

**THE PERCEPTIONS, KNOWLEDGE AND EXPERIENCES OF BREAST –
FEEDING WOMEN LIVING WITH HIV/AIDS IN THE OSHAKATI
DISTRICT – NORTHERN NAMIBIA**

by

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**A full thesis submitted in fulfilment of the requirements for the degree of
Magister Curationis in the School of Nursing, University of the Western Cape.**



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DECLARATION

I declare that *The perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District – Northern Namibia* is my own work, that it has not been submitted for any degree or examination at any other university, and that all the sources have been indicated and acknowledged by complete references.

Hilma Ndesheetlua Kalimba

October 2007

Signed:.....



KEYWORDS

- Acquired Immunodeficiency Syndrome
- Anti-retroviral Therapy
- Breast-feeding
- Formula feeding
- Mixed feeding
- Feeding choices
- Human Immunodeficiency Virus
- Intermediate Hospital Oshakati
- Mother-to-Child Transmission
- Prevention of Mother-to-Child Transmission



ABBREVIATIONS

AIDS – Acquired Immunodeficiency Syndrome

ANC – Antenatal Care

ARV – Anti-retroviral Therapy

EBF – Exclusive breast-feeding

HIV – Human Immunodeficiency Virus

IHO – Intermediate Hospital Oshakati

MOHSS – Ministry of Health and Social Services

MTCT – Mother-to-Child Transmission

PHC – Primary Health Care

PMTCT – Prevention of Mother-to-Child Transmission

PNC – Postnatal Care

RA – Research Assistant

RMT – Regional Management Team

WHO – World Health Organization



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ABSTRACT

Women, who are HIV-positive, may transmit the virus to their babies during labour and through breast milk. HIV-positive mothers have to be counselled and encouraged to make informed decisions about the feeding of their babies to avoid this transmission. The feeding choices are exclusive breast-feeding, exclusive formula feeding or modified feeding.

This study focused on the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District, northern Namibia. A qualitative descriptive research design was used to conduct the study.

The research study was conducted at the Prevention of Mother-to-Child Transmission (PMTCT) Clinic, in the Intermediate Hospital, Oshakati. The Medical Superintendent of the hospital gave the researcher permission to conduct the study at the PMTCT clinic. A purposive sample was used consisting of 14 breastfeeding women who were HIV-positive and aged between 15-49 years. The ages of their babies were between one day and six months.

The data was collected through individual face-to-face interviews. The interviews were tape-recorded with the permission of the respondents. The interviews were transcribed verbatim and data were analysed by thematic content analysis. The Health Belief Model guided the description and interpretation of the data.

Findings from the study revealed that some women had inadequate knowledge about the transmission of HIV through breast-feeding. Their breastfeeding choices were influenced by their knowledge and perceptions while their experiences were shaped by their relationships with their partners and family. Their families, the community and the health professionals generally did not support them. Breast-feeding women living with HIV/AIDS had difficulties in coping with their condition within the community.

The research results indicated a need to: educate the community on the transmission of HIV/AIDS and the risks related to mixed feeding; to encourage their partners,

family members and professionals to offer support where needed, and to monitor the breastfeeding women's adherence to exclusive breast / formula feeding. The areas of concern amongst the breast-feeding women were the fear of stigma, discrimination and abandonment by their family members and their husbands/partners. The research findings will be disseminated to Ministry of Health and Social Services as well as the Medical Superintendent of the Intermediate Hospital, Oshakati.

Further research on Community and Home Based Care for breastfeeding mothers is strongly recommended with regard to the prevention of MTCT and finding a way to inform HIV positive mothers about feeding choices to protect the lives of their babies.

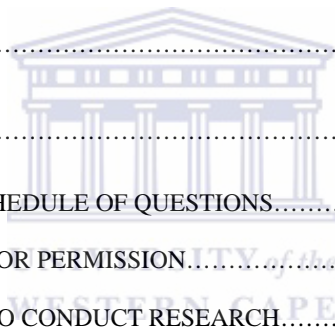


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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The transmission of HIV/AIDS from infected women to infants is the most significant cause of vertical infections among children under the age of 15 years (Government of the Republic of Namibia, 2004c: 1). HIV infects one in every five Namibian women aged 15-49 years. Most of the HIV/AIDS transmissions occurred during sexual intercourse between men and women (Southern Africa AIDS Information and Dissemination Services, 2003: 1). In many countries HIV transmission via breastfeeding has been identified as a major cause of death amongst young babies (Koppelaar, 2000: 5).

In Namibia, mothers living with HIV/AIDS are faced with a dilemma related to breast-feeding. The local culture dictates that women breast-feed their babies for a prolonged period of time, while the Government of the Republic of Namibia's health policy and the World Health Organization (WHO), state that women who are HIV positive should breast-feed exclusively for the first four to six months after birth. The abrupt weaning of babies and introduction of solid food should follow this exclusive breastfeeding (WHO, 2003: 7).

This study focuses on the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District. The background of the problem, research question, research methodology and related objectives will be described in Chapter One.

1.2 BACKGROUND / RATIONALE

Namibia is located in the southwestern part of the African continent. It has a surface area of 824,285 square kilometres. It shares borders with Angola to the north, Botswana to the east, South Africa to the south and the Atlantic Ocean to the west (Government of the Republic of Namibia, 1992: 1).

Namibia has a total population of 1,826,854. Females form 51% (936,718) and males 49% (890,136) of the total population. More than half of the population (58%) live in the northern part of the country. The Namibian census of 1991 reported that 28% of the population live in the urban areas, and 72% live in the rural areas (SAfAIDS et. al., 2003: 4). The population density is 38%. Some parts of the country are unpopulated due to the desert. The Oshakati District is located in Oshana Region, in the northwestern part of Namibia (Government of the Republic of Namibia, 2000: 2).

The first four HIV-positive cases in Namibia were diagnosed in 1986 and ever since the numbers have gone up dramatically. According to the mortality rate in hospitals, HIV is the major cause of deaths since 1996. Thus, HIV/AIDS has become a major public health problem in Namibia (Government of the Republic of Namibia, 2001b: 1).

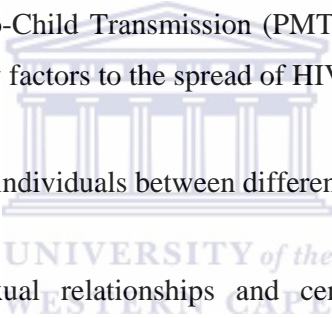
The Oshana region is the smallest of all thirteen regions in Namibia, with an area of 5290 square kilometres with a population of 161,915. There are 73,957 male and 87,958 females according to the 2001 Population and Housing Census (Government of the Republic of Namibia, 2000: 3). The region has one district hospital, namely the Intermediate Hospital Oshakati (IHO). There are three towns in the region, which are Ondangwa, Ongwediva and Oshakati, governed by municipal councillors. The region shares borders with three other regions, Omusati to the south and west, Ohangwena to the north and Oshikoto to the east. The economy of the region is centred mostly in its three fast growing towns, where many companies and industries were established. The rural community relies on subsistence agriculture, which includes cattle farming and small business enterprises (Government of the Republic of Namibia, 2000: 4).

People emigrate from the neighbouring countries into Namibia to seek a better life. People within Namibia move from rural areas to towns, looking for jobs or employment opportunities. Cross-border trade between countries has influenced the prevalence of HIV/AIDS among the Namibian people. Immigration happens in areas where good transport systems are in place, allowing for rural-urban movement. This movement of people has led to an increase in the transmission of HIV/AIDS. The Trans Kalahari Highway passes through the country. Some women in this region have

sexual relationships with the truck drivers which leads to the spread of HIV/AIDS (Jackson, 2002: 30).

Poverty makes more people vulnerable to the impact of HIV/AIDS infection. Action AID, a well-respected international development agency which alleviates poverty in many countries, recognises the irony that its own development efforts are likely to have contributed inadvertently to the spread of HIV/AIDS (Jackson, 2002: 29). Many people live in poverty and unhealthy conditions. Unemployment in the country is also a contributory factor to the spread of HIV infection. People need money to buy food and to provide for other basic needs. Poverty amongst the Namibian people and unemployment both contribute to the spread of HIV/AIDS infection (Government of the Republic of Namibia, 2000: 13).

The Prevention of Mother-to-Child Transmission (PMTCT) programme in Namibia, suggests that the contributory factors to the spread of HIV infections are:

- 
- The high mobility of individuals between different places in the country;
 - Cross-border travel;
 - Intergenerational sexual relationships and certain cultural practices and beliefs;
 - The disintegration of traditional family structure;
 - High prevalence of other sexually transmitted infections;
 - Gender inequalities;
 - Widespread alcohol and substance abuse;
 - Poverty, and
 - Ignorance (Prevention of Mother-to-Child transmission of HIV, 2004: 3).

The report of the 2002 National HIV-positive Sentinel Survey shows an increase in the percentage of HIV-prevalence amongst Namibian women (Government of the Republic of Namibia, 2002b: 13). Oshakati is a semi-urban area surrounded by informal settlements. The area is overpopulated and most of the people are unemployed. According to the statistics captured in a register at the PMTCT clinic in

Intermediate Hospital Oshakati, most of the breast-feeding women who are HIV-positive live in those informal settlements (findings in records of the PMTCT clinic).

The current practices of breast-feeding women living with HIV/AIDS in the Oshakati District will be investigated in this study. The research study will offer an in-depth understanding of the perceptions, knowledge and experiences of the participants regarding HIV/AIDS. Based on the information obtained, the research findings may guide the way in which breast-feeding women living with HIV/AIDS could be assisted and their needs be met.

1.3 FRAMEWORK OF THE STUDY

The Rosenstock (1965) Health Belief Model (HBM) guided this study. The HBM was developed to provide a framework to explain why individuals take part in health programmes. The model suggests that people take action with regard to their health problems. Individuals act to promote health because they are aware that they are susceptible to a health problem; they believe that the condition might have serious consequences and feel that the problem is a threat to their health. Individuals also believe that a course of action is available to minimize the consequences and that the benefits would outweigh the costs or barriers. Benefits relate to health protection and/or disease prevention. Information provided to the women enabled them to change their behaviours.

The HBM was useful for this current study because it provided a theoretical basis for the decisions which HIV-positive women made with regard to specific feeding choices, and their decision to participate in the PMTCT programme. The HBM was also found to be relevant to this study, as it allowed the researcher to establish whether women living with HIV/AIDS took any action with regard to the transmission of HIV to their babies.

1.4 PURPOSE OF THE STUDY

The purpose of the study was to explore the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District, Namibia, in

an attempt to gain insight into their understanding about HIV/AIDS, their decisions about feeding choices and the type of support they may require.

1.5 RESEARCH PROBLEM

In Oshakati District, most of the women who are HIV positive live in informal settlements and do not have access to clean water. They are unemployed and cannot afford to buy infant formula. They are also expected to breastfeed their babies for a prolonged period of time, based on their cultural norms. If these women choose not to breast-feed their babies, the community would identify them as people living with HIV/AIDS. For mothers who are HIV positive with limited access to clean water and sanitation, the choices of whether to breast-feed or not, could be a painful decision. These decisions are generally based on the women's knowledge and socio-cultural values, which make their experiences unique. This study is aimed at exploring the research question, "What are the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District?"

The WHO stated that babies of women who were HIV positive should not be breast-fed (WHO, 2004). The information that HIV is transmitted through breast milk should reach all women in rural and urban settings. However, women who are HIV positive have fears and concerns of being labelled with HIV/AIDS.

This study is the first of its kind to be conducted in the Oshakati District, specifically to investigate the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in this district.

1.6 AIM AND OBJECTIVES OF THE STUDY

1.6.1 AIM OF THE RESEARCH

The aim of this study is to explore the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District in northern Namibia.

1.6.2 OBJECTIVES

- To describe the perceptions, knowledge and experiences of breast-feeding women living with AIDS in the Oshakati District.
- To identify the challenges encountered by breast-feeding women living with HIV/AIDS in the Oshakati District.
- To determine whether the existing support systems for breast-feeding women living with HIV/AIDS in the communities in the Oshakati District were adequate.

1.7 DEFINITION OF CONCEPTS

Perceptions: Abilities to see, hear or become aware of something (South African Pocket Oxford Dictionary, 2003: 660).

Knowledge: Information and skills gained through experience or education (South African Pocket Oxford Dictionary, 2003: 500).

Experiences: Events which leave an impression on one (South African Pocket Oxford Dictionary, 2003: 310).

Breast-feeding women:

Women who feed babies with milk from the breasts (South African Pocket Oxford Dictionary, 2003: 102).

HIV: It means Human Immuno-deficiency Virus. A virus, which attacks, kills, and damages the cells in the body's immune system (Jackson, 2002: 1).

AIDS: Acquired Immune Deficiency Syndrome, which means that the body loses the ability to fight against infections because the immune system is weakened by HIV (Jackson, 2002: xxi).

Oshikundu A traditional drink prepared from maize meal and boiled water.

Sexually Transmitted Infections (STIs):

Infections that can be transmitted through sexual practices, when one partner is infected and infects the other partner (Jackson, 2002: 334).

MTCT: Mother-to-Child Transmission. It means that HIV is transmitted from mother to child via breast-feeding (Government of the Republic of Namibia, 2003a: 1).

Prolonged period:

For the purpose of this study, prolonged period is defined as a period of breast-feeding continuing for a long time, e.g. two years or more (South African Pocket Oxford Dictionary, 2003: 713).

Exclusively breast-feeding:

Feed the baby with breast milk only, without any other solid food or water added to the feeding programme (Jackson, 2002: 161).

Voluntary counselling and testing:

Counselling and testing of people who want to know their HIV-status on their own request (Government of the Republic of Namibia, 2003a: 11).

1.8 RESEARCH DESIGN

An exploratory, descriptive qualitative research design was utilized to conduct the study. The study was qualitative in nature to get closer to the people and the situation studied. It allowed the researcher to uncover and understand the perceptions,

knowledge and experiences of breast-feeding women living with HIV/AIDS (Nashandi, 2002: 29-30).

The study explored the views, beliefs and attitudes of the women towards infant feeding options. The researcher determined which problems breast-feeding women living with HIV/AIDS experienced, by conducting individual face-to-face interviews (Burns & Grove, 1993: 225).

The study was conducted in the Intermediate Hospital Oshakati (IHO). Purposive sampling was used to select the research respondents and the sample comprised fourteen breast-feeding women living with HIV/AIDS. Their babies were aged between one day and six months. Data were obtained through individual, in-depth, face-to-face interviews. The data was analysed using thematic content analysis. Trustworthiness, validity and reliability were ensured throughout the data collection process. Ethical considerations were attended to by: gaining permission from the Medical Superintendent to conduct the study, obtaining written consent from the respondents and assuring them of their rights to confidentiality.

1.9 OUTLINE OF THE STUDY

Chapter 1: This chapter orientates the reader to the topic and explains the reason for this study, namely to explore the perceptions, knowledge and experiences of breast-feeding women who are HIV-positive and living with HIV/AIDS in the Oshakati District. A summary was given regarding the research problem, and the aim and objectives of the research.

Chapter 2: The HBM was used as a conceptual framework for this study. The model was used to explain individual differences in preventive health behaviour. The relevant literature regarding the health threat, namely the transmission of the HIV from mothers to their infants, as well as the implications of the transmission, is discussed in depth.

Chapter 3: In this chapter the research methodology, study design, study sample, data collection procedures, data analysis procedures, trustworthiness, ethical

consideration and limitations of the study are discussed. The researcher describes the demarcated field of the research. Thematic content analysis was used to analyse the data and the themes which emerged were discussed in detail.

Chapter 4: The data analysis, presentation of the findings and interpretation of the results are presented. A qualitative study was done and a sample of fourteen breastfeeding women living with HIV/AIDS was used.

Chapter 5: A summary of findings, conclusions and recommendations is presented in this chapter. This chapter relates the recommendations of the research study to the gaps in the research findings.

1.10 CONCLUSION

In this chapter the introduction to the study, the statement of the problem and the theoretical framework was presented. The background, purpose of the study and research problem was discussed. The aim and objectives of the research study was described and an overview of the research design given.

The transmission of HIV/AIDS from mother to child remains a major challenge in Africa. In Namibia the transmission is especially prevalent in women of childbearing age living in the informal settlements of Oshakati. An exploration of their perceptions, knowledge and experiences may provide an insight into the type of challenges that they face and the type of support that they may require.

The next chapter will deal with the literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter a review of the literature related to the research study is presented. Resources from the library at the University of the Western Cape were used. From these sources, literature regarding the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS were obtained.

The purpose of this literature review was:

- To acquaint the researcher with the subject.
- To identify theories or models relevant to the topic investigated.
- To integrate this research with the previous literature on the topic.

The review of the relevant literature contained in this chapter will be presented as literature relating to HIV/AIDS, the transmission of HIV/AIDS, the PMTCT in South Africa and Namibia as well as the PMTCT programme in Oshakati, Namibia. The literature related to the objectives of the study will be reviewed and the conceptual framework used for the study will be described.

2.2 HUMAN IMMUNO-DEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME

HIV is the Human Immunodeficiency Virus that causes AIDS. HIV attacks, kills and damages the cells in the immune system of the body, namely CD4 cells. The immune system protects the body from disease, infection and certain cancers. When the immune system loses too many CD4 cells, a person is not able to fight off infection and can develop serious infections. AIDS is the condition whereby the body loses the ability to fight against infections because HIV weakens the immune system. People who have AIDS can get very sick with infections that most healthy people could fight

off (Nashandi, 2002: 51). A person can be HIV positive for many years without any signs of disease.

HIV/AIDS was first reported in the United States of America in 1981 and is now a major problem all over the world. AIDS is the final stage of HIV infection when the virus has seriously weakened the immune system of the body (Jackson, 2002: 38). People with AIDS are more likely to develop cancers, such as Kaposi sarcoma, cancer of the cervix and lymphomas. Many myths have been spread about AIDS and it is important for every person to know about HIV/AIDS. There is no cure for HIV/AIDS and while treatment may help and some people manage their disease, the condition is still fatal (Jackson, 2002: 13).

According to UNAIDS, reasons for this state of affairs are:

- *Ignorance about AIDS and the HIV transmission,*
- *Lack of suitable counselling and testing services,*
- *The stigma and discrimination attached to AIDS, which can result in rejection and violence against people known to be HIV-positive and*
- *Culture* (Pendukeni, 2004: 16-17).

2.2.1 HIV/AIDS amongst women in the United States of America

More than 20 years have passed since the first diagnosis of AIDS in America. There were a handful of women among the first cases and it was thought to primarily affect gay men (Margolese, 2003: 1).

- By 1999, AIDS had become the fifth leading cause of death among American women aged 25 – 44.
- The proportion of AIDS cases among women has more than tripled from 7 percent in 1985 to 25 percent in 2001.
- The World Health Organization (WHO) estimated that there were 180,000 women who were HIV positive in the United States in 2001.
- HIV has hit the African-American communities hard. Women in these communities account for over 82 percent of all female AIDS cases in the United States (Margolese, 2003: 1).

2.2.2 AIDS in Africa (Developing countries)

The African continent is the hardest hit by HIV/AIDS in the world (Jackson, 2002: 67). Amongst the ten highest affected countries in the world, seven are in the Southern African continent with at least one adult out of five living with the virus in this region.

HIV/AIDS in Africa is becoming part of everybody's reality and Africans have to learn how to deal with the different aspects and consequences of the disease. AIDS in Africa represents a complex set of challenges. The disease destabilizes communities and breaks down family ties. African extended-family relationships and communities that are traditionally regarded as support systems for family members have been undermined. There is an increase in the number of orphans due to AIDS. When their parent(s) die the children are left to cope with difficult circumstances. Women are left without breadwinners and are expected to play roles as mothers, carers and breadwinners (Nashandi, 2002: 4).

In the African context, children are considered a symbol of wealth, investment and social security. While women, who are HIV-positive, often carry their burden alone, they are normally expected to ignore their own health due to cultural obligations to care for their families. Instead of caring for themselves they care for their spouse or partner, their baby who is HIV-positive, as well as having to provide care and support to the sick and to orphans (Jackson, 2002: 2).

Sub-Sahara Africa is the poorest region globally and at the end of 1997 the most badly affected by the HIV-epidemic. One tenth of the adult female population in Africa aged 15-49 years are living with the virus (Nashandi, 2002: 4). Social and economic factors, such as migration, inaccessibility to health facilities, poor living conditions, and cultural practices like extra marital relationships, contribute to the spread of AIDS infections (Take Control, 2001b: 4).

In Nigeria, a densely populated country in sub-Saharan Africa, over 5% of the adult population is HIV-positive. In Botswana, 35.8% of adults are now infected with HIV, while in South Africa, 19.9% are infected. With 4.2 million infected people, South

Africa has the largest number of people living with HIV/AIDS in the world (UNAIDS, 2000: 9).

However, a qualitative research study conducted in Kayelitsha, South Africa in 2000 indicated that 25% of the participants sampled did not believe that HIV caused AIDS (Sexton, 2002: 6). This ignorance about the cause of AIDS complicated the implementation of precautions to prevent the spread of AIDS. Many people who are HIV-positive live normal lives for many years, proactively taking care of their health and optimising their immune systems through using antiretroviral drugs.

2.2.3 HIV/AIDS in Namibia

Namibia is among the seven countries that currently has the highest HIV-prevalence rates in the world (SAfAIDS, 2003: 1). HIV/AIDS is the most important public health problem in Namibia, ranking as the number one cause of death and hospitalisation in the region. The Government of the Republic of Namibia recognises the threat and challenge that HIV/AIDS poses for the Namibian people. The government has taken measures to respond purposefully to the epidemic. Structurally, the Ministry of Health and Social Services (MOHSS) is the leading Ministry in the Government of the Republic of Namibia who is responding to the HIV/AIDS epidemic. An HIV/AIDS policy has already been formulated with National and Regional coordination mechanisms in place (Government of the Republic of Namibia, 2003a: 3).

According to the MOHSS National Sentinel Sero Survey carried out amongst pregnant women at antenatal clinics countrywide, the results indicated an increase in HIV-infections in these women from 1992 to 1998. In Oshakati District, which had the highest prevalence rates of HIV-infections in Namibia, the prevalence rate in pregnant women increased from 4% in 1992 to 34% in 1998. In the National Sentinel Zero Survey, 3890 blood samples were taken from pregnant women between August and November 2000. It showed that one out of every five women tested HIV positive. The highest prevalence rate was in the age group between 24 and 29 years (Government of the Republic of Namibia, 2001a: 4). These results of the MOHSS indicated that there was an increase of HIV/AIDS among pregnant women in Namibia.

A study by Nashandi (2002) showed that a lack of information and knowledge about sexuality and a lack of power to discuss and negotiate safe sex made the women more vulnerable to HIV/AIDS. Most women in this study did not discuss condom use with their partners due to the violent reactions that these discussions may elicit from their partners. Women often became infected with HIV/AIDS as a result of unsafe sexual practices. Husbands generally did not take part in preventing the spread of HIV/AIDS infections. The study indicated that there was a need to involve husbands and partners in all the efforts to assist the women in coping with the situation of living with HIV/AIDS (Nashandi 2002: 4).

The PMTCT programme in Namibia aimed to inform and educate women in Namibia about the risk of transmitting HIV to babies via breast-feeding. During the antenatal period, women who are HIV-positive were counselled about the risks and benefits of breast-feeding and informed about replacement feeding to help them make informed decisions about infant feeding. The women, who were financially independent and could afford to buy formula, should have done so. Although the women were willing to choose formula feeding, the availability of running water remained a constraint, especially in the rural areas (Government of the Republic of Namibia, 2003a: 19). Research on the possible effect of Antiretroviral (ARV) drugs on preventing the transmission of HIV during breast-feeding is currently underway.

HIV/AIDS-infections are increasing amongst Namibian communities. Many people believe that *witchcraft* or evil spirits cause the HIV-disease. People do not acknowledge AIDS as the primary cause of death. Some families claim that the person died of pneumonia, tuberculosis or malaria (Nashandi, 2002: 1). Later it would become known that the person died of AIDS-related illness. Traditional healers play an important role in the lives of people in Namibia. Most people living with HIV/AIDS visit traditional healers because they have little access to western medicines and have great belief in traditional medicine (SAfAIDS et. al., 2003: 8). In the light of the above practices, women experience problems regarding their decision to disclose their HIV status and feeding choices for their babies.

2.3 TRANSMISSION OF HIV/AIDS

There is still a misunderstanding in Namibia about how HIV is transmitted from one person to another. By knowing the basics on how to avoid being infected by the virus, people who are HIV negative may prevent themselves from being infected and those who are HIV positive will avoid infecting others. There are various ways of how HIV/AIDS can be transmitted from one person to another, such as:

2.3.1 Sexual practices/behaviours

HIV infection is transmitted primarily through sexual intercourse, especially through unprotected vaginal or anal intercourse. Micro-lesions of the vagina of the women, which can occur during intercourse, serve as a point of entry. Women become more infected than men with HIV during unprotected sexual intercourse since they have a larger mucosal surface, which may be the entry point for the virus. HIV can also be transmitted through oral-sexual contact (van Dyk, 2002: 19).

Research has shown that untreated Reproductive Tract Infection (RTI) and Sexually Transmitted Disease (STD) increase the risk of the transmission of HIV during unprotected intercourse. Young girls for example who have been raped by older, and stronger men are at risk. It is well known that older men, *sugar daddies*, offer schoolgirls gifts or money in return for sex, and this contributes to the spread of HIV/AIDS (van Dyk, 2002: 20). Van Dyk further stated that one should always keep in mind that one single unprotected sexual contact with a partner, who is infected with the virus, may in some cases become a date with death and that the best way to prevent HIV transmission to children is to prevent HIV infections in parents-to-be.

2.3.2 Contamination

The HIV can be transmitted from one person to another through receiving HIV-contaminated blood in a blood transfusion.

(a) Blood transfusions and blood products

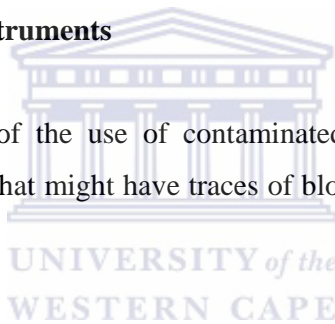
According to WHO (2000), there is a 90 – 95% chance that someone receiving blood from an HIV-infected donor will become infected with HIV themselves. All donated blood should therefore be screened for HIV-antibodies. Blood that is found to be infected should be destroyed (van Dyk, 2002: 24).

(b) Injecting drug abusers

Jackson (2002: 173) stated that people who share syringes and needles to inject drugs run a very high risk of becoming infected with AIDS, and transmitting the virus to their partners. Other routes include:

(c) Blood contaminated instruments

Contamination as a result of the use of contaminated medical equipment. Razor blades or other implements that might have traces of blood on them can also transmit the virus



(d) Other routes

Eye splash with infected blood and the sharing of toothbrushes.

According to Jackson (2002: 168), HIV can be transmitted through contaminated needles and sharp instruments and/or contaminated medical equipment, which were used by infected people and also through contact with infected blood at the scene of an accident.

2.3.3 Mother-to-Child Transmission (MTCT) of AIDS

Estimates of the rate of MTCT of HIV/AIDS in cohorts of women who have not received any preventive treatment, such as antiretroviral therapy, ranged from 15-25% in industrialized countries to a staggering 25-45% in developing countries. The highest rates of MTCT (WHO, 1998: 5) have been found in women in Africa. Much of the increased rates of transmission seen in women in sub-Saharan Africa is

associated with breast-feeding, since many of these women breastfeed their babies for about two years.

Mother-to-Child Transmission of HIV/AIDS is the major cause of HIV-infection in children. A research study done in KwaZulu-Natal in 2004, found that HIV could be transmitted from a mother who is infected, to her baby via the placenta during pregnancy, through blood contamination during childbirth or through breast-feeding (Sexton, 2000:3).

The Minister of Health and Social Services in the Government of the Republic of Namibia stated that, in Namibia, heterosexual intercourse and MTCT remain the most common modes of HIV/AIDS transmission. Monitoring the HIV-prevalence among pregnant women would be a key indicator to assess progress in limiting the spread of the disease. Orphanhood has become an indicator for adult mortality with close to 14% of children under the age of 15 having lost one or both parents. Everybody has to learn how to deal with the different aspects and consequences of the disease. It is important to consider the differences in the experiences of men and women who are HIV-positive. While men living with HIV need support and care, the low social status of women and socially constructed barriers further infringe on their access to health care (Sexton, 2000: 2).

There are two major routes of transmission of HIV from the mother to the child, namely:

- **Transmission during pregnancy and labour**

The transmission of HIV infection in pregnancy occurs during labour and the delivery. If women have been infected before or during pregnancy, they can transmit the virus to their foetus, because the HIV viral load is very high during that period (Jackson, 2002: 145). The author states that birth control for breast-feeding women living with AIDS should be encouraged. These women should use condoms to avoid becoming re-infected with HIV.

- **Transmission through Breastfeeding**

HIV can also be transmitted through breast-feeding if the mother is infected and decides to breast-feed her baby for a period of more than six months. The WHO suggests that among the infants born to mothers who are infected with AIDS, those who are breast-feeding are more likely to be infected than those who are formula-fed, even allowing for other factors known to be associated with MTCT of HIV/AIDS (WHO, 1998: 7).

According to Jackson, (2002: 146) babies are infected through MTCT by women who breast-feed their babies for a prolonged period of two years. This practice is common amongst infected women who live in rural and remote areas. The HIV is transmitted through breast milk, with about one in seven breast-fed infants born to women who are HIV-positive acquiring HIV in this way. Women face difficult choices about whether to continue breast-feeding to protect their infants from other illnesses or provide alternatives to breast milk (Aids Action, 1998: 2).

The WHO directed health workers to be honest with pregnant women regarding the risk of transmitting AIDS to their children through breast-feeding. The health workers should advise the mothers that formula feeding is recommended where safe water is available (WHO, 2004: 16). In wealthy families, bottle-feeding may not be considered because of the stigma attached to mothers who do not breast-feed their children. Everything possible should be done to empower and enable women to make appropriate and informed decisions and also to provide the necessary information regarding breast-feeding among uninfected women, and the alternatives for breast-feeding among the infected (Jackson, 2002: 152).

According to an African study the knowledge which a woman has about HIV being transmitted through breast-feeding, makes the decision about whether to breast-feed or not to breast feed, potentially a very difficult one (Chopra et al, 2000: 66).

Humphrey, who headed a research project that investigated the spread of HIV through breast-feeding in Zimbabwe, disagreed with discouraging women living with HIV/AIDS to breast-feed. Humphrey, in Nolen stated that, *you can't say, don't breast-feed. That is a death sentence for many babies. Fine, they won't get HIV, but*

they will die of diarrhoea. Humphrey suggested that the relative risks of HIV-transmission via breast milk versus neonatal death as a result of diarrhoeal disease should be considered when mothers are advised about feeding choices (Nolen, 2004:1, 3). It appears as if Humphrey's viewpoint was not taken into account when the WHO or the MOHSS of Namibia made policy decisions about breast-feeding practices of HIV-positive women.

The discovery that HIV could be transmitted to infants through breast-feeding, necessitated a global policy debate regarding the universal promotion of breast-feeding practices, particularly in developing countries. As a result of a study done in South Africa regarding MTCT, it was recommended that pregnant women who were HIV positive should be counselled at antenatal clinics about HIV-transmission through breast milk and how to prevent the transmission (Sexton, 2000: 3).

2.4. FEEDING OPTIONS

There are three feeding options, namely, exclusive breast-feeding, and exclusive formula feeding or mixed feeding. Socio-cultural practices affect infant feeding. In some families women are not allowed to choose how to feed their infants. The father or even the elders in the family would decide which method of feeding would be used (McCoy et. al., 2002: 31).

2.4.1 Exclusively breast-feeding

Breast milk protects the infant from disease by providing the thick yellowish first milk (colostrum), which is the first vaccine of the infant. Breast milk provides perfect nutrition and resistance (antibodies) against infection and strengthens the bond between mother and baby. With breast-feeding there are no additional costs involved, e.g. bottles and teats and there is also a lesser risk for neonatal hazards like choking during feeding. Breast-feeding prevents the risk of malnutrition, e.g. diluted or inappropriate replacement feeds, and it also prevents infection, e.g. diarrhoea and dehydration caused by the use of contaminated water when preparing formula feeds (Jackson, 2002: 160).

Breast-feeding can be made safer by using effective feeding techniques and health workers should be able to demonstrate and advise mothers in this regard. According to Jackson (2002: 163), a mother who develops mastitis, cracked or bleeding nipples can feed the baby with the healthy breast and should seek urgent treatment. Milk from the infected breast, should be expressed and properly heat-treated or discarded.

Breast-feeding is usually the best way to feed an infant, but if a mother is HIV-positive, replacement feeding can reduce the risk of HIV transmission to her infant. Babies, who are HIV-positive, need breast milk more than babies who are HIV-negative, given that their immune systems are likely to weaken. However, in places where the mortality rate of babies is high as a result of replacement feeding, replacement feeding cannot be recommended (Jackson, 2002: 160-161).

The mechanisms associated with transmission of HIV through breast-feeding and factors related to protection from such transmission, remain poorly understood. A researcher in Khayelitsha, South Africa, conducted a study that confirmed that HIV transmission occurred through breast-feeding, which means that if mothers did not breast-feed, there would be no postnatal transmission of HIV (Sexton, 2000: 3).

There are a few options available to the HIV-positive mother who prefers to breast-feed her baby. However, irrespective of the option the mother may choose, she will need the support of her family to cope with the guilt that she might feel about transmitting the HIV to her child. No woman wants her infant to be infected or deliberately sets out to take risks, although numerous pressures may lead to increased risk-taking. Women and men whose babies become infected will need all possible support to care for the baby (Jackson, 2002: 165).

One option is to express the breast milk into a clean container, heat the milk to kill the virus, cool it and use a cup to feed an infant (Jackson, 2002: 164). Another option is to use a wet nurse, who should of course be tested for AIDS and must remain HIV-negative throughout the breast-feeding period. This option should only be considered if it is culturally acceptable. Any difficulties experienced with the selected option, should be reported to the community health nurse practitioner at the clinic for further discussion and advice (Jackson, 2002: 161).

In Namibian cultures, it is expected that women breast-feed their infants for a prolonged period of two years. Breast-feeding women living with HIV/AIDS in Oshakati District are faced with a dilemma of whether or not to breast-feed their infants. This becomes problematic because women would then be forced to reveal their status and they are afraid of being abandoned, rejected, or disowned by their families (Nashandi, 2002: 18).

In previous years, when babies aged one year or more had to be weaned from breast-milk, they were sent to the grandmothers, until they forgot the breast of the mother. This was the tradition among breast-feeding women. During the late 1990s and early 2000s, this practice changed. Women were weaning the infants after four months of life and since the babies were too small to be cared for by their grandmothers, it presented the breast-feeding mothers living with HIV/AIDS with new challenges.

Despite the recommendation for exclusive breast-feeding, it is not an easy task for mothers to implement due to cultural, practical and/or health reasons. The United Nations Children's Fund (1998) reported on rates of exclusive breast-feeding during the first three months of life in countries in sub-Saharan Africa. See Table 1 below:

Table 1: Estimated Rates of Exclusive Breastfeeding for Three Months in Selected Countries in Africa UNICEF (1998)	
Country	Percentage
Nigeria	2 %
Zambia	13 %
Zimbabwe	16 %
Uganda	70 %
Botswana	35.8 %
Namibia	34 %
South Africa	19.9 %

The recommendations of the WHO are to discourage women who were HIV positive from breast-feeding, in an attempt to avoid the HIV transmission. Exclusive breast-feeding is recommended for the first six months of life to achieve optimal growth, development and health (WHO, 2004: 7). These recommendations became a dilemma for health service providers to guide women who are HIV-positive on the choices regarding the breast-feeding. The discrepancies between the government health policy and the WHO recommendations caused confusion among breast-feeding mothers about when to stop breast-feeding. Neither the policy, nor the WHO supported mixed feeding (Government of the Republic of Namibia, 2003a: 19).

The Government of the Republic of Namibia proposed that to reduce postnatal HIV-transmission, all women who were HIV-positive should be encouraged and supported to provide exclusive formula feeding. It was, however, found that many people/families in Namibia could not afford formula feeds. The women have no clean water, no money and no knowledge on how to prepare replacement feeding. The MOHSS therefore recommended that women who are HIV-positive, practice exclusive breast-feeding for four months followed by sudden weaning, to prevent the transmission of HIV to their babies. They also have to be supported in implementing their decisions on how to feed their babies (2004a: 28).

2.4.2 Exclusively formula feeding

The other feeding option is exclusive formula feeding. This option poses socio-cultural constraints regarding the provision of exclusively formula feeding. It is difficult to deal with a crying baby if you do not have formula milk. The only way to comfort the crying baby is to put the baby to the breast. McCoy et. al., (2002: 31) state that where poor socio-economic conditions prevail, mothers experience practical difficulties, like the access to boiling water and formula feeds, and would find it difficult to resist putting a crying child to the breast. The stigma attached to formula feeding can make it difficult for women to carry out their decisions to exclusively formula feed.

For mothers who choose replacement feeding and carers of orphaned babies, the formula-feed options include buying commercial formula or using the milk of cows,

goats or sheep to which sterile water and sugar are added. These formula-fed babies should be given multi-vitamin supplements. In many settings in rural Africa, animal milk is much more accessible and affordable than commercial formula milk (Jackson, 2002: 165).

A research study, conducted in Kenya, found that formula-fed infants of HIV-positive mothers had a 40% reduction in HIV-transmission, compared to a group of breast-fed infants. McCoy et. al., (2002: 30-31) stated that during the first three months of life, infants in the formula-fed group had increased rates of diarrhoea, dehydration and respiratory infections. The mothers recruited for this study had access to clean water, free formula, and received frequent and regular support in the form of home visits by health workers. These infants were free from HIV-infections.

2.4.3 Mixed feeding

As a result of the cultural practices of exclusive breastfeeding and the cost of formula feeding, many women use mixed feeding, namely, a combination of breastfeeding and formula feeding. Mixed feeding is more risky for HIV-transmission than exclusive breast-feeding. Infants are exposed to both HIV infection through breast-feeding, and the risks associated with replacement formula. The infant can contract HIV because of the damage to the epithelial integrity of the intestine of infants that may facilitate entry of the virus if using replacement formula (Jackson, 2002: 161).

The mothers-in-law base the practice of mixed feeding on the traditional socio-cultural norms, which are then enforced by the older women in the community. McCoy et. al., (2002: 31), state that women who wanted to choose exclusive breast-feeding, faced social barriers, since they were pressurised to choose mixed feeding. These women were unable to implement their own choice as they were being persuaded by older women in the family to adhere to cultural practices.

WHO and UNICEF advise mothers in wealthy countries to avoid breast-feeding, assuming that they can afford safe replacement feeding. They also recommend the poorer countries to avoid breastfeeding where free provision of formula milk is guaranteed for six months. This practice of supplying formula milk is not sustainable

in most countries. Foster, cited in Jackson (2002), states that the cost of the 22 kilogram of formula milk required to feed an infant for the first six months of life, is more than the annual income of many poor caregivers.

It has become clear that developing countries are faced with the unique challenges of sprawling informal settlements, unemployment and limited infrastructure. The women of Namibia are faced with the cultural expectation of prolonged breast-feeding and are at risk of exposing their HIV-status, if they should practise abrupt weaning.

2.5 PREVENTION OF THE TRANSMISSION OF HIV/AIDS

The transmission of HIV/AIDS can be prevented through education of the community members on handling sick patients hygienically. Individuals have to change their sexual behaviours. Abstaining from sexual intercourse is the best way to prevent the transmission of HIV/AIDS. Everyone has to be faithful to one trustworthy partner. HIV-positive breast-feeding women should avoid re-infection of the disease by the use of condoms (Jackson, 2002: 121).

To avoid the transmission of HIV/AIDS include amongst others, to prevent the use of contaminated blood transfusions and contaminated blood products. Drug abusers must not share syringes and needles to avoid transmitting the virus to their partners. Contaminated needles, syringes, sharp instruments and use of contaminated medical equipment should be avoided.

Avoid eye splashes with infected blood and the sharing of toothbrushes should not be practiced. Medical equipment, razor blades etc. must be cleaned before use. Blood products should be properly screened before the transfusion (Jackson, 2002: 172).

2.5.1 Prevention of transmission from mother to child

Prevention of HIV between prospective parents is vital to prevent the transmission of the disease from mother to child. Primary prevention includes the dissemination of accurate information to the community, including the sharing of health information regarding the transmission of HIV. Pregnant women who are HIV-positive must be

treated with anti-retroviral drugs and encouraged to practice safe feeding options (Jackson, 2002: 148).

Avoiding breast-feeding and the use of formula feeding is the best method to prevent HIV transmission. HIV counselling and testing services in hospitals must be put in place. The perceived benefits to the HIV-positive women in the current study are to enrol in the PMTCT programme and access to antiretroviral drugs for pregnant women. Husbands and partners have to be included in the health education programs presented at the clinics (Jackson, 2002: 154).

A study conducted in Uganda in 1999 found that when the Ugandan health care professionals gave a single dose of Nevirapine to the mother at the onset of labour and to the baby after delivery, the mother-to-child-transmission of HIV was reduced. This is the standard practice at the PMTCT clinics in Namibia (Government of the Republic of Namibia, 2004a: 7).

2.6. THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) PROGRAMME

For many years, the health care providers took steps to assist women who are HIV-positive to prevent MTCT. In the absence of any intervention, around a third of mothers who are HIV-positive pass the virus to their newborns. In the late 1990s it was found that a half of these infections occurred during breast-feeding (Government of the Republic of Namibia, 2003a: 5).

The Prevention of mother-to-child transmission programmes to protect children against the transmission of HIV/AIDS will be described in the context of developing countries in Southern Africa, namely South Africa and Namibia.

2.6.1. The PMTCT programme in South Africa

The programme was implemented at the 18-targeted PMTCT sites in South Africa to help improve the effectiveness and efficiency of PMTCT services. Its goals were:

- The first was in terms of reducing the rate and overall numbers of HIV transmission from mother to child.
- The second was to improve the health status of children and mothers, whether HIV positive or HIV negative (McCoy et. al., 2002: 24).

McCoy et. al, (2002) confirmed that breast milk was the best source of nutrition for the first 4-6 months of life. Unhygienically prepared formula feeding could lead to newborn babies being exposed to infections. The study conducted in Khayelitsha, indicated specific challenges with regard to the practice of formula feeding, i.e.:

- Women receive inadequate information about how to prepare formula feeding safely, and most feeds were prepared incorrectly.
- Providing safe and exclusive formula feeding was difficult, because the people did not know how to prepare feeds (McCoy et. al., 2002: 29).

McCoy's study explored the perceptions of the breast-feeding women's use of the PMTCT services. The following reasons for not using the service were identified:

- A stigma was attached to the PMTCT services. It was seen as a clinic attended by people who are HIV-positive.
- Long distances and the unavailability of transport caused some women not to attend their follow-up visits regularly at the PMTCT clinic.
- Long waiting time for services was unacceptable to the women.
- Unconcerned attitude and rude behaviour of clinic staff were constraints.
- Women were not sure whether the nursing staff would maintain confidentiality and anonymity (McCoy et.al, 2002: 13-17).

2.6.2 The PMTCT programme in Namibia

In September 2001, the Minister of Health and Social Services of Namibia launched the PMTCT programme in the country. Two pilot sites, Katutura and Oshakati Hospitals were chosen to start with the implementation of that programme. Specific objectives for the programme were:

- To introduce the PMTCT programme using Nevirapine;
- To establish viability and sustainability of such a programme on a national scale;
- To reduce the transmission of HIV from the infected mother to her child;
- To provide Highly Active Antiretroviral Therapy (HAART) to improve the quality of life and prolong the lifespan of parents and reduce early orphanhood; and
- To improve the care of children (Government of the Republic of Namibia, 2002a: 28).

To guide the implementation process at the two sites, a PMTCT committee was established with focal persons within the National Aids Coordination Programme (NACOP) and at two sites in Katutura and Oshakati Hospitals.

The committee of the PMTCT programme recommended the following feeding options to be adhered to in Namibia, according to the WHO:

- Exclusive breast-feeding for the first four months and fast weaning.
- Replacement feeding when affordable, culturally acceptable, sustainable, feasible and safe (WHO, 2004: 4).

Voluntary counselling and testing (VCT) was available for everybody who wanted to use these services, especially the pregnant women. The benefit of VCT in pregnant women was to identify HIV-positive women, offer antiretroviral drugs and thereby reduce the HIV transmission to their babies. However, the availability and accessibility of affordable VCT services could prove problematic. The governmental policy makers countrywide should address the need for clinics that offer VCT services. These services could use the rapid HIV-antibody tests because the distances from clinics and lack of transport make it difficult for the people to come back to the clinic for their test results (Government of the Republic of Namibia, 2002b:30). If the VCT-test was offered at certain clinics, the community should be well-informed about such services. Health care professionals and community health workers should also be

sensitised and trained in pre- and post-HIV-test counselling. In Namibia, VCT is provided at the PMTCT clinics but is being under-utilised by the community (Government of the Republic of Namibia, 2002b: 30).

The use of antiretroviral (ARV) drugs for example, Nevirapine, is restricted to pregnant women who are HIV-positive and registered with the Prevention of Mother-to-Child-Transmission programme. Health workers monitor these women closely to avoid resistance to the treatment (Government of the Republic of Namibia, 2002a: 31). ARV-drugs, taken by the mother before and during delivery, can reduce the risk of HIV being passed to the child. However, the best way to prevent HIV transmission in children is to prevent HIV-infections in parents-to-be.

The Government of the Republic of Namibia has carried out various activities and research projects to reduce the rate of HIV/AIDS infections. There were a few direct attempts to adequately meet the needs of the breast-feeding women living with AIDS. However, inadequate focus has been placed on intervention strategies and support for the women in Oshakati District (Government of the Republic of Namibia, 2003b: 12).

The perception of the researcher is that there is still a need for an open discussion on the disease and the women's concerns about being labelled HIV-positive for not breast-feeding. Due to the differences in contexts, namely, their environment, personalities, attitudes, cultures and their unique past experiences, it has become necessary to explore how women perceive the situation and how they express their need for support.

2.7 THE PMTCT PROGRAMME IN OSHAKATI, NAMIBIA

In 2002 the Government of the Republic of Namibia implemented the PMTCT programme in the Intermediate Hospital Oshakati, as a pilot study. Between 2002 and 2005, 1223 mothers who were HIV-positive and 92 partners were attending the PMTCT clinic. All respondents were enrolled in the PMTCT programme and came for follow-up on a regular basis. The main objective of the programme was to explore the prevention of PMTCT of HIV in Namibia through using ARV-drugs (Government of the Republic of Namibia, 2004a: 22).

2.8 CONCEPTUAL FRAMEWORK

The HBM of Rosenstock guided the description and interpretation of the data. The HBM is a model that was developed to provide a framework to explain why people participate in health programs. The focus of the model was to increase the use of preventive services such as screening services and immunization (Rosenstock, 1965)

The HBM is spelled out in terms of four constructs representing the perceived threat and net benefits:

- Perceived susceptibility: Opinion of chances for one to get a condition.
- Perceived severity: Opinion of how serious a condition is.
- Perceived benefits: Action to reduce risk or seriousness of impact.
- Perceived barriers: Side effects and psychological costs of the advised action (Nutbeam & Harris, 1999: 251).

According to Polit & Hungler (1995: 116), the HBM was developed to provide a framework to explain why the individuals participate in health programs. HBM has been used in the field of HIV/AIDS prevention. The model explains why people take action regarding their health problems, namely: individuals act to promote health; they become aware that they are susceptible to particular problems; they believe that the condition may have serious consequences; and that the problem may present a threat to their health.

The breastfeeding women were aware that their babies are susceptible to HIV/AIDS through breast milk. There are some benefits (perceived benefit) in breast-feeding the baby, even if the mother is HIV positive. Breast milk is the best as it contains valuable vitamins, which strengthen and build the immune system of the baby. Therefore it is important that the women breast-feed their babies for the first 4- 6 months of life, practise abrupt weaning and thereafter introduce them to solid food.

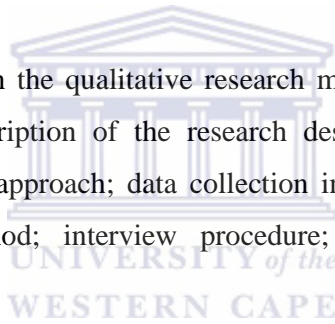
The HBM was used for this study since the study explored *the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS*. It was the choice of breast-feeding women living with HIV/AIDS to decide whether they wanted or not to

participate in the PMTCT programme, and if they decided to participate, to be assisted in their decisions on infant feeding.

2.9 CONCLUSION

This chapter reported on studies done regarding the problem of HIV/AIDS-transmission in breast-feeding women who are HIV positive. The literature highlighted the needs and challenges experienced by the breast-feeding women living with HIV/AIDS in Africa in general and in Namibia in particular. An overview was given about the specific programmes that focus on the prevention of mother-to-child transmission of HIV/AIDS. Finally, a theoretical model was identified to assist with the analysis of research data pertaining to the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in Oshakati, Namibia.

The next chapter focuses on the qualitative research methodology that was used to conduct the study. A description of the research design; research setting; study population; data collection approach; data collection instrument; trustworthiness of the study; sampling method; interview procedure; data analysis and ethical consideration is given.



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology includes the styles, procedures and ways of collecting and analysing data in a research investigation (Polit, Beck & Hungler, 2001: 465).

In Chapter Two the literature review of this study was presented. The contextual situation of women living with HIV/AIDS in the Oshakati district in Namibia was described. Studies relating to the transmission of HIV/AIDS from mother to child were discussed and the impact of government policy on the decisions of HIV-positive women about infant feeding was explored.

In this chapter, the process and methods used to conduct the study is explained. The research methods as well as the sampling of participants are described. The instruments used for data collection and data analysis as well as the ethical measures that were adhered to, is discussed.

3.2 RESEARCH DESIGN

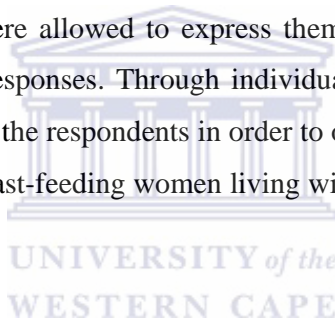
To comply with the qualitative nature of the study, an exploratory, descriptive research design was used to obtain complete and accurate descriptions of the situation as it existed (Burns & Grove, 1993: 24). An exploratory design was the most appropriate, because it was the first time that this topic was investigated in the Oshakati District. Exploratory research involves the testing of the ideas and viewpoints of the breastfeeding women living with HIV/AIDS in Oshakati. This will allow the researcher to describe the current situation and by doing so, develop an insight into their experiences (Patton, 1990: 178).

A qualitative descriptive study was used to gain in-depth information from the respondents (Mouton, 1996: 102). According to Burns and Grove (1993: 277) ... *qualitative research is a systematic approach used to describe the life experience of*

the individual and give meaning to the subject.... Qualitative data places emphasis on people's lived experiences. It is well suited for identifying the meaning that people place on the events, processes and structure of their lives. Their perceptions, knowledge and experiences become clear and can be placed in context with the social world around them (Patton, 1990: 94). Descriptive research allows the researcher to present a detailed account of the experiences of participants. The description includes their understanding of the topic under investigation and in this study the researcher may uncover the reason for the participants making specific feeding choices.

Qualitative research is done in natural settings. According to Babbie and Mouton (1999: 646), it allows the researcher to observe, describe and understand the subject, in order to explain human action in a natural setting.

In this study the women were allowed to express themselves in their vernacular to give the most appropriate responses. Through individual face-to-face interviews the researcher could get close to the respondents in order to obtain the information needed about the experiences of breast-feeding women living with HIV/AIDS in the Oshakati District.



In-depth interviews enabled the researcher to gain a better understanding of how the respondents perceived, understood and experienced their situation and how they coped within their respective communities. The intention was to explore the experiences of these women in order to draw conclusions and suggest recommendations to health related services.

3.3. SELECTION OF THE RESEARCH SAMPLE

The study population included breast-feeding women living with AIDS and attending the routine follow-up visits at the PMTCT clinic, Intermediate Hospital Oshakati (IHO), Northern Namibia. A study population is the entire group of people, which is the object of research and about which the researcher wants to determine some characteristics (Bless & Higson-Smith 1995: 85). According to Brink (2000: 133), sampling is the process of selecting a group of people or a portion of a target

population for a study. The Intermediate Hospital Oshakati was the site selected for the study.

A small sample of fourteen women who were enrolled in the PMTCT programme was selected. These women were of reproductive age, 15-49 years, who visited the health facility during the period of the research study. The research study was conducted during August and September of 2004. A purposive sample was used, to include breast-feeding women living with HIV/AIDS. The strategy in purposive sampling is to select units that are determined to be typical of the population under study (Bless & Higson-Smith, 1995: 95). This is a type of sampling in which subjects are selected because they are identified as knowledgeable regarding the subject under study, in this case breastfeeding women living with HIV/AIDS.

Qualitative studies tend to use small samples, in order to enable the researcher to investigate the situation in depth. Brink (2000:142), suggests that a few subjects should be selected for a qualitative study because many subjects could complicate the data analysis. Burns and Grove state that the researcher, using insight gained from the initial data collection would seek subjects with particular characteristics (2001: 376).

The sample criteria were:

- Breast-feeding women living with HIV/AIDS.
- Women willing to participate voluntarily in the study.
- Women who agreed to be interviewed and agreed to have the interviews tape-recorded.
- Women willing to describe their experiences regarding breast-feeding
- Women enrolled in the PMTCT programme.
- Women whose babies were of the age between one day and six months, and
- Women able to communicate in English or Oshiwambo.

The registered nurse in charge of the PMTCT clinic assisted the researcher to identify potential respondents. A copy of the sample criteria was given to the registered nurse in charge of the clinic. The registered nurse identified potential participants whom she

believed matched the sample criteria. She communicated this information telephonically to the researcher.

The researcher waited in an office at the clinic and the registered nurse referred potential participants to her. This happened during the two days that the women attended follow-up visits at the PMTCT clinic, namely on Tuesdays and Thursdays during August and September 2004. The women were informed about the aim of the research and those who agreed to participate in the study, were interviewed. The procedure and the reason for the tape recorder was explained and the researcher proceeded to obtain written informed consent from the participants (Appendix D).

3.4 RESEARCH INSTRUMENT

The instruments used were demographic questionnaires, interview guides and field notes of the nonverbal responses of the participants.

The demographic questionnaires allowed the researcher to capture the characteristics of the women who participated in the study. The data was used to provide some contextual information about the women.

The reason for using an interview guide was to ensure that information obtained from the fourteen breast-feeding women who were HIV-positive, covered the same material during the interviews and addressed the objectives of the research study. The interview guide also allowed the interviewer an opportunity to probe, should the responses of the respondents have been inadequate

According to Babbie & Mouton, (2001:643) the interview guide is a data collection instrument in which one person (interviewer) asks questions to another person (respondent). A semi-structured interview guide was developed to meet the objectives of the study (Appendix A, Section B). The schedule included a section on the demographic data of the respondents to capture the characteristics of the respondents (Appendix A, Section A). The following information was obtained: age, marital status, educational level, religion, employment, and number of children.

With the collection of the qualitative data, the interview guide was tested before the actual study was done. It allowed the researcher, to develop interview skills and to familiarize her with the questions. The interview guide was the main research instrument used by the interviewer to collect data about the perceptions, knowledge and experiences of the breast-feeding women living with AIDS in the Oshakati District – Northern Namibia (Appendix A, Section B).

The nursing personnel who were working in the PMTCT clinic during the time of the research study were used to test the interview guide. They were selected because of their experience in engaging with breast-feeding women living with AIDS. They were also in a position to provide comments on the instrument. The nurses were also asked to evaluate the interview guide critically in terms of content, clarity, style, format and the language of the questions. They were requested to consider the time required to complete the interview. This critical evaluation of the instrument was not done for the purpose of testing the validity of the instrument.

The nursing personnel provided valuable feedback for the modification of the interview guide. The wording and statements in the items that were not clear were highlighted and corrected, for example, the question on feeding of the babies. The nurses could not understand whether the feeding referred to the current babies or babies born before the HIV-status was confirmed.

During the in-depth interviews respondents had direct face-to-face contact with the interviewer and were encouraged to give honest answers. This method enabled the interviewer to use probe questions in order to get in-depth information. It also allowed the interviewer to clarify the questions, which were misunderstood by the interviewees (Burns & Grove 1993: 250).

Individual face-to-face interviews, however, have disadvantages, amongst others;

It is time consuming; respondents give wrong or incomplete information; respondents may experience time constraints (Polit & Hungler 1995: 245).

To overcome these disadvantages, the researcher negotiated with the interviewees to be available for a minimum of thirty minutes. The researcher also reviewed the individual questions with the respondents first, to ensure that the questions were correctly understood.

The advantages of semi-structured, face-to-face interviews are that:

- The researcher has an opportunity to probe in order to get more information;
- A number of different people can be interviewed;
- Systematic and comprehensive information can be obtained;
- It keeps the interaction focused and allows individual perspectives and experiences to emerge to gather high-quality data (Patton, 1990: 354).

During this study the researcher had to ask probing questions to obtain comprehensive information about the participants' feeding choices and occasionally to re-direct the interview. This interaction also facilitated the establishment of trust as it conveyed to the participants that the researcher was interested in their responses.

3.5 DATA COLLECTION

Finlay & Ballinger, (2006: 38-39) describe data collection as a precise, systematic method of gathering information, which is relevant to the study.

According to Patton (1990: 283), there are four people-oriented mandates in the collection of qualitative data:

Firstly, the qualitative methodologist must get close enough to the people and situation being studied to personally understand in-depth details of what goes on. In this study, the researcher attended the PMTCT clinic in order to meet with the breast-feeding women living with HIV/AIDS, who enrolled themselves in the PMTCT programme. Secondly, the qualitative methodologist must aim to capture what actually took place and what people actually said. In this study, the researcher

interviewed the women living with HIV/AIDS individually, in order to explore their perceptions and experiences with regard to breastfeeding. Thirdly, qualitative data must include a great deal of pure description of people, activities, interactions and settings. The demographic data questionnaire provided a fair amount of description about the women. During the interviews they described their experiences. Fourthly, qualitative data must include direct quotations from people, both what they spoke and what they wrote (Patton, 1990: 32). The researcher therefore recorded the views of the women so that many of the direct quotations of what they said could be recorded in the research report. Examples of verbatim quotations include:

Respondent 08: *My mother said ...cultural, and according to her family's beliefs and myths, the baby cannot be breast-feeding if he/she overnight without breast-feeding. I should wean the baby immediately.*

Respondent 10: *I decided to leave the house, but the relationship with the parents is fine and I decided to stay there.*

3.5.1 The data collection process

The data collection was done during March and April 2005 in the Intermediate Hospital Oshakati, Oshana Region, Namibia. The focus of the face-to-face interviews was to explore the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS.

The researcher explained to all the respondents individually, about the aim of the research study and the expected benefits for both the researcher and the respondents. The researcher would develop research capacity and the respondents would contribute to the body of knowledge about the experiences of breast-feeding women living with HIV/AIDS.

Thirteen out of the fourteen breast-feeding women living with HIV/AIDS signed the voluntary informed consent form. One woman agreed to be interviewed, but refused to sign. She misunderstood the reason for the interview and assumed that the researcher would broadcast her HIV-status through the Namibia Broadcasting Company (NBC).

Interviews were conducted in a local language (Oshiwambo) while the women were waiting to see the nursing personnel at the clinic. The breast-feeding women living with HIV/AIDS responded in their own words and expressed their individual perceptions, knowledge and experiences. Data was recorded on an audio-recorder with the permission of the respondents. The respondents were assured that this was only to ensure that no important details would be left out. Notes were written after each interview.

The in-depth interviews allowed the researcher to ask probing questions until saturation of information was reached. It also allowed the researcher to focus on a particular issue, for example, to identify important decisions, (sudden weaning) during the interviews. Interviews conducted face-to-face are more intimate and enabled the researcher to build relationships with the respondents. The researcher could observe the non-verbal communication demonstrated by the respondents, which indicated confusion or lack of understanding. The interviews were conducted in a quiet environment without disturbances. The interviews lasted between twenty to thirty minutes. Provision was made for respondents to state any other additional information they had in order to avoid missing important issues.

The transcriptions were done one to two hours after the interviews. The tape recordings were transcribed verbatim and later translated from Oshiwambo into English. The registered nurse in charge of the PMTCT clinic checked the data for accuracy and consistency, and verified the transcriptions and translations, which were done by the researcher. The tapes and transcripts are available for the purpose of examination of the thesis.

To ensure anonymity, the names of the respondents were not used during the transcribing of interviews. Codes were used and linked to the names of the respondents. Data collected were locked up in a safe place. Each interview was transcribed on a separate sheet, numbered according to the interviews and identified with all the relevant data e.g. date, time of interview, as well as code number for the respondent.

3.6 DATA ANALYSIS

According to Marshall and Rossman (1995: 111), '*data analysis is the process of bringing order, structure and meaning to the mass of collected data*'. Qualitative data analysis is the process of systematically organizing the field notes, interview transcripts and other accumulated materials until they are understood in such a way as to address the basic research question. In addition, it enables the researcher to communicate that understanding to the other people who are involved in the research process (Patton, 1990: 374).

The researcher used the thematic content analysis method to analyse the data collected. Abbott and Sapsford (1999: 135) suggest that analysis brings order to the data, organising it into patterns, categories and descriptive units. The process involves looking for similarities and differences in the data. These similarities and differences represent the categories and sub-categories, which according to Patton (1990: 381) *present the primary patterns in the data*.

Thematic content analysis provides a systematic means of identifying the frequency and order of words, phrases and sentences in a transcribed case. The analysis is designed to re-organize these words, phrases and sentences into categories, chosen because of their theoretical importance to the study. Categories are further explored across cases and grouped into various themes (Burns & Grove, 2001:619).

The researcher listened to the audio taped interviews immediately after the daily interview sessions to note emerging patterns. The researcher listened carefully to all the information and read the transcripts and notes in order to understand the meaning of what was said. Notes about non-verbal communication were recorded during and after the interviews. The transcriptions were repeatedly read and all prior knowledge regarding the data or preconceived ideas were bracketed. The focus was on the responses to the interview questions as transcribed. Key phrases and words used repeatedly were underlined. Summaries of responses were read three or four times with the aim of identifying the main categories. The researcher wrote down ideas as they came to mind. Data analysis assisted the researcher to discover categories and themes embedded in the interviews (Streubert & Carpenter, 1999: 24). The identified

categories were grouped together under main headings and subheadings according to their similarities.

Quotes from statements of the respondents were used to illustrate and support the findings of the study. The raw data after each interview was checked against the existing categories for similarities and differences. The process of analysis stopped when no new information was found, and saturation of discovered information was reached. The emerged themes and categories were compiled to write the report on the findings.

3.7 TRUSTWORTHINESS OF THE STUDY

Trustworthiness of the study was considered during the research process namely, credibility, transferability, dependability and conformability.

For the purpose of a qualitative study, the following applied:

An attempt was made by the researcher to ensure credibility through face-to-face engagement with respondents. Babbie and Mouton (2001: 277) suggest that through close contact, the researcher would build a trusting relationship with the respondents. In this study the researcher was participating in the collection of the data in order to explore the perceptions, knowledge and experiences of breast-feeding women living with AIDS. She employed specific strategies to gain the participants' trust by listening attentively, maintaining eye contact and responding appropriately. The tape-recorded data, transcripts of the interviews and anecdotal field notes ensured the availability of raw data.

According to Polit and Hungler, (1995: 362) transferability is ensured through comprehensive description of the context and the purposive sampling of participants. In this study the researcher collected sufficient detailed information through individual face-to-face, in-depth interviews to provide a comprehensive description of the experiences of the breastfeeding women living with HIV/AIDS. Demographic data was collected to provide contextual detail. Sampling was purposive (see 3.3). In

qualitative studies, transferability refers to experiences of participants within similar contexts.

Babbie and Mouton (2001: 277), state that an external reviewer could ensure dependability through an external audit that involves scrutiny of the data and relevant supporting document. Transcripts were verified by a registered nurse and are available for scrutiny. It is argued that a qualitative study that establishes credibility also establishes dependability

Conformability in qualitative research focuses on the characteristics of the data (Babbie & Mouton, 2001: 277). In this study, the tape-recorded cassettes allowed the researcher to do verbatim translations. Direct quotations of the respondents' responses were used in the analysis of the data and reporting of the research findings.

3.8 ETHICAL CONSIDERATION

Sellers (1993: 69), describes ethics as a discipline of systematic reflection and analysis designed to enable the people to resolve questions about what ought to be done in a consistent manner. This included confidentiality and respect for clients as unique individuals. According to Searle (2005: 97), professional ethics are moral dimensions of attitude and behaviour based on values, judgement, responsibility and accountability, which the practitioner takes into account when weighing up the consequences of her professional actions.

In this study, ethics clearance was granted by the Higher Degrees Committee of the University of the Western Cape before the commencement of the research. Permission to do the research study in Oshakati was obtained from the Permanent Secretary of the MOHSS in Namibia and the Senior Medical Superintendent of IHO.

The dignity, privacy and confidentiality of the respondents were respected. The information, which was provided, was kept strictly confidential to be utilized only for the purpose of the study. Respondents signed informed consent before the interviews took place. Participation was voluntary and respondents signed the informed consent form after they were informed about the aim of the study. The benefits associated

with the study, namely, that they will contribute to the information base of the experiences of breastfeeding women in Namibia, were explained to them. They were also reassured that there were no real risks associated with their participation in the study. They were informed that they were allowed to terminate their participation in the study at any time.

The names of the respondents were recorded on the interview schedule and linked to code numbers in the master list to ensure anonymity and confidentiality (Jackson, 2002: 187). All the documents and audiotapes were stored in a locked cupboard. The researcher was the only person who had access to this cupboard. The research report was written in such a way that individuals could not be identified through their responses. Polit et. al., (2001: 75) state that the researcher should maintain honesty and present accurate information in reporting of the findings. Verbatim quotes were interspersed in the research report to reveal the voice of participants.

The information obtained regarding challenges of the breast-feeding women living with HIV/AIDS, concerning the feeding options, provided important baseline information and will be discussed in Chapter Four.

3.9 PERMISSION TO CONDUCT RESEARCH

Permission to do the research study in the Oshakati District was obtained from the Ministry of Health and Social Services in Namibia (Appendix B). Permission to conduct the research study in Intermediate Hospital Oshakati was obtained from the Senior Medical Superintendent of the hospital (Appendix C). The respondents also gave consent by signing the informed written consent forms (Appendix D).

3.10 DELIMITATION OF THE STUDY

This study was conducted in Oshakati District in the northern part of Namibia. The research was not limited to ethnicity or culture, but all the research respondents were Oshiwambo speaking women. The study sample was aimed at including breast-feeding women living with HIV/AIDS in the Oshakati District. The study sample was limited to those women who were enrolled in the PMTCT programme and attending

the follow-up visits at the PMTCT clinic during the time this study was conducted. The women had babies ranging in age from birth to six months old. The study is limited to a small sample size to collect in-depth information about the respondents.

3.11 CONCLUSION

The chapter described the overall research design, which guided the researcher in the investigating of the perceptions, knowledge and experiences of breast-feeding women living with AIDS in the Oshakati District. An explorative, descriptive design was utilized for the study. The study was conducted at the PMTCT clinic in the Intermediate Hospital Oshakati.

Research ethics and human rights were adhered to. In the next chapter research outcomes will be presented and discussed.



CHAPTER FOUR

RESEARCH OUTCOMES: PRESENTATION AND DISCUSSION

4.1 INTRODUCTION

In the previous chapter, the research methodology was presented and discussed. In this chapter data analysis will be discussed, according to the identified themes, categories and sub-categories.

The data was collected through individual face-to-face interviews. The first part (Section A) of the interviews covered the demographic information of the respondents. The data collected in the second part (Section B) addressed the following research question: What are the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District?

In this chapter the research outcomes of the study are presented and discussed in relation to the findings of other research studies.

4.2 SECTION A: DEMOGRAPHIC DATA

The sample consisted of fourteen (N=14) breast-feeding women living with HIV/AIDS in the Oshakati District - Oshana Region.

The age of the women who participated in the research study ranged between 15 – 49 years. The majority age group was between 30 – 39 years (N=7) followed by 20 – 29 years (N= 4) and then 15 – 19 years (N=3).

Nine (N=9) of the fourteen breast-feeding women living with HIV/AIDS who took part in the research study were unmarried, while five (N=5) were married.

The education level ranged from grade five up to tertiary education. One respondent (N=1) completed the Basic Education Teaching Diploma (BETD). Ten (N=10) respondents' educational qualification ranged from Grade eight up to Grade 12. Two

(N=2) respondents attended primary school (grade one to grade seven) and one (N=1) respondent did not attend school. Thirteen respondents were literate and one was illiterate.

The findings dealing with the employment status of the respondents indicated that, twelve (N=12) of the fourteen (respondents) breast-feeding women living with HIV/AIDS in the Oshakati District were not employed, and only two (N=2) were employed.

The findings on the parental status of the respondents indicated that eleven (N=11) out of the fourteen breast-feeding women who participated in the study had one to two children. Two women (N=2) had 3-4 children and only one woman (N=1) had five children.

All the respondents spoke Oshiwambo. The researcher communicated easily with the respondents. Since the research sample was small, no generalizations could be made about the data. However, the following issues were observed.

Ten (N=10) of the respondents belonged to the Lutheran church, while one (N=1) of the respondents belonged to the Anglican Church. Three (N=3) respondents belonged to the Roman Catholic Church. The findings of the study indicated that the majority of the respondents were members of the Lutheran Church. The major Christian denomination practised in Namibia is Lutheran.

Most of the respondents in this research study were unmarried mothers. Sometimes, their partners were married men or *sugar daddies* (older men who have sexual relationships with young girls). This is in line with the findings of the NDHS, (2000: 54) which indicated that single mothers seem to be a national phenomenon.

Some mothers were young, which is a very unfortunate situation. They did not complete school since they had to do some work to earn an income. They found themselves in a difficult situation of being mothers at a young age while they were also expected to take care of their parents. On the one hand, the teenagers found themselves in a crisis of being infected with HIV/AIDS. On the other hand, the

teenagers experienced emotional turmoil, guilt feelings and conflict when they realized that the goals they had set in life were now unlikely to be achieved, for example finishing school to get well-paying employment. As a result of their pregnancies the teenager respondents left school before they had completed Grade 12.

Only nine (N=9) of the fourteen breast-feeding mothers participating in the study were supported by their partners and husbands, though they were not working. The other five partners of the breast-feeding women discontinued the relationships when they found out that the women had been infected with HIV/AIDS.

4.3 SECTION B: QUALITATIVE DATA

In this study, categories were identified and clustered according to specific themes. The data are presented in a report writing style and the findings relate to the conceptual framework. The purpose of qualitative data analysis is to organize the research data into a meaningful research report. The researcher identified similarities in the data from the onset of the data collection process, which was based on the responses to the following research question: What perceptions, knowledge and experiences do HIV-positive breast-feeding women have in Oshakati-District – Northern Namibia?

Transcripts of the interviews were read and re-read. The responses of individual respondents were further interrogated since respondents referred to a number of different issues in a single response, e.g.

Respondent 14: I breast-feed her for the first day. The second day I start to give formula milk from the tin. I will give formula milk only. I ... aah! The reason I give formula milk, is because when I breast-feed, the baby start vomits ... but if I give formula milk ... the baby is fine. [Long pause] (Sign of emotion noticed on her face, eyes were full of tears). Like now, I do not have milk ... the breasts are empty. I cannot do otherwise.

The respondent was answering the question related to breast-feeding. However, in her response she provides additional information about the challenges she experienced

with breast-feeding as well as the reason for switching to formula feeding. The reason for her having to choose formula feeding in this instance is unrelated to her HIV status. The response of this breast-feeding woman was categorized as:

- Abrupt weaning (Inadequate breast milk)
- Feeding problem (baby vomits)
- Choosing formula feeding

I proceeded with the data analysis process at an individual response level and thereafter cross-case analysis was done. In cross case analysis the similarities and differences between individual responses were captured, e.g. some respondents practised abrupt weaning when the infants were one day, three months or four months old. The respondents also offered different reasons for weaning, e.g. cultural, financial constraints or inadequate production of breast milk. Many respondents based their breastfeeding choices on the perceptions they held about, amongst others, the cultural expectation about breastfeeding. If a baby did not have breast milk for one entire day and night the baby should be weaned. The women also had knowledge about the HIV-transmission via breast milk but their perceptions about exposing their HIV-status influenced their decisions to breastfeed their babies. Their perceptions, based on prior knowledge and socio-cultural experiences, generally emerged during the data analysis phase of the research process.

Once all the categories were identified, they were grouped into the following themes, e.g. knowledge about HIV and infant feeding, choices about infant feeding, challenges experienced by breast feeding women, support needed by breast feeding women.

KNOWLEDGE ABOUT HIV AND INFANT FEEDING

- Knowledge about HIV.
- Knowledge about transmission of HIV/AIDS.
- Knowledge about infant feeding.

CHOICES ABOUT INFANT FEEDING

- Exclusive breast-feeding.

- Exclusive formula feeding.
- Mixed feeding.

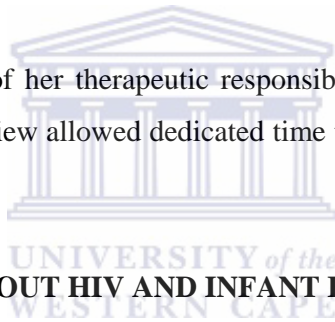
CHALLENGES EXPERIENCED BY BREAST-FEEDING WOMEN

- Challenges with the family.
- Challenges with the partners.
- Financial challenges.

SUPPORT NEEDED BY BREAST-FEEDING WOMEN.

- Support from the partners and family.
- Support from the community.
- Support from the health professionals.
- Support from Health Service Providers (Policy).

The researcher was aware of her therapeutic responsibility versus the research role and at the end of each interview allowed dedicated time to address the concerns of the respondents.



4.3.1 KNOWLEDGE ABOUT HIV AND INFANT FEEDING

Respondents described their knowledge about HIV/AIDS, its transmission and their knowledge about infant feeding.

4.3.1.1 Knowledge about HIV/AIDS and its transmission

Knowledge about HIV and its transmission is important to everybody and especially to breast-feeding mothers in order to avoid MTCT (Government of the Republic of Namibia, 2004a: 3). The interview guide allowed me to determine what the individual respondents understood about HIV/AIDS and how it is transmitted. It appeared as if some women knew very little about HIV/AIDS.

Respondent 6: *HIV/AIDS is a killer disease.*

Respondent 10: *I never hear about HIV. I only hear about AIDS. AIDS is a*

disease that develops by using used instruments, for example razor blade or through used needles. Contaminated razor blades, which are used by traditional healers, cut the skin and will infect the next person with HIV/AIDS.

Respondent 11: *HIV is a disease, which causes AIDS.*

Respondent 12: *HIV/AIDS is a disease that develops in unhygienic conditions.*

According to the literature HIV is a virus, which attacks, kills and damages the cells of the immune system of the body (Jackson, 2002: 1). AIDS is the condition whereby the body loses the ability to fight infections because of a weakened immune system (Jackson, 2002: xxi).

It is noted that despite the efforts of the Government of the Republic of Namibia in giving information about HIV/AIDS, there are still people who do not have adequate information about HIV/AIDS. These women can still be vulnerable to further re-infection. The above-mentioned information is similar to the findings from a study conducted in Kayelitsha, South Africa, which indicated that breast-feeding women living with HIV/AIDS did receive some information, but not enough to fully understand everything about HIV/AIDS (Sexton, 2000: 6).

According to Nashandi (2002: 4), lack of information, knowledge about sexuality and lack of power to discuss and negotiate safe sex, made the women more vulnerable to HIV/AIDS.

Amongst Namibian communities, HIV/AIDS is increasing. Many people believe that witchcraft or evil spirits cause the HIV/AIDS-disease. People do not acknowledge AIDS as the primary cause of death (SAfAIDS et. al., 2003: 8).

Although there are those who have little information about HIV/AIDS, some women do have knowledge of how HIV/AIDS is transmitted.

Respondent 13: *HIV/AIDS is a disease, which a person can get through sexual activities with a person who is infected with HIV/AIDS.*

Respondent 03: *HIV/AIDS can be transmitted during pregnancy, breast-feeding and the mother can transmit the virus if she involves in unprotected sexual activities.*

Respondent 10: *It can be transmitted if the baby has been breast-fed and you give other food. It is possible to develop thrush or sores caused by additional food you give to the baby. The nurses told us that if you are having cracked nipples, you could transmit the virus to your baby.*

Respondent 09: *It can be transmitted if you do not follow information given to you, for example, if you decide to breast-feed the baby for longer than four months. Transmission happens also through breast milk.*

Some respondents explained that HIV is a virus, which causes AIDS. Most of the breast-feeding women who participated, understood that HIV/AIDS is a killer disease. Some said that it is an infection that is transmitted from the woman who is HIV positive to her child during pregnancy, labour and delivery, or through breast-feeding. A few stated that AIDS is a disease that develops in unhygienic conditions by using contaminated instruments, for example razor blades that can cut the skin. Some explained that HIV/AIDS is a disease that people can get when they have a sexual relationship with a person infected with HIV/AIDS. This information is similar to the information in the Government of the Republic of Namibia's survey report (2002: 9).

Most women do not discuss condom use with their partners. Women will become infected with HIV/AIDS as a result of unsafe sexual practices. There is a need to involve husbands and partners in all efforts to assist their women in coping with the situation of living with HIV/AIDS (Nashandi, 2002: 4).

Some respondents mentioned that cracked nipples could also transmit HIV from mother to child if the mother is breast-feeding. Those women who have some information about HIV/AIDS said that they have heard it through listening to the radio. The nurses at the clinic also gave health education during antenatal clinic visits. A few read the information in the books and pamphlets.

Respondent 03: *The nurses who are working in the office next door told us ... I read also in the books and pamphlets.*

Respondent 04: *The nurses told us during antenatal care at the clinic.*

The information shared by the breast-feeding women, is in line with the PMTCT guideline, which state that, all pregnant women and their partners attending antenatal care should be given information about HIV and the transmission of the disease (Government of the Republic of Namibia, 2004a: 8).

It seems that there are still some women who did not hear about HIV/AIDS. One respondent stated that she did not understand clearly what HIV/AIDS meant. One said that she has never heard about HIV, but she only heard about AIDS. The lack of knowledge could be as a result of ignorance about the spread of HIV, or the messages aimed at informing the community about HIV/AIDS is not communicated effectively.

The study revealed that some breast-feeding women living with HIV/AIDS have knowledge about the transmission of HIV from mother to child. However, a lot needs to be done concerning the awareness of HIV/AIDS transmission in the Oshakati district, Namibia.

According to the United Nations strategic approach to the prevention of transmission of HIV to infants and young children, there are four focus areas, namely:

- Prevention of HIV infection, especially in young women and pregnant women;
- Prevention of unintended pregnancies among HIV-infected women;
- Prevention of HIV transmission from HIV-infected women to their infants; and
- Provision of care, treatment and support to HIV-infected women, their infants and families (Jackson, 2002: 146).

A sustainable and significant impact will be achieved only when all four areas are in place and functioning. Primary prevention programmes provide education about safer sex, condoms and diagnosis and treatment of sexual transmitted diseases (WHO, 2004: 12).

The guidelines for the PMTCT state that the most common mode of HIV transmission in children is vertical infection from women who are HIV-positive to their children during pregnancy, labour and delivery, or through breast-feeding (Government of the Republic of Namibia, 2004a: 3).

According to Sexton, (2000: 3), the transmission of the *virus occurs during pregnancy (risk of infection is 5-10%), labour and/or delivery (risk of infection is 10-20%), and through breast -feeding (risk is thought to be 10-20%) in breast-feeding women who continue to breast-feed after the first year.*

This study indicates that many women have an idea of what HIV/AIDS is, and how it is being transmitted. They received most of their information from the nurses at the clinic. However, the perception that HIV/AIDS is a disease that develops in unhygienic conditions, may negatively impact on their decisions pertaining to breast-feeding versus formula feeding.



4.3.1.2 Knowledge about infant feeding

Infant feeding is a challenge when it comes to HIV-positive mothers, especially if the mother opted for breast-feeding. HIV-positive mothers are doing their best to feed their babies. They should therefore receive support in whatever choice they make regarding feeding. Breast milk is the best feeding for the babies for proper growth and development, but in the context of HIV, this has to be modified to minimize the risk of HIV-transmission (WHO, 2004: 12).

There are other feeding options and nurses should provide information to assist the HIV positive mothers with the feeding of their babies. Replacement feeding is the process of feeding an infant who is not receiving any breast milk, with a diet that provides all the nutrients the child needs (Government of the Republic of Namibia, 2004c: 29). It includes for example, commercial infant formula or modified animal milk. Where replacement feeding is not possible, mothers may choose among three other strategies to reduce the risk of breast milk transmission. The strategies are:

breast milk options of wet nursing, expressing and heat-treating breast milk, and breast milk banks (WHO, 2004: 17).

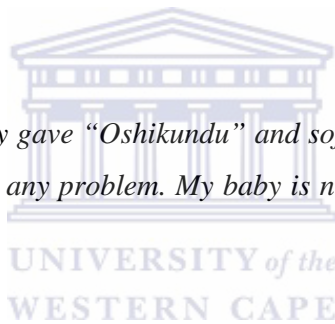
The response to the question about breast-feeding and other feeding options were:

Respondent 05: *Breast milk is the best to feed the small baby. I decide to breast feed the baby at the age of four months and I will introduce other available food.*

Respondent 02: *I will read the pamphlet in the tin to prepare the formula when my baby turns six months.*

Respondent 07: *I will go back to the hospital to be shown by the nurses how to prepare formula.*

Respondent 10: *I only gave "Oshikundu" and soft porridge as from birth. The baby did not develop any problem. My baby is now nearly to turn six months. She grows well.*



Some women opted for exclusive breast-feeding for the first four months and then changed to other feeding methods. Breast-feeding women living with HIV/AIDS indicated that they have knowledge about feeding of infants. However, the study reveals a lack of knowledge how to prepare formula feed.

Commercial infant formula, modified animal milk, for example cow's milk, is closest in nutrient composition to breast milk. Formula is usually available in powder form to be mixed with water. Instructions on the tin should be followed exactly to ensure that it is not too concentrated or diluted. Animal milk can also be modified to suit the babies (Government of the Republic of Namibia, 2004c: 29).

A wet nurse should be a tested HIV-negative woman, who agrees to feed the baby. She understands the implications of HIV, HIV testing and counselling and that she should be tested regularly. She has to be counselled about HIV and the implications of becoming infected while she is breast-feeding the baby (WHO, 2004:17).

The findings of this study indicated that the breast-feeding women living with HIV/AIDS and who participated in this study, did not have knowledge about a wet nurse and their responses related mainly to breast-feeding, formula feeding and soft porridge.

4.3.2 CHOICES ABOUT INFANT FEEDING

Some categories that emerged from the choices that HIV-positive mothers made about infant feeding were: exclusive breast-feeding; exclusive formula feeding and mixed feeding.

4.3.2.1 Exclusive breast-feeding

There are two feeding options that a HIV-positive mother can choose to minimize HIV transmission to the baby; exclusive breast-feeding and abrupt weaning or exclusive replacement feeding (breast milk substitute).

The research findings show varying responses.

Respondent 6: I feed the baby with breast milk. Oh, I would like to avoid the transmission of the virus to my baby. I will introduce the baby to formula milk when he becomes three months. The nurses in the hospital who are working in the maternity ward told us to stop breast-feeding after four months at the antenatal clinic, to avoid the transmission of HIV infection through breast milk.

Respondent 10: I breast-feed and give also water until he turns four months. After four months I never give him milk and water anymore. I give him now soft porridge.

Respondent 12: I give only breast milk, nothing else. I decided to start with formula milk and soft porridge, when the baby becomes four months. The nurses in the clinic told us to make choices about the feeding of babies.

Respondent 9: *I breast-feed for three months and introduce the baby to soft porridge and “Oshikundu” to prevent the baby against HIV/AIDS infections.*

The women decided to practice exclusive breast-feeding and would introduce the babies to formula milk, soft porridge and “Oshikundu” after four months, until the babies are big enough to take available normal food. Some of the mothers who opted for breast-feeding, breast-fed their infants for a period of three to four months exclusively. Their choices are based on their need to avoid the transmission of HIV infection through breast-feeding.

Breast milk is cheap and is best. It is culturally expected that mothers breast-feed the babies. Most participants were aware of the slogan “breast milk is best” and “breast-feed for a healthy nation” (Sexton, 2000: 3). WHO states that exclusive breast-feeding with early cessation should be used by breast-feeding women who are HIV positive, for whom replacement feeding is not acceptable, feasible, affordable, sustainable or safe. In many countries where HIV-prevalence is high, exclusive breast-feeding is recommended for the first six months of life (WHO, 2004: 17).

Respondent 10: *I decide to breast feed my baby for two months and after that I will introduce formula. I am employed. The expressed milk will not be enough while I am at work.*

Respondent 07: *I decided to breast feed the baby but my partner came and took the baby away for three days. She was two months old. The time the baby came back, I introduce soft porridge and “Oshikundu”. I am not working and I do not have money to buy formula.*

One respondent decided to breastfeed her baby, but her partner took the baby away for three days. Culturally, if babies are not breast-fed for one night, they cannot be breast-fed any longer. The mother opted to introduce soft porridge and “Oshikundu”. She was unemployed and did not have money to buy formula. The partner was not supporting her and he discontinued their relationship. This also happened to some of

the other respondents. It is also important to note that those women who are employed may decide to switch to formula feeding.

A few respondents stated that they breast-feed the babies because they know that the babies would grow well if they are breast-fed. They knew the benefits of breast-feeding. However HIV-positive women believed that a course of action was available to minimize the consequences of transmitting HIV to their babies. They had to practice abrupt weaning when their babies are four months old.

Respondent 05: *I believe that in the breast milk there is everything needed by the baby. The baby will grow well if she is sucking from her mother's breasts.*

Jackson (2002: 160) stated that in breast milk the infants will get everything they need concerning nutrition, especially those nutrients needed to help build the immune system of the infants.

According to the HBM an individual would take action if they perceive that their health is threatened. A lack of knowledge is described as a potential barrier to taking relevant health action. Respondents stated that they will go back to the hospital for more information, which indicates that there is a need for breast-feeding women who are HIV/AIDS-positive to be given proper guidance by the nurses. It is also equally important that this guidance should be given individually to suit their circumstances (WHO, 2003: 10).

Breast milk is an economic and safe mode of infant feeding and is important in promoting the mother-infant-relationship. It prevents the child from developing diarrhoea and other childhood illnesses and may enhance the infants' 'intellectual development'. After six months babies should receive adequate and safe complementary food up to 24 months and beyond (WHO, 2004: 12). However, according to Jackson (2002:160), breast milk has the benefits of containing antibodies that are needed by infants, but the risk of being infected by HIV outweighs the benefits gained by breast-feeding infants.

One respondent was challenged by her baby's reaction to breast milk. The mother opted to change the feeding practice. The mother could have gone back to the clinic or hospital to ask for more information because there could be another reasons why the baby was vomiting which could have been unrelated to the breast milk. She stated:

Respondent 14: *The reason I give formula milk, is because when I breast-feed, the baby start vomits ... but if I give formula milk ... the baby is fine.*

In Namibia, cultural factors influence the choices of women to breast-feed. The study indicated that HIV-positive mothers are faced with dilemmas of culture when it comes to breast-feeding. An example is the problem of the baby who overnighted without breast-feeding and was declared not fit for breast-feeding was a challenge to that specific mother. She is obliged to respect and adhere to cultural beliefs and stop breast-feeding. This could affect the baby's health negatively as she may not have money to buy formula milk. The mothers are afraid of being questioned about not breast-feeding young infants of five months, for example. This perception may be one of the reasons why mothers may opt to provide mixed feeding in order to satisfy their partners and elders in the families.

In Kenya, it was found that choice was improved if the partner was aware of the HIV-status of the mother and involved in the decision whether to breastfeed or to formula-feed (WHO, 1998: 12). It appeared in this study that the mothers' choices about exclusive breast-feeding depended on their current knowledge and experiences.

With regard to exclusive breastfeeding, abrupt weaning and the introduction of replacement feeds, the findings of this study are in line with the studies conducted in Africa and India. These studies indicate that women exclusively breast-feed their infants for four months, practice abrupt weaning and then introduce soft food as a replacement feeding (Government of the Republic of Namibia, 2003a: 6).

4.3.2.2 Exclusive formula feeding

There are other feeding options that nurses could share to assist the HIV positive mothers namely, replacement feeding, for example commercial infant formula or modified animal milk.

These research outcomes will describe the understanding of the breast-feeding women living with HIV/AIDS about the formula feeding of the infants. They were asked about the preparation of infant formula feeding.

Respondent 13: *The nurses in the hospital showed me how to prepare ... the day I was discharged in the hospital. My baby is now three weeks old. When she become four months I will go back to the hospital ... the nurses will show me again about the preparation of the formula.*

Respondent 04: *The instructions are stated clearly on the tin and there is also a pamphlet with information. I will follow the instructions.*

Respondent 11: *I do not know how to prepare. I will not give formula milk to my baby. After four months I will give soft porridge water and other drinks available.*

Respondent 09: *I do not know how to prepare. I neither will nor use formula milk. My husband was far from home and at that time I never informed my parents about my HIV status. I knew there is nobody who will buy formula food for the small baby. I thought at the age of four months the baby will be big enough to take other food.*

The study revealed that some of the participants did not know how to prepare formula feeds. The breast-feeding women living with HIV/AIDS, who experienced problems with the preparation of formula feed, decided to go back to the hospital for additional information.

Most of the breast-feeding women living with HIV/AIDS have knowledge about the preparation of the formula milk. The women knew about the pamphlet in the tin with clear information on how to prepare the formula. Some of the breast-feeding women living with HIV/AIDS, who do not know how to prepare the formula, opted for soft porridge and “Oshikundu” as a replacement feeding.

Although the nurses might have informed mothers about the preparation of formula feeds, they appeared to be uncertain. The mothers who did not know how to prepare the formula milk are a cause of concern because if the milk is not prepared well, or if there is no clean water, it could cause diarrhoea in infants. The unavailability of clean water and using of dirty utensils make the children of mothers infected with HIV vulnerable to malnutrition. It may be difficult to provide breast milk substitutes to children from underprivileged populations (Coutsoudis, 2004: 90). Coutsooudis also states that infant formula feeding cannot be recommended in all communities, especially in rural areas and to people who are living in poverty. Clean water should be available and the people should know how to prepare formula safely (Clarke, 2003: 10).

The findings indicated that some of the respondents who opted for infant formula feeding after they stopped with breast-feeding have knowledge on how to prepare it. However, infant formula feeding is a challenge on its own, due to the fact that even those breast-feeding mothers who decided to breast-feed for four months only, could not afford formula feeding and decided on alternative feeding practices. These women received health information from the nurses at the antenatal clinic to avoid breast-feeding for a prolonged period of time to minimize MTCT. The decisions of the women about infant feeding were dependent on their past and current knowledge, experiences as well as the real or perceived challenges that they face.

4.3.2.3 Mixed feeding

Mixed feeding in this study is understood as the type of infant feeding whereby the mother is breast-feeding and at the same time she is giving other feeding, including formula feeds, juice, porridge, “Oshikundu” and water.

The PMTCT programme in Namibia is aimed at informing women about the risk of transmission of HIV to babies via breast-feeding. During the antenatal period, women who are HIV positive are counselled about the risks and benefits of breast-feeding and informed about replacement feeding (Government of the Republic of Namibia, 2003a: 19).

Respondent 12: *I have a concern about exclusive breast-feeding and exclusive formula feeding. This is not an easy task to practice at home. Like me ... if I think about the weaning of the baby ... during the day is not difficult. Think now... the formula milk get finish during the night and the baby start crying ... Can I tolerate the crying of this baby... no... really? I will put the baby back to the breasts. This is also a possibility of some women who decided to give formula milk exclusively ... something wrong can be practised there.*

Respondent 14: *The nurses do not know what we are doing there in the community. She can ask me here what I feed her... I will tell her what she want to hear from me ... but in the mean time is not what I am doing at home. To make things easier, I could give something else to satisfy the baby, here... I will tell her that I am breast-feeding”.*

The study revealed that the breast-feeding women living with HIV/AIDS had difficulties to practice exclusive breast-feeding or exclusive formula feeding. When they run out of the formula milk or have insufficient breast milk they were forced to give something else to the babies even though they were aware that mixed feeding would transmit HIV/AIDS from mother to the baby.

It also happens when the mothers came for follow-up visits and are asked by the nurses about feeding practices, they would tell the nurses what they are expected to do, while at home they did something else. The importance of exclusive breast-feeding should be emphasised as mixed feeding increases the risk of HIV transmission and other infections. Mixed feeding is the most dangerous feeding practice (Sexton, 2000:4).

A few respondents breastfed and at the same time gave water, juice, other drinks, soft porridge, “Oshikundu” or other available feed. Due to inadequate information about the choices of feeding practices, the respondents were not all aware about the danger of using mixed feeding for the babies. The study indicated that mixed feeding is not a choice but rather an alternative as mothers were left with no other means to satisfy their babies.

Within the Southern African communities it is a taboo for mothers not to breast-feed their babies (Southern Africa HIV/AIDS Action, 2003a: 10). In many countries and from various cultures, mothers are unable to make decisions about formula feeding as fathers and grandmothers interfere in these decisions (SAfAIDS, 2003). Men are likely to be supportive if they are asked for their opinion and how they feel about their choices of infant feeding (WHO, 2004: 17).

Choices about infant feeding are dependent on the guidelines on child feeding, i.e.: The guidelines of the National Policy on Infant and Young Child Feeding of the Republic of Namibia (Government of the Republic of Namibia, 2003a) states:

The policy recognises the WHO/UNICEF/UNAIDS policy guidelines on HIV and infant feeding, incorporated the Namibian situation, and reflects government commitment to:

- *Promote, protect and support breast-feeding for the first six months, and continued breast-feeding to two years or beyond with adequate complementary foods from six months and optimal feeding for children up to five years.*
- *Counsel and support mothers who are HIV-positive to care for themselves, and practice one of the following children feeding options safely*
- *Exclusive replacement feeding using infant formula, modified cow’s/goat’s milk, where they are affordable or are available in the home; and*
- *Exclusive breast-feeding for the first four months and abrupt weaning to alternative feeding options (Government of the Republic of Namibia, 2003a: 11-12).*

Nevertheless, this National Policy on Infant and Young Child Feeding of the Government of the Republic of Namibia is still under review and is currently not available (April 2005). In 2000, the WHO Technical Consultation stated in its conclusions and recommendations of the existing policy in support of both feeding options that:

- *Where formula feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breast-feeding by infected women is recommended; otherwise exclusive breast-feeding is recommended during the first months of life; and*
- *When HIV-infected mothers choose to breast-feed from birth or stop breast-feeding later, they should be provided with specific guidance and support for at least the first two years of life of the child, to ensure adequate replacement feeding (Khoza, 2002: 3).*

In this study, a variety of feeding methods were practiced, which showed that the women differed in their understanding of the risks related to feeding practices. One respondent stated that she could tell the nurses what they wanted to hear, but in the meantime it was not what she was doing at home. Mixed feeding with both breast milk and other feeds is the most dangerous practice regarding the transmission of HIV-infection from mother to child (WHO, 2004: 16).

Women needed to reduce their risky behaviours in order to improve their health condition and that of their children.

4.3.3 CHALLENGES EXPERIENCED BY BREAST-FEEDING WOMEN

A number of categories emerging from the research study related to challenges experienced by breast-feeding women living with HIV/AIDS.

4.3.3.1 Challenges with the family

The breast-feeding women living with HIV/AIDS experienced problems with their families. In this study some breast-feeding women living with HIV/AIDS were stigmatised by their families.

Respondent 12: *I have many problems. You know ... my father died after many years now. My mother, I do not know where she is. I stay with my family members at Oshikolongondjo. They are old people and do not have money to support me. I feel guilt because I get pregnant while I was still at school. The family members say I run after boyfriends, now ... get pregnant, and now sit with the baby and ...mmmh! I get what I seek, the disease. They say also that my baby perhaps is infected with the disease.*

Respondent 02: *My in-laws are not treating me as a human being in my husband's absence... my baby and me. They said that I infect their brother with my disease ...they used to accuse me. It looks like we are strangers there.*

Respondent 05: *Because, I mean [Long pause] I get pregnant. I did not complete Grade 12. My father's money did not serve a purpose. Me, myself... I think he will not be pleased with me. I feel guilty.*

The breast-feeding women living with HIV/AIDS had to contend with family members who ignore them, accuse them of bringing shame to the family and of wasting hard-earned money. They also had to conform to the decisions of the elders in the family, fathers or partners.

Culturally, the women were, and still are, undermined by the men as they are financially dependent on their families, partners and husbands. The respondents who had problems, had no other way, rather than to keep quiet and wait for problems to resolve themselves. In the Oshiwambo culture, women should wait for men to take decisions and the women should accept and obey what the men decided. With many of the choices they make, they have to adhere to the culture (Nashandi, 2002: 60).

According to Sexton (2000: 4), women may be stigmatised if they do not breast-feed. Women who are HIV-positive prefer to breast feed since they believe that replacement feeding will disclose their HIV-status to their partners and family members.

The findings of this study about the rejection, harassment and abandonment of women who find themselves having HIV/AIDS were similar to those of Nashandi where the women were abandoned, rejected and being thrown out of their homes. According to the respondents, they disclosed their HIV-status to their families, and friends to get support, but they got negative responses from those close to them (Nashandi, 2002: 26).

According to the findings of this study, these respondents experienced a variety of problems. The greatest problem was the disillusionment brought on by cultural beliefs, financial constraints and stigmatization. The women were forced to accept the decisions of their in-laws and partners. Some respondents found it very difficult to cope with their in-laws with regard to their HIV-positive status. The members of the family-in-law blamed them for infecting their sons or brothers. Some of the respondents had not revealed their HIV-status to their family at the time of the interviews. The reason for non-disclosure was fear of rejection or discrimination. The respondents, who were still at school when they became pregnant, felt guilty, depressed, isolated and ashamed. They felt that they have wasted their parents' money and sensed that their parents were not pleased with the situation in which they found themselves.

The outcomes of this study resemble those of a study conducted in Kayelitsha, South Africa, which stated that the breast-feeding women living with HIV/AIDS were rejected, discriminated and stigmatised (McCoy et. al., 2002: 31). These negative feelings expressed by family members impacted on the women's decision to disclose their HIV status to their family members.

4.3.3.2 Challenges with the partners

The challenges related to partners included, amongst others:

Respondent 12: *The partner ...I saw him last when I informed him that I am pregnant and infected with HIV/AIDS. He discontinues our relationship. I am not working ... money to support me and my baby is not there.*

Respondent 02: *I have problems with my husband. He is working in the south. He does not react on my complaints at home.*

Respondent 07: *I have a problem with my husband ... I informed him about my HIV status and request him to go for voluntary counselling and testing, but ... he refused. He said I could not tell him about my disease. The other day he said that he is not prepared to go for the test.*

Some respondents had problems with their partners. The partners either threatened to terminate the relationship or terminated it. Even if the women wanted to tell their partners in order to seek support, they feared the possible risks of disclosure (McCoy et. al., 2002: 20). Nashandi (2002: 20) also states that even if the women wanted to tell their partners in order to get support, they feared the possible risks of disclosure. Vetten & Bhana (2001: 19), explain that women who keep their status secret experienced stress and guilt feelings, since they are aware of the consequences of their secrecy.

Some of the respondents tried to convince their husbands to go for voluntary counselling and testing but they refused. Others disappeared when they learned that the women were pregnant and they were HIV-positive. The women were often blamed for the things that went wrong because of their infections. This showed that the husbands were not well-informed about the benefits of voluntary counselling and testing. Meursing and Sibindi (1999: 3) state that women living with HIV/AIDS fear to be stigmatized and rejected by partners, family and friends.

4.3.3.3 Financial challenges

Finances remain one of the major challenges which breast-feeding women living with HIV/AIDS have to face. Without money, life is difficult.

Respondent 8: *I feel so bad ... I am not employed. I do not have money. I live in poverty. My parents do not have money.*

Respondent 13: *I have to travel the long distance every month. I cannot afford. The time [Long pause] if I do not have money ... I shall ... not go to the hospital to collect my medicine. The money is scarce. [Long pause] People with transport cannot bring me here, if I do not pay that money”.*

The parents of the breast-feeding women living with HIV/AIDS are poor and do not have money to assist them. Not all of the breast-feeding women living with HIV/AIDS could afford to pay for transport to attend the nearest health facilities. Many times they failed to collect their drugs from the health facilities because they did not have any funds, although they knew that they had to take that medicine for the rest of their lives.

Ten breast-feeding women living with HIV/AIDS were unemployed. There is an indication that poverty and unemployment were the main reasons for not attending their follow-up clinic appointments. A partner could not be forced to do something for the baby. Therefore the women might decide to keep quiet about her HIV-status, so that the husband or partner could support them financially.

4.3.4 SUPPORT NEEDED BY BREAST-FEEDING WOMEN

From the challenges experienced by breast-feeding women living with HIV/AIDS, they expressed the need to be supported by various people. They needed support from, amongst others, their partners, family and the service providers.

4.3.4.1 Support from the partners and family

The respondents had problems of rearing their infants without assistance and support from partners and family.

Respondent 06: My partner neglects my baby and me when I inform him that I have been infected with HIV/AIDS. He is working, but never gives me money to assist with the bringing up of the baby.

Respondent 12: The father of my baby just disappeared ... I cannot tell you where he goes. I have to bring this baby up alone. People do not care. I need support. I am not working. Money to support my baby and me is not there.

The findings of the research study revealed that the breast-feeding women living with HIV/AIDS were neglected by their partners and often rejected by their family.

It seems that some partners of the breast-feeding women living with HIV were working. They did not want to be associated with them and also did not bother to support them morally or materially. As a result, these women suffered physically and psychologically. People were not interested to render the necessary support to help them cope with the challenge of HIV.

According to Government of the Republic of Namibia, (2004c: 28), the partners who are involved in the health programmes, which assist breast-feeding women living with HIV/AIDS, are prepared to support their wives and babies to survive with the disease. It is those partners who are not involved in the health programmes that pose a risk because they refuse to go for testing.

4.3.4.2 Support from the community

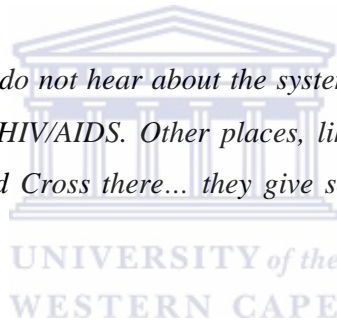
The respondents were asked whether they knew about services in the community for breast-feeding women living with HIV/AIDS.

Respondent 02: *There are not support systems. Aa ... You mean ... the people who visit sick patients in their homes! They come from Catholic AIDS Action (CAA).*

Respondent 10: *I heard women come together to discuss about the problems they have with their babies. They teach each other how to make good food ... and how to prepare milk for the babies.*

Respondent 11: *Me myself ... I hear people talking about something like that ... but I did not listen well ... or you ask about those? Probably there are systems broadcasted through the radio. I did not hear myself... is only what I hear people talking ... Perhaps there are, I don't know. Women who cannot meet their needs need to be visited in the community where they are staying.*

Respondent 14: *... I do not hear about the systems you are talking about, for mothers living with HIV/AIDS. Other places, like Oukwanyama side, I hear people say... the Red Cross there... they give some milk and soap for some mothers.*



The study revealed that there is a perceived lack of community services or the services were not readily accessible to all women. In areas where services were not available, women were suffering, as they were not assisted. The support systems available were not for the breast-feeding women living with HIV/AIDS in the community. Some women did not hear about the support systems in the community.

The researcher did not identify any existing support systems in the community of Oshakati District, which specifically addressed the problems of the breast-feeding women living with HIV/AIDS. There were other support systems in the community, but those support systems were for the assistance of people who are HIV-positive. The support systems, which were available, were the Catholic AIDS Action (CAA) group, a group of people doing Community Home-Based Care (CHBC). They visit the sick and old people in their homes. The CAA has developed support groups where women meet to share their difficulties, advise and encourage each other, pray and have bible studies. Home-based care and counselling training is also provided for

volunteers, especially women, as they are the caregivers. The training empowered the women to assist others who were also HIV-positive in their communities or homes. The support services that are currently provided by MOHSS, CAA and the Ministry of Women Affairs and Child Welfare (MWACW) have no programs which specifically target breast-feeding women living with HIV/AIDS.

The support systems provided for breast-feeding women living with HIV/AIDS in Namibia have been proposed, but have not been implemented as yet. There are also social welfare grants that women can access in order to get financial assistance. Even though the above-mentioned support services exist, access to these services for women living with HIV/AIDS is not guaranteed. There is a need to educate the community about infant feeding and PMTCT since some of the respondents were not aware of the services available in the community.

4.3.4.3 Support from the health professionals

The breast-feeding women living with HIV/AIDS need to be monitored to assess whether the women are following their prescribed guidelines regarding the feeding of the infants.

Respondent 14: Why are the nurses not coming to our homes to see whether we are practising the right thing as they tell us to do at home? There is nothing to avoid us to give mixed feeding in the villages, but if we will be asked here in the clinic what we do at home, we will tell the nurses the right thing, but is not what we do at home. We need to be visited there at our homestead.

Respondent 11: Is it possible to give assistance for the breast-feeding mothers who cannot meet their needs? I think is better for the nurses to come and see what is happening in the community.

The study revealed the need for breast-feeding women living with HIV/AIDS to be supported by nurses. A respondent suggested that the mothers were providing the information that nurses wanted to hear, and that it may not necessarily be true.

The study indicated a lack of counselling services to breast-feeding mothers to make the proper choices on the feeding of their babies. Some breast-feeding women living with HIV/AIDS were confused about the information they had been given or suggested that it was inadequate. However, some women found it difficult to choose a feeding option because of cultural or social reasons. Health workers need to be aware of these reasons and be sensitive to the fears expressed by women. They have to provide extra support to assist these women to overcome the difficulties and barriers related to infant feeding. According to Coutsoydis (2004: 90), the quality of counselling should be prioritised in all programmes if women are to make informed choices.

The statements given by the respondents, to avoid HIV transmission through breast-feeding, were in line with the policy of the Government of the Republic of Namibia. Breast-feeding women living with HIV/AIDS in the Namibia country currently practice the PMTCT programme through the MOHSS. The above-mentioned programme regarding HIV/AIDS transmission was introduced to minimize the risk of HIV transmission (Government of the Republic of Namibia, 2004a: 2).

4.3.4.4 Support from Health Service Providers (Policy)

The breast-feeding women living with HIV/AIDS were eager to get support from the health service providers, who in this study, is the Ministry of Health and Social Services within the Government of the Republic of Namibia.

Respondent 12: Can the Government arrange a group of people somewhere to distribute some grants for us? They can give something like milk or sugar or butter, so that we can feed our babies. [Long pause] I know we are many now with this disease ... if they can give some sugar to some women, milk to others and butter to others again. I know for the Government it is impossible to give financial assistance for us all. Truly speaking ... we need help.

Respondent 13: *Why the medicine we collect here in Oshakati hospital not in other health facilities in the community? Please, the health care providers ... put those medicines also in some clinics.*

The study indicated that the participants perceived the long distances and lack of transport from the rural areas to the health facilities, as constraints to attending follow-up appointments. Respondents felt that something should be done about the services for people living with HIV/AIDS, with a particular focus on breast-feeding women living with HIV/AIDS. Breast-feeding women living with HIV/AIDS could not collect the ARV drugs periodically as they were supposed to do (Sexton, 2000: 21). The breast-feeding women were supported with ARV treatments to prevent the spread of HIV/AIDS. The use of ARV medicine reduces the proportion of children who become infected vertically to 3% or lower.

The MOHSS is working hand in hand with the Non Governmental Organisations (NGO's) to develop and implement HIV/AIDS programmes within the communities in Namibia. During the time of this study there were no programmes that were specifically established for breast-feeding women living with HIV/AIDS.

The MWACW was also networking with other Ministries and NGO's to support people living with HIV/AIDS at a National and Regional level. These support systems were not focusing specifically on the support of breast-feeding women living with HIV/AIDS. At the time of this research, the Namibian Government was in the planning stage of providing support for breast-feeding women living with HIV/AIDS.

The findings of the study indicated that currently the access to health services and other resources for breast-feeding women living with HIV/AIDS was available. However, the women have problems of transport, as not all of these facilities were within walking distance from where the women reside.

The researcher knew her therapeutic responsibilities and at the end of the interview she addressed the concerns of the respondents by advising them to consult the social workers' office for further management and advice. The women also needed advice to register for maintenance grants.

4.4. REALIZATION OF THE OBJECTIVES OF THIS RESEARCH STUDY

The aim of the study was to explore the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District. Evidence was collected during individual face-to-face interviews with the breast-feeding women living with HIV/AIDS. Their knowledge was explored through probing of their responses. The research findings reflected their knowledge about HIV and its transmission, their infant feeding practices and their choices regarding infant feeding.

The experiences were described when they responded to specific questions about HIV/AIDS and breast-feeding. The researcher is of an opinion that she attained the aim of the research study, because in her research report she presented a detailed account of the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS. It should be noted that the participants' perceptions emerged mainly during the analysis phase of the study. The women assigned their individual opinions and insights to their experiences. Some of their perceptions were flawed when based on incorrect information, namely that HIV/AIDS develops in unhygienic conditions.

The researcher also attended to all the objectives of the study, including:

- **To describe the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS.**

Some of these women have a limited knowledge about HIV, its transmission and choices of infant feeding and preparation of formula milk. They also have limited knowledge about their own sexuality and personal rights. Their knowledge about the services such as counselling, VCT and health education services in the community was also limited. The involvement of partners in feeding choices was indicated to stimulate co-operation amongst partners and between husband and wife. It would also improve the prevention of the spread of HIV during the breast-feeding period (Government of the Republic of Namibia, 2004a: 28).

Although there were some misconceptions about feeding choices among HIV-positive mothers, some breast-feeding women who are living with HIV indicated knowledge about MTCT and on the importance of exclusive breast-feeding for the first four months of life and replacement feeding afterwards (see 4.3.2.1).

The breast-feeding women living with HIV/AIDS are driven by various social expectations and cultural values especially where gender relationships are imbalanced. Many of their perceptions about their feeding choices were based on these socio-cultural norms and values.

The breast-feeding women living with HIV/AIDS in Oshakati District experience difficulties in accessing services related to HIV/AIDS, since the services are either limited or absent.

The study concluded that some breast-feeding women living with HIV/AIDS have wrong perceptions about HIV-transmission and the use of antiretroviral drugs. As a result they did not practice exclusive breast-feeding. This can be avoided where replacement feeding is acceptable, feasible, affordable, sustainable and safe

- **To identify the challenges encountered by breast-feeding women living with HIV/AIDS in the Oshakati District.**

The researcher identified certain challenges that are common to these women. The challenges related to their families, their experiences with the partners and financial challenges (see 4.3).

These women also experienced significant barriers in choosing the exclusive breast-feeding option for cultural reasons including social stigma, rejection and discrimination by their families and partners.

During the analysis of the research data, other challenges were identified, amongst others: unemployment, a lack of money to buy formula milk, and the inaccessibility to public transport. The women do not receive financial support from their family or partners. It was concluded from the study that there was inaccessibility related to a

continuous uninterrupted supply of formula milk. The inaccessibility to anti-retroviral drugs to breast-feeding women living with HIV/AIDS was another challenge (see 4.3.4.4).

- **To determine whether the existing support systems for breast-feeding women living with HIV/AIDS in the communities in the Oshakati District were adequate.**

The following gaps were identified with regard to the support system of breast-feeding women living with HIV/AIDS. There are inadequate professional support systems, counselling services, financial aid services and support groups for the respondents. There is a need for professionals to monitor what is happening in the community. A support system, which is currently available, is the PMTCT programme implemented in Oshakati hospital. The women may not perceive this programme as a support as they use it minimally. Women enrolled in the programme to try and prevent the HIV-transmission to their babies (see 4.3.4). It was concluded in this study that there were no support groups aimed to specifically address the needs of the breast-feeding women living with HIV/AIDS in the Oshakati District.

4.5. APPROPRIATENESS OF THE RESEARCH METHODOLOGY

The appropriateness of the qualitative methodology is discussed using the four mandates (criteria) for collection of the qualitative data. The criteria suggested by Patton for the qualitative methodologist to explore the appropriateness of the method will be discussed (1990: 283).

The first criterion states that the qualitative methodologist gets close enough to the people and the situation being studied to personally understand the details of what goes on. The researcher found the face-to-face interview appropriate in the sense that she could see the respondent's non-verbal communication and ask probing questions. Reactions could be recorded for the example, respondents' crying, allowed the researcher to better understand their emotions. The study conforms to the criteria of a qualitative study since there is personal understanding of what is going on.

Time was spent with the respondents to build relationships. The trust relationship was confirmed when one woman stated that she could tell nurses what they wanted to know, although this was not what she did at home. She felt comfortable to share this kind of information with the researcher.

Respondent 14: *There is nothing to avoid us to give mixed feeding in the villages, but if we will be asked here in the clinic what we do at home, we will tell nurses the right thing, but is not what we do at home* (see 4.3.2.3).

The second criterion of data collection in qualitative research is to capture what the people actually said. The researcher used the interview as an instrument of data collection and a tape recorder to capture what the people actually said and transcribed the data verbatim. A structured interview provides the opportunity for the researcher to obtain the required information and write a narrative report.

The third criterion suggests that qualitative data must include a great deal of pure description of the people, activities, interaction and settings. The researcher interviewed breast-feeding women living with HIV/AIDS. Their ages are between 15 - 49 years. Their babies are of the age between one day and six months. All these breast-feeding women are enrolled in the PMTCT programme at Oshakati hospital. They attend the PMTCT clinic and they make decisions about infant feeding choices

The fourth criterion states that qualitative data must include a great deal of direct quotations from people. When the report was written, the actual words of the people were used. The researcher uncovered their perceptions with regard to their choices about infant feeding. It was also discovered how the respondents perceived the condition of being infected with HIV while breast-feeding. The data is presented in a narrative format, and many direct quotations are used to qualify the themes that emerged from the data.

The qualitative research methodologist expects to connect with people on a one-to-one basis or within a focus group. The above-mentioned discussion provides evidence that the study conformed to the criteria as suggested by Patton, (1990: 32).

4.6 REFLECTION ON THE CONCEPTUAL FRAMEWORK

Polit and Hungler, (1995: 116) stated that the HBM was developed for providing a framework to explain why individuals take part in health programmes.

The HBM provided a framework to explain why the individuals participate in the health programs. In this study there is evidence that the respondents took part in the Mother to Child Prevention Programme because they believed that they would get assistance. The benefits would be in health protection and disease prevention. The women believed that they should react when their health is jeopardised and they want to stay healthy.

Breast-feeding women living with HIV/AIDS feared that their infants could contract HIV if they are breast-feeding. They also knew that mixed feeding is dangerous for the infants. They decided to get information from the health facility on how to protect their infants against the transmission of the disease. People take action regarding their health problems (see 4.3.2.3).

Breast-feeding women living with HIV/AIDS knew how to prevent high-risk behaviour through changing their habits. They have had the opinion that HIV transmitted to their infants is a serious condition. Introducing alternative feeding could reduce the condition of HIV transmission. They decided to stop breast-feeding at four months to avoid the HIV transmission to their babies (see 4.3.2.2).

The women went to the clinic to seek advice and to get an opinion about the condition so that they could decide whether they were going to use that information and take a decision. They decided whether they were going to participate in the health promotion programme or not. Their decision was influenced by their relationship with their partners/husbands and families. The breast-feeding women living with HIV/AIDS were rejected by their families and abused by their partners or husbands.

According to the HBM and its relation with this study the breastfeeding women have psychological costs because they were aware of HIV transmission to the babies through breastfeeding. Women were aware of the implications of their decision about

infant feeding if they are HIV positive. The barriers that women experienced if they chose to formula feed were rejection, abandonment, discrimination and violence. They were afraid to reveal their HIV status to their husbands. Some of the husbands and partners were not supportive of the women's choice not to breastfeed a six month old baby. In some cases women may be forced to breastfeed their babies to the age of two years (Government of the Republic of Namibia, 2004b: 27).

The HBM was valuable in this study because it provided a framework to analyse the data with regard to the perceptions and beliefs of the breast-feeding women living with HIV/AIDS in making choices about their own health and the health of their babies.

4.7 CONCLUSION

In this chapter a detailed account of the main research outcomes are presented. The demographic questionnaire provided contextual data, which showed that most of the participants were unmarried and unemployed. From the qualitative data analysis four main themes emerged. It was clear from the findings that the perceptions, knowledge and experiences were interwoven and challenging to present in a research report.

The researcher also opted to include a reflection on the qualitative research process, the conceptual framework used for the study and a self-assessment on the attainment of the research objectives.

The next chapter will focus on the conclusions of the study and the recommendations that were based on the research outcomes.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter the data analysis, research outcomes and interpretation of the results were discussed. The researcher also applied Patton's criteria to judge the appropriateness of the research methodology used in this study (1990). In this chapter the conclusions of this study are highlighted and the most appropriate recommendations presented.

Seeing that it is the first study to explore the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District, the research findings could provide valuable base-line information to health professionals in the region.

5.2 CONCLUSIONS AND RECOMMENDATIONS

The conclusions will be presented according to the themes that emerged from the research study. However many of the conclusions are linked to more than one theme. The recommendations will be based on the gaps identified in the discussion of these conclusions

5.2.1 Knowledge about HIV/AIDS and infant feeding

The research findings indicated that most of the breast-feeding women living with HIV/AIDS in Oshakati District understood that HIV/AIDS is a killer disease and that HIV could be transmitted from mother to child. A few of the women suggested that the disease develops as a result of unhygienic conditions.

The study indicated that the women received their information from the nurses at the antenatal clinics. They considered these nurses as resource people who would be able

to provide information about HIV-transmission in general and about formula feeding in particular.

The women also knew that they had to practise abrupt weaning after a period of four months. However, some of them admitted to practising mixed feeding. They were living in the rural area, did not have access to clean water and they were also having problems with transport. The formula milk was not affordable to all the participants due to financial constraints.

Most of the women chose the option of abrupt weaning followed by Oshikundu and maize porridge. This implied that as a result of the contextual factors described earlier, these women could not choose the option of formula feeding.

It is recommended that:

A strategic health education plan should be developed to disseminate accurate information about the transmission of HIV/AIDS via breast milk. Health information sessions should be compulsory at all the antenatal clinics and pamphlets should be made available during these sessions. All the health facilities, media, television and local radio stations should be encouraged to become involved in the dissemination of information. The women should be informed about the factors that would increase the risk of HIV-transmission through breast-feeding. It is also very important to reinforce the risks associated with mixed feeding.

5.2.2 Choices about infant feeding

The breast-feeding women living with HIV/AIDS in Oshakati District experienced real limitations with regard to their choices about infant feeding. In addition to the contextual factors that impacted on the women's freedom to choose, the attitude of their male partners, spouses and families also restricted their choices. Women had the perception that if they did not breastfeed their babies they would reveal their HIV-status. A gap was also identified with regard to the monitoring of the feeding practises, namely, to observe what was really happening in the community.

It is recommended that:

Male nurses organize health education sessions targeting the partners and spouses of these women to address the cultural aspects that may impact on the women's feeding choices. The partners/spouses should be educated on the importance of VCT and the PMTCT programme. It will encourage the partners to share the burden of the HIV-status and reduce stigma, rejection and discrimination against women. It would also promote the improvement on the VCT services and the prevention of the spread of HIV.

5.2.3. The challenges experienced by breast-feeding women

The participants revealed that their main challenges related to financial constraints and the attitudes of their husbands, partners and their families. Many of the women were unemployed and dependent on their partner/husband's income. Unfortunately, once the women revealed their HIV-status the partners and husbands abandoned them, or those who stayed, refused to go for voluntary testing.

A partner physically removed their baby from one of the participants for a period of three days. The mother, who conformed to her cultural beliefs, could not breastfeed her baby following this forceful removal and had to introduce replacement feeding. A young unmarried, unemployed HIV-positive mother experienced feelings of guilt for not completing her high school education.

These unique scenarios point to a community that empowers men to make decisions on behalf of women. The women in turn experience feelings of dependency, guilt and abandonment and their choices are limited by cultural norms and values.

It is recommended that:

The perceptions, knowledge and experiences of the partners and husbands of the breast-feeding women living with HIV/AIDS in Oshakati, Namibia, are explored. Such research findings could be valuable to plan a comprehensive intervention strategy to impact on the PMCT in the district.

5.2.4 Support needed by the breast-feeding women

The women expressed the need for peer support structures where they could meet with other women who share the same experiences. They were aware that such support groups existed for people suffering from other health conditions. However, they were not aware of such groups for breast-feeding mothers living with HIV/AIDS.

Most of the women indicated that they needed support in educating their partners and spouses about vertical transmission of HIV. Some required assistance to persuade the husbands/partners to go for voluntary testing while others suggested that they should be *forced* to undergo VCT.

The women also suggested that the nurses who work at the PMTCT clinic should visit the breastfeeding women living with HIV/AIDS in the Oshakati District regularly in their homestead to give technical support and guidance.

There was a general appeal by the women that milk formula be subsidized by the government.

It is recommended that:

Health workers need to be adequately trained to provide support services to the breast-feeding women living with HIV/AIDS in the clinics. They should be able to recognize the fears expressed by these women and then to provide appropriate support to assist HIV-positive women to overcome the difficulties and risks associated with breast-feeding. The information will help the women to make informed choices, as they will understand the implications of their choices. Appropriate assistance and support should be given to breast-feeding women living with HIV/AIDS once they have made their feeding choices.

The professional nurses should monitor how the breast-feeding women living with HIV/AIDS and their partners are coping in the real situation. Nurses need to assess the individual mother's circumstances to determine the most feasible and safe method of feeding her baby. The women should be informed about the different feeding options and the risks related to mixed feeding. The partners and family members

should be informed about the importance of supporting their partners when they make choices about infant feeding.

Support groups are established in the communities. Women should be encouraged to share ideas and their experiences on, for example, how they will feed their babies after the age of four months. If breast-feeding women living with HIV/AIDS join support groups in the community, they will feel that they are with others who are going through the same experiences, and they may learn more about HIV/AIDS. Community groups should be established in order to empower the breast-feeding women living with HIV/AIDS to survive and to overcome their challenges.

Finally, the recommendations with regard to support should be co-ordinated so that a decision is made as to where the support services must be made available. However the current services should be optimally utilized since the women did not perceive the PMTCT clinic as a support service. Breast-feeding women living with HIV/AIDS should be encouraged to attend the clinics to get ARV drugs for prevention of HIV-transmission. ARV drugs should be distributed to the existing health facilities like health centres and clinics to shorten the distances to the Intermediate Hospital Oshakati. It should also be determined which kinds of support systems are needed and where services need to be established in the community. The community members should be given an opportunity to decide at which location they need that service. It will ensure that the breast-feeding women living with HIV/AIDS in the Oshakati District are provided with the required support.

5.3 LIMITS TO THIS RESEARCH

This study centred on how various responses influences the perceptions, knowledge and experience of breast-feeding women living with HIV/AIDS in Oshakati District. The intention of the study is not to represent the circumstances of all breast-feeding women living with HIV/AIDS in Namibia. The aim was to give an indication of the situation women are faced within a Namibian society and the issues they are confronted with.

During interviews one of the respondents was not completely open in her responses, as she did not trust that the researcher would not disclose their HIV status to others. Breast-feeding women living with HIV/AIDS were afraid to reveal their HIV status to their partners, because they feared abandonment.

The results from this study cannot be generalised to all those breast-feeding women living with HIV/AIDS who participated in the PMTCT program in other districts, as only a convenience sample was used in Oshakati District. The women highlighted the issues that undermined the counselling process as well as the need for further research.

5.4 CONCLUSION

This chapter focused on the conclusions drawn from this exploratory study. It appeared as if most of the women had knowledge about the transmission of HIV/AIDS via breast milk and that they were aware of the need for the abrupt weaning of the babies at the age of four months. However, of concern was that the women admitted to using the high risk, mixed feeding option.

Another concern centred on the perceived lack of support that the women received from their husbands/partners and family members. It is therefore imperative that the recommendations proposed by the researcher be disseminated to health service professionals and policy makers in the Oshakati District. Alternative support services need to be established in the rural areas, for example, the distribution of ARV drugs to other health facilities in the Oshakati District.

However, despite all the constraints, many of the women who participated in the research study were aware of: the transmission of HIV via breast milk, the value of abrupt weaning after four months and the importance of ARV treatment to protect their babies. This means that with a concerted, comprehensive effort from the family, their partners and the health professionals more women could be supported in the choices they make about infant feeding, particularly if they are HIV-positive.

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APPENDIXES

APPENDIX A

INTERVIEW SCHEDULE QUESTIONS

Title: The perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District-Northern Namibia.

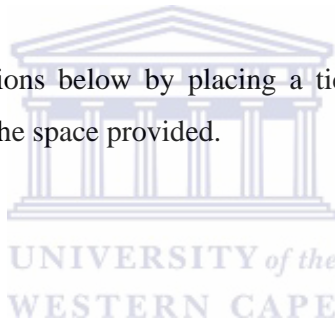
Name of the Health Facility.....

Name of the Region

Interview Number

Date of the interview

Please answer all the questions below by placing a tick in the appropriate box or filling in the information in the space provided.



SECTION A:

Demographic data

1. Age

15 – 19 yrs	
20 – 29 yrs	
30 – 39 yrs	
40 – 49 yrs	

2. Marital status

Single	
Married	
Widowed	

Separated/Divorced	
Others (specify)	

3. Educational status

Primary	
Secondary	
Tertiary	
Others (specify)	

3 Religion

Lutheran	
Catholic	
Anglican	
Baptist	
Others (specify)	

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WESTERN CAPE

4 Are you employed?

Yes	
No	

5 How many children do you have?

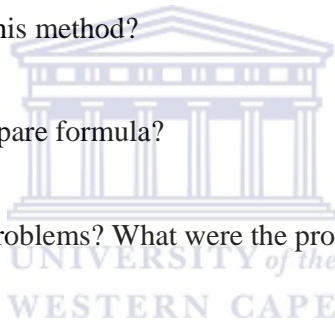
Children	
0 -2	
3 - 4	
5 - 6	
7 - 8	

SECTION B

INTERVIEW GUIDE QUESTIONS

Explore the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District.

1. What do you understand about HIV/AIDS? Please explain.
2. Can HIV/AIDS be transmitted from you to your baby?
3. How do you feed your baby?
4. Why have you selected this method?
5. Do you know how to prepare formula?
6. Did you encounter any problems? What were the problems?
 - Family
 - Spouse/Partner
7. What have you done about these problems?
8. Are there any support systems for the breast-feeding women living with HIV/AIDS in the community?



APPENDIX B

Enquiries: H.N. Kalimba
Tel: 065-220740/220675
Fax: 065-221338/220303

P.O. Box 1262
Oshakati

20 November 2004

The Permanent Secretary
Ministry of Health and Social Services
Private Bag 13198
Windhoek
NAMIBIA

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN OSHAKATI DISTRICT.

DEAR SIR

I am a distance Master Degree student at the University of the Western Cape.

As a requirement for the study, I would like to conduct a research study in Oshakati District, as from April 2004-May 2005. The study title is as follows: **“The perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in Oshakati District-Northern Namibia”**.

The study population will include breast feeding women living with HIV/AIDS in Oshakati District. The intention of the study is to explore problems experienced by the breast-feeding women living with HIV/AIDS in order to establish and or strengthen support systems in the Oshakati community to address the problems they encountered.

Therefore I humbly request your good office to grant me permission to conduct my study. Attached find the copy of the research proposal, which has been approved by the Ethics Committee, at the University of the Western Cape.

It will be highly appreciated if my application meets your favourable attention.

I thank you very much in advance.

Yours Sincerely

.....

H. N. KALIMBA



APPENDIX C

Enquiries: H.N. Kalimba

Tel: 065-220740/220675

Fax: 065-221338/220303

P.O. Box 1262

Oshakati

20 November 2004

The Senior Medical Superintendent

Intermediate Hospital Oshakati

**RE: APPLICATION FOR CONDUCTING A RESEARCH IN
INTERMEDIATE HOSPITAL OSHAKATI.**

DEAR SIR

I am a distance Master Degree student at the University of the Western Cape. The study started in April 2003. As a requirement for the study, I intend to do a research study in Intermediate Hospital Oshakati as from April 2004. The study title is as follows: **“The perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in Oshakati District.”**

I would like to have a study population of breast-feeding women living with HIV/AIDS in Oshakati District. My intention is to put and or strengthen the existing support systems/interventions to assist in their problems.

I would like to do my research study at the Prevention of Mother-to-Child Transmission clinic where this women are treated.

Therefore I humbly request your good office to grant me permission to conduct my study. Attached find the copy of the research proposal, which has been approved by the Ethics Committee, at the University of the Western Cape.

It will be highly appreciated if my application meets your attention.

I thank you very much in advance.

Yours Sincerely

.....

H.N. KALIMBA



APPENDIX D: CONSENT FORM

THE PERCEPTIONS, KNOWLEDGE AND EXPERIENCES OF BREAST-FEEDING WOMEN LIVING WITH HIV/AIDS IN THE OSHAKATI DISTRICT-NORTHERN NAMIBIA.

My name is Hilma Ndesheetelua Kalimba. I am a distance Master Degree student at the University of the Western Cape. The study started in April 2003. I am conducting a study on *the perceptions, knowledge and experiences of breast-feeding women living with HIV/AIDS in the Oshakati District*. I will appreciate your participation in this study. The interview will last at least 30 minutes and will be audio-taped. I will respond to your answers in the interview schedule, but your name will not appear on that schedule. Whatever information you provide will be kept strictly confidential and will not be viewed or discussed with other people. Your identity will not be made known to other people.

You may ask questions during the interview if you wish so. You can refuse to answer any questions without giving any reason. You are free to withdraw at any time during the interview if you do not want to continue anymore.

Do you agree to participate in this study?

Yes / No

Signature _____ of _____ the interviewer.....

Date

Signature _____ of _____ the interviewee.....

Date

Thank you very much for participating in this study!