

Chapter 5

Findings, limitations and recommendations

5.1 INTRODUCTION

The purpose of the study was to explore the knowledge that pregnant women attending two antenatal clinics have of HIV transmission through breast-feeding. This chapter discusses the findings and limitations of the study and makes recommendations for strategies to improve the knowledge of antenatal women on transmission of HIV through breast-feeding and further research.

5.2 PART A: DEMOGRAPHIC DATA

The demographic data explored in the study included age, educational level, income per family and amount of income, which might influence antenatal women's knowledge of HIV transmission and choice of infant feeding method.

5.2.1 Respondents' age (item 2)

All the respondents were in the stated reproductive age group of 15-45 years and none was older than 46 (see chapter 4 figure 4.1).

5.2.2 Respondents' education level (item 3)

Most of the respondents were literate and could read and understand health information on HIV transmission through breast-feeding (see chapter 4, figure 4.2). This finding supports the BIAS report, which indicated that in Botswana the literacy rate for adult females 15 years and older was 82.4% (*FACT Botswana* 2002:2). NACA and CSO (2004:51) found that 69% of the population interviewed could read and understand English and Setswana.

The fact that all the respondents were literate meant that they could read and understand written and verbal health information on MTCT of HIV. Therefore, the respondents were able to read and understand the risk of HIV transmission through breast-feeding and could

choose appropriate infant methods with reduced risk of MTCT. However, despite their literacy, there were still many respondents who were not aware of HIV transmission through infant feeding methods, and had a poor understanding of the risk of HIV transmission of different infant feeding methods. In this study, antenatal women with Standard 4-7 educational level scored low on knowledge of mode of adult HIV transmission with a mean of score of 63.6 compared to those with secondary and tertiary education, who scored, 76.1 and 77.6, respectively. Thus the respondents with higher education scored higher. Therefore, in this study, higher education was associated with a better understanding of MTCT. ACORD (2002:6, 22, 27) found that respondents with a low educational level knowledge did not use condoms to prevent HIV compared to those with higher education.

5.2.3 Marital status (item 4)

Of the respondents, 76.6% were single or cohabiting, which could affect the decision to participate in the PMTCT programme, since HIV testing and infant feeding method choice may be greatly influenced by the male partner's decision (see chapter 4, figure 4.3). Single pregnant women, who did not have partners who might question their decision, might easily choose to participate in the PMTCT programme. However, some single and cohabiting mothers might find it difficult to disclose their HIV-positive status for fear of losing their partner and therefore choose not to join the PMTCT programme and choose wrong infant feeding methods.

Tlou et al (2000:24) found that mothers' participation in PMTCT programmes was influenced by their male partners or significant others' decision. HIV testing is an anxiety-producing situation and there is need for emotional or psychological support from spouses or significant family members.

Therefore, single or cohabiting mothers might lack the emotional and psychological support of their partners during pre-test counselling and adherence to infant feeding methods if they tested HIV positive.

In this study most of the women came alone for the first antenatal care when HIV counselling is done. In Hong Kong, however, Ho and Loke (2003:238) found that the majority of antenatal women had the HIV screening test together with their spouses. Therefore, there is a need to encourage the participation of male partners and close relatives in HIV counselling for emotional, psychological support and adherence to chosen infant feeding methods.

5.2.4 Main source of income and amount of income per family (items 5, 6)

This study found that many of the respondents were dependent on other people for financial support (see chapter 4, table 4.2). These respondents could be unable to make an independent decision on the infant feeding method and/or joining the PMTCT programme as they rely on other people for financial support. In addition, 48.3% (29) of the respondents had an income of P1,000 or below, which might be inadequate to provide for basic needs and other resources for preparing and storing of formula milk (see chapter 4, table 4.3). The expense of formula milk might prevent women to opt for exclusive formula feeding, thus exposing their babies to HIV, because they cannot afford to buy formula milk; fuel for boiling and refrigerators storage facilities. This may lead to mothers to use mixed feeding.

Of the respondents, 11.7% (7) cited income as a barrier to choosing formula milk feeding (item 23). These respondents might be unable to buy milk supplies or afraid of formula milk being out of stock.

In the three pilot areas in South Africa of Paarl (Western Cape), Rietvlei (Eastern Cape) and Umlazi (KwaZulu-Natal), Doherty et al (2006:93) found that mothers who had chosen formula replacement feeding ran out of formula milk supplies before the next visit and either had to buy or do without it. However, the Botswana government provides free formula milk to mothers enrolled in the PMTCT programme (Lewis 2001:5; Baggley et al 2002:55). In countries that can afford formula milk, HIV-positive mothers' decision to breast-feed defeats the WHO, IAS and UN recommendation to prevent MTCT through avoiding breast-feeding (Altman 1998:1; Newell 2004:1).

Latham and Preble (2000:1657) emphasise that the use of formula milk requires other resources like firewood for sterilisation and boiling of water, refrigerators for storage, a safe water supply and sanitation. Lack of these resources could lead to diarrhoea diseases and malnutrition, which are the leading causes of death in formula fed infants in developing countries.

None of the respondents mentioned the use of other milk feeding alternatives like fresh or processed cows or goat's milk for HIV-positive women as suggested by Dadian et al (2003:3) to prevent MTCT. This could be due to the fact that formula milk is given free to all HIV-positive mothers enrolled in the PMTCT programme.

5.3 PART B: KNOWLEDGE OF HIV TRANSMISSION THROUGH BREAST-FEEDING

5.3.1 Mode of HIV transmission (item 8)

Although the respondents were aware of general adult transmission of HIV, most did not relate it to MTCT. Of the respondents, between 53.3% and 68.3% scored moderately on MTCT of HIV during pregnancy, delivery, breast-feeding and sores on the breast (see chapter 4, figure 4.4).

However, this study found the respondents' knowledge of adult HIV transmission good compared to Masupu et al (2003:46), who found that only 39.9% gave the correct responses to the critical questions on HIV/AIDS transmission through sex, sharing utensils, razor blades and injection needles, etc. This could be because with time more information had been disseminated to the community on HIV. Also antenatal women are more exposed to health information during PMTCT counseling than none pregnant women. Thus, this finding may be different in women not attending antenatal clinics.

5.3.2 Knowledge of HIV transmission through breast-feeding (item 9)

The study found that many of the respondents did not associate HIV transmission with infant feeding methods (see chapter 4, table 4.4). This could be due to inadequate counselling on the transmission of HIV through different infant feeding methods by the

PMTCT counsellor as well as lack of reinforcement during antenatal clinic attendance by service providers. Another contributory factor could be that the majority of service providers (nurses) were not trained in PMTCT and were accordingly not confident about advising pregnant women attending antenatal clinics on MTCT. Tlou et al (2000:24) also found that respondents had little knowledge of MTCT.

The women with little knowledge of MTCT of HIV pose a risk of transmitting HIV to their unborn babies and through breast-feeding due to this poorly perceived susceptibility and the inability to make an informed decision on appropriate infant feeding methods (take appropriate action). Oguta et al (2001:47, 88) found that 98.2% of HIV-positive mothers breast-fed their infants due to little knowledge of HIV transmission through breast-feeding. In addition, this study found that mothers with increased knowledge of MTCT chose an appropriate and safer infant feeding method and considered other feeding alternatives apart from breast-feeding.

5.3.3 Understanding of infant feeding methods (item 10)

The majority of the respondents did not understand the different infant feeding methods (see chapter 4, figure 4.5) and had difficulty differentiating between “complementary” and “exclusive” (see chapter 4, figure 4.5). This meant that they did not understand perceived susceptibility, severity of transmitting HIV through infant feeding methods and might not be able to take appropriate action to prevent HIV transmission. Poor understanding of infant feeding methods may be due to inadequate counselling and reinforcement of MTCT information by counsellors and service providers. Tlou et al (2000:24) found that mothers had little knowledge of MTCT.

A poor understanding of infant feeding methods meant that the respondents could not choose an infant feeding method in view of the risk of HIV transmission. This could also mean that they did not realise their perceived susceptibility or the seriousness of HIV transmission through infant feeding methods and therefore could not take appropriate action (choose appropriate infant feeding method). Masupu et al (2002:1), Lewis (2001:1-5) and Dabis et al (2001:15) found that individuals’ knowledge of mother-to-child HIV

transmission influenced their decisions on an appropriate choice of infant feeding method and could put children's lives at risk of HIV infection.

5.3.4 Rating of the risk of HIV transmission (item 11)

The respondents poorly rated the risk of HIV transmission through different infant feeding methods (see chapter 4, table 4.5). For example, only 30% (18) correctly rated the risk of HIV transmission to be high in mixed feeding. This shows a poor understanding of the risk of HIV transmission which is in line with the findings of Long and Ankarah (1996:222), Coovadia and Coutsooudis (2001:5), who found that mixed fed babies had an increased risk of HIV transmission due to the damage of gastrointestinal tract which allow HIV entry into the blood stream. To support this finding Miotti et al (1999:1), Rutenberg et al (2003:3) also found that a large number of infants acquired HIV through breast-feeding and that the use of exclusive breast-feeding reduced the risk of HIV transmission by almost half.

5.3.5 Mode of HIV transmission in breast-feeding (item 12)

The respondents had a better understanding of HIV transmission through contaminated breast milk, with low scores on transmission through broken breast skin, cracked nipples, sores in the baby's mouth and diarrhoea. This indicated a poor association of conditions in a breast-feeding mother and baby with damage to gastro-intestinal tract, like sores in the mouth and diarrhoea (see chapter 4, figure 4.6).

Understanding the risk of HIV transmission is important. Van der Horst et al (2002:13) found that the presence of HIV ribonucleic acid (RNA) in breast milk increased the risk of HIV transmission fivefold. Coovadia and Coutsooudis (2001:7) and Essex et al 2002:564) found that HIV transmission was increased in mastitis, breast abscess, cracked nipples, fissures, sores on the breast and bleeding from the nipples. Therefore, avoidance of breast-feeding in these conditions reduced the risk of HIV transmission. In addition, Newell (2004:15) states that conditions that damage the gastro- intestinal tract, like oral thrush and gastroenteritis, also increase the risk of HIV transmission. This could result from feeding with cow's milk, allergic reactions to complementary feeds, and infection.

Poor association of these conditions in antenatal women may lead to poor perceived susceptibility, perceived severity and ability to take appropriate action due to poor understanding of the appropriate feeding methods and dangers of feeding in those conditions. Brown (1999:1) states that individuals' perceived susceptibility, severity and ability to take appropriate behaviour motivate individuals to take preventive measures/behaviour in a situation (HIV).

5.3.6 Respondents' knowledge of preventive measures of HIV transmission during breast-feeding (items 13, 14)

The respondents had a better understanding of preventive measures for MTCT, including avoidance of breast-feeding, use of formula milk, use of antiretroviral drugs in the pregnant woman and child (see chapter 4, table 4.6). This means that the respondents had the necessary information on the preventive measures but did not understand the risks associated with different infant feeding methods. Therefore, they could choose the wrong infant feeding method, which might put the babies at risk of HIV transmission. Socio-economic factors, social support systems, stigmatisation and discrimination also influenced the choice of infant feeding method.

Coovadia and Coutsoodis (2003:1, 3, 7), Rutenberg et al (2003b:3) as well as Jimenez et al (2004:9) found that the use of formula milk feeding and antiretroviral drugs in the pregnant woman and the baby reduced the risk of HIV transmission. The other methods that could be used are; nursing mother, heat treatment, expression of colostrums, cows or goats milk, which were not mentioned by any of the respondents in this study. The other factors which may influence the choice of infant feeding method are; socio economic, socio support system stigma and discrimination.

5.3.7 Family members association of formula milk with HIV status (item 15)

The study found that, a large number of people associate formula milk feeding with HIV positive status (see chapter 4, table 4.7). Thus, it is perceived that the choice of formula milk reveals ones HIV status, which may act as a barrier to individuals who want to

maintain confidentiality. This shows that stigma and discrimination is a strong barrier towards individual's ability to take appropriate action.

5.4 PART C: FACTORS THAT INFLUENCE CHOICE OF INFANT FEEDING METHOD

5.4.1 Number of children born to respondents (item 16)

Of the respondents, 50% (30) had other children and 50% (30) were pregnant for the first time (see chapter 4, table 4.8). This meant that half the group may have been exposed to pre-test counselling and taught about HIV/AIDS at the maternal and child health services and counselling centre. Thus, the respondents who were previously exposed to information on MTCT might have been better equipped and able to make an informed decision on an infant feeding method.

5.4.2 Previous baby's feeding method (item 17)

The majority of the respondents had used complementary breast-feeding to feed their previous babies (see chapter 4, table 4.8).

5.4.3 People who influenced choice of infant feeding method (item 18)

The majority of the respondents stated that they made an independent decision on choice of infant feeding method (see chapter 4, table 4.9). However, there was a very small margin between the respondents' choices and the family members' expectations. This indicated that the family members'/social support systems' expectations greatly influenced the choice of infant feeding method. This could act as a barrier as pregnant women might be unable to take appropriate action for fear of offending relatives' expectations especially those of the husband and the in-laws.

Muko et al (2004:137) found that the majority of respondents chose breast-feeding due to the strong influence of the social support system. Seidel et al (2000:1) found that some mothers who had chosen formula milk feeding could not easily do so as close relatives insisted on breast-feeding. Therefore, all HIV-positive pregnant women should be

counselled on infant feeding methods and be supported by health personnel in their choice to ensure adherence to the chosen method.

5.4.4 Planned feeding methods for the expected baby (item 19)

Of the respondents, 73.3% planned to use complementary breast-feeding and 16.7% (5) chose exclusive breast-feeding (see chapter 4, table 4.10). These findings indicated that the WHO and UN's recommended exclusive breast-feeding to reduce the risk of HIV transmission was not a popular feeding method.

Shapiro et al (2005:7-10) and De Paoli et al (2001:313, 315, 318) found that exclusive breast-feeding was rarely practised and was poorly adhered to due to cultural norms that encouraged mixed feeding and breast-feeding.

5.4.5 Respondents' reasons for choice of infant feeding (item 20)

The study found that of the respondents, 78.3% (47) planned to use the infant feeding method based on nutrition and the risk of HIV transmission. This showed that the mothers valued breast-milk and were aware of the risk of HIV transmission during breast-feeding, and also had perceived susceptibility of transmitting HIV through breast-feeding.

5.4.6 Cultural beliefs on feeding methods (item 21)

Of the respondents, only 11.6% (7) expressed harmless cultural beliefs related to breast-feeding, which meant that the norms, cultural values and beliefs were not barriers to their choice and use of the chosen infant feeding method.

5.4.7 Religious beliefs (item 22)

Only a few respondents had religious beliefs related to breast-feeding and there were no harmful beliefs.

5.4.8 Influence of income on choice of infant feeding method (item 23)

Of the respondents, only 11.7% (7) could not choose formula milk because of financial constraints (item 23). This could be because formula milk is provided free of charge to all mothers who join the PMTCT programme.

5.4.9 Family members' expectations of chosen of infant feeding method (item 24)

The majority of the respondents' family members expected them to use complementary and exclusive breast-feeding (see chapter 4, table 4.14).

5.4.10 Family members' reasons for choice of infant feeding method (item 25)

The majority of the respondents' relatives chose an infant feeding method because it was cheap, readily available and was nutritious for the baby rather than considering the risk of HIV transmission. The choice of infant feeding methods other than the family members' preference could lead to poor social support. Thus, the social support system might insist on a method that could increase the risk of HIV transmission. Therefore, there is a need to educate the community/public on the risk of HIV transmission through infant feeding methods.

5.4.11 Stigmatisation and discrimination (items 26, 27)

Items 26 and 27 explored stigma and discrimination associated with infant feeding methods. Of the respondent, 72% (43) felt that their relatives would reject or enquire about the use of formula milk (item 26). This meant that women might feel obliged to disclose their HIV-positive status even if they would like to keep it confidential. Thus, individuals not willing to disclose their HIV status might breast-feed as a way of keeping their HIV status from being known. Stigmatisation and discrimination or non-supporting relatives and guardians could act as barriers to taking appropriate action (choice of safer infant feeding methods). In addition, 35% (21) of the respondents expressed the need to maintain privacy and confidentiality in distributing formula milk (item 27). The clinics should develop a

system to distribute formula milk without clients being seen to avoid stigmatisation and discrimination.

Limson (2001:1) found that, due to stigmatisation and discrimination, HIV/AIDS is treated with great secrecy and confidentiality in societies. Rutenberg et al (2003b:26) and Chopra et al (2002:301, 304) also found that HIV-positive mothers found it difficult to explain the reasons for not breast-feeding. But those who had disclosed their HIV status received support from family members and adhered to the chosen infant feeding method. Willumsen and Rollins (2001:32) found that some mothers' abandoned formula milk supplies at the clinics, preferring to buy formula milk from the shops, and some mothers who had chosen replacement formula milk feeding, breast-fed in public places for fear of stigmatisation and discrimination.

Seidel et al (2000:1) and Muko et al (2004:137) found that HIV-positive mothers who had chosen formula milk feeding were laughed at, and physically abused by close relatives who insisted on breast-feeding and it is for this that many HIV-positive mothers chose breast-feeding for fear of stigmatisation and discrimination.

In order to reduce stigmatisation and discrimination, it is necessary and urgent to continue disseminating information to the community on HIV and PMTCT. The community mobilisation groups should continue to educate the public about the disease and encourage individuals to test and HIV-positive individuals to go public about the disease or HIV-positive status. These could include public figures like politicians, sportsmen so that the public understands that the disease can affect anybody and there is no need to attach stigma or discriminate against HIV/AIDS individuals.

5.5 PART D: SOURCES OF INFORMATION ON HIV AND BREAST-FEEDING (ITEM 28)

The study found that there was an adequate flow of information from various sources, including friends, pamphlets, radio, television, the internet, the PMTCT, and PMTCT Newsletter (item 28). The fact that friends were the main source of information meant that there was a need to teach the community, especially women of child-bearing age, about

MTCT and appropriate infant feeding methods so that they pass on correct information. Thus education programmes need to be designed to cover secondary schools and meeting places for women, such as hospitals, maternal and child health services and community groups where many women of this age meet. This would allow the reproductive age group to acquire correct and appropriate information on MTCT, which could then be passed on to friends.

NACA and CSO (2004: 64) found that information on HIV/AIDS was mainly acquired through the radio (61%) and television 39%. In addition access to information through television increased from 39 to 66%, possibly because the study was done in the city where more people had access to television.

5.5.1 Participation in the PMTCT programme (item 29)

The PMTCT programme plays a vital role in the transmission of information on MTCT. Of the respondents, only 56.7% (34) participated in the PMTCT programme despite the fact that all pregnant women were encouraged to go for pre-test counselling or join the programme. This could be due to fear of knowing one's HIV status or of stigmatisation and discrimination.

Trained counsellors should conduct pre- and post-test counselling on HIV and infant feeding methods for all outpatients and pregnant women attending antenatal clinics. The counsellor should attend to all clients in the clinic requiring HIV counselling. The PMTCT counsellors should also conduct infant feeding counselling during pre- and post-test counselling on HIV. This particular time may not be psychologically good as the clients may be concentrating on and worried about the outcome of the HIV test results. PMTCT untrained nurses/health workers may not be able to reinforce and support the pregnant women attending antenatal clinics on PMTCT while providing health services. Therefore, there is a need to train more nurses/service providers on PMTCT counselling.

5.6 LIMITATIONS

The following limitations were identified in the study:

- The researcher had planned to use random sampling but the clinical situation did not allow that method to be implemented. Therefore, convenience sampling was used, which limits the generalisability of the results.
- The researcher had to explain the terms “complementary” and “exclusive” feeding methods after the interview because the respondents lacked information on these terms. This could have influenced their responses.
- Because of the limited scope of this study a small sample of 60 respondents was used, therefore the findings cannot be generalised to the population.

5.10 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for improving knowledge of HIV transmission through breast-feeding.

5.10.1 Improved knowledge of HIV transmission through breast-feeding

To improve public knowledge of HIV transmission through breast-feeding:

- Educational programmes should be launched in all the clinics and communities on methods of HIV/AIDS transmission during pregnancy and breast-feeding to improve awareness and reduce stigmatisation and discrimination. This might also improve adherence to and appropriate choice of infant feeding methods.
- Antenatal women should be encouraged to come to the clinics with their spouses/partners or close relatives on the first antenatal visit to promote male involvement and provision of social and emotional support as well as adherence to chosen feeding methods.
- All HIV positive pregnant women should be counseled on child feeding methods and be supported by health personnel on their choice to ensure adherence to the chosen method.

5.10.2 Nursing practice

To improve nursing practice:

- Formula milk issuing should be done in consulting rooms or the counsellor's room to maintain privacy and confidentiality, prevent unintentional disclosure of individuals' HIV status, and avoid stigmatisation and discrimination.
- The adequacy of counselling on infant feeding methods should be investigated and reinforced by service providers/nurses attending to women in the antenatal clinics.
- Women attending antenatal clinics should be encouraged to bring their spouses, partners or significant others during the initial antenatal clinic visit when pre-test counselling is done.
- Nurses/ service providers should be trained on PMTCT in order to offer continuous counseling, emotional and psychological support to pregnant women in the antenatal clinics who choose formula milk feeding. This can be done through in service trainings, workshops or seminars.
- All HIV-positive pregnant women should be counselled on infant feeding methods and be supported by health personnel on their choice to ensure adherence to the chosen method.
- In order to reduce stigmatisation and discrimination, the community should be educated on HIV and PMTCT. This can be done through community mobilisation groups that should continue to encourage individuals to test and those who are HIV positive (e.g., public figures like politicians, sportsmen, celebrities) to go public about the disease or HIV-positive status.

5.10.3 Nursing education

- With regard to nursing education, the nursing curriculum should continuously be updated on PMTCT so that the new graduants will be kept abreast of the new development on PMTCT issues.

5.11 FURTHER RESEARCH

Further research should be conducted on the following topics:

- An observational study to determine the amount of counselling and support on PMTCT required during a normal antenatal clinic session by both trained and non-trained PMTCT service providers to establish the need to train health workers in PMTCT.
- An investigation into the adequacy of the information given during the pre-test and post-test counselling sessions on the risk of HIV transmission through infant feeding methods and the reinforcement by other clinic health workers/service providers should be conducted.
- An investigation into the stigma and discrimination associated with infant feeding methods.
- Assessment of pregnant women's knowledge of HIV transmission through infant feeding practices in other parts of the country to improve the generalisability of the findings.

5.12 REDUCTION OF HIV TRANSMISSION THROUGH BREAST-FEEDING

In order to achieve the overall aim of the study, the researcher is of the opinion that the Ministry of Health should ensure that health care professionals are made aware of the women's knowledge of HIV transmission through breast-feeding, by disseminating the findings of studies on this topic through workshops, seminars or in-service training. Ongoing education of health care professionals in developments in PMTCT should be done through periodic evaluation of the knowledge and skills of the health care providers and in-service training, seminars or workshops.

- Measures should be put in place to improve health education being provided on MTCT HIV transmission through breast-feeding to target the whole population, with special emphasis on women of child-bearing age (15-45 years), to increase their knowledge of HIV transmission through infant feeding methods. More health care

- professionals should be trained in counselling to inform women of HIV transmission through breast-feeding. Health care providers should provide culturally sensitive counselling on breast-feeding and increase acceptability of infant feeding methods.
- The media should disseminate health information on MTCT to bring about positive behaviour changes in women regarding HIV transmission. The community should be involved in HIV/AIDS programmes to improve levels of knowledge and reduce stigmatisation and discrimination. This could include the formation of HIV/AIDS support groups, community mobilisation groups and peer education programmes.

5.13 CONCLUSION

HIV/AIDS poses a major public health problem, and MTCT is the primary source of HIV infection in children under 15. In Botswana, there is a high rate of HIV-positive women, which represents babies at risk of acquiring HIV from their mothers through pregnancy, delivery and breast-feeding. Individuals' knowledge of MTCT of HIV influences their decisions on an appropriate choice of infant feeding method and could save the lives of children at risk of HIV infection.

This study wished to describe and explore whether the knowledge of MTCT of HIV through breast-feeding and of preventive measures on HIV/AIDS was associated with the choice of safer infant feeding methods. The aim of the study was eventually to propose strategies to promote the reduction of HIV transmission from mother to child through breast-feeding. The purpose of the study was to explore the knowledge that women attending antenatal clinics have on the transmission of HIV through breast-feeding.

The study provided information on the knowledge that women attending antenatal clinics have of the PMTCT of HIV. The findings should assist in the preparation of patient and community education programmes on matters relating to the prevention of mother-to-child HIV transmission through breast-feeding. Health workers can use the information gained to render client-centred care and counselling, with particular attention to the stigma inherent in HIV/AIDS diagnosis. The results should assist the Ministry of Health to introduce measures and reinforce existing policies and strategies on breast-feeding and supply of formula milk feeds.

5.14 FINAL COMMENT

The decision of HIV positive women to choose appropriate infant feeding method depends on perceived susceptibility and perceived severity of HIV transmission through the infant feeding methods. Therefore this study found that women attending antenatal clinics had moderate understanding of HIV transmission through infant feeding methods. The poor rating of HIV transmission through different infant feeding methods calls for strategies to be put in place to improve this anomaly. It is also believed that the study will assist health care providers to identify the areas where antenatal women lack information as improvement of these areas may lead to reduced MTCT and improve PMTCT services.