

ORIGINAL RESEARCH ARTICLE

Experiences of HIV-Infected Mothers Regarding Exclusive Breast-Feeding in the First Six Months of the Infant's Life in Mangaung, South Africa

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Abstract

In 2011, the Department of Health in South Africa committed to promote, support and protect breast-feeding. Subsequently, the supply of free formula milk to HIV-infected mothers was discontinued, with these mothers encouraged to breast-feed. This was also in compliance with the WHO's call for countries to adopt a single-feeding practice for HIV-infected mothers. This study explored the experiences of HIV-infected mothers regarding exclusive breast-feeding in the first six months following an infant's birth. Qualitative data was collected through in-depth unstructured interviews at a community health centre among mothers aged 18 years and above, who opted for exclusive breast-feeding. Thematic data analysis was undertaken. The study results revealed that mothers had positive experiences, such as motivation, satisfaction and being well informed. Some mothers had negative experiences, such as anxiety, family pressure and guilt, leading to non-adherence to exclusive breast-feeding. The experiences of participating mothers were mainly influenced by socio-cultural issues and information from healthcare workers. The study findings highlight the need to intensify advocacy, communication and social mobilization to the communities at large regarding exclusive breastfeeding. (*Afr J Reprod Health* 2019; 23[4]:27-34).

Keywords: Exclusive breast-feeding, experience, mother-to-child transmission, infant mortality

Résumé

En 2011, le ministère de la Santé de l'Afrique du Sud s'est engagé à promouvoir, soutenir et protéger l'allaitement maternel. Par la suite, l'approvisionnement en lait maternisé gratuit pour les mères touchées par le VIH a été interrompu, ces mères étant encouragées à allaiter. Cela était également conforme à l'appel lancé par l'OMS aux pays pour qu'ils adoptent une pratique d'alimentation unique pour les mères infectées par le VIH. Cette étude a exploré les expériences des mères atteintes par le VIH concernant l'allaitement maternel exclusif au cours des six premiers mois suivant la naissance d'un nourrisson. Des données qualitatives ont été collectées lors d'entretiens approfondis et non structurés dans un centre de santé communautaire auprès des mères âgées de 18 ans et plus, qui ont opté pour l'allaitement maternel exclusif. Une analyse thématique des données a été entreprise. Les résultats de l'étude ont révélé que les mères avaient des expériences positives, telles que la motivation, la satisfaction et une bonne information. Certaines mères ont vécu des expériences négatives, telles que l'anxiété, la pression familiale et la culpabilité, ce qui a conduit au non-respect de l'allaitement maternel exclusif. Les expériences des mères participantes ont été principalement influencées par les problèmes socioculturels et les informations fournies par le personnel de santé. Les résultats de l'étude soulignent la nécessité d'intensifier le plaidoyer, la communication et la mobilisation sociale auprès des communautés en général concernant l'allaitement maternel exclusif. (*Afr J Reprod Health* 2019; 23[3]: 27-34).

Mots-clés: Allaitement maternel exclusif, expérience, transmission mère-enfant, mortalité infantile

Introduction

The World Health Organization (WHO) recommends exclusive breast-feeding by all mothers, including those who are HIV infected¹.

Exclusive breast-feeding in the first six months, coupled with anti-retroviral therapy to mothers and infant prophylaxis, has been found to minimize Mother-to-Child Transmission (MTCT) through breast-feeding². In spite of this milestone,

exclusive breast-feeding by HIV-infected mothers still creates a dilemma among health workers and some communities, since MTCT can still occur through breast-feeding³⁻⁵. Notwithstanding the well-researched benefits of breast-feeding, most notably the prevention of infant mortality and morbidity due to diarrhoea, pneumonia and under nutrition², the fear of HIV infection in some individuals and communities still clouds breast-feeding practices among HIV-infected women. In deciding on replacement or breast-feeding in HIV-infected women, the WHO recommends the consideration of socio-economic and cultural contexts of the population, quality of health services, HIV prevalence among pregnant women, and the main cause of child under-nutrition and infant and child mortality^{1,6}.

The Prevention of Mother-to-Child Transmission (PMTCT) through breast-feeding should always be balanced with the possible risk of child mortality induced by replacement feeding¹. Despite its association with MTCT, breastfeeding remains a global challenge^{7,8}. Accordingly, the global target for exclusive breast-feeding in the first six months is targeted at a minimum 50% by 2025 and in 2014, it was at 38%⁸. An assortment of challenges regarding exclusive breast-feeding has been identified in Africa and other parts of the world. Cultural beliefs and practices, unsupportive work environments, lack of family support, fear of stigma, lack of knowledge and skills were identified as some of the barriers to breast-feeding in some studies⁹⁻¹². Other factors found to influence the practice of exclusive breast-feeding in low-income countries include employment, education, place of delivery and family pressure^{13,14}.

In their meta-analysis on prevalence of key breast-feeding indicators in 29 sub-Saharan African countries between 2010-2015, Issaka *et al*¹⁵ found the overall prevalence of breast-feeding to be less than 50%. According to UNICEF, the exclusive breast-feeding rate in South African was at 8% in 2012¹⁶. Contrastingly, a study conducted

by Siziba *et al* found the exclusive breast-feeding rate to be 12% in 2013 in four of the nine South African provinces¹⁷.

Additionally, Southern and Eastern Africa are the most affected by the HIV burden, and also among the highest in child mortality⁶. Therefore, it is imperative that HIV prevention is balanced with other child survival strategies such as breast-feeding. Victora *et al*⁷, assert that only 37% of children under six months are exclusively breast-fed in low-income and middle-income countries. In their study on constraints to exclusive breast-feeding in Nigeria, Agunbiade *et al*¹⁸ found that only 19% of breast-feeding mothers whose babies were below six months practised exclusive breastfeeding. Prior to 2012 in South Africa, HIV-infected mothers who opted for replacement feeding received free commercial formula from public health facilities for six months¹⁹. Through the Tshwane Declaration of August 2011, the South African government committed to promote, support and protect breast-feeding²⁰. Subsequently, the provision of free formula to HIV-infected mothers who choose formula feeding was discontinued, and all mothers were encouraged to breast-feed²⁰. The Declaration was also in response to the WHO (2010) recommendation that national authorities should implement a single feeding practice for HIV-infected women¹. This was a new approach to mothers and some health professionals. The researchers in this study also observed that some HIV-infected mothers were still despondent about breast-feeding. Therefore, the practice needed to be explored and explained further, so that it is understood better by its intended beneficiaries. In this regard, the experiences of the mothers would provide an understanding of some of the barriers to exclusive breast-feeding, such that best practices could be enhanced. These empirically generated experiences would in turn inform the policymakers concerning the salient factors contributing to non-adherence to exclusive breast-feeding by HIV infected mothers. These factors could be inimical to overall child survival.

Methods

Study design

A qualitative study was conducted to describe and explore the exclusive breast-feeding experiences of HIV- infected mothers during the first six months of the infants' life. Purposive sampling was applied in the participants' selection process, based on the researcher's predetermined selection criteria.

Study settings and population

The study was conducted in an urban community health centre in Mangaung, South Africa. HIV- infected mothers aged 18 years and above who chose to exclusively breast-feed their babies in their first six months, were included to participate voluntarily in the study. *Ergo*, their infants had to be older than six months at the time of data collection.

Data collection

Individual unstructured in-depth interviews were conducted in a private consulting room of the community health centre in 2014. Demographic data was first obtained from each participant, stating age, marital status, education level and number of children. A grand tour question was: 'Kindly describe your exclusive breastfeeding experiences in the first six months after your baby's birth?' Probing questions were asked until saturation point after interviewing fifteen HIV- infected mothers. The audio-recorded interviews were conducted in South Sotho (the local language), translated to English, and transcribed verbatim.

Data analysis

Each interview transcript was systematically coded, and concepts and connections identified, followed by generation of themes^{21,22}.

Results

Table 1 presents the socio demographic characteristics of the participants, of whom 11

were between the ages of 20-30, and 4 (four) were aged 31-40 years. Six (6) were married, and 9 (nine) were single. All participating mothers had formal education, 1 (one) primary, 13 high school, and 1 (one) tertiary. Unemployment was high, with 13 mothers unemployed. Additionally, all mothers had attended antenatal clinic, 6 (six) of whom already knew their HIV-positive status on the first visit while 9 (nine) were diagnosed positive during pregnancy. Three themes emerged from the collected data. These were positive experiences, negative experiences, and challenges encountered.

Positive experiences

Well informed

Mothers reported that they were well informed about exclusive breast-feeding and were aware of the benefits thereof, including PMTCT interventions. They mostly concurred both the information and interventions had a positive impact on their breast-feeding experiences. One of the mothers stated:

I was taught at the clinic that breast milk was good, and that the Nevirapine syrup that the baby was getting would protect my baby from getting HIV. I was also told not to give the baby anything except the breast-milk for six months.

Satisfaction and motivation

Satisfaction and motivation were the result of being well informed, as mothers were not anxious about their babies contracting HIV. Disclosure of HIV status also had a major impact on the satisfaction and motivation because mothers who disclosed their status received support, and were not always worried about people's reaction concerning their HIV status. Collectively, these positive experiences also contributed to mothers' adherence to breast-feeding as indicated below:

I wanted to give my baby the best I could, so I was very content and happy about breastfeeding.

Table 1: Socio-demographic characteristics of HIV-infected mothers in Mangaung, Free State Province, South Africa (N=15)

CRITERION	CHARACTERISTIC	FREQUENCY
Age	20-30 years	11
	31-40 years	4
Marital status	Married	6
	Single	9
Level of education	Primary School	1
	High school	13
	Tertiary	1
Employment status	Employed	2
	Unemployed	13
Period of diagnosis of HIV infection	Known positive on first antenatal visit	6
	Diagnosed HIV in pregnancy	9
Planned versus unplanned pregnancy	Planned	3
	Unplanned	12

I disclosed my status to everyone. I talk a lot about it, even to strangers. Some people used to comment about my breastfeeding while I was HIV-positive. I would tell them that my child was safe because I was taking ARV's and not mixed feeding.

Negative experiences

Anxiety

Some of the HIV-infected mothers experienced anxiety despite the health education they received. They were still fearful of their babies contracting HIV. Non-disclosure of HIV status also contributed to perceived lack of support and negative experiences of stigma and discrimination should their HIV-positive status be known.

I was anxious because I knew there is a possibility of my baby's infection from breast milk My worst time was when I had to fetch the results of the baby's first test. I was very anxious and did not sleep that night.

Guilt

Guilt emanated from non-adherence to exclusive breast-feeding and HIV infection.

I am even afraid of taking him for the test as I know I mixed fed him. I already feel guilty about what I did, and I pray every day that my child should be HIV-negative.

One mother who was misinformed about the duration of breast-feeding her baby and had to discontinue abruptly at six months, expressed guilt about not being able to continue breast-feeding beyond six months.

It's so painful to me that I had to deprive my baby of love because of the HIV. It made my life difficult in many aspects ... I had already accepted my status, which was yet another setback. I felt sad and even guilty when I had to stop breast-feeding. It was like the first time the status was revealed to me.

Feeding incongruence

A mother who gave birth to preterm twins, and was well informed about exclusive breast-feeding, discovered that her babies were given formula at the hospital while she was also providing expressed breast milk to them.

On several occasions when I took breast milk to the nursery, I found that my babies had been fed with formula. When I asked about it, the nurses told me that my milk has never been sufficient for those two babies ... I was told several times at the clinic that it should either be breast milk or formula alone, that breast milk was best, and never to mix feed because babies can contract HIV and other infections ... Why was I not told from the beginning that my milk was not enough? Why was I advised on something that was not feasible?

Family pressure and conflict

Other practices associated with exclusive breast-feeding resulted in family pressures and conflict, leading to cessation of breastfeeding before six months. Such practices included babies not getting water, expressing breast milk, and mothers going back to work.

My father was very dissatisfied about the issue of expressing breast milk. He said it was disgusting to wash the utensils with breast milk where we wash other dishes and keeping the milk in the fridge with other food items ...

A mother who had to go back to work left the baby with her mother who was also against expressing breast milk. She had to stop breast-feeding before six months.

There are some things that made me suspect that the baby did not even get that expressed breast milk, but I kept quiet as there was nothing I could do. I then stopped breast-feeding at four months.

Challenges encountered

Mixed feeding

Mixed feeding resulted from factors such as family pressure and the perception that babies were not provided with enough milk. One mother related her mother's insistence that the baby could not survive without water, an insistence to which she eventually surrendered.

I experienced some problems when my mother came to visit. She fiercely contended that a child could not survive without water ... My mother ended up giving the baby some water and I had to stop breastfeeding.

Mothers also related how they had to introduce formula milk. They believed their babies cried a lot because they received insufficient milk.

I started giving my baby formula at one month because he would not stop crying.

So I believed he was not getting enough milk.

Misinformation

Some of the mothers indicated that they only breastfed for six months. They were taught at the clinic that HIV-infected mothers were only to breast-feed for six months, which led to unhappiness. This is contradictory to WHO and South African guidelines, which state that HIV-infected mothers can breast-feed exclusively for six months, introduce complementary feeding, and continue breast-feeding for about two years^{6, 23}. One mother stated:

Breastfeeding was a good experience for me. I became very sad when I had to discontinue the practice. I wanted to continue, but was told never to exceed six months. So, it was difficult for me and my baby, who would cry for hours and ... I even wished I had not started at all ... I got this information from the clinic

Resuming work

Exclusive breast-feeding impacted negatively on working mothers when they had to return to work. They were informed about expressing breast milk and leaving it with the caretakers to feed the babies during the day. They were compelled to stop breastfeeding due to family pressures and mistrust. One of the mothers averred:

I returned to work and left my baby with my mother, who insisted that the baby needs water from birth and some porridge from four months. I realised I could be endangering my child because it was obvious my mother was going to give her some other things, so I decided to stop breast-feeding.

Discussion

Participating mothers had a variety of experiences influenced by a number of factors. Data from this study shows some socio-demographic

characteristics did not impact HIV-infected mothers' exclusive breast-feeding experiences in the first six months of the infant's life. These characteristics ranged from level of education to whether or not the pregnancy was planned.

Participants aged thirty to forty years had more positive experiences. Married mothers experienced less challenges. In this regard, being married or staying with a partner was a predictor of more positive experiences, adhering to exclusive breast-feeding and more support on the chosen method of feeding; this was consistent with some findings from other studies^{24,25}. Some of the fifteen participating mothers were employed. Their negative experiences started when they had to return to work, and both had to discontinue breast-feeding before six months. Contrastingly, the mothers who had known their status before pregnancy had fewer negative experiences and challenges.

Furthermore, positive experiences resulted from the health education provided regarding exclusive breastfeeding, disclosure of HIV status, and the level of support provided. The mothers were eager to breast-feed exclusively and less anxious about HIV transmission to their babies because of the capacity of antiretroviral therapy and exclusive breastfeeding to minimise the risk of MTCT. Disclosure of HIV status also led to more positive experiences, such as support, which resulted in adherence to exclusive breast-feeding. A study conducted in South Africa by Sibeko *et al*³ revealed that non-disclosure of HIV status was also found to be an obstacle to PMTCT. Incorrect information provided to mothers by some healthcare workers, that HIV-positive mothers should only breast-feed for only six months, contributed to negative experiences; such as abrupt weaning which deprived the babies of the continued benefits of breast milk. Correct information should always be provided to communities, because misinformation could have detrimental effects on the health outcomes of the very communities. In addition, healthcare workers' attitudes, skills and knowledge have an impact on the sustenance of exclusive breastfeeding⁷. This was attested to by the experiences and the remarks

of the mother whose babies were mix-fed at the hospital, with the mother concluding that she was taught and expected to practice something that was not feasible.

Family pressure, which emanated from previous culturally induced practices, also had negative implications, which led to strained relationships, mixed feeding and early cessation of breast-feeding. This demonstrates there was still some ignorance concerning exclusive breast-feeding in general, and not only among HIV-infected mothers. These pressures also impacted on mothers who had to return to work and leave the babies with caretakers. The totality of the participating mothers' experiences highlights the issue of extending maternity leave to six months. A breast-feeding review of six countries by Mangasaryan *et al*¹⁰ also revealed ignorance by some healthcare providers, lack of family support, work and limited maternity leave as obstacles to breastfeeding.

Ethical Considerations

Approval to conduct the study was obtained from the Head of the Free State Department of Health, while ethical clearance was granted by the University of South Africa, with clearance number: HSHDC/270/2013. Participation was voluntary and informed consent was sought from each participant. Confidentiality, privacy and anonymity were ensured by conducting the interview privately and the use of pseudonyms in the audio recordings.

Limitations

The study was conducted in one community health centre with HIV-infected mothers aged 18 years and above. The participating mothers were mainly from selected townships and informal settlements around Mangaung, which could affect the generalisability of the findings to all mothers in the surrounding areas. The inclusion of mothers younger than eighteen years could have provided more value as this an age cohort most likely to be victims of unplanned teenage pregnancies. This

study also focused on HIV-positive mothers who opted for exclusive breast-feeding, and not those who had opted for exclusive formula feeding. Therefore, the findings cannot conclusively determine exclusive breastfeeding for the first six months of the infant's life to be generally accepted by mothers.

Conclusion

The study demonstrated that although the mothers were receptive to the practice of exclusive breastfeeding, there were some factors which still affected its sustenance. Provision of health education and counselling contributed positively to the mothers' experiences. However, the fact that some of the education was incorrect, had negative effects. Although the study was mainly on HIV-infected mothers, the data shows that health workers have to continually be informed on infant and young child feeding policy. Lack of knowledge by other family members also impacts negatively on exclusive breastfeeding, and highlights the need to intensify community mobilisation and participation. Some mothers were still anxious about MTCT, which highlights the need for continuous counselling throughout pregnancy and breast-feeding. The study results also demonstrate the importance of considering the socio-cultural contexts of health recipients when formulating policies. Working mothers have to be supported at policy-making level by considering extension of maternity leave to at least six months. Provision of longer lunch breaks for breast-feeding mother has been implemented by some employers, but some mothers work far from home and cannot benefit from such policies which benefits some.

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Competing Interests

None declared.

Contribution of Authors

SP collected and analysed data, and also drafted the manuscript. JMM supervised the study and provided guidance on the manuscript in preparation for publishing.

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