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Counsellors' Perspectives on Antenatal HIV Testing and Infant Feeding Dilemmas Facing Women with HIV in Northern Tanzania

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Abstract This study investigated the infant feeding advice that counsellors were giving HIV-infected pregnant women in Moshi, Tanzania, the factors they thought had an impact on women's infant feeding choices and their role in influencing these decisions. The data are drawn from in-depth interviews with 16 nurses working as counsellors in their spare time in an antenatal trial of prevention of mother-to-child transmission, five local HIV/AIDS counsellors and two medical doctors, whose counselling experience ranged from less than six months to nine years. Informed choice of infant feeding method by HIV-infected women, as recommended by UNAIDS/WHO/UNICEF Guidelines, was seriously compromised by the actual advice given, directive counselling, lack of time to cope with a positive HIV test result, and lack of follow-up support, regardless of socio-economic status. Infant feeding options were not always accurately explained, but counsellors believed most women had little choice but to breastfeed and were unlikely to exclusively breastfeed, despite advice. It was apparent that the risks and benefits of the options open to HIV-infected women were complicated for the counsellors, not only the women. Counsellors needed additional training in non-directive counselling and infant feeding options to ensure a better quality of advice-giving and support to follow-up women at home.

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Keywords: mother-to-child-transmission of HIV; breastfeeding; infant feeding; HIV/AIDS; counselling; Tanzania

MOTHER-TO-CHILD transmission of HIV is an urgent and growing problem in resource-poor settings. It has been estimated that with no preventive measures taken, the risk of transmission in sub-Saharan Africa is 21–45% [1], with breastfeeding accounting for at least a third of that risk [2]. Voluntary counselling and testing (VCT) for HIV are recommended during pregnancy [3] so that, among other reasons, women can be offered antiretroviral drugs and infant feeding advice. Guidelines on breastfeeding and HIV prepared by UNAIDS, WHO and UNICEF in 1998 promote fully informed choice of infant feeding method for HIV-positive mothers (Box 1) and recommend that breastfeeding should continue to be protected, pro-

moted and supported among HIV-negative mothers and among mothers of unknown HIV status [4].

However, studies in resource-poor settings have identified constraints and barriers for pregnant mothers who are offered VCT antenatally [5–7], and the best infant feeding method in these settings for infants of HIV-positive mothers is still being debated. A Kenyan randomised trial comparing breastfeeding with formula feeding found that breastfeeding approximately doubles the rate of infection in infants [8]. Exclusive breastfeeding was shown to reduce the risk of HIV transmission compared to mixed feeding in one observational study in South Africa [9,10]. Nicoll and colleagues argue that breastfeeding is a significant factor in the

Box 1. UNAIDS/WHO/UNICEF Guidelines for Preventing MTCT [21]

- Early access to adequate antenatal care.
- Voluntary and confidential counselling and HIV testing for women and their partners.
- A short course of perinatal antiretroviral treatment (AZT) given to HIV positive women in the last weeks of pregnancy through delivery (and possibly also to their newborn infants).
- Improved care during labour and delivery.
- Counselling for HIV-infected pregnant women should include the best available information on the benefits of breastfeeding, the risk of HIV transmission through breastfeeding and the risks and possible advantages of alternative methods of infant feeding.
- Support for HIV-infected mothers who choose not to breastfeed, to enable them to use breastfeeding replacements safely, without violating the International Code of Marketing of Breast Milk Substitutes and related resolutions of the World Health Assembly.

53 transmission of HIV to infants, but that formula
54 feeding is rarely appropriate for most infants in re-
55 source-poor settings, regardless of whether or not
56 they are exposed to HIV infection [11]. It has been
57 argued that the promotion of exclusive breastfeeding
58 for the general population would have numer-
59 ous positive effects in addition to possible
60 reduction of HIV in infants [12–14]. The concept
61 of “safer breastfeeding practices” has been intro-
62 duced for this reason (Box 2) [14–16]. Several stud-
63 ies have demonstrated that it is possible to support
64 women to exclusively breastfeed [17–20].

65 In Tanzania breastfeeding is universal and pro-
66 longed partial breastfeeding is widely practised
67 [22,23]. According to the Tanzania Demographic
68 & Health Survey 1996, the median duration of
69 breastfeeding was 21.6 months nationally and
70 22.6 months in the Kilimanjaro region [24]. In a
71 prior study in the Kilimanjaro region we found that
72 few infants were exclusively breastfed and the ben-
73 efits of exclusive breastfeeding by HIV-positive
74 mothers were being questioned by pregnant women
75 [25].

76 For prevention of mother-to-child transmission
77 (PMTCT) of HIV to be successful, it is important to
78 have skilled counselling to provide guidance and

help HIV-infected women make choices appropriate 79
to their situation and to which they can adhere. It 80
has been suggested that many weaknesses exist in 81
the counselling currently being provided by most 82
PMTCT programmes, and that resources should be 83
invested to address these [26]. A number of studies 84
have investigated women’s attitudes towards VCT, 85
existing barriers and choice of infant feeding meth- 86
od [7,27–30]. However, only a few studies have de- 87
scribed counsellors’ perceptions and examined how 88
effective they are at conveying the complex issues 89
involved in VCT [31,32]. 90

The purpose of this study was to investigate how 91
HIV/AIDS counsellors perceived the dilemmas that 92
HIV-infected women face when making decisions 93
about infant feeding options. Specifically, we in- 94
vestigated: 95

- the kind of infant feeding advice that counsellors 96
give HIV-infected women, 97
- the factors that counsellors think will affect wo- 98
men’s feeding decisions, 99
- counsellors’ perceptions of the feasibility of im- 100
plementing the WHO/UNAIDS/UNICEF Guide- 101
lines on breastfeeding and HIV, and 102

Box 2. Safer Breastfeeding Practices [14–16]

- Exclusive breastfeeding for 4–6 months, followed by rapid weaning.
- Reducing the duration of breastfeeding.
- Proper positioning and latching during breastfeeding.
- Practising safe sex during breastfeeding period.
- Seeking medical care immediately for breast problems or when babies have mouth problems (e.g. oral thrush).
- Avoiding breastfeeding from bleeding or fissured nipples.
- Providing post-natal antiretroviral prophylaxis to the infants.
- Heat treatment of breastmilk (especially when other foods are introduced).

103 • counsellors' perceptions of their own role vis-à-vis pregnant women.
104

105 **Participants and methods**

106 The participants recruited for this study were all
107 16 of the HIV/AIDS counsellors who had been
108 trained in 1999–2000 specifically for a PMTCT trial
109 in Moshi, the regional capital of an urban district of
110 the Kilimanjaro region. We also included five local
111 HIV/AIDS counsellors and two medical doctors with
112 different training backgrounds, who had been
113 working with HIV VCT for many years (Table 1).
114 All but two participants were from the Kilimanjaro
115 Christian Medical College (KCMC), while the two
116 were from the Kilimanjaro Women's Group against
117 AIDS, a local NGO [33] collaborating with KCMC in
118 the ongoing PMTCT trial. Only one was a man,
119 which reflects the gender balance among HIV/AIDS
120 counsellors locally. In this paper we will refer to all
121 23 participants as "counsellors".

122 The data presented are drawn from in-depth in-
123 terviews with these counsellors. One counsellor
124 functioned as the main informant and outcomes
125 from each interview were discussed with her. She
126 was interviewed twice, the second time in order to
127 summarise and clarify the findings at the end of
128 the study. The interviews were mainly conducted
129 in Kiswahili. English was used only when the in-
130 terviewer (the first author) lacked sufficient Kiswahili
131 to express herself.

132 Each participant signed a statement giving in-
133 formed consent, and for the analysis each was given
134 a fictitious name, used also in this paper. Ethical
135 clearances and research permission were obtained
136 from the Tanzanian National AIDS Control Pro-
137 gramme, the Ministry of Health, the Tanzanian
138 Commission for Science and Technology, the Tan-
139 zanian Food and Nutrition Centre, the KCMC Ethical
140 Research Committee and the Norwegian
141 Committee for Medical Research Ethics.

142 A semi-structured interview design was em-
143 ployed to allow the sensitive area of HIV transmis-
144 sion to be discussed as openly as possible. The
145 interview guide covered a broad range of topics
146 and allowed for additional questions on emerging
147 themes. A continuous validation process took place
148 whereby emerging themes were included in subse-
149 quent interviews and discussed with one main in-
150 formant; this has improved the validity of the
151 findings. The interviews ranged in length from 45

Table 1. Characteristics of participants (n = 23)

Characteristic	No
Age	
20–29	
30–39	2
40–49	
50–59	8
60–69	2
Marital status	
Single	8
Married/co-habiting	12
Co-habiting	2
Divorced	1
Breastfeeding experience^a	
Yes	19
No	3
Occupation	
Nurse	21
Doctor	2
Counselling training	
– 1–2 weeks general training + PMTCT sensitisation-1-2	7
– 1–2 weeks general training + 4 weeks PMTCT training	2
– 1–2 weeks general training + 8 weeks PMTCT training	1
– 4–8 weeks PMTCT training + 2 weeks breastfeeding course	3
– 4 weeks PMTCT training	5
– 8 weeks PMTCT training	3
– 1 year on-going training including supervision + 4 weeks PMTCT training	2
Work experience	
0–5 months (PMTCT only)	11
1–5 years (VCT)	3
6–9 years (VCT)	9

^a Excluding the male counsellor.

minutes to two hours. The field work was conducted
from August 2000 through January 2001.

The interviews were tape-recorded, transcribed
and coded using the qualitative programme Open
Code [34]. Emerging and recurrent themes were
identified, and views in agreement with or opposi-
tion to these themes were juxtaposed to determine
the extent to which particular themes were present
or absent in the accounts of other respondents [35].

161 **Study site**

162 Infant mortality in the Northern Highlands, of
163 which the Kilimanjaro region is a part, was reported
164 to be 41 per 1000 live births in 1996 and the under-
165 five mortality rate 69 per 1000 live births [24]. In
166 Moshi, the HIV sero-prevalence of pregnant women
167 attending antenatal clinics was reported to be 20%
168 in 1998, three times higher than in 1992 [36].

169 KCMC is one of five hospitals in Tanzania that
170 since 1999 has been involved in a UNICEF-funded
171 VCT and PMTCT trial. All of the staff at this site
172 were said to have gone through awareness-raising
173 workshops on PMTCT issues. Guidelines for the in-
174 tegration of PMTCT at these sites include VCT, ob-
175 stetric care and monitoring and evaluation [37-
176 39]. Guidelines on infant feeding specifically for
177 HIV-infected women in Tanzania were also devel-
178 oped with support from UNICEF [40]. At KCMC
179 the VCT consisted of one pre-test counselling ses-
180 sion, HIV testing and one post-test counselling ses-
181 sion for women who test HIV positive, including
182 infant feeding advice. Rapid on-site HIV testing
183 was used and confirmed by Western Blot if the re-
184 sult was positive or indeterminate. Results were
185 available the same day. A short course of zidov-
186 dine was provided for HIV-infected mothers ante-
187 nally (weekly from 36 weeks) and during labour.
188 Modified obstetric care and advice on infant feed-
189 ing were also provided. The infant feeding method
190 recommended for HIV-infected women were exclu-
191 sive breastfeeding with abrupt weaning, modified
192 cow's milk or formula feeding. HIV-infected moth-
193 ers giving birth at KCMC who opted for infant for-
194 mula were given supplies only while at the clinic.

195 Monitoring of HIV-infected infants, infection
196 rate and follow-up of zidovudine adherence were
197 in the protocol, but depended on partners returning
198 for postpartum care at KCMC. Male partners were
199 also offered VCT, and this was especially recom-
200 mended if the woman had HIV. We used the com-
201 ponents of this trial as a point of reference for the
202 interviews. However, our study was not designed
203 to evaluate the training of the counsellors recruited
204 for the PMTCT trial or any other component of the
205 PMTCT trial.

206 In the following pages, we have combined pre-
207 sentation of the results of the study with discussion
208 of their meaning and implications.

The "good counsellor"

209

210 Counselling can be defined as a directive process
211 of helping someone to accept and use information,
212 and give advice for solving or coping with a prob-
213 lem, or as a non-directive process of helping some-
214 one make a decision and plan how to solve or cope
215 with a problem [41].

216 Proper counselling and support for HIV-infected
217 mothers is crucial [42,43], but is regarded as prob-
218 lematic at most PMTCT sites [16]. The counsellors in
219 this PMTCT trial were nurses on different wards in
220 the hospital, working as counsellors on their days
221 off for a small sum of money. Most of the PMTCT
222 counsellors had had only four weeks of training
223 for this work, 11 of the 16 had been doing PMTCT
224 counselling for less than five months, one of them
225 had less than five years of experience with VCT,
226 while four of them had six to nine years of experi-
227 ence (Table 1). They reported job related stress, in-
228 cluding a heavy and mentally demanding
229 workload, an off-duty time, an unpredictable client
230 flow and long hours.

231 According to the counsellors, most of the women
232 offered VCT (70-80%) agreed to be tested for HIV.
233 They believed that their main role was to prepare
234 women for HIV testing and receiving the results.
235 They felt that the most important personal qualities
236 needed for the job were to be sensitive, non-judg-
237 mental, self-sacrificing and understanding. On the
238 one hand, they saw their role as not imposing their
239 own values on women. On the other, they com-
240 monly described a "good" counsellor as one able
241 to convince pregnant women to "do what the coun-
242 sellor wants" and accept VCT, and a "bad" counsel-
243 lor as one with whom many women refused VCT.
244 Several counsellors regarded it as a failure if they
245 could not convince the pregnant woman to have
246 an HIV test and disclose her status, and some de-
247 scriptions of "counselling" appeared to contain a
248 coercive element:

249 *"You give the woman a choice but you tell her that*
250 *the best she can do is to be tested. When I do pre-test*
251 *counselling and she disagrees, I encourage her to be*
252 *tested until she agrees"* (Gloria)

253 *"The HIV-infected mothers often tell me that they*
254 *would not like to disclose their status to husbands.*
255 *In that situation the only thing I can do is to con-*
256 *tinue to advise her until she agrees to disclose her*
257 *status."* (Halima)

258 “It is necessary that the counsellor is understanding
259 and has the knowledge to convince the mother until
260 she agrees to be tested for HIV. A counsellor will
261 know she has succeeded in her work when the wo-
262 man has agreed to be tested.” (Jessie)

263 Williams et al. express doubts about non-direc-
264 tive counselling and conclude that the boundary
265 between choice and coercion is not clear-cut for
266 many practitioners [44]. Although the counsellors
267 showed understanding as to why a pregnant woman
268 would choose not to be tested, this empathy was
269 lost in the face of their own interest in being suc-
270 cessful.

271 Two counsellors with more education and train-
272 ing in counselling issues were concerned about the
273 inadequacy of the support given to women in the
274 trial:

275 “We are giving the mother a big burden to carry.
276 Finding out that she is HIV-infected is like an earth-
277 quake, and changes her life. There is often pressure
278 to disclose her status to her partner.” (Adrophina)

279 “Pregnant mothers should be better prepared. They
280 come to the antenatal clinic for one problem (preg-
281 nancy), and they may leave with a different prob-lem
282 (HIV-infection) ... without knowing if they will get
283 any support at home.” (Irene)

284 The meaning of informed consent is uncertain if
285 women have had no time to consider what to do if
286 they turn out to be HIV positive. Research in an

Tanzania also suggests that disclosure should not 287
be regarded as a one-time event, but rather as a 288
process of decisions [45] which cannot all be taken 289
in one session. Our findings support this conclusion 290
that a one-time pre-counselling session may not be 291
sufficient for pregnant women who visit an antena- 292
tal clinic, unaware that VCT will be offered. 293

294 These counsellors gave most of their attention to
295 the HIV-positive women. The time seemed to be
296 spent advising uninfected women on how to pre-
297 vent infection, the higher risk of transmitting HIV
298 to a nursing child if a woman is infected during
299 pregnancy or the breastfeeding period, or the feasi-
300 bility of demanding safe sex. For those who were
301 not infected, post-test counselling can be summar-
302 ised as:

303 “Congratulations! Now go home and demand safe
304 sex! Goodbye!”

To breastfeed or not? 305

306 UN-supported infant feeding advice for women
307 with HIV is shown in Box 3. Most of the counsellors
308 believed that women who decided not to breastfeed
309 risked the stigmatisation of being identified as HIV-
310 infected. This was given as a major reason why
311 many of the HIV-infected women decided to breast-
312 feed.

313 “If the neighbours find out that you are not breast-
314 feeding, they will suspect that you are HIV-infected.”

Box 3. Infant Feeding Methods

Commercial infant formula The UNAIDS/UNICEF/WHO Guidelines list commercial infant formula as the first recommended feeding alternative for HIV-infected mothers who choose not to breastfeed. Other options are:

Home-prepared formula of cows milk where the milk is diluted by mixing 100 ml of milk + 50 ml water + 2 teaspoons sugar and the mixture is boiled. The infant will need 150 ml per kg of body weight per day and feeding should be done using a cup. Micronutrient supplementation is recommended because animal milk may have insufficient zinc, iron, vitamins A and C and folic acid.

Exclusive breastfeeding is defined as breastfeeding in the absence of all other fluids and solids and is recommended for up to six months of age, during which time breastmilk alone can satisfy all the infant’s nutritional and fluid needs. Drops or syrups containing vitamins, mineral supplements or medicines can be given in addition to breastmilk. + **Abrupt weaning** hinges on the theory that the reason why mixed feeding is associated with the highest rates of MTCT of HIV is because other foods in some way damage the infant gut epithelium which thus promotes the establishment of HIV infection if infected breastmilk is ingested at the same time.

Expressed and heat-treated breastmilk Heat treatment of expressed breastmilk will kill HIV in the milk. To pasteurise the milk, it should be heated to 62.5 degrees C for 30 minutes. Or it can be boiled and then cooled immediately, by putting it in a refrigerator or standing the container in cold water.

315 *That will have a lot of consequences in most com-*
 316 *munities.” (Elibariki)*

317 Another major reason cited for breastfeeding
 318 was poverty, i.e. lacking the means to buy cow’s
 319 milk or milk powder. Therefore, only women who
 320 could disclose their status to their husbands and
 321 whose husbands had the money, could choose an
 322 alternative to breastfeeding. Since most women
 323 were both socially and economically dependent
 324 on men, the counsellors regarded the involvement
 325 of men as crucial but complicated.

326 *“If she does not disclose her status to her husband,*
 327 *where will she get support and what will she buy*
 328 *milk with?” (Jessie)*

329 *“Many women are scared, especially those who do*
 330 *not have their own source of income. They know*
 331 *that they will get no help if they are isolated, re-*
 332 *jected or sent away.” (Zainabu)*

333 *“The thing is, even if the HIV-infected woman has*
 334 *been given advice and knows how the virus is trans-*
 335 *mitted and what to do, she tells me that she cannot*
 336 *tell anybody... So you see, we are talking to the one*
 337 *with the least power, the bread-winner for the child*
 338 *who has the infected milk. But you see, it is very of-*
 339 *ten the only little thing she has to enable the child to*
 340 *survive. Very little power to decide on her own po-*
 341 *erty, yet a responsibility to take care of the family.*
 342 *What little the husband has is diverted to drinking*
 343 *and after he drinks, he is the most powerful person.*
 344 *So we may be talking to the wrong person.” (Elibariki)*

345 The counsellors realised that HIV-infected moth-
 346 ers had to make plans in order to take care of all
 347 contingencies and often to hide the truth.

348 *“I realised that this mother would have problems if*
 349 *she was not breastfeeding. The mother herself said*
 350 *that she would need time to plan what to do and*
 351 *where to go if she disclosed her HIV-status and*
 352 *her husband threw her out. If he decides to throw*
 353 *me out now, I will not know where to go with my*
 354 *child, and where will I deliver? It will be very diffi-*
 355 *cult, and I will not get any food.’ After listening to*
 356 *her, I decided that it was best for her to deliver first.*
 357 *Maybe she could tell the husband that she was HIV-*
 358 *infected before she had given birth.” (Zainabu)*

Thus, breastfeeding was seen as the only possible
 option for the majority of the women.

“Oh, this trial is not for the housewives or the rural
women. The target is the educated women with eco-
362 nomic means because they have money and educa-
 363 *tion; it will not be a problem for them. When you*
 364 *counsel them and give them infant feeding advice,*
 365 *they will understand and they can afford it. So far*
 366 *I have not counselled any poor HIV-infected woman*
 367 *who decided not to breastfeed her infant.” (Zai-*
 368 *nabu)* 369

“There are a minority, only those with permanent
 370 *jobs, who can afford to practise an infant feeding*
 371 *option. But they are not really typical. That means*
 372 *we are targeting a minority who are able to take*
 373 *our advice, and disregarding the majority, who are*
 374 *not able to afford the substitutes. This is a form of*
 375 *discrimination.” (Elibariki)* 376

Most of the counsellors assumed that those who
 chose an alternative to breastfeeding also had all
 the necessary knowledge, skills and domestic fac-
 379 ilities to prepare the milk in a safe and hygienic way. 380

“If the mother does not breastfeed her child, feeds it
 381 *cows’ milk, dilutes the milk according to the in-*
 382 *structions and has clean utensils... then there is*
 383 *no problem.’ (Annie)* 384

On further probing, however, the same counsel-
 385 lor added: *“Some will manage, and some will not*
 386 *manage. A minority will manage.”* 387

Exclusive breastfeeding 388

Most of the counsellors realised that the infant
 389 feeding advice could be difficult to implement, es-
 390 pecially in rural settings. In this region, mothers-
 391 in-law are very respected, and it was considered a
 392 dilemma to oppose them by not breastfeeding. In-
 393 deed, there was a consensus among the counsellors
 394 that exclusive breastfeeding was the best option for
 395 HIV-infected women, even though most mothers
 396 were thought only to partially breastfeed. Accord-
 397 ing to the counsellors, although the majority of
 398 HIV-infected mothers who received counselling
 399 said they would practise exclusive breastfeeding,
 400 it was questionable whether they would do so, not
 401

402 least because of common beliefs about the necessity
403 of giving water to infants.

404 *“Although most mothers say that they will practise
405 exclusive breastfeeding, it may not be true. Let’s
406 think about it! The poor HIV-infected mother says
407 that she will practise exclusive breastfeeding, be-
408 cause she has no money to buy cow’s milk or milk
409 powder. But what about her own nutrition? Is she
410 healthy enough to produce all that milk? It can be
411 difficult to breastfeed. That’s what I mean when I
412 say we are only singing theory when giving ad-
413 vice.”* (Edith)

414 *“Even though we are teaching them about exclusive
415 breastfeeding, really, in my opinion, based on my ex-
416 perience, there is no one who will resist and not give
417 the child anything other than breastmilk for the first
418 four months! No one! What we teach the mothers is
419 something very different from what they prac-
420 tise.”* (Gloria)

421 *“It is a common belief that water is necessary for
422 quenching thirst.”* (Zainabu)

423 *“Many of them believe that if you only breastfeed
424 the infant it will cause a hard stool and that water
425 will prevent constipation.”* (Edith)

426 *“The mothers don’t know what to do when their
427 child is crying a lot. Most of the time a child is cry-
428 ing for the breast, but they will give water because
429 they believe that their milk is not suffi-
430 cient.”* (Irene)

431 Many of the counsellors reported that mothers
432 questioned the safety of exclusive breastfeeding.
433 However, a few were of the opinion that an HIV-in-
434 fected mother was more likely to practise exclusive
435 breastfeeding having been counselled to do so.

436 *“The HIV-infected mother may practise exclusive
437 breastfeeding. She knows that she is infected and
438 her incentive is for the child to survive. This incen-
439 tive is the reason why it may be easier for an HIV-
440 infected mother to practise exclusive breastfeed-
441 ing”* (Daniela)

442 None of the counsellors had themselves practised
443 exclusive breastfeeding. All of the women counsel-
444 lers said that if they themselves had HIV, they
445 would not breastfeed but would use milk powder

or cow’s milk. Most of them questioned the safety 446
of exclusive breastfeeding, and thought it would 447
not be a viable or safe option. 448

*“If I myself were HIV-infected, I would not disclose 449
my status to close family members. I would not be 450
afraid of people in the community, but I would not 451
tell them that I was infected! Instead I would tell 452
them that my breasts have some problems. You 453
can even start pretending during pregnancy that 454
there is something wrong. You tell them there is a 455
sore on one breast, you fake a discharge on it and tell 456
them that your breast milk is not good. When you 457
have given birth no one will question why you don’t 458
breastfeed.”* (Conceição) 459

Expressed, heat-treated breastmilk 460

Although expressed, heat-treated breastmilk was 461
not one of the options included in the protocol on 462
infant feeding for HIV-infected mothers at this site, 463
we explored the counsellors’ views on this method. 464
Three of the counsellors who had received three 465
weeks of breastfeeding counselling training in- 466
cluded this option in their infant feeding advice. 467
Most of the others expressed disbelief that heating 468
could inactivate the virus. Since they were not 469
convinced themselves and believed it was a difficult 470
concept to understand, they thought it would be 471
even more difficult to instruct and convince HIV- 472
infected mothers to try it. 473

*“We have been told that the HIV-virus is killed by 474
heating the breast milk to 60–62 degrees. But even 475
I am not convinced that the HIV-virus will be killed. 476
Furthermore, to try to tell this to a mother, to edu- 477
cate her until she understands and agrees that if 478
you heat treat breastmilk the HIV-virus will be 479
killed. That will be a very difficult task.”* (Daniela) 480

It is unfortunate that most of the counsellors dis- 481
regarded expressed, heat-treated breast milk as a 482
feeding methods since it has been demonstrated to 483
be a feasible option for HIV-infected women in 484
Tanzania [46], and is an option that could be pur- 485
sued especially during the weaning period. 486

Conflicting messages 487

In antenatal clinics in Tanzania, breastfeeding 488
has been promoted as the best infant feeding meth- 489
od since the early 1990s. However, since the UNA- 490

491 IDS Guidelines were amended in 1998, the risk of
492 HIV transmission through breastfeeding has been
493 included in the health information provided at an-
494 tenatal clinics. There was concern among the coun-
495 sellors that mothers would find it difficult to
496 understand how something can be best and hazard-
497 ous at the same time. One commented that the slo-
498 gan “Breast is best” was not valid anymore.

499 *“Really things are a bit vice versa. In 1998, the year*
500 *before last, there was a seminar where we were*
501 *taught about the benefits of breastfeeding. We edu-*
502 *cated all mothers to practise optimal and exclusive*
503 *breastfeeding. But now during health education we*
504 *mostly tell them about the dangers of breastfeeding,*
505 *that HIV may pass through the milk. We used to tell*
506 *them to start breastfeeding within 30 minutes after*
507 *birth, but now it is all changed. Therefore, you*
508 *shouldn’t be surprised if breastfeeding is going to*
509 *be a practice of the past. Mothers will continue with*
510 *these tins of milk...*” (Pamela)

511 Counsellors need to be knowledgeable and un-
512 derstand how to put this change of message across.
513 One of the more experienced counsellors felt that
514 the training received by health care workers had be-
515 come inadequate and we were told about some of
516 the double messages health educators can give

517 *“The quality of the knowledge we are receiving is*
518 *quite limited. Not only the counsellors, but even*
519 *public health educators themselves sometimes have*
520 *incorrect knowledge... In fact, it is justly dange-*
521 *rous.”* (Elibariki)

522 *“I attended a breastfeeding campaign where moth-*
523 *ers were told to exclusively breastfeed. Later, I over-*
524 *heard a conversation where one of the educators, a*
525 *nurse, was saying to a mother that it was not so*
526 *bad if once in a while she gave the child boiled wa-*
527 *ter. I asked her why she was now telling the mother*
528 *that she could add water but during the campaign*
529 *said not to. She replied that teaching about exclusive*
530 *breastfeeding was just theory and had nothing to do*
531 *with practice. So, even the nurses who are teaching*
532 *exclusive breastfeeding are sometimes encouraging*
533 *mothers to give water.”* (Joyce)

534 **Conveying facts or creating confusion?**

535 In Tanzania, as in other African countries [27],
536 health care workers’ words are often taken as the fi-

nal word. It is therefore essential that counsellors 537
are thoroughly trained and have high-quality, up- 538
to-date information to impart. A few counsellors, 539
like Gloria, did not have a clear understanding of 540
what exclusive breastfeeding meant or what there 541
should not be a prolonged period of weaning. Other 542
counsellors also questioned whether abrupt wean- 543
ing was practical for the lactating mother. 544

545 *“We advise them to exclusively breastfeed and at*
546 *three months to terminate breastfeeding. They are*
547 *told to gradually reduce breastfeeding already from*
548 *the second month, maybe to 5–6 feeds a day, to*
549 *gradually attune the child. As the amount of breast-*
550 *milk is reduced from the second month, they are told*
551 *to supplement with formula so that the child will*
552 *not get ill.”* (Gloria)

553 When it was indirectly suggested to her that this
554 was mixed feeding, she replied:

555 *“This is what I teach them, and it is based on my*
556 *own experience. If you stop breastfeeding instantly,*
557 *the child will get ill. That’s why you gradually re-*
558 *duce breastmilk from the second month, and at the*
559 *end of the third month they should stop breastfeed-*
560 *ing.”* (Gloria)

561 None of the counsellors had been informed dur-
562 ing training how infants should be fed after the
563 abrupt cessation of exclusive breastfeeding. The ad-
564 vice they gave to dilute cow’s milk with water so
565 that it would be nutritionally adequate for infants
566 of various ages also varied.

567 *“We tell them about how to mix modified cow’s milk,*
568 *you take half cow’s milk and mix it with a quarter of*
569 *water. Then you add 800 g of sugar, we show them*
570 *the amount with a spoon. We are also advising them*
571 *to give vitamin and mineral supplements.”* (Re-
572 hema)

573 *“We tell them to mix two parts of milk with one part*
574 *of water.”* (Gloria)

575 *“The amount of milk, water and sugar is according*
576 *to the weight of the child. We have all this informa-*
577 *tion in a notebook and can calculate the needs of*
578 *each child.”* (Halima)

579 The counsellors said they informed mothers
580 about the risks and benefits of each infant feeding

581 method. The risks of malnutrition and diarrhoea if
582 the infant was not breastfed were regarded as small
583 by these counsellors. They perceived the risk of HIV
584 transmission through infected breastmilk as much
585 greater. Yet most of them did not know the actual
586 risk of HIV transmission through breastfeeding.

587 *"We tell them the fact that a newborn child has a*
588 *60% chance of not being HIV-infected. Then we in-*
589 *form them that if they decide to breastfeed the child*
590 *will most certainly be HIV-infected."* (Irene)

591 *"We have been told that maybe 3% of children born*
592 *to HIV-infected mothers will not be HIV-in-*
593 *fected."* (Virginia)

594 **Follow-up and support**

595 The counsellors had high expectations of what
596 they should achieve. They recognised that HIV-pos-
597 itive women need support in their choice of infant
598 feeding method and safeguarding against stigmati-
599 sation by the community. They knew it was time-
600 consuming to give proper instructions and provide
601 support, especially in relation to infant feeding.

602 *"It is necessary to instruct the mother carefully*
603 *about how to prepare the milk, taking into consid-*
604 *eration the utensils she has. She also needs to know*
605 *how much cow's milk and sugar the child should*
606 *be fed for each meal, to practise at home and then*
607 *to come back and show you. This has to be repeated*
608 *two or three times in order to make sure she has un-*
609 *derstood. When she shows you, then you will know*
610 *if she has understood or not. If she makes a mistake*
611 *you have to correct her. If the mother is not in-*
612 *structed, the child will either get too much or too lit-*
613 *tle milk. It is necessary to spend one hour to instruct*
614 *her how to prepare the milk."* (Annie)

615 The counsellors emphasised the necessity of fol-
616 lowing up HIV-infected mothers at home, to see
617 how they were getting on. However, no hospital
618 transport was available to facilitate this; if the
619 counsellors wanted to do home visits, this was con-
620 sidered voluntary and outside their working hours,
621 at their own expense. Thus, home visits were sel-
622 dom undertaken.

623 Furthermore, if mothers did not return for fol-
624 low-up, the counsellors did not know how they
625 ended up feeding their infants, missing the oppor-

626 tunity to get feedback on how their advice worked
627 in practice. From the counsellors' point of view, this
628 was a major weakness of the PMTCT trial. It con-
629 tributed to their feelings of lack of control and re-
630 duced the possibility of them doing their work
631 adequately.

Beyond mother and community 632

Pregnant women attending antenatal clinics 633
where VCT is being offered tend to be the first 634
member of the family to be tested. 635

"Most African men will not agree to be HIV tested,
636 *but will blame their wives for being the source of in-*
637 *fection."* (Zainab)

"Women can even be blamed for a pregnancy by
639 *their partner if that pregnancy is not wanted. Any-*
640 *thing that you blame the man for, they will deny and*
641 *saying that he has nothing to do with them. There is not*
642 *an open discussion of how to solve this problem.*
643 *Most of the time it is the woman's responsibility to*
644 *prevent pregnancy and to solve their other reproduc-*
645 *tive problems. Within a marriage it is difficult to*
646 *prevent MTCT of HIV if the husbands are not willing*
647 *to participate. The best thing would be to counsel the*
648 *couple together so they can try to implement the ad-*
649 *vice they are given together."* (Irene) 650

Targeting only the pregnant woman at the ante- 651
natal clinic in countries where men do not usually 652
accompany their wives makes male involvement 653
difficult. According to the counsellors, only a few 654
men had taken the opportunity to come to the an- 655
tenatal clinic for testing and counselling. 656

Many of the counsellors were of the opinion that 657
communication on HIV and infant feeding should 658
be aimed at the community at large and not just 659
HIV-infected mothers. The support and motivation 660
of both partners and the community were seen to 661
be essential to the successful feeding of infants born 662
to infected mothers [47-50], but women first had to 663
risk disclosure [51]. Strategies for how to do this 664
may need pilot testing first [52]. This was beyond 665
what this PMTCT trial was able to offer at the time 666
of our study, however, and counsellors received no 667
training on how to facilitate partner involvement, 668
support disclosure or deal with existing barriers. 669
Lie points out that hospital settings are usually 670
not a very supportive context for relationship- 671

672 building and do not easily facilitate openness with
673 regard to taboos and socially sensitive issues [41].

674 **Methodological considerations**

675 Counsellors' attitudes, perceptions and self-re-
676 ported practices in giving advice on infant feeding
677 methods are important. While their views may dif-
678 fer from those of the women they counsel and may
679 be skewed by their own social and professional
680 backgrounds, they are the crucial link between pol-
681 icy and practice.

682 During the interviews the reports of the counsel-
683 lours seemed to be truthful and credible, and they
684 showed no signs of wanting to impress the inter-
685 viewer. We did not take into account that some of
686 them may have been HIV-positive themselves, al-
687 though this awareness might have strengthened
688 our understanding of their responses.

689 We included all the PMTCT counsellors at this
690 antenatal site, and believe they are representative
691 of counsellors elsewhere. Eleven of them were new-
692 ly trained and their views most probably reflect
693 their inexperience. We did not analyse the data in
694 relation to the difference between them and those
695 with more experience.

696 The views of the counsellors were based on their
697 experience of giving advice to HIV positive women.
698 It is important to note that pregnant women atten-

ing this antenatal clinic were probably not repre- 699
sentative of all women in this part of Tanzania, 700
but were usually urban or peri-urban with at least 701
primary schooling. They were either more finan- 702
cially secure, or referral patients, or willing to pay 703
out-of-pocket for the better facilities and services 704
provided at this referral hospital. This may not be 705
the case in other antenatal settings in Tanzania 706
where women are of lower socio-economic status, 707
have less access to health care and lower levels of 708
education. There is therefore no reason to believe 709
that the problems revealed in this study are less 710
pronounced in other settings. 711

712 **Conclusions**

The UNAIDS/WHO/UNICEF Guidelines were 713
meant to ensure that HIV-infected pregnant women 714
would be given an opportunity to make an in- 715
formed choice as to how they would feed their ba- 716
bies and enable them to adhere to this choice. 717
This study found that choice was seriously compro- 718
mised by the actual advice given, directive counsel- 719
ling, lack of time to cope with a positive HIV test 720
result, and lack of follow-up support, regardless of 721
socio-economic status. Infant feeding options were 722
not always accurately explained, but the counsel- 723
lors believed most women had little choice but to 724



AIDS awareness, Dandora health centre. Kenya, 1998

725 breastfeed and were unlikely to exclusively breast-
726 feed, despite advice.

727 It was apparent that the risks and benefits of the
728 options open to HIV-infected women were compli-
729 cated for the counsellors, not only the women.
730 Many counsellors' inexperience in counselling
731 and/or limited knowledge of alternative feeding
732 methods was critical. The fact that the majority of
733 pregnant women who were offered VCT accepted
734 it seems to be explained, at least in part, by coun-
735 sellors pressuring women into saying yes, by their
736 own reports. The fact that counsellors themselves
737 were not supported to give support to women after
738 their babies were born, can be considered a major
739 failing.

740 Health care workers appointed as antenatal
741 PMTCT counsellors need to do counselling as part
742 of their jobs, not in their free time, and to be paid
743 accordingly. To ensure a good quality of advice-
744 giving, counsellors need additional in-service train-
745 ing in non-directive counselling and regularly up-
746 dated, accurate information on infant feeding
747 options. If exclusive breastfeeding and infant feed-
748 ing alternatives are to be viable options for HIV-in-
749 fected mothers in this setting, intensive efforts to

promote understanding of these practices, not least 750
among health care workers and other role models, is 751
necessary. Counsellors need guidelines on weaning 752
and support to be able to follow up the mother at home 753
after their babies are born, both for the women's 754
sake and so that counsellors themselves are aware 755
of the impact and outcomes of their counselling. Fi- 756
nally, it must be recognised that women can only 757
make a real choice of infant feeding method and re- 758
ceive follow-up support at home if they can be open 759
about their HIV-status and know they can count on 760
the help of their partners and communities. 761

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References

1. Msellati P, Newell M-L, Dabis F. Rates of mother-to-child transmission of HIV-1 in Africa, America and Europe: results from 13 perinatal studies. *Journal of Acquired Immune Deficiency Syndrome and Retrovirology* 1995;8:506-10.
2. Peckham C, Gibb D. Mother-to-child transmission of human immunodeficiency virus. *New England Journal of Medicine* 1995;333:298-302.
3. WHO/UNAIDS/UNICEF. HIV and Infant Feeding. Guidelines for Decision-Makers. Geneva: UNAIDS; 1998.
4. WHO/UNAIDS/UNICEF. HIV and Infant Feeding. A Guide for Health Care Managers and Supervisors. Geneva: UNAIDS; 1998.
5. Gaillard P, Melis R, Mwanyumba F, et al. Vulnerability of women in an African setting: lessons for mother-to-child HIV transmission prevention programmes. *AIDS* 2002;16(6):937-8.
6. Temmerman M, Ndinya-Achola J, Ambani J, et al. The right not to know HIV-test results. *Lancet* 1995;345:969-70.
7. Kuhn L, Mathews C, Fransman D, et al. Child feeding practices of HIV-positive mothers in Cape Town, South Africa. *AIDS* 1999;13(1):144-6.
8. Nduati R, John G, Mbori-Ngacha D, et al. Effect of breastfeeding and formula feeding on transmission of HIV-1. A randomized clinical trial. *JAMA* 2000;283(9):1167-74.
9. Coutsooudis A, Pillay K, Spooner E, et al. Influence of infant-feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study. *Lancet* 1999;354:471-6.
10. Coutsooudis A, Pillay K, Kuhn L, et al. Method of feeding and transmission of HIV-1 from mothers to children by 15 months of age: prospective cohort study from Durban, South Africa. *AIDS* 2001;15(3):379-87.
11. Nicoll A, Newell M-L, Peckham CS. Breastfeeding is a major factor in HIV-transmission. *BMJ* 2000;321:963.
12. Coutsooudis A. Promotion of exclusive breastfeeding in the face of the HIV pandemic. *Lancet* 2000;356:1620-1.
13. Latham MC, Preble EA. Appropriate feeding methods for infants of HIV infected mothers in sub-Saharan Africa. *BMJ* 2000;320:1656-60.
14. Humphrey J, Iliff P. Is breast not best? Feeding babies born to HIV-positive mothers: bringing balance to a complex issue. *Nutrition Reviews* 2000;59(4):119-27.
15. Humphrey J, Iliff P. Is breast not best? Bringing balance to a complex issue. *SAFAIDS News* 2001;9(3):18-20.
16. Piwoz E, Ross J, Iliff P. Prevention of HIV transmission from mothers to infants. *SAFAIDS News* 2001;9(4):2-5.

17. Haider R, Ashworth A, Kabir I, et al. Effect of community-based peer counsellors on exclusive breastfeeding practices in Dhaka, Bangladesh: a randomised controlled trial. *Lancet* 2000;356:1643-7.
18. Coutoudis A. Breastfeeding: what is a mother to do? Presentation 13 at Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Kampala, 9-13 September 2001.
19. Ameena G, Bland RM, Rollings NC et al. Supporting exclusive breastfeeding amongst South African breastfeeding women living in an HIV-epidemic rural area. Poster 488 at Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Kampala, 9-13 September 2001.
20. Morrow AL, Guerrero ML, Shults J, et al. Efficacy of home-based peer counselling to promote exclusive breastfeeding: a randomised controlled trial. *Lancet* 1999;353:1226-31.
21. UNAIDS. New initiative to reduce HIV transmission from mother to child in low-income countries [press release]. Geneva: UNAIDS; 29 June 1998.
22. Shirima R, Greiner T, Kylberg E, et al. Exclusive breastfeeding is rarely practised in rural and urban Morogoro, Tanzania. *Public Health Nutrition* 2001;4(2):147-54.
23. Agnarsson I, Mpello A, Gunnlaugsson G. Infant feeding practices during the first six months of life in a rural area in Tanzania. *East African Medical Journal* 2001;78(1):6-10.
24. Bureau of Statistics, Tanzania, Macro International Inc. Tanzania Demographic and Health Survey 1996. Washington MD: Bureau of Statistics; Macro International Inc; 1997.
25. de Paoli M, Manoni R, Helsing E, et al. Exclusive breastfeeding in the era of AIDS. *Journal of Human Lactation* 2001;17(4):313-20.
26. Coutoudis A, Greiner T, Rollins N, et al. Free formula milk for infants of HIV-infected women: blessing or curse?. *Health Policy and Planning* 2002;17(2):154-50.
27. Seidel C, Brown J, V, Dano B. Experiences of breastfeeding and vulnerability among a group of HIV-positive women in Durban, South Africa. *Health Policy and Planning* 2000;15(1):24-33.
28. Boyd FM, Simpson WM, Hart GJ, et al. What do pregnant women think about the HIV test? A qualitative study. *AIDS Care* 1999;11(1):21-9.
29. Pool R, Nyanzi S, Whitworth JAG. Attitudes to voluntary counselling and testing for HIV among pregnant women in rural south-west Uganda. *AIDS Care* 2001;13(5):605-15.
30. Pool R, Nyanzi S, Whitworth JAG. Breastfeeding practices and attitudes relevant to the vertical transmission of HIV in rural south-west Uganda. *Annals of Tropical Paediatrics* 2001;21:119-25.
31. Grinstead OA, van der Straten A. Counsellors' perspectives on the experience of providing HIV counselling in Kenya and Tanzania: voluntary HIV counselling. *AIDS Care* 2000;12(5):625-42.
32. Lie GT, Biswalo PM. Perceptions of the appropriate HIV/AIDS counsellor in Arusha and Kilimanjaro regions of Tanzania: implications for hospital counselling. *AIDS Care* 1994;6(2):139.
33. Setel P, Mtwewe S. The Kilimanjaro Women's Group against AIDS. In: Klemp K-I, Biswalo PM, Talle A, editors. *Young People at Risk Fighting AIDS in Northern Tanzania*. Oslo: Scandinavian University Press; 1995. p. 149-60.
34. Linkvist A, Dahlgren L, Emmelin M. Open Code Qualitative Programme. http://www.umu.se/phmed/epidemi/for_kning/open_code.html [Downloaded 2001].
35. Strauss A, Corbin J. Basics of qualitative research. Techniques and procedures for developing grounded theory. 2nd ed. Thousand Oaks, California: Sage Publications, Inc; 1998.
36. Epidemiology Unit, National AIDS Control Programme. National AIDS Control Programme HIV/AIDS/STD Surveillance. Tanzania Mainland. Report No. 13. p1-30. Dar es Salaam: Tanzania Ministry of Health, 1998.
37. Killewo C, John T, Nyoni S. Prevention of MTCT of HIV. *Obstretic Care Guidelines for Health Care Service Providers*. Dar es Salaam: Tanzania Ministry of Health/UNICEF; 1999.
38. Lyamuya E, Said KH, Ipuge Y. Proposed framework for voluntary and confidential HIV counselling and testing in the planned prevention of mother to child transmission of HIV pilot project in Tanzania. Dar es Salaam: UNICEF; 1999.
39. Somi GR. Monitoring and evaluation plan of the pilot project on mother to child transmission of human immunodeficiency virus. Dar es Salaam: National AIDS Control Programme; 1999.
40. Mtwewe S, Taylor A. Prevention of MTCT of HIV through breastfeeding. Guidelines for HIV positive women. Guidelines 1 for Hospital-based HIV Counsellors. Dar es Salaam: UNICEF; 1999.
41. Lie GL. The disease that dares not speak its name. Studies on Factors of Importance for Coping with HIV/AIDS in Northern Tanzania. Bergen: Research Center for Health Promotion, Faculty of Psychology, University of Bergen, 1996.
42. Mhloyi A, Mercy B, Robson K, et al. Use of alternatives to breastfeeding in Makonde district, Zimbabwe. Poster 315 at Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Kampala: 9-13 September 2001.
43. Nduati R, Mbori-Ngacha D, Kalibala S, et al. Breastfeeding practice among women accessing healthcare at PMTCT sites in Kenya. Poster 331 at Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Kampala: 9-13 September 2001.
44. Williams C, Alderson P, Farsides B. Is nondirectiveness possible within the context of antenatal screening and testing?. *Social Science and Medicine* 2002;54:339-47.
45. Maman S, Mbwambo J, Hogan NM, et al. Women's barriers to HIV-1 testing and disclosure: challenges for HIV-1 voluntary counselling and testing. *AIDS Care* 2001;13(5):595-603.
46. Kitinya W, Jorgensen A. Pasteurisation of expressed breast milk: the experience of HIV infected women. Poster Abstract WePeB5947. AIDS 2002 Conference. Barcelona, 7-12 July 2002.

47. Ross MH. Counselling pregnant HIV-seropositive women with regard to feeding their babies. *AIDS* 2000;14(14):2207-8.
48. Daoussi R. Feeding infants when mothers are HIV positive in African settings: how can communities be mobilized to support mother's decision? Poster Abstract MoPeF3956. *AIDS 2002 Conference*. Barcelona, 7-12 July 2002.
49. Rutenberg N, Nduati R, Mbori-Ngacha D, et al. Prevention of HIV transmission from mothers to infants. Poster 303 at Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Kampala: 9-13 September 2001.
50. Kiare J, Richardson B, Kreiss J, et al. Antiretroviral compliance and infant feeding practices of HIV-1 infected women in Nairobi, Kenya. Poster 321 at Third Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Kampala: 9-13 September 2001.
51. Painter TM, Matia DM, Diaby KL, et al. Women's disclosure of actions to prevent mother-to-child HIV transmission (MTCT) in Abidjan, Côte d'Ivoire. Poster Abstract ThPpD2147. *AIDS 2002 Conference*. Barcelona, 7-12 July 2002.
52. Luo C. Strategies for prevention of mother-to-child transmission of HIV. *Reproductive Health Matters* 2000;8(16):144-55.

Résumé

Cette recherche analyse les conseils donnés par les consultants aux femmes enceintes séropositives sur l'alimentation des nourrissons à Moshi, Tanzanie, les facteurs pouvant selon eux influencer le choix des femmes et leur rôle dans ces décisions. Les données proviennent d'entretiens avec 16 infirmières travaillant comme consultantes pendant leur temps libre dans un projet de prévention anténatale de la transmission de mère à enfant, cinq conseillers locaux sur le VIH/SIDA et deux médecins, dont l'expérience dans les consultations allait de moins de six mois à neuf ans. Le choix informé de la méthode d'alimentation par les femmes séropositives, recommandé par les directives ONUSIDA/OMS/UNICEF, était compromis par les conseils donnés, le dirigisme des consultations, le manque de temps pour faire face à un test positif de dépistage du VIH et le suivi insuffisant, quelles que soient les circonstances socio-économiques des femmes. Les consultants n'expliquaient pas toujours précisément les options, mais pensaient que la plupart des femmes n'avaient guère d'autre choix que d'allaiter et que, malgré les conseils, elles ne nourriraient probablement pas leur bébé exclusivement au sein. Les risques et les avantages des options étaient compliqués pour les consultants, pas seulement pour les femmes. Les consultants devaient être formés à conseiller sans diriger et à présenter les différentes options pour garantir des conseils de qualité et un suivi des femmes à domicile.

Resumen

Este estudio investigó los consejos sobre la alimentación infantil impartidos a mujeres embarazadas y infectadas con VIH en Moshi, Tanzania, los factores que en la opinión de los consejeros incidían en las decisiones que tomaran las mujeres acerca de la alimentación infantil, y la influencia de los consejeros sobre dichas decisiones. Se tomaron los datos de entrevistas con 16 enfermeras que trabajaban como consejeras durante su tiempo libre como parte de un ensayo prenatal de prevención de la transmisión materno-infantil; cinco consejeros locales de prevención del VIH/SIDA; y dos médicos cuya experiencia como consejeros variaba de entre menos de seis meses y nueve años. La opción de un método de alimentación infantil recomendada para las mujeres infectadas con VIH por UNAIDS/OMS/UNICEF fue limitada por los consejos impartidos, la consejería directiva, la falta de tiempo para asimilar el resultado positivo de una prueba de VIH, y la falta de un seguimiento que apoyara a las mujeres, irrespeto de su nivel socio-económico. Evidentemente, los riesgos y beneficios de las opciones recomendadas para las mujeres infectadas con VIH eran complicadas para los consejeros y para las mujeres mismas. Los consejeros necesitan más entrenamiento en la consejería no-directiva, y acerca de las opciones de alimentación infantil, para asegurar una consejería de calidad y un seguimiento que apoye a las mujeres.