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Challenges for Safe Replacement Feeding among HIV-Positive Mothers in Hai Phong and Ho Chi Minh City, Vietnam: A Qualitative Study

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Infant feeding practices are critical for HIV-positive mothers and their children to reduce the risk of HIV transmission through breast milk and the risk of diarrhea and malnutrition from unhygienic replacement feeding. A mother's decision whether to breastfeed and take antiretroviral drugs (ARVs) or to avoid all breastfeeding needs to balance the risk of HIV transmission through breast milk and the risk of death from infections such as diarrhea and respiratory disease.

A 2009 FANTA-2 study of infant and young child feeding (IYCF) practices among HIV-positive women in two Vietnamese cities of high HIV prevalence, Hai Phong and Ho Chi Minh City (HCMC), found important challenges for safe replacement feeding.

Key findings

- None of the mothers interviewed met the WHO conditions for safe replacement feeding.
- Early introduction of complementary feeding was widespread.
- Lack of safe water and poor hygiene were important barriers to safe replacement feeding.
- Many mothers and caregivers said they received little or no guidance on infant feeding from health care providers.
- Inadequate and inconsistent supply of formula constrained safe replacement feeding.
- A weak continuum of care in maternal and child health services hampered effective interventions to prevent mother-to-child transmission of HIV.

What is safe replacement feeding?

The World Health Organization (WHO) *Guidelines on HIV and infant feeding 2010: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence* recommends that HIV-positive mothers stop breastfeeding only when they can provide a nutritionally adequate and safe diet without breast milk and replacement-feed infants who are HIV negative or of unknown status only when specific conditions are met. Replacement feeding means not breastfeeding at all and giving an infant foods and liquids other than breast milk. During the first 6 months of life, an infant who is replacement-fed should be given a suitable breast-milk substitute—commercial infant formula or home-prepared formula with micronutrient supplements.

Is safety really a problem?

Yes. The study team found challenges to safe replacement feeding at all levels—households, health care services, programs, and policies. The study included in-depth and key informant interviews with HIV-positive mothers of children under 15 months old. None of the mothers interviewed practiced exclusive replacement feeding, and most had introduced complementary foods before their infants were 6 months old. None of the households met all the

WHO conditions for safe replacement feeding. Findings are summarized below according to each of these conditions.

Condition 1: Safe water and sanitation are assured at the household level and in the community.

Lack of safe water and poor hygiene were important barriers to safe formula feeding. Mothers and other caregivers did not consistently wash their hands before preparing and feeding formula or consistently use clean water to prepare formula. Many caregivers said they discarded leftover formula, but a few stored it and used it again later.

Condition 2: The mother or other caregiver can reliably provide sufficient infant formula to support the normal growth and development of the infant.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria provide the funding for free infant formula for HIV-positive mothers in Vietnam. However, challenges in free formula provision affected how much formula infants were fed and how soon they were introduced to other foods.

Condition 3: The mother or other caregiver can prepare infant formula safely and frequently enough so that it is safe and carries a low risk of diarrhea and malnutrition.

The 2010 WHO guidelines call for all HIV-positive pregnant women and mothers to have access to skilled counseling and support for safe infant feeding and ARVs to promote HIV-free infant survival. One theme that emerged from the study was that health care providers lacked time or training to provide infant feeding counseling. Mothers who did not consistently visit health facilities received infant feeding information from HIV support group members, who were eager to counsel them but did not have an accurate understanding of HIV and IYCF.

Condition 4: The mother or other caregiver can feed the infant formula exclusively for the first 6 months of life.

The predominant infant feeding pattern among the informants was early introduction of complementary foods. Many mothers and caregivers introduced sweetened rice flour soup to infants as young as 2 or 3 months old. The reasons they gave included inadequate access to infant formula, the belief that solids were necessary to support growth of infants, advice and encouragement from health care providers and mothers-in-law, and the perception that the free infant formula provided was of poor quality.

Condition 5: The family and community are supportive of this practice.

HIV is still highly stigmatized in Vietnam. This study found that stigma and discrimination affected parents and children in diverse ways that made it difficult for HIV-positive mothers to formula-feed exclusively. Eligibility for free formula was seen as a sign of HIV infection and discouraged some families from picking up supplies near their homes. Not breastfeeding also raised suspicion of HIV infection, leading some mothers to pretend to breastfeed in front of relatives or make excuses that they had too little breast milk or their infants were uninterested in breastfeeding. For some mothers, exclusive replacement feeding resulted in involuntary disclosure of their HIV status to family and friends.

Condition 6: The mother or caregiver can access comprehensive child health services.

To minimize the risk of child mortality from diarrhea and respiratory diseases associated with unhygienic or inadequate

The findings of this qualitative study are meant to provide insights into behaviors, knowledge, perceptions, and challenges related to IYCF in the context of HIV in Vietnam but not to describe or characterize any particular reference population or HIV program. The data represent the experiences of a small number of HIV-positive people. However, mothers from both the north and south were included in the sample, and the consistency of findings across the two sites strongly suggests that they reflect key issues regarding infant feeding in the context of HIV in Vietnam.

formula feeding, WHO recommends that "[n]ational programs . . . provide all HIV-exposed infants and their mothers with a full package of child survival and reproductive health interventions with effective linkages to HIV prevention, treatment and care services." The informants in this study indicated that services for pregnant women, women in labor and delivery, and postpartum and infant care were compartmentalized, with little connection between antenatal care and postnatal maternal checks and ARV services.

RECOMMENDATIONS

In 2011, the Vietnam Ministry of Health will revise the national guidelines for prevention of mother-to-child transmission of HIV (PMTCT). The 2010 WHO recommendations urge countries to decide whether health services should mainly counsel and support HIV-infected mothers to avoid all breastfeeding or to breastfeed and receive ARVs, based on estimations of which strategy is likely to give infants the greatest chance of HIV-free survival. Below are recommendations based on the findings of this study for both options and for a third alternative, continued promotion of informed choice.

If Vietnam decides to recommend exclusive breastfeeding and ARVs for HIV-positive women, the following actions should be considered:

1. Phase out the provision of free infant formula, which could bias mothers to opt for replacement feeding.
2. Inform health care providers and communities of the change in policy.
3. Accompany the policy change with a vigorous social and behavior change communication (SBCC) campaign to support exclusive breastfeeding for 6 months.

If Vietnam decides to recommend exclusive formula feeding for HIV-positive mothers, the government should invest in the following improvements to prioritize HIV-free infant survival:

1. Address stigma and discrimination at community and health system levels to improve access to and uptake of PMTCT and ART services.
2. Test pregnant women for HIV during antenatal care visits wherever possible so that they can be counseled appropriately on infant feeding before their infants are born.
3. Counsel caregivers of HIV-positive infants on sanitation and hygiene and identify ways to improve access to safe water.
4. Train health care providers to deliver consistent messages on infant nutritional needs and the timely introduction of complementary feeding.
5. Institute regular follow-up of HIV-exposed infants and use this opportunity to counsel HIV-positive mothers on optimal infant feeding.
6. Build a collaborative approach among health care providers at all contact points for HIV-positive women and their infants to promote and monitor optimal infant feeding.
7. If free infant formula provision is continued, coordinate among donors to ensure consistent, adequate, and equitable distribution.

If Vietnam decides to recommend giving HIV-positive mothers a choice between exclusive breastfeeding or exclusive replacement feeding, the government should consider the following actions:

1. Require health care providers to counsel HIV-positive women (and their partners and families when possible) on the risks and advantages of both options and help them determine whether exclusive replacement feeding is feasible and safe.

2. Reconsider the provision of free infant formula, which could persuade mothers to opt for replacement feeding.

Reference

WHO, UNAIDS, UNFPA, and UNICEF. 2010. *Guidelines on HIV and infant feeding, 2010: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence*. Geneva: WHO.

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