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Challenging Assumptions: Breastfeeding and HIV/AIDS

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Abstract
Significant experience and research evidence regarding Human Immunodeficiency Virus (HIV) and infant feeding have accumulated since recommendations on infant feeding in the context of HIV were last revised. This evidence has major implications for how women living with HIV might feed their infants, and how health workers should counsel these mothers.
The quality of infant feeding counselling is poor with inadequate information provided for women to make appropriate choices (Abiona *et al.*, 2006). Infant feeding counselling, as currently implemented, does not prepare women for the challenges of adhering to their infant feeding choices. Women face new challenges in the postpartum period and ongoing community-based support and resources are important to sustain infant feeding practices.
The recommendation on infant feeding should be improved putting into consideration the social and cultural problems women go through in the community and also health workers should be well equipped not only to provide counselling but support the women through decision making and practicing of their choices.
Keywords: counseling, challenges, infant feeding

1. Introduction

Completely avoiding breastfeeding is not a safe or feasible option for many HIV-positive mothers in resource-poor areas. Although commercial infant formula is the recommended infant feeding option for HIV-positive mothers in developed countries, mothers in poor countries face issues such as the expense of infant formula, lack of access to safe water, unsanitary living conditions, increased risks to their children from common childhood illnesses, inadequate health care, and socio-cultural factors.
Mothers within these regions are recommended to breastfeed for 6 months before they introduce complementary feeds, and this poses a risk to the infant.
Early childhood illnesses like diarrhoea and pneumonia which pose less risk to children in the Europe are far more severe and life threatening to children in other parts of the world. In one study, formula feeding was associated with a 14-fold increase in diarrhea-associated mortality for all infants and a 25-fold increased risk in infants less than two months old. A recent study in Ghana, India, and Peru also found that non-breastfed infants had a 10-fold higher risk of dying when compared to predominantly breastfed infants. The question is, if exclusive breastfeeding is the optimal choice in our part of the world, how best can it be promoted and how can these mothers be supported to exclusively breastfeed their infants for the first six months? Good question; readers will be glued to your policy brief to find answers to this question… Hope you provide them with the answers
Mothers who are HIV positive have to make a choice either to solely formula feed their infants thus if they pass the AFASS or exclusively breastfeed for six months.
Most mothers however decide to exclusively breastfeed because of socio-cultural and economic reasons.
The policy recommends that an HIV positive mother be given ART to help reduce transmission of the infection to the infant through breastfeeding, the emphasis is on lifelong ART, but with the kind of healthcare system available in most Sub-Saharan Africa countries the issues of access and availability still remains a problem thus even if the drugs are affordable the mother getting access to it remains a uncertain. High maternal viral load will contribute to lowering the overall infant HIV-free survival.
Women who are however able to cross this barrier and make the decision to breastfeed for six months face a lot of challenges within the society. According to Laar etal., 2009, a mother who opted to exclusively breastfeed for six months could not implement this because of partner and community members' stigmatizing behaviour towards her after she disclosed her status to them. Leshabari (2007), also presented a study that has demonstrated that there is a gap between the individual woman's intentions to exclusively breastfeed and her possibilities to put her intentions into practice in a context where kin and neighbours make up part of the decision-making team surrounding infant feeding. The issue in this regard is not just about the choices of the mothers but socio-cultural values also play a role in putting these choices into practice.
Moreover, many women are unable to determine whether or not they have mastitis and may continue to

breastfeed increasing the risk of transmission.
Also the importance of sticking to breast milk only in the first six months is not possible since most mothers tend to practice mixed feeding for various reasons like the child needs to drink water after eating and the breast milk not been sufficient for the child.
According to Abiona etal., (2006), in Africa, giving infants water to supplement breast milk has posed a challenge to the promotion of exclusive breastfeeding. Clearly, to ensure that HIV-positive mothers who choose to breastfeed do so exclusively, beliefs and attitudes in relation to giving infants water need to be addressed. While breastfeeding is almost universal and breastfeeding typically continues till18–24 months, exclusive breastfeeding is not common. Foods and liquids are commonly added to the infant's diet well before he or she is 6 months of age.

The recommendations now revised advocates that mothers known to be HIV positive should give commercial infant formula milk as a replacement feed to their HIV uninfected infants or infants who are of unknown HIV status, when specific conditions are met (AFASS).
Also a lot barriers to replacement feeding like stigma associated with not breastfeeding, the high costs of replacement foods & fuel for cooking, an unreliable supply of electrical power, poor access to safe water and poor access to storage facilities Laar etal., (2009), also poses a challenge to mothers who want to opt for replacement feeding.
Laar et al., (2009), noted however that there has being conscious efforts by nurse counsellors to frown on the AFASS of infant formula. Laar eal., emphasised that the Prevention of Mother-To-Child Transmission of HIV (PMTCT), "In-charges" assert that, being signatories to the Baby-friendly Hospital Initiative, it is binding on them not to display infant formula at their facilities. Most are not aware that the initiative allows them to advice and offer options to the mother on formula feeding especially in situations like HIV positive mother.
According to Leshabari (2007), The nurses also found themselves unable to give qualified and relevant advice to HIV-positive women on how best to feed their infants, they perceived both exclusive breastfeeding and exclusive replacement feeding as culturally and socially unsuitable.
Furthermore, successful formula feeding cannot be achieved just by making available the feed but partner and community support is necessary and this can only be achieved through disclosure of status. However, disclosure of HIV-positive status to a partner is greatly feared and this has a bearing on and is an obstacle to the practice of replacement feeding. Kuhn and colleagues (2004) similarly assert that fear of disclosure may be an impediment to choosing formula feeding, and a study in Uganda found that women who succeeded in adhering to replacement feeding had family support (Matovu *et al.*, 2002).
Replacement feeding in some communities may also be interpreted as a sign of HIV especially if no legitimate explanation such as caesarian section, is given. Therefore, a woman who chooses this method is carefully watched. The costs of infant formula, and the scorn and suspicion that is perceived to cultivate, makes replacement feeding an option only for those who have disclosed their HIV status to their partners or those who are unmarried and living alone(Leshabari, 2007).

Without education, services, and support, many HIV-exposed women stop breastfeeding at six months in order to decrease their infants' exposure to HIV. However, recent data show that young infants who stop breastfeeding at such a young age are at extreme risk for morbidity and mortality.
Therefore, it is critical that adequate funding and support are available to ensure that HIV-positive mothers have access to the individualized advice, care, and support that will help them to maximize their baby's HIV-free survival by practising and doing the right thing.

Recommendations
Every effort should be made to accelerate access to ARVs for both maternal health and also prevention of HIV transmission to infants. The new thing here is acceleration of the rate of ARV uptake/access
Recognizing that ARVs will not be rolled out everywhere immediately, guidance needs to be given on what to do in their absence.
All HIV-infected mothers should receive appropriate counselling which includes provision of general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the option most likely to be suitable for their situation. Whatever a mother decides, she should be supported in her choice.
Understanding the socio-cultural and economic circumstances in which HIV-infected women find themselves may lead to better communication between policymakers and women, thus increasing community acceptance of

the recommendations.

The nurses who counsel these mothers and other stakeholders should be regularly updated with new information to deal with issues appropriately. They should also be trained to take note and consider peculiar problems reported by the mothers and seek guidance in counseling where necessary.

A mother's choice to either breastfeed exclusively or use formula feed maybe dependent on her but putting this choice into practice involves a larger group thus partner and other people within her household and the community and as such these people will need to be considered when the recommendations are been revised.

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