Chapter Two

THEORETICAL FRAMEWORK FOR THE STUDY

2.1 HISTORICAL BACKDROP TO THE STUDY OF INFANT FEEDING

Throughout history there have been eras during which women have sought methods of infant feeding as alternatives to feeding their babies themselves (Taback, 1991). For example, in ancient civilisations wet nurses were used. In the Hebraic tradition only the infant of a mother who had died or who could not feed her own child was given to a wet nurse. If a mother had to go out to work in the fields and a wet nurse was not available then an artificial feed could be utilised. This feed tended to be in the form of a type of gruel (a broth made from flour, grain, water and occasionally animal milk). However, infants did not usually gain weight and thrive on this type of feed (Goldfarb & Tibbetts, 1980; Ross & Labbok, 2004). Nevertheless, it is only in modern times that formula feeds have been used as substitutes for breast milk.

Formula feeding has assumed particular significance as a way of preventing mother to child transmission of HIV. South Africa is currently in a state of crisis, in that it is in the throes of an HIV pandemic. Despite medical advances and increased knowledge of the HIV virus, the incidence of the disease is on the increase, a
factor which is especially true in the African population and amongst pregnant mothers (WHO, 2003).

2.2 THE INFLUENCE OF AFRICAN CULTURE ON INFANT FEEDING

In Southern African culture, rites and cultural practices have always been part of an oral tradition and little or no documentation of these cultural practices was made prior to 1950. In that year Eileen Jensen Krige's work entitled “The Social System of the Zulu”, was published and was one of the first in-depth studies to formally document the cultural beliefs and practices of the African people. Salber (1957; 1993), was another historian to document the beliefs of the African culture especially with regard to breastfeeding. The history of breastfeeding in Southern Africa is poorly understood, and is true of all social and class groups (Dohn, 2005). The lack of historical and anthropological data about breastfeeding cultural beliefs and practices over the last two centuries has hampered the many attempts that have been made to analyse the physiological and social causeways of the HIV epidemic. The blame, stigma, fear and isolation in the midst of physical suffering and illness, all implicated in responses to HIV infection and transmission, appear to have roots in the past (Ndaba, 2004).

In the late 1940s and early 1950s South African medical and health professionals began collecting data on breastfeeding in the wider context of social and community health initiatives. One of the most extensive and interesting collections was undertaken by Dr Eva Salber (1957;1993). Salber's research expanded on the importance of breastfeeding and the responsibility that many mothers felt
towards supporting this practice. Grandmothers, relatives and fathers play an important role in encouraging breastfeeding. African culture treats lactating women and their infants with special regard and they provide support with food, rest and infant care during this period.

In African cultures it is believed that the unborn foetus, the newly born infant, as well as the mother’s breast milk are vulnerable to evil forces. Mortality amongst infants and babies under one year is closely associated with early weaning in the African culture (Ndaba & Burns, 2004). In the African culture it is believed that a mother moving through a poisoned or evil space (for example across a road or path), could poison the child or the breast milk (Salber, 1993). Often when an infant dies, especially in the first year of life, the cause of death is seen as being due to the mother weaning her infant too early or by the mother performing an act that would poison her breast milk.

The only time in the Southern African and specifically the Zulu culture, that is contraindicated for an infant to drink its mothers milk is in the first days of life, when it is fed on cow’s milk or amasi. It is believed that the mother’s milk could cause sickness. Breast milk is also regarded as sacred, so that when the child is younger than six months, if the child is left alone or with relatives, the mother squeezes a few drops of her breast milk over the head, breast and back of the child as a form of protection in her absence (Salber, 1993).

It is considered inadvisable for the mother to become pregnant again, until the child is weaned, as such a pregnancy is believed to
result in the child being mentally handicapped (Krige, 1950, cited in Ndaba & Burns, 2004). For this reason, a man is not allowed to cohabit with his partner until she has weaned the baby. However, it is reported that most women are concerned that their partner will stray, so in this lengthy time they often lie to him and tell him that they have already weaned the child (Salber, 1993). However, a contradiction in the African culture, is the belief that when the infant is one month old, mothers need to begin feeding other foods in the form of semi-solids, as they believe that breast milk is insufficient to make the baby grow (Coutsoudis, Pillay, Spooner, Kuhn & Coovadia, 1999).

2.3 BREASTFEEDING IN SOUTH AFRICA IN THE CONTEXT OF THE HIV/AIDS CRISIS

At the present time infant feeding practices have come under the spotlight because of the HIV/AIDS (Human Immunodeficiency Virus type 1 / Acquired Immunodeficiency Syndrome) pandemic and the awareness that this virus may be transmitted through breast milk. AIDS is one of the most feared and rapidly spreading diseases of the 21st century (Larsen, 2004). Worldwide there are estimated to be 8500 new infections daily, with 1000 of these being children (Larsen 2004). AIDS is one of the top five causes of death worldwide in infants and young children (Capute & Accardo, 1996).

Developmental problems appear in approximately 75 to 90% of children diagnosed with HIV infection (Butelr, Hittelman & Hauger 1991 cited in Rossetti, 2001). These deficits include motor delays, with the children either not acquiring or even losing their milestones; acquired microcephaly; as well as cognitive deficits.
These children also present with speech and language delays, visual spatial deficits and problems with social and adaptive behaviour (Rossetti, 2001).

Through the centuries breastfeeding has been deemed as so important that when a mother died or was ill and thus unable to feed her infant her own breast milk, a wet nurse was found. A wet nurse was usually a woman with an infant or her infant had died when it was young. The character of the wet nurses as women, and the quality of their breast milk, was vitally important both in European societies as well as within the African community (Ndaba, 2004). However, despite these beliefs, poorer and less healthy women were often employed in this role.

One of the most salient issues in reviewing the literature on breastfeeding, in the context of the current HIV/AIDS pandemic, is how the African culture places such importance on breastfeeding and how it is seen as the mother’s responsibility. National and international breastfeeding literature, particularly after 1950 stressed the individual woman’s responsibility to breastfeed, but paid scant attention, if any, to the role of fathers, friends or kin folk, let alone wet nursing, shared suckling, work environment demands, psycho-social conflicts or other contextually crucial issues (Anderson, 2003). During World War Two, many women had to enter the workforce for the first time and so communal non-commercial infant milk-banks were established in hospitals, operating in the same way that blood banks operate today. Milk was expressed by women and then stored until it was needed by orphans or children born to mothers who were unable to breastfeed.
Although in some cultures wet nursing is considered traditional practice and especially in the African culture, there is a risk of HIV transmission to the infant through breastfeeding if the wet-nurse is a person living with HIV/AIDS. There is also a risk of transmission of HIV from the infant to the wet-nurse, especially if she has cracked nipples.

In addition, there is much stigmatisation of women living with HIV. The women who are infected have to battle the power dynamics within their own families, between their partners and their mothers and mothers-in-law. In many parts of South Africa, infants are suckled for comfort or nourishment, both intermittently and often, by relatives and caregivers, which has significant implications for HIV/AIDS transmission.

2.4 TRANSMISSION OF HIV/AIDS THROUGH BREASTFEEDING

By 1990 the first papers were being published establishing breast-milk as a possible transmission route for HIV. Hospitals began to measure and analyse the viral load in breast milk, to establish the layers of infection possibilities for HIV infected infants. Some infants are born HIV free, despite having an HIV infected mother, while others are born HIV positive and seroconvert to an HIV negative status. The goal for medicine is therefore to establish ways to maintain these infants’ negative HIV infection status (Ndaba, 2004).
Although it has been established that HIV is transmissible through breast milk (Ziegler, Cooper & Johnson 1985; Coovadia, 2005), the actual mode of transmission of the HIV virus through breast milk is unknown to date. Vertical transmission of HIV refers to transmission from mother to child and can take place in utero, during delivery and postnatally through breastfeeding. Risk factors for the postnatal transmission of the HIV infection, include the practice of breastfeeding, duration of breastfeeding, cracked nipples, mastitis, breast abscesses, and oral thrush in the baby. Bam, Kritzinger & Louw (2003), state that research in the Department of Health reports stat 23.9% of pregnant mothers that receive pre-natal care are HIV positive. However, Adler (2000) reports that some mothers only discover that they are living with HIV/AIDS when their babies are diagnosed.

Breastfeeding contributes to a significant risk of mother-to-child transmission (MTCT), and studies in Africa have shown that breastfeeding increases the risk of MTCT by 43% (Ziegler 1985). The implication is that approximately a third to a half of all MTCT could be due to breastfeeding (McIntyre, 2005). HIV infected cells are present in the breast milk of HIV positive mothers and these infected cells are found to be present throughout the breastfeeding period. MTCT from breast feeding is also influenced by the stage of the HIV condition in the mother and is more likely during the phase of acute HIV infection, if there are symptoms of AIDS, immune deficiency signs or breast pathology such as mastitis, or if the infant has oral thrush or gastrointestinal disease (Dunn, Newell, Ades & Peckham, 1992). MTCT of HIV is more likely the longer the mother breastfeeds the child. Withholding of the mothers’ colostrums, which contain many antibodies, will not reduce the threat of MTCT significantly. In many African cultures
breastfeeding of children has been reported, in some cases, to continue until the child is five years of age (UNICEF, 2005). Reasons for this extended period of breastfeeding appear to be predominantly related to economic and convenience factors.

The World Health Organization (WHO, 2005) has a policy statement for “HIV and infant feeding”. This policy takes an ‘informed choice’ approach, meaning that mothers have the right to choose the method of feeding, but they should be fully informed of the benefits and risks of their chosen method of feeding in their particular circumstances (Kent, 2005).

2.5 ADVANTAGES OF BREASTFEEDING

There are many advantages to breastfeeding. Women have been doing it since the beginning of time and it is the most natural activity in the world. There is also evidence that breastfeeding promotes the bond between mother and child (Urban, 2001). This bonding is very important for the survival of the infant as well as the infant’s feelings of security and well-being. Breastfeeding stimulates the release of the hormone oxytocin in the mother’s body. This hormone, as well as stimulating uterine contractions which help the uterus to return to its normal position after birth and milk ejection, promotes the development of maternal behaviour and also bonding between the mother and the child (Uvnas, Moberg & Eriksson, 1996).

In addition, breastfeeding also has the advantage that it is hygienic as there are no bottles to clean or formula to mix. From a
nutritional point of view, breast milk contains everything that the infant requires for its physical development. A strong body of evidence exists showing that exclusive breastfeeding reduces the incidence and severity of diarrhoea, respiratory and other infectious diseases. There is also evidence that breastfeeding lowers the risk of non-infectious illness such as insulin dependent diabetes mellitus (Sheard, 1993).

Another advantage of breast milk is that it is always at the right temperature for the infant. Breastfeeding is also of a great comfort to the infant, in that it involves direct skin contact with the mother as well as the infant being able to hear its mother’s heart beat. Many studies have expanded on the benefits of mother and infant skin to skin contact, not only for bonding but also for the infant’s growth and development (Nduati & Mbori-Ngacha, 2000).

2.6 DISADVANTAGES OF BREASTFEEDING

One of the major disadvantages of breastfeeding for a mother living with HIV/AIDS is that the virus may be transmitted to her child. Thus, mothers living with HIV are encouraged to feed their infants on milk substitutes such as NAN or Lactogen produced commercially by Nestle (South Africa). Breastfeeding contributes to a significant risk of MTCT, and it has been shown that prevention of breast-fed related HIV transmission could significantly reduce MTCT (Urban, 2001). HIV infected cells are present in the breast milk of HIV positive mothers and these infected cells are found in the breast milk throughout the breast feeding period.
A further disadvantage of breastfeeding is the fact that the mother needs to always be on hand to provide the milk, unless she has the equipment and knowledge to express her breast milk and correctly store it until her infant is ready to receive the feed. Furthermore, the mother who breastfeeds is constrained in terms of when she can return to fulltime employment. Mothers who are HIV positive also tend to have increased difficulty with breastfeeding. Among the difficulties is the fact that they often suffer from mastitis, which is an infection of the breasts where they become inflamed and passing milk becomes painful.

Ideally, when and if the mother does need to return to work, the employer should help to minimise the separation of working mothers and their infants. In an ideal world employers provide adequate maternity leave, part-time employment, provision of facilities for breastfeeding or expressing breast milk and childcare facilities at or near the place of work. However, South Africa is not at present operating under ideal conditions and due, predominantly to economic reasons, optimal employment situations for lactating mothers are seldom provided. Hence a disadvantage of breastfeeding, is that it often presents obstacles to the mother being able to re-enter the market place.

In addition, the feeding of HIV positive infants can be difficult as they often have difficulty in swallowing. This difficulty is often attributable to oral lesions, which are painful to the infant and make swallowing difficult. In a study of 55 HIV positive children, more than 45% were found to have dysphagia (Pressman & Morrison 1988, cited in Arvedson & Brodsky 1993). Infants with HIV also have an increased need for nutrition due to their being ill, because when one
is ill the body requires more energy to fight off any infection (McIntyre, 2005).

However, formula milk is usually adequately fortified with micronutrients including iron. The difficulties facing many mothers from low socio-economic circumstances is that formula milk is expensive, and the mothers have to acquire knowledge of the correct practices for preparation of the formula. Mothers from low socio-economic circumstances are also confronted with the task of having the appropriate equipment necessary to implement a bottle-feeding routine as well as access to appropriate sanitation. The most basic component of implementing a bottle-feeding routine is access to clean water, not only to sterilise the feeding equipment but also to actually make and prepare the formula. According to the Department of Health, 20% of the population still do not have access to fresh running water (Dept of Health, 2005). It is reported that the major obstacle to fulfilling this task is a lack of funding from the Government.

The Innocenti Declaration (1990) (South African Government Guidelines), stated that the optimal goal for maternal and child health and nutrition is that all women should be encouraged to practise exclusive breastfeeding for a period of six months and thereafter they should continue to breastfeed their infants up to two years of age or beyond, whilst receiving appropriate complementary food. However, with the advent of HIV/AIDS the South African Department of Health (2004) has recommended that mothers living with HIV, formula feed their infants to prevent the spread of the virus to their children.
Consequently, the feed of choice for HIV positive mothers worldwide, would appear to be to provide their children with formula milk. Commercial infant formula, based on modified cow’s milk or soy protein, is closest in nutrient composition to breast milk, though it may lack some substances such as long chain essential fatty acids present in breast milk (Dunn et al, 1992).

2.7 NUTRITIONAL SUPPORT AS A FORM OF EARLY INTERVENTION FOR INFANTS WITH HIV/AIDS

Early childhood intervention is a term shared by many fields of health care. The primary goal of early intervention is to facilitate development in order to prevent developmental delays and disorders from occurring and to lessen the severity of existing developmental delays and disorders as early as possible (Guralnick, 1997).

The provision of optimal support for the HIV infected infant’s nutritional status, can potentially help to prevent weight loss, minimize protein depletion and improve responses to opportunistic infections. Both the nutritional status and immune status are important (Rosenthal, Sheppard & Lotze, 1995). Nutrition is vitally important as it impacts on early communication and therefore will have an impact on early communication intervention, with the most critical developmental period in a child’s life being the first 36 months (Evens, Louw & Kritzinger, 2004). Breast-feeding provides infants with all the nutritional support that they need. Formula is said to contain as many nutrients as breast milk, however where breast milk and formula differ is that breast milk contains antibodies that help the infant to fight infection. Nevertheless, when breast milk is infected with the HIV virus, the chances of the
infant contracting the virus are as high as 50% (Coovadia, 2005). Thus breast-feeding is usually discouraged if an adequate alternative is available.

The biggest problem confronting patients with paediatric HIV/AIDS is failure to thrive (Bentler, 1992 cited in Rosenthal et al, 1995). In the case of children living with HIV/AIDS, they often require extra calories and protein in order to catch-up on their growth. Furthermore, in children living with HIV, specific nutrient deficits are often seen, namely zinc, selenium and folate (Raiten, 1990 cited in Rosenthal et al, 1995). In addition, infants may need further nutrients if they have disease manifestations, such as fever and diarrhoea. The impact of HIV/AIDS on infants and toddlers is that it renders them one of the most vulnerable populations requiring early intervention (Louw, 2004). Communication development starts at a young age and needs a supportive environment that stimulates the infant to communicate so that optimal development takes place (Rossetti, 2001).

There is increasing recognition at the international level that good nutritional status is an outcome that depends not only on good food but also on good health services and good care (Kent, 2005). Health services include a broad range of measures for the prevention and control of disease, including the maintenance of a healthy environment. The difficulty with infants born to mothers living with HIV/AIDS is that they often end up as orphans in care centres once their mothers die. These children are then brought up by care-givers and due to the large numbers of children, these care-givers are often unable to facilitate the communication development needed by these children (Louw, 2004). AIDS orphans in care
centres are also not encouraged to self soothe, thus they have no way of comforting themselves (Bam, Kritzinger & Louw, 2003). Thus, infant feeding is not simply the physical transmission of nutrients. There should be a strong component of caring in it, through the closeness and contact that can be provided during feeding. Breastfeeding can be regarded as a kind of health service because of the fact that it immunizes the infant against a broad variety of diseases (Guralnick, 1997; McIntyre, 2005). The role of speech-language pathologists is to identify, assess and treat as well as consult and coordinate with and refer to, other appropriate professionals or services (Evens, Louw & Kritzinger, 2004).

2.8 ALTERNATIVES TO BREASTMILK

There is no perfect breast milk substitute; however there are a number of options available to mothers living with HIV/AIDS. Firstly, there is home prepared formula, which can be made with fresh animal milk, with dried milk powder or with evaporated milk. Safe use of formula with any of these types of milk involves modification of the protein and salt content to make it suitable for infants. Micronutrient supplements are also recommended, because animal milk may provide insufficient iron and zinc and contain less than the required amounts of vitamins A, C, and folic acid. If micronutrient supplements are unavailable, it is recommended that complementary foods rich in iron, zinc, vitamins A, C and folic acid be introduced at four months (Coovadia, 2004).
The second type of breast milk substitute is unmodified cow’s milk; however this type of milk has the potential to cause serious problems leading to dehydration and death in some infants. The reason for this situation is that under one year of age unmodified cow’s milk is too rich for the infant’s immature intestines to fully digest. Consequently, it is recommended that this alternative be considered as an option to HIV positive women, only in exceptional circumstances (Dohrn, 2005).

Commercial infant formula, based on modified cow’s milk or soy protein, is closest in nutrient composition to breast milk, although it may lack some substances like long chain essential fatty acids present in breast milk. It is usually adequately fortified with micronutrients including iron (WHO, 2004).

Formula is usually available as a powder to be reconstituted with water. The instructions on the tin for mixing the formula should be followed exactly so as to ensure that it is not too concentrated or diluted. Over-concentration can overload the infant with salts and protein which can be dangerous and over-dilution can lead to malnutrition.

A further disadvantage of breastfeeding is that it is not always convenient or socially acceptable to breastfeed and it may be difficult for the mother to find a setting that affords privacy to perform this duty.
2.9 POLICIES REGARDING FEEDING

Nutritional management of infants in the 1-month to 1-year age group needs to be monitored closely as there is usually rapid growth as well as weight fluctuations. At this stage the main food intake of infants of HIV positive mothers, is formula, as the role of breastfeeding is controversial. However, if the mother has no other alternatives, due to reasons such as the formula being too expensive, the World Health Organisation recommends breast feeding (WHO, 1987 cited in Larsen, 1998).

According to the literature available at the time of the study feeding policies in South Africa tended to promote breast-feeding for all infants as it is quick and convenient as well as being of good nutritional value for the child (UNICEF, 2004). However with the advent of HIV/AIDS, breast-feeding has been identified as one of the primary means for HIV virus transmission (Bulterys & Lepage, 1998; Gilbert, Selikow & Walker, 2002). Current research suggests that HIV positive mothers should not breast feed their infants but should only provide them with formula feeds until such time as solids are introduced (Brent, Redd, Dworetz, D'Amico & Greenberg, 1995; Coovadia, 2004; National Association of People Living with HIV and AIDS 2004). In this respect UNICEF(2000) maintains that “in assisting a mother in making an informed decision as to how best she should feed her infant, the risks and viability of feeding the infant with breast milk substitutes (mainly formula feeding) must be balanced and weighed against the risks of HIV transmission via breast milk”.
Despite the currently understood benefits of breast-feeding there has been a reduction in breast-feeding in South Africa (Haffejee, 1990, Gauteng Department of Health, 2005) and other developing countries (WHO, 2004) in recent decades. One reason for this development may be attributed to the fact that in recent decades there have been more working mothers and that milk substitutes have enabled these mothers to return to work sooner. Many modern women are also concerned about the ravages that breast-feeding may have on their bodies. This decrease in breast-feeding has led to world-wide attempts to promote breast-feeding. Local examples of the promotion of breast-feeding include the Baby-friendly Hospital initiative (WHO, 1999) as well as the ‘Breast is Best’ campaign (Gauteng Health, 2000).

In line with these initiatives, the South African Department of Health released a document in January 2000 entitled ‘National Breastfeeding Guidelines for Health Workers and Health facilities’. This document states that health workers should “protect, promote and support breastfeeding as a norm, bearing in mind that HIV is transmissible through breast-milk”. A criticism that can be levelled against this approach is that it appears to suggest that breastfeeding should be promoted despite it being a route of transmission for HIV. The Director General for the Department of Health states that with the possibility of HIV transmission through breastfeeding, some HIV positive mothers are likely to opt not to breastfeed. The Director General also states that counselling and demonstration of the preparation of infant formula or other breast milk substitutes should only be given to individual mothers who have made a decision not to breastfeed (Department of Health, 2000). Health workers are advised to promote exclusive breast feeding for about
six months after birth and to work to eliminate obstacles to attaining this goal (Dept of Health, 2000).

Two years later the Gauteng Health Department published a document that was distributed to all the Hospitals and Clinics in Gauteng addressing the issue of children living with HIV/AIDS. The document was entitled Management of HIV infection in Children: Guidelines for Clinics and Hospitals (November, 2001) and provides a number of policy guidelines for the management of HIV positive children. Firstly, the document states that no discrimination should take place; secondly, one must be compassionate, show empathy, and maintain confidentiality at all times. Finally, attention should be paid to pain and suffering, and quality of life should be maintained as long as possible especially in the later stages of life, in children living with AIDS. However, a limitation of this document is that it does not discuss the issue of HIV transmission to the infant via breast milk.

In developed countries, exclusive formula feeding is the standard recommendation for HIV-infected mothers (Urban, 2001), because the risk of MTCT far outweighs the advantages of breast-feeding. However, in contrast with this viewpoint, a longitudinal, observational study reported in the Lancet (354:471 – 476; Coutsoudis, Pillay; Spooner; Kuhn & Coovadia; 1999), states that exclusive breast-feeding, that is, when an infant is given no other food or drink of any sort, may be less likely to transmit infection than mixed feeding (giving the infant formula, as well as other types of feeds e.g. mieliemeal porridge). Thus there are contradictions in the research as to the best method of feeding infants born to HIV positive mothers.
2.10 FEEDING POLICY AT CORONATION HOSPITAL

The Prevention of Mother to Child HIV Transmission Programme was set up in Gauteng in 1998. This programme involved more than 188 hospitals and clinics providing thousands of mothers with free formula for the first six months of their babies' lives.

Coronation hospital, a secondary-level hospital, referral centre and academic institution in Gauteng Province, South Africa, provides paediatric, obstetric and gynaecological services. HIV testing and counselling is routinely offered to all pregnant women at their first antenatal visit. An HIV testing algorithm using Rapid tests and confirmatory ELIZA are used for HIV diagnosis (WHO, 2004). The existing MTCT programme, established in 2000, provides an entry point for pregnant women to receive Anti-Retroviral (ARV) Treatment services. A CD4 cell count is used to determine medical eligibility for ARV treatment with triple ARV treatment being indicated for women with a CD4 cell count below 250 cells/mm (Dorenbaum, Cunningham & Gelber cited in Jay, Ross & Labbok, 2002).

The procedure at Coronation Hospital in Gauteng Province, is to provide mothers with the choice of breast-feeding or bottle-feeding. The reality is that in developing countries general recommendations are more difficult to implement because the benefits of breast-feeding are greater, and in poor socio-economic circumstances may outweigh the risks of MTCT. It is felt that if the mother living with HIV does not have access to running water and adequate methods of sanitizing bottles, or does not have access to or knowledge
regarding how to correctly mix the formula milk, then it would be better for the infant to be breastfed (Coovadia, 2004).

Current guidelines developed collaboratively by the United Nations Programmes on AIDS, World Health Organisation and United Nations Children’s Fund (WHO, 2004), recommend that access to voluntary and confidential HIV counselling and testing be made available to both men and women. It is also recommended that counselling of an HIV-infected woman should include information on the benefits and risks of breast-feeding, with particular reference to her unique situation in order to empower her to be able to make an informed decision on whether or not to breast-feed.

The risks of mother-to-child transmission through the mother’s breast milk are explained during counselling at Coronation Hospital. If the mother decides to bottle-feed then free milk formula is provided for the first six months of the child’s life. This amount is equivalent to about four 450gm tins of formula, depending upon the child’s weight. The mother does not have to bring the child with her every month to receive the formula, but she has to ensure that she brings the child’s ‘Road to Health Card’, which provides proof that the child does in fact exist.

In a discussion with Dr Coovadia, the Head of Department for the HIV/AIDS unit at Coronation Hospital he commented, “When children born to women living with HIV can be ensured uninterrupted access to nutritionally adequate breast-milk substitutes that are safely prepared and fed to them, then they are at less risk of illness and death from not being breastfed. However when these conditions are not fulfilled, in particular in an
environment where infectious diseases and malnutrition are the primary causes of death during infancy, artificial feeding then increases the children’s risk of illness and death” (Personal Communication, 22 March 2005).

Coronation Hospital’s programme of providing HIV positive mothers with free infant formula for the first six months runs counter to the recommendations provided by the World Health Authority (cited in McIntyre, 1987), which is to end free and subsidised supplies of infant formula in hospitals and maternity facilities. The World Health Authority states their reason for promoting breastfeeding is that once a mother stops breastfeeding, she does not bond as well with her child, if the child lives and the mother dies, the world will be left with a generation of orphans and that breast milk will provide the infant with the antibodies it needs to fight off infection (Kent, 2005).

In June and July of 2005 the HIV milk programme at Coronation Hospital, as well as all other Government hospitals, was placed in jeopardy as these sites experienced huge shortages of the Nan Pelargon formula. Nestle, the company that has the Government tender to supply the milk formula was unable to produce enough formula to keep up with demand. The Sunday Times newspaper (August 14, 2005), reported that there was a ‘Baby milk crisis’, and this crisis was experienced countrywide. The demand had exceeded the supply. Nestle were reportedly stepping up production and their factories were operating through the night to increase production.

Lilian Mnisi, Gauteng deputy director for the Prevention Programme for HIV/AIDS stated that ‘they did not know what they were going
to do if they did not get milk formula’. The Deputy Director was reported to have said that women would make a wasted trip to hospitals in August 2005 as they did not have any formula. She also stated that they did not have any contact details for the mothers and so were unable to warn them not to attend the clinic. A dietician at Coronation Hospital expressed the view that she was worried that the mothers who did not receive formula would switch to breastfeeding, which would put their babies in danger of being infected with HIV. Although the milk formula crisis was subsequently resolved, it serves to highlight the large numbers of South African women living with HIV who are dependent on government funded supplies of milk formula to feed their infants.

2.11 SUMMARY OF CHAPTER

This chapter adopted a deductive approach by describing the historical backdrop to the study of infant feeding; African cultural influences on infant feeding; the impact of the HIV/AIDS pandemic on infant feeding practices; the transmission of HIV/AIDS through breastfeeding; the advantages and disadvantages of breastfeeding; alternative nutritional support as a form of early intervention for infants infected with HIV/AIDS; and infant feeding policies of various bodies including the World Health Organisation. Against this theoretical backdrop the chapter concluded with a focus on the feeding policy at Coronation Hospital at the time of the study.