Language as a Resource for Improving Health: Using Swahili-Based Concepts in Responding to Infant HIV

Jean Burke
Australian Catholic University

Abstract
This article addresses the importance of recognising how language can structure understandings and behaviour in public health. It will be demonstrated by reference to community responses to HIV transmission to infants in Central Tanzania, using Swahili words and concepts to understand behaviour around infant feeding and improved wellbeing of children and their mothers. These examples are drawn from the findings of a qualitative study conducted in Tanzania in which data analysis was guided by the grounded theory principle of using natural language, supplemented by Swahili concepts developed and used by respondents themselves once their importance for deeper understanding was realised. The use of language in this study opened up Tanzanian ways of thinking and revealed positive dimensions to concepts more widely expressed in negative ways, such as ideas of maximising immunity (rather than reducing risk) and building openness (rather than fighting stigma). This article shows how linguistic conceptualisations are important cultural resources, and it is a contribution to improved understandings of cultural context in order to deal more effectively with infant HIV. It may also improve understanding of Swahili language and culture for researchers, policy-makers and practitioners who are not Swahili speakers, and demonstrate the importance of a linguistic perspective for public health initiatives.

Introduction
Culture and language influence the ways in which people respond to HIV. This is demonstrated in a qualitative study, conducted in Central Tanzania, where certain Swahili concepts emerged as significant in the choice of infant feeding methods to prevent HIV. The study on which this article is based was conducted in the Dodoma Urban District and several rural villages in the Dodoma region of Tanzania in 2003. Dodoma is the designated capital of Tanzania, located in Central Tanzania. The predominant tribe in the region is the Gogo, who are semi-pastoral, with a mix of tribes in the capital centre. Swahili is the official national language of Tanzania and the medium of instruction in primary schools and adult education. Swahili belongs to no single ethnic group; it was employed intentionally to break down tribal boundaries and build national unity.

However the mother tongue of most people is their tribal language,[1] such as Kigogo (spoken by the Gogo tribe). The researcher had been located in this region for seven years and conducted this exploratory study prior to the introduction of infant HIV prevention programmes in the area.

Background: Preventing HIV transmission to infants

An understanding of social and cultural context is important for effective health interventions. Studies in East Africa[2] have stressed how critical it is to focus on the language used to describe AIDS and its symptoms, and public responses to the epidemic, in order to understand behaviours and social changes and to intervene effectively. Some researchers in Tanzania have used Swahili words to assist readers to understand local perspectives on HIV,[3] and infant feeding and HIV.[4] This study employs Swahili words and concepts to build a grounded theoretical framework for understanding how social ties influence infant-feeding decisions. In practical terms, it aims to improve understandings of cultural context, through a focus on language, in order to deal more effectively with infant HIV.

In the United Republic of Tanzania, preventing infant HIV is a significant issue in infant health, and infant feeding is a challenge to such prevention. The majority (94%) of children are breastfed in Tanzania[5] and this generates a critical dilemma: while HIV may be transmitted during breastfeeding, avoidance of breastfeeding may contribute to infant malnutrition, illness and death. International and national guidelines have responded to evolving evidence, such as the greater risk of HIV

[1] Karsten Legere, "Language endangerment in Tanzania: identifying and maintaining endangered languages," *South African Journal of African Languages* 26:3 (2006): 99-112.

[2] Aldin Mutembei et al., "Communicating about AIDS: changes in understanding and coping with help of language in urban Tanzania," *Journal of Asian and African Studies* 37:1 (2002): 1-16; Philip Setel, *A Plague of Paradoxes: AIDS, Culture, and Demography in Northern Tanzania* (London: The University of Chicago Press, 1999).

[3] Mutembei et al., 2002; Setel, 1999.

[4] Marina M. de Paoli, Rachel Manongi and Knut-Inge Klepp, "Are infant feeding options that are recommended for mothers with HIV acceptable, feasible, affordable, sustainable and safe? Pregnant women's perspectives," *Public Health Nutrition* 7:5 (2004): 611-619; Karen M. Moland, "Mother's milk, an ambiguous blessing in the era of AIDS: the case of the Chagga in Kilimanjaro," *African Sociological Review* 8:1 (2004): 83-99.

[5] National Bureau of Statistics, Tanzania, *Tanzania demographic and health survey 2004/05* (Dar es Salaam: National Bureau of Statistics, 2005), 177.

transmission via mixed feeding[6] compared to exclusive breastfeeding,[7] and to concerns about the social acceptability and feasibility of various infant feeding methods. Current guidelines recommend exclusive breastfeeding for the first six months as the method of choice, with complementary feeding after six months, as well as gradual weaning and replacement feeding only when specific conditions are met,[8] which is close to general public health recommendations. However, local community expectations and practices favour the more risky mixed feeding. Mothers who feed their infants contrary to community expectations and practice, whether by replacement milk or exclusive breastfeeding, may be socially stigmatised and exposed to pressure and rejection by male partners and other kin. Deeper understanding about the social, interpersonal and cultural context of infant feeding in relation to HIV can assist in the planning and implementation of prevention programmes and community education programmes that are grounded in people's concerns and experiences.

Methodology

The study gained ethical approval from the Tanzanian Council for Science and Technology (COSTECH), the National Institute of Medical Research, Tanzania (NIMR) and the Human Research Ethics Committee (HREC) of the University of New South Wales.[9] A sample of six HIV-positive mothers from a self-help group of people living with HIV and four relatives of mothers with HIV (three women and one man) were interviewed in-depth to provide understanding about HIV and infant feeding and the support the mothers received. The leader of the self-help group approached women and family members and invited them to

---

[6] Mixed feeding is defined as feeding with breastmilk in addition to other liquids and solids. World Health Organization (WHO), *International Code of Marketing of Breast-milk Substitutes* (Geneva: WHO, 1981); World Health Organization, *New data on the prevention of mother-to-child transmission of HIV and their policy implications: conclusions and recommendations,* WHO Technical Consultation UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV, 11-13 October 2000 (Geneva: WHO, 2001).

[7] Exclusive breastfeeding is defined as breastfeeding while giving no other food or drink, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicine. World Health Organization, 1981; World Health Organization, 2001.

[8] World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund and United Nations Population Fund, *Guidelines on HIV and infant feeding: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence* (Geneva: WHO, 2010)

[9] Jean Burke, "Jamii, social ties and networks: Managing HIV and infant feeding in Central Tanzania," (PhD thesis, University of New South Wales, Sydney, 2009)

participate. A sample of 20 key informants (12 women and eight men) was also interviewed after initial approaches were made to the official heads of selected organisations, followed by snowball sampling. Those selected included health workers, policy developers and opinion leaders from a balance of health and non-health sectors, rural and urban regions and government, and religious and independent sectors.

Focus groups were accessed through these key informants and were facilitated by two leaders of the self-help group. Homogenous groups were purposely selected based on gender, life stage and location, leading to 13 focused discussions. These were conducted with three groups of women, three of men and three mixed-gender groups of traditional midwives, traditional healers and village leaders in the three rural sites. Discussions were also held with an urban group of Muslim women and on two occasions with the self-help group of people with HIV (of mixed gender) which also acted as an advisory group to the study, with preliminary findings presented to them for feedback.

Three languages were used in the data collection process: English, Swahili and Kigogo. Key informants chose to use English or Swahili, while relatives and mothers with HIV used Swahili. Most group discussions were conducted in Swahili but some also used Kigogo, with the assistance of an interpreter. Written informed consent was given in interviews, and oral consent in groups. Transcriptions of the audio-taped data were analysed thematically, using grounded theory developed by Glaser and Strauss,[10] which encourages the use of natural language and 'in-vivo coding'[11] from language used by informants. The data was analysed by the author[12] with minimal translation to English, both to save time and retain meaning, a strategy advocated by Strauss and Corbin.[13] The author's fluency in Swahili made this possible. Through analysis, categories of Swahili words or concepts were developed as core organising themes for a framework which would show how social ties influence infant-feeding decisions. The idea of using concepts as

[10] Barney G. Glaser and Anselm L. Strauss, *The discovery of grounded theory: strategies for qualitative research* (Chicago: Aldine, 1967).
[11] Anselm L. Strauss and Juliet Corbin, *Basics of qualitative research* (Thousand Oaks, CA: Sage Publications, 1990).
[12] This study was conducted towards a PhD in social work from 2003-2009 under supervision and with minimal resources which did not permit multiple analysts.
[13] Anselm L. Strauss and Juliet Corbin, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (Thousand Oaks, CA: Sage Publications, 1998).

culturally available resources, as proposed by Jordens,[14] reinforces their value in building explanations in complex contexts. Their use in this study acknowledges that cultural and linguistic conceptualisations provide entries to understanding and responding to HIV, and are not necessarily barriers to health promotion.

Results: Swahili-based concepts

Using real language begins with, and respects, the informants' views. Analysis of the data in this study revealed how respondents defined key concepts around infant feeding in ways that gave a rich understanding of how they perceived, ordered and described their world. The following concepts are general ones used in everyday life in Tanzania; they have been selected as useful for application in the East African context of HIV and for expanding understanding of Swahili concepts amongst non-Swahili speakers. They exemplify how language structures understandings and behaviours and can act as a cultural resource for improving public health.

Salama

Survival of children was prioritised by study respondents when evaluating what form of infant feeding was best. Divergent arguments of diverse methods were based on experiences of children exposed to HIV who were "going well," who were alive and healthy whether they were presumed or tested HIV-negative or even had HIV. For example, one mother with HIV narrated several stories of babies born to HIV-infected mothers who either wet-nursed, or used goat's milk or hospital-provided formula milk. She reported on the results, respectively: "*She grew well and is walking now"… "He is going well"… "Now the child is big… and going well at school."* This is primarily a reference to their external health, rather than HIV status, since she also reported that an HIV-infected mother is "going well." The word *salama* was prominent in these discussions as the sought-after goal or achievement. This concept means safety, sound health and peace. Depending on the context, *salama* can mean wellbeing (regardless of a person's HIV status), or being HIV-free.[15] In this way health and survival are ultimately perceived as possible and achievable regardless of HIV status as measured by laboratory blood results.

For some respondents, choices about infant feeding in the context of HIV were a moral issue of fear and *salama*. An HIV counsellor, for example,

[14] Chris Jordens, "A theory of language is a trusty workbench," in *Discourse and Health Conference, Sydney, 23-24 November 2006*.

[15] *Salama* has been appropriated for commercial use as a brand name for condoms.

suggested a mother with HIV *"doesn't breastfeed then she is giving safety (salama) to her baby,"* while a doctor argued that *"a child will certainly die unless they are breastfed by someone else."* Milk was described in binary form, morally judged as safe or dangerous, good or bad. Breast milk, instead of signifying life and health, was perceived as bringing death and danger. A village-based father suggested *"after being tested [for HIV] both must understand and agree on a decision that the milk is bad."* Fear was more often spoken about than risk, which is more common in Western discussions. No single word in Swahili represents 'risk' as uncertain danger, instead, separate words are used, either danger (*hatari*) or uncertainty (*mashaka*). At the other conceptual end, however, *salama* covers both safety and security. Notions of risk as a cultural construction[16] suggest that uncertainty may be feared and risk understood as certain danger, rather than in a more nuanced way. So local perceptions of risk attach danger to breast milk itself, and then prescribe a response of risk elimination, such as weaning, rather than managing risk.

Kinga

Maximising *kinga* (immunity) was an important way of evaluating methods of feeding infants. In Swahili, *kinga* means immunity, antibodies, protection or, more literally, shield.[17] *Kinga* is a central idea to HIV and AIDS and is a key word in *UKIMWI (ukosefu wa kinga mwilini*), meaning AIDS. Study participants referred to this concept when evaluating breast milk and other kinds of milk in relation to HIV infection and child survival. They discussed the *kinga* of breast milk, being the maternal antibodies that give infants protection from all sorts of diseases, and the *kinga* of cow milk, which was free of HIV. A few stated metaphorically that replacement milk was itself *kinga*, or protection, in contrast to the "poison" of breast milk. Hence, breast milk and replacement milk have different kinds of *kinga*: maternal antibodies or being HIV-free. This positions *kinga,* or immunity, as an asset situated in mothers' bodies or accessed as a resource in the community. Respondents also spoke about people having varying levels of *kinga* to explain variations in people's health or (lack of) infection. Respondents noted how poverty affects maternal nutrition and hence decreases immunity and how wealth can purchase *kinga* in the form of medicines, including antiretrovirals and replacement milk. The attention of respondents, however, was clearly on ways to boost or maximise the immunity

[16] Jens O. Zinn, "Recent developments in sociology of risk and uncertainty," in *Forum: Qualitative Social Research* 7:1 (2006), http://www.qualitative-research.net/index.php/fqs/article/view/68/ 140 (accessed 2 February 2006).

[17] Within sexual relations *kinga* is a term used for condoms.

available through nutrition, or the purchase or supply of medicines. So, for example, the idea of mothers using antiretroviral drugs while breastfeeding was generally approved of as a way to combine both kinds of immunity, rather than trading them off, and as a way to support the wellbeing (*salama*) and survival of both mother and child. Moreover, respondents exemplified how social ties could be channels for providing *kinga* (immunity) in order to save children's lives. One village leader linked such collective responsibility to preventative action: "*Because it is the community of the child…some good people will give out help if they can give it…protection* (kinga) *so the child won't get it."* By providing cow or other milk, such people in the community would be seen as giving protection to the child from HIV transmission.

Findings pointed to how social relations (*jamii*) manage HIV and infant feeding in complex, dynamic ways, by acting as *kinga* to prevent or permit the flow of milk and HIV. Social ties function as social resources within which mothers can exercise social power to widen choices for infant feeding. A mother's social ties function as *kinga* when they are pathways for supplying milk that shields infants from HIV. As such they operate as social capital or 'insurance' (*kinga*) against poverty and limiting choices when "activated by AIDS."[18] Yet this social immunity may also be eroded by HIV. "Social risks,"[19] such as abuse, neglect, relationship breakdown and social rejection, restrict infant feeding choices[20] because they block social acceptance and resource and information flow. Social ties can either be agents of shame or protect mothers from it. Close kin, especially fathers, can play an important role in protecting infants from HIV infection (and mothers from social risks) or they can hinder such protection. A mother's networks may practise strategies to avoid shame, such as the private feeding of an infant or offering explanations for not breastfeeding to observers which are more acceptable than HIV prevention, and hence enable her to sustain certain infant feeding.

---

[18] Mike M. Mtika, "The AIDS epidemic in Malawi and its threat to household food security," *Human Organization* 60:2 (2001): 178-188.

[19] Sebalda C. Leshabari, Astrid Blystad and Karen M. Moland, "Difficult choices: infant feeding experiences of HIV-positive mothers in northern Tanzania," *Journal of Social Aspects of HIV/AIDS* 4:1 (2007): 544-555.

[20] Tanya Doherty at al., "Effect of the HIV epidemic on infant feeding in South Africa: 'When they see me coming with the tins they laugh at me'," *Bulletin of the World Health Organization* 84:2 (2006): 90-96; A. Mramba, "Barriers to the exclusive breastfeeding options for the prevention of mother-to-child transmission (MTCT) of HIV in Dar-es-Salaam, Tanzania," in *XVI International AIDS Conference, Toronto, Canada, 13-18 August 2006.*

Uwezo

Uwezo was an important Swahili concept referred to by respondents when discussing the comparative options of infant feeding methods and the involvement and influence of others. The word *uwezo* means ability, power and authority. As a broad, flexible term, *uwezo* refers to any available resources or powers which can enable action, encompassing material wealth, abilities and social resources (see Table 1 below). Hence, distinctions in socio-economic status are often signified and discussed in terms of differing amounts of *uwezo*, or its presence or absence. For example, one health worker described how "*the capacity* (uwezo) *in the villages is small. For cattle owners it is easy… the mother can…keep giving cow's milk without anxiety… But for small farmers who don't have capacity* (uwezo)*, who depend on the hand-hoe, it will be difficult."*

Table 1: Examples of capacities at different social levels

Levels of *uwezo* (capacity)	**Examples of *uwezo* (capacities)**
Individual	Health, income, cattle-ownership
Family	Wealth, social connections, cattle-ownership
Community	Presence of milk cows, safe water, services
Institutional	Interventions, such as HIV tests, drugs
National	Technology, knowledge, funding

Respondents considered different types of *uwezo* as relevant depending on the kinds of infant feeding choices. The capacity to choose or not was a type of moral *uwezo* which some respondents spoke of in terms of 'non-choice.' This could mean that breastfeeding may be seen as morally unavailable due to potential HIV infection, or physically unavailable due to maternal illness, with consequent struggles to obtain available milk. Or breastfeeding may be seen as the only option due to a lack of economic resources (*uwezo*) to afford replacement milk. Respondents focused more on issues of physical capacity (*uwezo)* when discussing breastfeeding, while issues of economic *uwezo* were considered more relevant for replacement milk decisions. Physical capacities such as *kinga*, maternal and breast health and milk production were relevant to assessing and encouraging safer forms of breastfeeding, such as exclusive breastfeeding or heat-treating breast milk. But economic resources can influence these capacities by ensuring access to medicines, sufficient nutritious food and rest. The issues related to replacement milk spoken about by respondents

were availability, cost, and knowledge of how to prepare them. Access to milk is a match between the individual capacity to afford it and its availability in the community.

The way *uwezo* is used indicates that it is understood as power or capital which is dynamic, social and interactive. Other Tanzanian studies have also noted the dynamic, diverse and relative nature of this concept.[21] This means influence is seen to exist and flow through social relationships in order to access resources such as milk and medicines that can be used to prevent HIV transmission. Hence, while a mother may seem to have no capacity to afford milk, negotiating through social connections may yield milk to act as protection through what works as a "moral economy of interdependence."[22] This informal economy through social connections operates in complex ways, using leverage through gender and generation hierarchies, that is, fathers and elder kin. *Uwezo* was a frequently recurring concept in any discussion about access. Strategies for access included household-sharing, gifts, loans, group meetings and collections, petitions and delegations, sometimes in complex mixes of social and economic transactions with milk accessed as a commodity, gift and/or service. Respondents noted that the possibility of family involvement should be acknowledged and addressed by health services.

Aibu

The concept of *aibu* (or shame) emerged as an important social force that restrains speech and actions. Shame affects infant feeding choice: mothers wishing to avoid shame (of maternal irresponsibility or suspicion of HIV infection) might choose to breastfeed in the conventional way, rather than use replacement milk or breastfeed exclusively, particularly if they are first-time mothers. Such shame comes from comparisons to peer values: not breastfeeding signals HIV infection or failed motherhood.[23] According to this study, the power of shame (*aibu*) to influence actions was more powerful for young mothers, especially those having their first child.

---

[21] Peter Gregersen, "Making the most of it? Understanding the social and productive dynamics of small farmers in semi-arid Iringa, Tanzania," (PhD thesis, Lund University, Sweden, 2003); Garth A. Myers, "Sticks and stones: hegemony and the language of African houses," 1996, http://ec.hku.hk/kd96proc/authors/papers/myers.html (accessed 12 December 2005).

[22] Ann Robertson, "Critical reflections on the politics of need: implications for public health," *Social Science and Medicine* 47:10 (1998): 1419-1430.

[23] Moland, 2004.

Fear and shame were spoken about by study respondents as driving forces which restrained choices in feeding infants much more often than stigma. One counsellor argued *"Some mothers fear what their neighbours will think of them…Why is this mother not breastfeeding today and all the time she was breastfeeding before! I think the main thing is shame (aibu)."* Only health workers and people living with HIV discussed stigma, as *unyanyapaa,* which also means harassment. Stigma is a new concept within Swahili, derived from Western education rather than African experience, but adopted as useful both by those who experience its effects and by Tanzanian experts. Research in Tanzania by Kilonzo and colleagues[24] also noted this challenge and concluded that programmes would need to explore how to talk about stigma indirectly. The word 'stigma' does not reflect the nuances in how most people in this study in Central Tanzania talked primarily about various effects of stigma, such as blame, shame, fear, rejection, withdrawal and despair. This runs counter to tendencies in Western and international discussions which focus on reducing and 'fighting' stigma, a negative term without an obvious contrasting positive one. It is noteworthy that respondents spoke about accepting HIV, being open and focusing on solutions such as building an environment in which stigma does not thrive, in order to widen choices for infant feeding and protect mothers' dignity.

Uwazi

Confidentiality (*siri*) is valuable in the context of HIV because secrecy respects an individual's rights and functions to protect specific women from the possibility of misunderstanding, shame and isolation. Yet people in this study talked about how fear and secrecy (*siri*) foster the spread of HIV, and advocated openness (*uwazi*) as an important way to stop HIV spreading. The positive concept of *uwazi* was talked about in many ways, most commonly used figuratively to mean transparency and clarity, in the sense of free unimpeded access through an opening (*uwazi*), or free flow of information without hindrance. Within social relationships, openness (*uwazi*) is a state of honesty and communication, acceptance and understanding which contrasts with hiding and keeping secrets (*siri*).

Openness (*uwazi*) is an ideal which respondents recommended individuals, leaders, groups and institutions embrace in order to prevent infant HIV. Central aspects to this concept are honesty and reality in relation to both communication and knowledge, that is, frank discussion

[24] Gad Kilonzo et al., "How are we going to talk about stigma in Swahili?" in *2nd National Multisectoral AIDS Conference in Tanzania, Arusha, Tanzania, 16-20 December 2002*.

about HIV and honest disclosure about being tested for HIV and HIV status. Usually HIV is not directly discussed in East Africa. Research participants talked about this as an important change that had started and needed to continue in order to respond to HIV effectively. Such openness was seen as necessary for effective support of mothers to occur, and for the sharing of responsibility for preventing infant HIV, rather than that responsibility being borne solely by the mother.

Uncritical acceptance and communication make it easier for mothers to choose infant-feeding methods which may prevent HIV. Because it changes a risk environment to a supportive environment that blocks HIV flow, openness is a form of *kinga*. A village leader aptly expressed this idea, that it ultimately provides immunity against infant HIV: "*People should recognise this matter, if it was open (wazi) then they would have a certain protection (kinga) by understanding this is a problem."* Openness, and the infant-feeding practices it permits, can act as a "social vaccine,"[25] just as direct communication and changes in sexual practices in Uganda had a reductive effect similar to a physical vaccine on HIV transmission.[26] Crucial aspects identified in the successful Ugandan response to HIV transmission included frank communication by leaders, active sharing of information by citizens within personal networks,[27] and the mobilisation of civil society, particularly NGOs, religious groups and people living with HIV.

Implications

The Swahili concepts described above influence infant feeding decisions in the context of HIV and are potentially useful in bringing about social change. The development of categories from Swahili words and concepts used by respondents themselves recognises that "our access to culture, knowledge and experiences is mediated by language,"[28] including how we categorise and conceptualise the world. These concepts exemplify the

[25] Edward C. Green, *Rethinking AIDS Prevention: Learning from Successes in Developing Countries* (Westport, CT: Praeger, 2003), 222.
[26] Janice A. Hogle et al., eds., *What Happened in Uganda?: Declining HIV Prevalence, Behavior Change, and the National Response* (Washington, DC: US Agency for International Development, 2002).
[27] Hogle et al., 2002; Daniel Low-Beer et al., "Knowledge diffusion and the personalisation of risk as key indicators of behaviour in Uganda compared to South Africa," in *XIII International AIDS Conference, Durban, South Africa, 9-14 July 2000*.
[28] Jordens, 2006.

"cultural references and resources" that UNESCO and UNAIDS[29] have called for when considering responses to HIV. Such concepts have been recognised by other scholars as helpful for understanding and communicating information about HIV in Tanzania.[30] Hence educators, health practitioners and those involved in shaping policies affecting their own communities ought to value their own local linguistic knowledge when external ideas and policies are trialled or introduced in communities. By explaining key concepts, they can demonstrate the importance of listening and learning from communities' perspectives for designing and implementing culturally relevant interventions. For example, where there is understanding that family and social networks provide social immunity and resources, recommendations for local adaptations of infant feeding counselling[31] point to including these important people in family, home-based or community counselling.

Swahili understandings of the various constructs of *aibu, kinga and uwezo* highlight dissonances in understanding with the western and non-equivalent concepts of stigma, risk and wealth. These dissonances may provide insights into the lower than expected rates of participation in programmes to prevent infant HIV. Any continual delay in understanding how people think and talk about important aspects of their lives can only work against establishing the essential trust, connection and action required for a Tanzanian villager to engage with Western, and hence foreign, concepts of disease, risk and treatment. Engaging with an emic perspective of HIV and utilising key local community constructions of infant feeding and HIV may go towards addressing community reluctance to respond to HIV prevention messages and programs as public health policy-makers hope and expect they might. For example, an acknowledgement of the overall community concern for child survival and wellbeing (*salama*) logically leads to recognising the benefits of embedding HIV prevention approaches in a holistic way within other maternal and child health initiatives, rather than as separate approaches. Similarly, interventions are better presented within a framework of building community strength and immunity (*kinga*) to resist illness, rather than ideas of 'risk.'

---

[29] United Nations Educational Scientific and Cultural Organization/Joint United Nations Programme on HIV/AIDS, *A cultural approach to HIV/AIDS prevention and care, Methodological handbook 4: Project design, implementation and evaluation division of cultural policies* (Paris: UNESCO, 2001).
[30] Mutembei et al., 2002; Setel, 1999.
[31] Leshabari, Blystad and Moland, 2007.

Careful attention was paid to the words used by informants in this study and the way they defined important concepts. For example, *uwezo*, as defined and used by respondents, points to a conceptual understanding of relative, multi-sited power directed towards specific aims, namely infant HIV prevention, which operates broadly as various kinds of capital. This makes possible a more nuanced understanding of power and resources as dynamic, social and interactive in ways not usually conceived of in English. Such conceptualisations show how language both reflects and shapes the way society perceives and organises itself, because it is embedded in culture and thought systems. Using concepts emerging from the language of respondents invites others into their cultural and linguistic frameworks. From an intersectional perspective, the use of language from the margins of tertiary global education to build theory and inform policy is a way to privilege voices not usually or widely heard and suggests a way to address inequality. Using Swahili to analyse findings and build theory positions it as a bridge of meaning between tribal cultures[32] and national and international policy and programmes, as it brings the experiences and conceptual frameworks of study informants to the centre. In this way Swahili language and thinking constitute a level of context which makes sense of community understandings and responses. It should alert people designing public health guidelines to the need to pay careful attention to the language used in communities so as to formulate messages grounded in people's concerns and experiences.

While it is rarely possible for policy-makers and researchers, community and health workers to engage fully with another culture or learn another language fluently, it can be very worthwhile to learn about some concepts salient to the communities in which they are working or do research so as to create meaningful dialogue and effect positive change. Such concepts are generally expressed in everyday words and heard frequently in conversations, and provide a way into understanding and engaging in culturally resonant ways. To this end, the incorporation of a linguist, linguistic consultation or a linguistic perspective may be seen as an essential contribution to any public health promotion, community education or development initiative.

Language and culture not only illuminate understandings and behaviours, they also inform the development of effective responses. Valuing

[32] There is conceptual equivalence between Swahili and Bantu tribal languages, such as Kigogo.

language as a resource resonates with the perspective articulated by Sen,[33] which incorporates culture as an important part of the 'capabilities' that people bring to development. Hence the concepts described in this paper can be useful for education, training and policy-making, facilitating more effective presentation of information about HIV and infant feeding. Maximising immunity (*kinga)*, for example, could guide assessments of infant feeding choices for women in different situations, depending on their *uwezo*, including their health status and social resources. Core concepts such as shame (*aibu)*, capacity (*uwezo)*, safety (*salama)* and openness (*uwazi*) could be used to frame counselling and community conversations because they have more resonance with Swahili-speakers than concepts such as stigma, income, risk and disclosure. They provide insight into ways of thinking about HIV that are particularly Tanzanian and African. A focus on language is an important strategy for reaching people with preventative messages and communicating about interventions.[34] Moreover Western practitioners could learn from these Swahili examples, which take a strengths-based approach by focusing on ways to build openness and acceptance, rather than approaches which 'fight' stigma.

Conclusion

This article, in showing how Swahili conceptualisations were important in explaining how social relationships in Central Tanzania influence decisions about infant feeding within the context of HIV transmission and infection, provides an example of how language shapes understandings and can influence behaviours. Such concepts can help in understanding how people respond to HIV, as well as serve as resources for improving the health of communities. Hence a linguistic perspective can make a unique contribution to public health initiatives. This is exemplified in how people in Central Tanzania spoke more often in positive ways about concepts which are more usually portrayed in their negative dimensions in Western conversations about HIV, talking of maximising immunity (rather than reducing risk) and building openness (rather than fighting stigma). Such approaches permit nuanced understandings and encourage conversations and thinking that focus optimistically and productively on the capacities already present in communities and how they can be directed towards achieving wellbeing and safety for children and their mothers.

---

[33] Amartya Sen, "How does culture matter?" in *Culture and Public Action*, eds. Vijayendra Rao and Michael Walton (Palo Alto, CA: Stanford University Press, 2004), 37-58.

[34] Mutembei et al., 2002.

Bibliography

Burke, Jean. "Jamii, social ties and networks: Managing HIV and infant feeding in Central Tanzania." PhD thesis, University of New South Wales, Sydney, 2009.

De Paoli, Marina M., Rachel Manongi, and Knut-Inge Klepp. "Are infant feeding options that are recommended for mothers with HIV acceptable, feasible, affordable, sustainable and safe? Pregnant women's perspectives." *Public Health Nutrition* 7:5 (2004): 611-619.

Doherty, Tanya, Mickey Chopra, Lungiswa Nkonki, Debra Jackson, and Ted Greiner. "Effect of the HIV epidemic on infant feeding in South Africa: "When they see me coming with the tins they laugh at me"." *Bulletin of the World Health Organization* 84:2 (2006): 90-96.

Glaser, Barney G., and Anselm L. Strauss. *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine, 1967.

Green, Edward C. *Rethinking AIDS Prevention: Learning from Successes in Developing Countries.* Westport, CT: Praeger, 2003.

Gregersen, Peter. "Making the most of it? Understanding the social and productive dynamics of small farmers in semi-arid Iringa, Tanzania." PhD thesis, Lund University, Sweden, 2003.

Hogle, Janice A., Edward Green, Vinand Nantulya, Rand Stoneburner, and John Stover, eds. *What happened in Uganda?: Declining HIV prevalence, behavior change, and the national response.* Washington, DC: US Agency for International Development (USAID), 2002.

Jordens, Chris. "A theory of language is a trusty workbench." In *Discourse and Health Conference, Sydney, 23-24 November 2006*.

Kilonzo, Gad, Mathur Sanyukta, Jessie Mbwambo, Laura Nyblade, and Peter Kopoka. "How are we going to talk about stigma in Swahili?" In *2nd National Multisectoral AIDS Conference in Tanzania, Arusha, Tanzania, 16-20 December 2002*: A31

Legere, Karsten. "Language endangerment in Tanzania: identifying and maintaining endangered languages." *South African Journal of African Languages* 26:3 (2006): 99-112.

Leshabari, Sebalda C., Astrid Blystad, and Karen M. Moland. "Difficult choices: infant feeding experiences of HIV-positive mothers in northern Tanzania." *Journal of Social Aspects of HIV/AIDS* 4:1 (2007): 544-555.

Low-Beer, Daniel, Tony Barnett, Alan Whiteside, and Rand Stoneburner. "Knowledge diffusion and the personalisation of risk as key indicators of behaviour in Uganda compared to South Africa." In

XIII International AIDS Conference, Durban, South Africa, 9-14 July 2000.

Moland, Karen M. "Mother's milk, an ambiguous blessing in the era of AIDS: the case of the Chagga in Kilimanjaro." *African Sociological Review* 8:1 (2004): 83-99.

Mramba, A. "Barriers to the exclusive breastfeeding options for the prevention of mother-to-child transmission (MTCT) of HIV in Dar-es-Salaam, Tanzania." In *XVI International AIDS Conference, Toronto, Canada, 13-18 August 2006*.

Mtika, Mike M. "The AIDS epidemic in Malawi and its threat to household food security." *Human Organization* 60:2 (Summer 2001): 178-188.

Myers, Garth A. "Sticks and stones: hegemony and the language of African houses," 1996, http://ec.hku.hk/kd96proc/authors/papers/myers.html (accessed 12 December 2005).

Mutembei, Aldin K., Maria A.C. Emmelin, Joe L.P. Lugalla, and Lars G. Dahlberg. "Communicating about AIDS: changes in understanding and coping with help of language in urban Tanzania." *Journal of Asian and African Studies* 37:1 (2002): 1-16.

National Bureau of Statistics (Tanzania). *Tanzania demographic and health survey 2004/05.* Dar Es Salaam: National Bureau of Statistics, 2005.

Robertson, Ann. "Critical reflections on the politics of need: implications for public health." *Social Science and Medicine* 47:10 (1998): 1419-1430.

Sen, Amartya. "How does culture matter?" In *Culture and Public Action*, edited by Vijayendra Rao and Michael Walton, 37-58. Palo Alto, CA: Stanford University Press, 2004.

Setel, Philip. *A Plague of Paradoxes: AIDS, Culture, and Demography in Northern Tanzania*. London: The University of Chicago Press, 1999.

Strauss, Anselm L., and Juliet Corbin. *Basics of qualitative research*. Thousand Oaks, CA: Sage Publications, 1990.

Strauss, Anselm L., and Juliet Corbin. *Basics of qualitative research: techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage Publications, 1998.

United Nations Educational Scientific and Cultural Organization/Joint United Nations Programme on HIV/AIDS. *A cultural approach to HIV/AIDS prevention and care, Methodological handbook 4: Project design, implementation and evaluation division of cultural policies*. Paris: UNESCO, 2001.

World Health Organization (WHO). *International Code of Marketing of Breast-milk Substitutes.* Geneva: WHO, 1981.

World Health Organization. *New data on the prevention of mother-to-child transmission of HIV and their policy implications: conclusions and recommendations.* Technical Consultation UNFPA/ UNICEF/ WHO/ UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV, 11-13 October 2000. Geneva: WHO, 2001.

World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund and United Nations Population Fund. *Guidelines on HIV and infant feeding: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence.* Geneva: WHO, 2010. http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf (accessed 5 October 2011).

Zinn, Jens O. "Recent developments in sociology of risk and uncertainty," *Forum: Qualitative Social Research* 7:1 (January 2006),www.qualitativeresearch.net/index.php/fqs/article/view/68/140 (accessed 2 February 2006).