Behavioural Advice for the Prevention of Mother-to-Child Transmission of HIV

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I. Introduction

As interpretations of diseases vary greatly from one society to another, approaches to curing them also vary depending on the context. Biomedicine¹ is a Euro-American development, based on the idea that natural science can explain illness and health in the human body (Borck 2003: 139–141). Biomedicine, being ‘evidence based’, seeks justification from natural scientific laws which build a formalised analytical frame for explaining the world (Loimeier et al. 2005: 18). Biomedical research, built on such universally valid laws, produces models showing functions and malfunctions, and practices which evidently do more good than harm to the human body, and it is used to legitimise health policies and guidelines.

Biomedical technology was spread all over the world, first by missionaries, and later by international agencies like the World Health Organization (WHO)², international development agencies and many more. It was assumed that this generally applicable school of medicine

¹ I will use the term medicine as an umbrella for all kinds of schools of health care. Biomedicine refers to a medical school based on human biology and physiology, which is the predominant school of medicine in Euro-American societies. Other schools of medicine are referred to as local or traditional medicine in this paper. I will stick to these terms wherever they match policy-makers’ terminology, despite criticism of the terms ‘modern’ and ‘traditional’ in the scientific community (cf. Wolf/Hörbst 2003; Greifeld 2003). The terms are criticised as being too dichotomous; moreover, ‘traditional’ implies a monolithic, derogative or out-dated notion, whereas ‘modern’ apparently means the opposite. These characteristics, however, do not match with local usages of the terms. Traditional healers are part and parcel of the contemporary health system in Lesotho, just as much as biomedical practitioners. Clients visit traditional practitioners as a complementary or alternative treatment option to biomedicine.

² The UNICEF and WHO International Conference on Primary Health Care held in Alma Ata in 1978, or the UN Millennium Development Goals of 2000 reflect this global spread.

would cure pathologies independently of local interpretations, and hence, in the global arena, biomedical approaches were promoted as the prioritised school despite a large variety of other therapeutic systems worldwide³. In recent years, malaria, tuberculosis and HIV/AIDS have been named by international agencies such as WHO, and institutions of the United Nations, as global scourges that are in the focus of biomedical research. In order to control the HIV pandemic, ways of blood screening, biomedical treatment and prevention techniques were developed in the global North and promoted by international agents in the global South, where the immunodeficiency syndrome is most prevalent. Despite the assumption that biomedical technology works globally, it is nevertheless imbued with the norms and values of Euro-American stakeholders. As a matter of fact, the majority of medical research is still taking place in industrialised and internationally influential arenas. The scientific concepts on which biomedicine is based are themselves products of a particular research background, as well as political and social interests associated with particular biomedical products⁴. Moreover, biomedicine is part and parcel of international health politics and health economy driven by Western stakeholders.

Wherever Western agents introduced biomedicine outside the global North, it did not replace existing systems of treatment and care altogether. In Lesotho, where my ethnographic research⁵ took place, there is a pluralistic health care system, as in many other developing countries. A complex network of local doctors and midwives coexists

³ For a discussion of globalisation and medicine, see for instance Wolf/Dilger 2003; Wolf/Hörbst 2003; Dilger/Hadolt 2010.

⁴ With regard to the history of medicine, I think here of the endeavours of microbiologist Robert Koch (1843–1910) which, without doubt, led to significant medical advancements. Notwithstanding, his inhuman clinical trials with African populations would not have been possible without the encouragement of the British and German colonial administrations, and thus the backing of the contemporary political and social culture.

⁵ The author conducted a longitudinal ethnographic study in Mafeteng District in the Southern Lowlands of Lesotho between 2007 and 2010, which involved thirty HIV-positive mothers, their families, lay counsellors and health professionals. All interviews with health professionals were held by the author in English, interviews with clients and counsellors were conducted in Sesotho and English with the help of a research assistant.

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alongside a multitude of Western-based biomedical practices, which clients use in parallel or alternately.

In this paper I intend to highlight the confrontation between local health practices and far-fetched biomedical notions. To this end, I will spotlight sequences in the chain of 'translation' (Latour 1986; Rottenburg 2009) of health information. I argue that stakeholders on each and every level fit health policy into a particular 'frame of reference' (Loimeier et al. 2005)⁶. Hence, the token which is passed between stakeholders is imbued with various attributes, while the token under study is actually an immaterial one: infant feeding recommendations for women living with HIV. The material part of it, here breast milk containing the HI virus, only comes into the picture at the grass-roots level, which includes mother and child. However, the immaterial message orbiting around the liquid shows how the stakeholders' perspectives vary: one and the same liquid is seen as 'immunologically valuable' on the one hand, and 'infectious' on the other.

In order to picture the pathway of a health message, this paper is organised in nine sections. The section following this introduction puts 'translation', being a vertical process of passing something on, into relation with various horizontally arranged 'frames of reference'. Section three to section eight each describe one 'frame of reference', starting with the global and moving on to the national, district, local and household levels. Section nine presents some concluding remarks.

II. Theoretical Approaches to the Transfer of Technology

Technology as a term stands for the logic behind the tools humans deploy to modify nature and it embraces all crafts, methods, knowledge systems and personnel that surround a technical solution. Medical technology includes instruments, machines and pharmaceuticals, information on their functions and applications, and services offered in biomedical health facilities, hence, everything and everyone involved with the diagnosis, monitoring or improvement of human conditions (Paslack 1999: 837–856; Helman 2007: 100–104). Available material, immaterial and personal assets may, however, not be the same in all health facilities. Immaterial assets, such as know-how, skills and practices that are needed to operate a particular tool, are prone to change. And personal training and staff coverage may affect the operation of a technical solution, in other words the effectiveness of a particular technol-

⁶ Both terms, 'translation' and 'frames of reference', will be discussed in the following section.

ogy (Helman 2007: 101–102). In summary, technological solutions may vary significantly whenever the tool is transferred over time, geographically or between persons.

Latour gave some thoughtful ideas regarding material and immaterial tokens by presenting two models – transfer by ‘diffusion’ and remodelling by means of ‘translation’ (1986). While Latour intended to explain power relations between stakeholders, his models also help us to understand how technology trickles down. His model of diffusion concerns the spreading of technology over time and space, while the token itself is not modified. An initial power triggers the process of handing it over with a certain velocity; reactionary interest groups or backward minds may, according to Latour, slow the process of diffusion down, while media through which power is exerted may, on the other hand, facilitate it. Alternatively, Latour presents a model of translation. Here, a token passes between people or institutions along certain patterns, but, in contrast to the former model, every actor modifies it according to own interests (1986: 268). While the model of diffusion is less relevant in the scope of this paper, Latour’s model of translation is very useful. Rottenburg applied Latour’s model of translation with regard to stakeholders in development cooperation. In development cooperation, as Rottenburg has argued, immaterial goods travel transnationally⁷:

‘In order for ideas (usually inscribed into models and artifacts) to circulate from one social world to another, from one frame of reference to another, they must be adopted, appropriated, and altered. Ideas are evidently unable to go very far on their initial impulses, with only the energy from their original frame of reference. To be transferred they have to be transformed, that is, translated. Every act of translation is inevitably also an act of performative omission and addition; otherwise the translation chain would break. Every act of translation is thus also an act of creation, producing something that did not previously exist.’ (2009: xxxi)

The application of the term ‘frame of reference’ in this field has previously been suggested by Loimeier, Neubert and Weißköppel (2005). These authors refer to groups of actors who share particular norms and values, such as standards of evaluation and orientation which mark ‘fundamental statements about the actual and ideal nature of the world. [...] Frames of reference are thus a form of supra-individual orientation and they apply to groups of people’ (Loimeier et al. 2005: 17). Thus, Loimeier et al. approach internationally diffused assets in various ‘frames of reference’ instead of simply comparing the ‘local’ and the ‘global’.

⁷ Elsewhere Rottenburg suggests referring to this phenomenon as ‘travelling of models’ (Rottenburg 1996).

While ‘translation’ conceptualises the circulation and thus the transformation of something by handing it on from one group to another, ‘frames of reference’, in contrast, are mindsets in which and by which the token is reformulated⁸. More precisely, by means of translation a good arrives in one frame from which it travels, enriched with values, into another frame.

The transmission of technological goods and know-how depends on various social factors. Hubig and Rottenburg noted in 2007 that functional organisational structures in Western countries depend on trust in the system as such, while structures in African countries more often rely on personal relations, such as patron-client relationships – a crucial difference affecting internal processes. Thus, technological exchange between Western and African countries may be affected, firstly, by a diversity of ideas regarding the interaction, coordination and involvement of stakeholders, secondly, by their interpretation of aims, prospective planning and sustaining affirmative preconditions, thirdly, by the idea of serving collective interests rather than immediate personal gratification, and last but not least, since elites or foreigners are usually not part of African social solidarity systems, by subversive sabotage and immediate rejection which may be considered the only means of resistance against a new technique (Hubig/Rottenburg 2007: 60–61). The authors argue that the implementation of a (technological) system in Africa is basically a process of transformation due to the social relations in African societies, rather than sheer transmission which works in less personalised settings (Hubig/Rottenburg 2007: 64).

These theoretical considerations show that goods are not global assets that can simply be copied and pasted. According to Latour, Rottenburg and Hubig, as well as Loimeier, Neubert and Weißköppel, material and immaterial goods undergo a process of remodelling during transfer, which will now be analysed in more detail. I will now describe the different frames a health policy enters and leaves as part of an ongoing process of translation. In doing so, I hope to shed light on the creative process of making health technology fit.

⁸ In the field of medical anthropology, Dilger and Hadolt encourage the study of constellations, or ‘contexts’, in which health practices make sense (2010: 25–26). The term ‘context’ describes a relation between a social practice and its situation. Communities, which are not bound to state borders, build social units that mobilise social and political constellations rather than mirroring them. A performative act (including the researcher’s performance) therefore forms the context (Dilger/Hadolt 2010: 23–24).

Despite the active, performative connotation of ‘making’ a context, I will use the term ‘frame of reference’, which seems to adequately express social interaction, technical innovations, economic and political constellations, as well as changing power relations at a certain locality.

III. Global Recommendations on Infant Feeding

In the course of the 1970s, a debate concerning the advantages of breast milk over breast milk substitutes arose in European countries. The debate entered organisations which promoted the debate's conclusions internationally, beyond just the Euro-American context. The advent of HIV/AIDS during the 1980s, and the realisation in the 1990s that the virus can be transmitted through breast milk fired up the 'bottle-breast controversy' again. Notwithstanding that the populations most affected by the rapid spread of the HI-virus were to be found in the global South, the debates and research focused on the global North.

In the 1970s, good infant feeding practice in resource-constrained settings has been debated by international organisations in order to stop the worrisome increase of commercial powdered baby milk as a replacement for breast milk. Nestlé invented artificial infant food (Kindermehl) in 1867 and promoted it widely throughout the post World War II baby boom (van Esterik 1995: 149). Protesting against commercial, artificial baby nutrition, internationally active organisations like WHO or the United Nations International Children's Emergency Fund (UNICEF), as well as non-governmental organisations such as La Leche League International (LLL), the Infant Formula Action Coalition (INFACT), and the International Baby Food Action Network (IBFAN), amongst others, set up campaigns to promote breastfeeding worldwide as the most socially and medically beneficial choice for a mother and her child. The debate merged with debates on feminism, arguing against a merely sexual notion of the female breasts and in favour of socially binding mother and child interaction (Dettwyler 1995), and became known as the 'bottle-breast controversy' (Maher 1992: 3–6).

With an emphasis on nutritional aspects, INFACT initiated a boycott of Nestlé products from 1977–1984, seeking wide support from mothers. Meanwhile, in the political arena, a coalition of IBFAN, WHO and UNICEF worked on an International Code of Marketing of Breast Milk Substitutes which was ratified in May 1981. 118 WHO member countries (excluding the US) agreed to implement this non-binding instrument of consumer protection. Campaigners from various institutions argued that companies make mothers and children irreversibly dependent on expensive products once lactation stops. Especially in developing countries with limited access to safe drinking water and refrigerators this feeding practice led to the death of large numbers of babies (Maher 1992: 3). Due to the poor quality drinking water in many resource-constrained countries, which mothers nevertheless used to prepare formula milk, babies were at risk of contracting infectious

intestinal diseases. Hence, international campaigns sought to promote long-term breast feeding worldwide (van Esterik 1995).

However, HIV/AIDS and the realisation that the virus can be transmitted through breastfeeding (Kennedy et al. 1990; Cutting 1992: 788–789; Lederman 1992: 290–296), crucially altered the public health message concerning breastfeeding in the early nineties. A new controversy arose concerning bottle versus breast feeding, and WHO guidelines attempted to ‘balance the risk of infants acquiring HIV through breast milk with the higher risk of death from causes other than HIV, in particular malnutrition and serious illnesses such as diarrhoea among non-breastfed infants’ (WHO 2001: 5; cf. GoL 2009: 56). Particularly in resource-constraint settings, this debate was of great importance since low quality drinking water posed a dilemma to policy makers. IBFAN estimated the risks and concluded that more children in Sub-Sahara Africa would die if not breastfed, and diarrhoea would kill 14 times more children than the transmission of HIV through exclusive breastfeeding would (Kisanga 2000: 4, 7). The network stated:

‘IBFAN Africa is concerned that if formula or other artificial feeding replaces breastfeeding in poor families with meagre resources, the outcome might be marginal reduction of HIV transmission and much higher rates of morbidity, mortality and malnutrition. [...] Even in countries with high seroprevalence of HIV (25 % of women infected), fewer than 4 % of infants will be affected through lengthy breastfeeding. [...] Recent research indicates that infants whose mothers are infected with HIV and exclusively breastfed, had a similar risk of acquiring the virus as those who were artificially fed, and this risk was significantly lower than for those who were mixed fed.’ (Kisanga 2000: 5)

IBFAN Africa concluded that the risk of vertical HIV transmission through breast milk has been overemphasised due to misinformation and the benefits of breastfeeding for mother and child must not be neglected (Kisanga 2000: 5, 14).

The following era of biomedical research on mother-to-child transmission via breastmilk emphasised abstention from mixed nutrition of infants. Researchers argued that mixing breastmilk and other nutrients would dissolve the child’s protective layer on the mucous membrane in the gut and raise the likelihood of allowing the virus to enter, whereas a healthy gut lining acts as a viral barrier (Coutsoudis et al. 1999: 471–476; Kisanga 2000: 16; Saadeh et al. 2005: 6; Ngandwe 2007). Hence, women should stick to exclusive feeding with infected breast milk and IBFAN suggested boiling it in addition: ‘Heat treatment of breastmilk expressed by an HIV-positive mother kills the virus in the breastmilk. Heat-treated breastmilk is nutritionally better to other milks’ (Kisanga 2000: 69). As an alternative, mothers may opt for exclusive replacement feeding with commercial infant formula if considered ‘Acceptable,

Feasible, Affordable, Sustainable, and Safe (AFASS)', but healthcare workers were encouraged at the same time to warn mothers about the stigma of not breastfeeding (WHO 2001; GoL 2004: 31; Desclaux/Taverne 2000: 34; Desclaux/Aliferi 2009: 821–829). Recently, the debate has taken a new turn: since about 2009 mixed feeding, which was previously banned, has become an option for mothers whose babies are in peril of malnutrition.

While the health advice given to mothers in the global North prioritised abstention from breastfeeding, breastfeeding was recommended in the global South. Desclaux and Taverne referred to these diametrically opposing recommendations for HIV-positive mothers as 'AIDS of the North' and 'AIDS of the South' (Desclaux/Taverne 2000: 8). While recommendations in the North were based purely on virological aspects, recommendations in the South also entailed arguments concerning nutrition and the social situation to a limited extent.

IV. From the Global to the National: 'Safe Infant Feeding' in Lesotho

Lesotho, a small mountain kingdom landlocked in the heart of the Republic of South Africa, carries one of the highest HIV burdens worldwide. With an HIV prevalence of over 25 percent among women aged 15–49 and an even higher prevalence of 40.2% percent among 30–34 year olds (GoL 2009: 1), Lesotho is to date home to an estimated 160,000 HIV-positive women (UNICEF 2010).

After the first case of HIV was detected in Lesotho in 1986, a national commission to coordinate HIV prevention and control activities, the National AIDS Prevention and Control Programme, was founded in the following year. In the mid nineties, the government of Lesotho recognised HIV and AIDS not only as a threat to public health, but also as a general scourge of development in all sectors. By the year 2000, the government of Lesotho had declared HIV/AIDS a national disaster (GoL 2007: 1), at a time when leading South African politicians were still in denial of the crisis in their country. Lesotho's politicians, in contrast, accepted the challenge. Besides efforts to reduce new infections through sexual intercourse, in 2003 the Ministry of Health and Social Welfare launched a programme entitled Prevent Mother-to-Child-Transmission of HIV (PMTCT). Without intervention, HIV can be transmitted vertically from a mother to her child during pregnancy, during delivery, and through breast milk. To prevent such infections, Lesotho's Ministry of Health and Social Welfare (MoHSW) and various international governmental and non-governmental partner organisations started to provide HIV prevention services in antenatal care clinics,

and published national guidelines for PMTCT services in 2004. These guidelines stipulated that health workers should encourage expectant mothers to exclusively breastfeed for six months, or to use expressed milk from the breast, which is boiled before being given to the child. Weaning should take place abruptly. Alternative feeding with milk formula was considered a less favourable option, for practical reasons: even though safe drinking water is available in plenty, many households in Lesotho depend on firewood for cooking, which does not always allow for timely and safe preparation of breast milk replacement for the child.

New targets were published in a strategic plan between 2006 and 2011 which stipulated universal access to antiretroviral treatment for people living with HIV/AIDS, as well as strengthened efforts to prevent mother-to-child transmissions. New PMTCT guidelines came out in 2007 in a draft version, following the 2006 WHO revision, and in 2009 as full guidelines, and other changes have also taken place in the meantime, about which nurses and counsellors have been informed during evaluations and in training sessions (GoL 2007; 2009). While the feeding recommendations have changed only slightly in terms of the length of the period of exclusive breastfeeding and the time of weaning, there have been major amendments concerning HIV testing in antenatal clinics. In the 2004 PMTCT guidelines, for instance, HIV tests were advisable but needed written consent, while the 2009 PMTCT guidelines no longer required the written consent of the expectant mother (GoL 2009: 8, 14). Screening for HIV became one of the standard procedures of antenatal care following an opt-out strategy⁹. In consequence, many HIV-positive women will be diagnosed for the first time while pregnant and thus antenatal care serves as an entry point for further counselling, treatment and care (Piwoz/Bentley 2005: 933–937; WHO 2001: 2). In 2005 around 50% of the expectant mothers agreed to be tested voluntarily for HIV during antenatal care, while in 2009 96% were tested and attended counselling sessions (MoHSW/NAS 2009: 2, 17; GoL 2009: 2). Large numbers of pregnant women now attend for examination, counselling and care, following the policy expressed in the preamble of protecting every single baby from getting infected by the mother. The guidelines recommend exclusive breastfeeding as the preferred feeding option for infectiological reasons and because of the immunological benefits for the infant:

⁹ Many people living with the virus undergo testing while they are in hospital, as Dilger states. The patient's consent is not obtained (Dilger 2010: 106). Whyte and colleagues also say that in 'Voluntary Counselling and Testing' – known as VCT – 'voluntary' has been replaced by 'HIV', so that the term is now 'HCT' ('HIV counselling and testing') (Whyte et al. 2010: 82–83).

- ‘Breast milk provides complete nutrition for the infant for the first six months of life.
- Colostrum, the milk produced during the first few days of the infant’s life, is rich in vitamins, antibodies, and has other anti-infective properties.
- Breast milk contains antibodies from the mother which are beneficial to the infant, as the infant’s own immune system is not completely developed during the first few months of life.
- Breast milk provides vital protection against deadly childhood illnesses such as diarrhoea and respiratory infections.
- Breast milk is easily digested and its composition changes to meet the developmental needs of the growing infant.
- Breast milk contains enzymes that help digestion of fat.
- Breast milk is natural and does not add extra cost.
- Breastfeeding promotes bonding between mothers and their babies.
- Breastfeeding helps the uterus to contract after delivery and reduces postpartum bleeding.
- Breast milk is always available and no special preparation is needed.’

(GoL 2009: 57)

New WHO guidelines were interpreted and adjusted according to the national frame of reference. These interpretations took into consideration the fact that Lesotho is one of the countries with the highest HIV rates, which need to be contained, and this principle was even superordinated to ethical considerations, namely the patient’s informed consent to blood screening. The globally diffused message concerning the feeding of HIV-exposed infants was thus conceptualised nationally, and entailed relations and interconnectedness (Loimeier et al. 2005: 23–24) with previous and following groups handling the token along the chain of translation.

V. From the National to the District: Approaches to Health Care

In Lesotho, the health discourse on a national level, as outlined above, is predominantly based on a biomedical discourse to which actors orient themselves. Mother’s milk is characterised as beneficiary and protective despite it’s harmful component, and this message is passed down to district level. Here, however, the dissemination process decelerates.

Each of Lesotho’s ten districts has a district hospital with a District Health Medical Team. Mafeteng district, on which I focus in this paper, comprises 19 biomedical health facilities under the auspices of a Dis-

trict Health Medical Team. Besides these biomedical facilities, about 800 registered local healers, such as 'ngaka', 'mathuela', 'sangoma'¹⁰ and 'traditional midwives', offer their services in Mafeteng district. While these four groups of traditional practitioners have been trained in different schools, the training of biomedical practitioners also varies. Despite the idea that biomedicine works on the basis of natural laws and global validity, medical and paramedical staff in Lesotho are trained in settings where the personnel and infrastructure are very different from those which are found in their later working environment. This situation is due to the fact that Lesotho has nursing colleges, but no Faculty of Medicine. In consequence, all biomedical doctors receive their training abroad and many do not return home afterwards, since other countries are able to offer better working conditions and higher wages. Due to the shortage of medical staff in Lesotho, the Ministry of Health and Social Welfare advertises opportunities for foreign doctors and predominantly to Kenyan nurses, who have been trained following different approaches to health and healing. At the time of this study, Mafeteng Hospital was staffed by five doctors, two of whom came from Zimbabwe and one from Pakistan; one of local origin had trained in Russia, and another post was vacant after a second local doctor had left for further training. The other 18 Health Centres did not have doctors, but an American paediatrician visited them one day a month to treat children. Counsellors are trained and employed by various NGOs within the health facility.

The District Health Medical Team supervises outreach activities, conducts training sessions and disseminates information among health practitioners in the district according to the ministry's various public health concerns, which seems a Herculean task in such a heterogeneous environment as Mafeteng district, and even more so given the fact that medical guidelines frequently change.

In the course of the 1970s, Basotho healers were invited for training activities with hospital staff but this collaboration suffered in the following decades. In the 1993 annual report by the Mafeteng Government

¹⁰ The terms seem to be used interchangeably, but different healers specialise in, for instance, divination, curing from malevolent powers, or treating the physical causes of disease. Some healers prefer herbal remedies, while others prefer to use mineral or animal parts for treatment; some consult the Bible for advice or they may analyse dream revelations. I suggest therefore that the healers are trained in various schools, since some interviewees indicate that they use the isiZulu language in their sessions which they acquired during their training in Zulu healing traditions. Others do not use isiZulu in their communication. Unfortunately, the secondary literature as well as my data lack any clear evidence of the various approaches to traditional preventive and curative medicine and related occupational titles (cf. Ashton 1952: 282 ff.).

Hospital, healers were still mentioned as the backbone of the national medical system in which patients are referred forth and back between institutions of different kinds. Despite the healers' recognition by the Ministry of Health as well as on district and local levels, they are no longer involved in training activities but simply co-exist alongside the biomedical system. Consequently, traditional midwives have no access to the newest policies on how to protect mother and child, as well as themselves, from HIV transmission during examination and confinement, since there is no curriculum for training, which the MoHSW should have provided the District Team with.

Clearly, HIV prevention and the treatment of patients with HIV/AIDS has resulted in shifts of the medical landscape in Lesotho. While the training of doctors and nurses differs, they share the notion that infection with the HI virus cannot be diagnosed other than through biomedical testing kits, so that biomedical facilities are the preliminary care-providers for those found to be carrying the virus. HIV prevention is negotiated here as a biomedical, not a social matter. The dissemination of information does not take into account the fact that various social parameters exist on the side of the medical practitioners. This notion seems to manifest itself in the limitations to access to training, materials and support, which have created additional competition and mistrust between traditional and biomedical health practitioners. The exclusive access of biomedical practices concerning a physically exhausting and highly stigmatised disease that affects the individual patient as well as the family collectively makes biomedical facilities powerful institutions. Subscribing to the urgent need for every citizen to be screened for HIV, in order to prevent transmission due to ignorance, and to encourage early enrolment in treatment programmes for those found to be HIV-positive, the Ministry of Health and Social Welfare initiated a general testing campaign in 2007 which was conducted by district teams. Every person who tested HIV-positive was referred to a biomedical health facility for further counselling and treatment. This 'Know Your Status' campaign underlined the superiority of biomedicine over other schools of health, since it alone can detect the virus, with the result that biomedical facilities gained large numbers of clients who would not otherwise have known that they were in need of medical care. Provision of HIV tests, counselling and antiretroviral treatment makes the facilities indispensable and powerful distributors of goods, treatment and care. In order to provide health care coverage for HIV-positive expectant mothers, the number of facilities providing PMTCT was increased from 37 in 2006 to 179 in 2008 in the whole of Lesotho (MoHSW/NAC 2009: 2; GoL 2009: 2) In Mafeteng district, the campaign achieved the highest coverage in respect of general HIV screening, but equally important: Mafeteng town is a centre for female

labour migration, due to its clothing industry, which is also reflected in a higher number of female clients in need of HIV treatment, and in particular, PMTCT treatment. On the side of these patients, medical plurality allows for complementary or alternative treatments in various schools of health, in other words what is sometimes referred to as healer shopping or medical tourism (Wolf/Hörbst 2003: 21). On the side of the healers, they were disadvantaged when biomedical institutions claimed a monopoly over the prevention and treatment of HIV-related opportunistic infections. Although some had been specialised on the treatment of infectious diseases, the sheer number of biomedical facilities, as well as the network of governmental, non-governmental, faith-based and media-based organisations promoted biomedical approaches to HIV treatment and care for the sick as biomedical field.

The local situation of actors belonging to different frames of reference leads to a 'dispute over the hegemony of interpretation' (Loimeier et al. 2005: 22) which has significantly affected medical care provision, and, as I will show, also medical care consumption. Hence, these particular constellations of diverse educational, political, economic and social aspects in Mafeteng district form the regional frame of health care, and precisely due to these conditions on district level the diffusion of the token, to argue with Latour, is not passed on smoothly. With a focus on interaction between client and staff in the following section, we enter the field in which personal relations become more pronounced than institutional (non-)cooperation.

VI. From the District to the Local Level: Communication between Client and Staff

HIV treatment guidelines trickle down step by step from the international to the national level, and on to the local level and into the health facilities. However, while counsellors in the hospital receive training on shifts and changes in policy, counsellors in the rural health centres are not yet trained. Consequently, it usually takes a couple of months before revised recommendations are disseminated countrywide. Procedures therefore differ from one site to another, between medical hierarchies, and perhaps even within the same facility (Field notes Kroeker: 15/01/2009). Nevertheless, monitoring the client's compliance with biomedical treatment, as recommended in the policy document, is the job of the nurses and counsellors. Ironically, an evaluation of patients' reasons for defaulting with treatment, conducted by the Mafeteng Government Hospital staff, revealed that about 60 % of the cases were actually due to mistakes of an administrative nature. Thus, in 2008 supervision of staff, particularly in terms of registration, became more restric-

tive and work performance, opportunities and challenges were discussed in monthly meetings. The US-based International Center for AIDS Care and Treatment Programs (ICAP) supervised the work of all those involved in prevention of mother-to-child transmission of HIV. From this time on, high numbers of adherent clients indicated the success of the nurse's work but also added various administrative responsibilities. In addition to examinations, nurses' cross-checking on clients and staff included double book keeping, monitoring of the birth register, keeping calendars which schedule patients for a certain date, and listing medication re-fill dates, while signatures and stamps serve as confirmation that the patient has undergone the scheduled treatment. Clients carry their health booklet 'Bukana ea Bophelo'¹¹ through all the stations and every entry is signed. Expectant mothers must additionally carry a booklet called 'Obstetric Record', and communication mostly takes place on the basis of the obstetric record and the questionnaires it contains. In this context, counselling on health issues appears as a burden to nurses and consequently follows the aim of making clients comply with the rule rather than understand what is expected of them. Understandably, staff attempt to reduce their workload, shift tasks on to others, and limit the time spent on patient-staff interactions. Lay counsellors, who have a history of PMTCT themselves, have filled this gap, as illustrated by the following interaction:

A twenty-year-old girl, Mpho, with a tiny baby enters the counselling room of a health centre in Mafeteng. Her thin, pale baby is six months old, but seems much younger and does not move much, as she sucks on a piece of orange the mother holds. The mother tested positive in antenatal care and received medication to prevent HIV transmission while in labour and under delivery as her booklets indicate. However, the infant tested HIV-positive at the age of six weeks and has now been brought for a confirmation test.

The counsellor asks the mother about her feeding practice and she explains with hesitation that she has opted to give only replacement food to the baby, which indicates that she is aware of exclusive feeding advice. The counsellor insists that she does not believe in her feigned compliance and the nurse checks the client's breast which produces milk. The client starts crying and admits that both her grandmother and mother told her to breastfeed and gave the baby other foods to supplement the little amount of breast milk the girl provided. A health counsellor advised her repeatedly not to mix the baby's food, so she stopped breastfeeding for a short period. However, her grandmother and her mother

¹¹ The Sesotho term 'bophelo' stands for both health and life and only from the context can the different meanings be determined, whereas in many cases there simply is no difference. Health is life and life is health. Likewise, disease and death has the same word stem '-lefu'. Therefore a local notion of 'bophelo' is generally inclusive and treated by 'ngaka', 'sangoma' or 'mathuela' (Romero-Daza/Himmelgreen 2004: 959).

were adamant that the child needed breast milk and they beseeched her to start again. She relented and resumed breastfeeding (Field notes Kroeker: 12/06/2008).

A nurse and two counsellors discussed the case vividly following this interaction. The nurse complained about the client's non-adherence to exclusive breastfeeding, which is advised in order to prevent the transmission of the virus to the baby. She argues that patients simply lack comprehension. One counsellor suggests summoning the grandmother in order to counsel her on exclusive feeding options. The second counsellor insisted that if the child was HIV-positive anyway, the mother could carry on mixed feeding in order to prevent further malnutrition, as the family did not have the means to constantly afford powdered milk. In order to save the life of this malnourished, HIV-positive infant¹², its HIV infection was in the end viewed as the more manageable risk, in the face of imminent starvation. Breast milk was seen on the one hand as contagious and on the other as a life-saving dietary supplement. The client, Mpho, for her part, was more interested in avoiding conflicts in a situation of double dependency.

The counsellors, being HIV-positive mothers themselves, suggested more pragmatic solutions to the problem. In this case, familial decision-making and collective care for the baby had prevented adherence to biomedical advice. The counsellors concluded that infant care is the concern of female household members and decision-makers should be included in the counselling session. The nurse, in contrast, was concerned about the compliance of the patient on the basis of individual consent and decision-making. Thus, the patient was held responsible for defaulting. Knowing this dilemma from experience, the counsellors assessed the situation at home to find out more about the patient's living conditions and powers of decision-making, and sometimes they provided women with excuses where conflicts could not be avoided. Especially those clients who had not disclosed their HIV-positive status were concerned that exclusive feeding practices would disclose their health condition. Counsellors sometimes advised mothers to justify weaning after six months of exclusive breastfeeding by saying: 'I had 'mastitis', therefore I needed to wean the child already' (Field notes Kroeker: 6/2008) which would prevent stigma as well as inadvisable mixed feeding.

In this frame of reference the token is dissociated from the ideas of globally-acting stakeholders, such as boycotting replacement food, and the personal interests of nurses, counsellors, clients and family mem-

¹² This option was not yet in the PMTCT guidelines when this interaction took place in 2008.

bers are added to it. Communication on infant feeding follows a premise of assuring compliance with the guidelines, instead of assuring comprehension of them.

VII. From the Local to the Household Level: The Client and her Family

HIV-positive mothers face a dilemma: ways of preventing mother-to-child transmission of HIV demand alterations in the normative infant feeding practice. In Lesotho, as in many other places in Africa, most HIV-positive women opt for exclusive breastfeeding in the counselling session and agree on abstinence from additional food or drink for the child. To assure this, an HIV-positive mother adhering to exclusive breastfeeding must therefore keep her baby with her at all times during the first six months, so that she can breastfeed on demand and avoid others feeding her baby (Field notes Kroeker: 4/12/2008). However, it confuses mothers to learn in Lesotho's health centres and hospitals that although HIV can be transmitted through breast milk, nevertheless they should feed their babies with this harmful nutrient which contains the virus (cf. Desclaux/Aliferi 2009: 821–829). Adding to this confusion, the national guidelines have changed several times. While the 2004 and 2007 guidelines were categorically against mixing breast milk and other nutrients, the 2009 PMTCT guidelines suddenly allowed mixed nutrition for the child, if it is in danger of being malnourished.

Even if a woman chooses to exclusively breastfeed during her counselling session in antenatal care, she is not likely to be the sole decision-maker but to be dependent on multiple carers who are not informed about recent biomedical feeding recommendations. Exclusive breastfeeding of children born to HIV-positive mothers poses difficulties, as women will be advised differently by family elders. In many cases relatives will give the child additional foods, without the mother being able to prevent it, since young women may not question their elders and superiors in the family hierarchy. As in many African societies, female relatives usually mind the children in the kitchen. Small children are frequently given tiny amounts of soft or pre-chewed food while the women are preparing meals for the family. In Lesotho, the first complementary food after water or watery solutions usually consists of goat's or cow's milk, maize porridge, or pre-chewed adult food (Field notes Kroeker: 10/06/2008; cf. Ashton 1952: 34; Thairu et al. 2005). Thus, while relatives take care of the child, it also gets used to the taste of adult food. High levels of food insecurity in Lesotho leave mothers to be malnourished. Many of those do not provide sufficient milk to feed their babies exclusively on breastmilk due to their own malnutrition

(cf. Kroeker/Beckwith 2011), hence the time of introducing additional foods also depends on this factor (cf. Quandt 1995: 130). Especially when the mother is sick or if she dies, such mixed feeding from an early age makes it easy to compensate for the lack of breast milk, since the child is already accustomed to other foods (Fjeld et al. 2008). Mixed feeding thus prevents malnutrition¹³ in the child if anything happens to the mother, and sickness of the mother or child is a great concern. In particular if a mother carries HIV and frequently falls sick, mixed feeding provides security, even if nurses and counsellors argue against it.

Apart from such practical reasons, grandmothers and other experienced women insist on long-term mixed feeding. Health messages transmitted by grandmothers in Lesotho are similar to health messages that used to be internationally promoted. In the 1980s, a governmental awareness campaign was launched encouraging women to breastfeed for as long as possible with the slogan 'Breast is Best'. A minimum of two years was considered necessary to secure the child's nutritional status and elderly mothers at that time were advised to 'encourage [their daughters-in-law] to identify minor breastfeeding problems so that they should not wean their babies, but should treat the problem while continuing to breastfeed' (Mafeteng Government Hospital 1993: 15). Moreover, international organisations and nurses argued that poor water quality would harm many children. Yet Lesotho is blessed with plenty of safe drinking water from the Maluti mountains. 80% of the population have access to clean wells or taps and the water does not need any further treatment such as boiling or chemical purification (MoHSW/ICF Makro 2010: 19). However, this message is passed on without any adaptation.

The scourge of HIV has changed the public health message time and time again, and what was once recommended was later considered risky. Today, even if young mothers enjoy support from family members regarding their decision to exclusively breastfeed, much confusion exists in the community over what this practice entails. In the course of a discussion with my informant Leshome and her mother Nkhono it turned out that mother and daughter had different definitions of 'exclusiveness'. Nkhono considered animal milk and water to be part of an exclusively milk-based diet for an infant. Leshome understood from the hospital counselling sessions that exclusive breastfeeding does not allow water or dairy products. A nurse accordingly comments: 'We

¹³ MoHSW estimated in 2009 that about 39% of Basotho children under 5 years of age are stunted (height correlated with age) and this figure has increased in recent years (18% in 2000). 15% are severely stunted (MoHSW et al. 2010: 132; cf. Romero-Daza/Himmelgreen 2004: 958, for a discussion of HIV and malnutrition, see also Kroeker/Beckwith 2011).

usually find the mothers-in-law giving water to the children, even if they are supportive of exclusive breastfeeding. They don't see water as a replacement food, they don't find it a problem' (Field notes Kroeker: 11/6/2008).

Confusion also existed over the term 'weaning'. While Leshome's mother used the term 'weaning' to refer to the time of introducing solid foods, her daughter defined the term 'weaning' as meaning the time when breastfeeding ceases completely. This becomes even more crucial if the child falls sick. As a home remedy and biomedical dehydration solution, sugared water or sugar-salt-solutions administered to the child relieve constipation and diarrhoea. Healers also recommend this 'pitsa' (Sesotho: liquid traditional medication) to treat common childhood diseases (Green 1985: 277–285). In both the biomedical and the local discourse, sugar water thus has the connotation of being healthy as it secures good digestion and prevents dehydration. For HIV-positive women, however, this cheap and easy home-made remedy is not advised by medical counsellors since it interferes with biomedical recommendations for an exclusive feeding practice. However, on the other hand, the PMTCT guidelines allow antibiotic syrups to be administered to the child during the first six months, which somehow contradicts exclusiveness, too. Here, the guidelines are contradictory in themselves.

VIII. Arriving at the Household Level: A Spiritual Approach to Prevention

While biomedical counselling in antenatal care focuses on modes of HIV transmission from mother to child, medical indications beyond HIV/AIDS can result in compliance with biomedical advice. LeTharo, one of my informants, denied her HIV-positive status and consequently did not agree to adjusting her infant feeding practice to HIV prevention. However, LeTharo complied with biomedical advice in the end for a completely different reason.

LeTharo assumed that she was affected by witchcraft which had resulted in recent bitter changes in her life besides her physical health condition. While local healers relieved her from the cause of her misfortune, biomedical care only offered to treat the results of it (Field notes Kroeker: 29/04/2009). Witchcraft, as a malevolent power exercised by a particular person, can purposely or accidentally cause sickness in another person. Witchcraft is used to take revenge, due to jealousy and greed, but at times people in a sensitive transitional state, such as pregnant or freshly delivered women and young children, are prone to be affected collaterally by strong substances which witches use for harming

community members. Whatever the reason may be, and whether the mother has been harmed accidentally or on purpose, a healer has to clarify the cause of the disease, whether ancestral punishment or witchcraft, and to remove the cause. A private doctor¹⁴ diagnosed that LeTharo had been bewitched and advised her to refrain from breastfeeding since her milk would also be affected and hence poisonous for the child (Field notes Kroeker: 08/12/2008).

If a breastfeeding mother falls victim to witchcraft her baby may for instance cry and refuse to drink its mother's milk 'after seeing an animal drinking from the mother's breasts' in a dream revelation (Field notes Kroeker: 12/3/2009). The child's refusal of the milk, or spitting it out if it has drunk a little due to hunger, can result in death. Such symptoms suggest a Basotho disease sent by 'Tokolosi', evil human-shaped spirits which transmit powers and deploy animals as carriers. In LeTharo's understanding, her breast milk contained harmful substances. A 'ngaka' will mix a 'pitsa' to be taken orally and an ointment including medicinal plants to treat the mother's physical complaint as well as the malevolent powers (Field notes Kroeker: 6/2008; 17/03/2009; 09/03/2009). LeTharo underwent this treatment to cleanse her from the evil powers, and she decided to feed her child with powdered milk only (Field notes Kroeker: 29/04/2009). Biomedical counsellors, whom she visited in addition to the traditional practitioner, supported her in her decision in favour of replacement feeding. Since she had a regular income she fulfilled the AFASS criteria, which nurses and counsellors basically compare with household income. In consequence, the biomedical counsellor and nurses were satisfied with LeTharo's compliance with biomedical protocols as stipulated in the national PMTCT guidelines.

IX. Conclusion: From Local to Global

HIV/AIDS, as a purely biomedically defined syndrome, receives most attention from biomedical researchers in industrialised countries, despite the fact that the highest prevalences are found in countries belonging to the global South. Following up on biomedical recommendations for the prevention of mother-to-child transmission of HIV, I have highlighted in this paper the internationally debated recommendations on safe infant feeding, the guidelines published by the World Health Organization, their interpretation by Lesotho's Ministry of Health and

¹⁴ LeTharo, being a 'good Christian', avoids the terms 'ngaka' or 'sangoma' and prefers the term 'private doctor', although there is no doubt that her practitioner follows one of the traditional schools of health and healing.

Social Welfare, and nurses' and counsellors' information exchange with their clients. At the end of this information chain I described the household level, where infant feeding advice is put into practice. While I cannot describe how the remodelling actually happens, I have noted various frames of reference in which health advice is interpreted.

This paper illustrates the transformation and the interrelatedness of a health policy, here, infant feeding recommendations for HIV-positive mothers, on various levels. Thus, in international, national, regional, local and home-based frames of reference, it is handled and imbued with attributes by the respective stakeholders who enter a creative process of adaptation. Stakeholders not only add attributes to the good and the practice, they also abandon values which were previously pivotal. This process thus entails translation rather than simple transmission of technology and its immaterial attributes, such as know-how, capacities and interpretations. Shaped by a diversity of ideas, environments and aims, the token is in flux all along the way on each and every level it passes. At the end of the chain, LeTharo's and Mpho's concerns are very different from those mentioned in the international debates and biomedical discourses. By looking at the whole process I have shown that as 'the global' is slowly but steadily translated into 'the local', there are no unilineal dichotomous global-local and modern-traditional relations.

Second conclusion: Biomedical practitioners are interested in finding a globally applicable health care policy based on evidence-based, rational, scientific research. However, the same liquid changes its characteristics along the way. It may be a body fluid, a carrier of social values, a life-saving nutrient, an indicator of bonding between mother and child, a means of preventing immunological deficiencies, a substitute for dirty water, a replacement for artificial powder, but also a hazardous liquid transmitting witchcraft, and a contagious material, depending on the frame of reference. Generally speaking, biomedical health carers follow a scientific or technological approach, while client and family mostly see the spiritual and social or emotional side of the situation. Breast milk (which is never actually part of the process) carries the most diverse ideas, aims and perspectives, from malevolent powers to scientific and technological notions, as this paper shows.

Thirdly, personal relations and individual interests are involved in the passage of the token. LeTharo avoided conflict with the biomedical counsellors, who checked on her compliance with biomedical protocols and were satisfied with her performance, while Mpho also aspired to this by telling a lie. LeTharo, in contrast to Mpho, managed to keep up a patron-client relationship with hospital staff, despite her apparently contradictory subscription to witchcraft ideas. However, witchcraft be-

lief was part and parcel of her local framework which affected decision-making with regard to her preferred infant feeding option. Personal relations with the healer, who knows and understands her situation, as well as with the counsellors, helped her to face the challenges in her life with locally comprehensible arguments. Arguments regarding biomedical prevention programmes, by contrast, were not translated. Understanding PMTCT procedures therefore seemed confusing for counsellors and nurses, as well as for the clients who were neither able to explain why infected milk protects a baby from contracting HIV nor to teach their family elders. Constant changes in the guidelines according to progress in medical research somewhere far away added to that confusion.

Here my argument links back to Rottenburg, who distinguished between the trust in the system in Western countries and the trust in personal relations. In a global perspective, the basic token is assumed to be free of social and emotional attributes and thus applicable to each and every context worldwide. Even though social aspects are not included at the beginning of the ‘chain of translation’ (which side is actually ‘the beginning?’), they become more and more important when reaching out to the local level. The more the health system relies on social ties and personal relations, the more emotional attributes are associated with the token itself.

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Summary

HIV/AIDS, as a purely biomedically defined syndrome, receives most attention from biomedical researchers in industrialised countries, despite the fact that the highest prevalences are found in countries belonging to the global South. Following up on biomedical recommendations for the prevention of mother-to-child transmission of HIV via breastmilk, this article describes the internationally de-

bated recommendations on safe infant feeding, the guidelines published by the World Health Organization, their interpretation by Lesotho's Ministry of Health and Social Welfare, and the nurses' and counsellors' information exchange with their clients. At the end of this information chain, health messages are interpreted and implemented at household level.

The token – here infant feeding advice – is passed from bodies of global relevance to national and local bodies. This paper illustrates how stakeholders on each and every level fit the token into their respective 'frame of reference'. As it passes through these different frames, the token is repeatedly 'translated' and thereby imbued with attributes, ideas, and interests which are valid in a particular frame. Thus, the immaterial value attached to the token reflects the stakeholders' diverse notions: one and the same liquid, here breast milk containing the HI-virus, is seen as immunologically valuable on the one hand, and infectious on the other, which makes it a highly politicised fluid.

Zusammenfassung

HIV/AIDS, als rein biomedizinisch definiertes Syndrom, erhält weltweit große Beachtung durch internationale Organisationen, die sich auf einen westlich geprägten, biomedizinischen Diskurs stützen, obwohl die höchsten HIV-Raten in den Ländern des südlichen Afrikas evident sind. HIV kann während der Schwangerschaft, der Geburt und über die Muttermilch von der Mutter auf das Kind übertragen werden. In diesem Artikel beschreibe ich daher die biomedizinischen Empfehlungen zur Prävention der HIV-Übertragung von Mutter auf Kind durch die Muttermilch. Empfehlungen zur sicheren Säuglingsernährung werden international debattiert, von der Weltgesundheitsorganisation veröffentlicht, von Lesothos Gesundheitsministerium interpretiert und von Krankenhausmitarbeitern vermittelt, bevor sie in den Haushalten zur Anwendung kommen.

Ich argumentiere, dass jeder Akteur die Anweisung dem jeweiligen 'frame of reference' anpasst und somit transformiert. Das, was von einem zum nächsten Akteur weitergegeben wird, wird mit Attributen angereichert und hier gilt es zu bedenken, dass es sich um materielle und immaterielle Güter handelt, die transportiert werden: Anweisungen zur Säuglingsernährung. Der materielle Part, die Muttermilch, kommt erst auf einem Graswurzellevel in den Fokus, während der immaterielle Teil, die Ansichten, was Muttermilch überhaupt ist, stark von den Interessen der Akteure abhängt. Dieselbe Flüssigkeit, Muttermilch, wird daher einerseits als immunologisch wertvoll oder andererseits als infektiös charakterisiert. Soziale Interaktion und institutionelle Einbettung prägen die jeweilige Interpretation einer hoch politischen Körperflüssigkeit.

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