

# Anthropological factors affecting HIV positive mothers in their choice of a feeding method, in Phnom Penh, Cambodia.

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## Background

Guide-lines have been set up to help HIV positive mothers make an "informed choice" about a feeding method for their new-born. As any public health measure, the concept of "informed choice" is a social construct. On the field, recommendations are shaped by the different actors' and institutions' ideas, political will and means at their disposal to enforce them. This research aims at exploring how institutional agency frame women's choices.

## Methods

Eighty semi-structured in-depth interviews with 49 HIV positive mothers. A first interview when the child is between 1 and 6 months old (M1); a second interview at age 6-11 months (M2). Sessions were conducted in Khmer, by a mature female researcher selected on the basis of age and personal communication skills. All the interviews have been taped, translated word for word and analyzed through coded entry point.

Context findings were recalled through customary ethnographic methods: participant observation in hospital and health centers settings, collection of life-stories and genealogies, use of key informants, daily log and local glossaries.

## Results

Results show that so far there is little room for a choice since either method (breast-feeding or milk substitutes) is attached to the institutions' *modus operandi*. The staff's sense and apportionment of risks is not free and in the context of an emotional issue, conformity with the establishment regulations will ensue. Hence, the axiom that presenting facts such as HIV transmission through breast-feeding or the risks attached to formula feeding can be done in an "objective way" becomes contentious. When looking at all the components included in the mothers' decision-making processes, local organization of the health system play a major role, outstanding the influence of cultural factors. Public or established institutions and person-centered NGOs promote different, sometimes opposite preventive measures.

## Profiles

Interviewee's mean age: 29, 2 years old. Mean number of children: 2, 4. Sixteen over 49 mothers (1/3) were illiterate, 29 had a mean of 5 years of primary education (data unknown for 5). Except for three mothers who could afford to pay for the formula by themselves, all the women interviewed were coming from the poor segments of society. Mean income was around one US dollar per day. Forty were directly referred by an NGO; 47 were relying on NGO's assistance for formula supply. Twenty six (more than half) were raising their children alone at the first interview. Six more were left alone at the second interview, as the husband was either dead, terminally sick or had abandoned them. One mother died after the first interview. Two babies died before the second interview.

## ***Existing Prevention of Mother To Child Transmission Programs***

In 2004, the national PMTCT program, still in its beginnings, can be found in the National Mother and Child Health Center in Phnom Penh, the main public hospital in Battambang and officially in some other provincial hospitals. The semi-private teaching hospital, formerly known as the "Cadres' Hospital" has been conducting research in PMTCT techniques and makes use of novel methods for a paying clientele. A large private charity runs a comprehensive program in Siem Reap and provides free formula to HIV positive mothers in Siem Reap and Phnom Penh. Two small NGOs catering to destitute women have included PMTCT components in their activities. The numbers of women benefiting from these schemes differ largely, from several thousands to less than one hundred a year. Access to mothers knowing their HIV status and willing to discuss vertical transmission through breast-feeding is severely limited.

## ***Mothers' perception of risk***

More than half of the mothers interviewed, whether they had breast-fed previously or not, declared that mother's milk was preferable due to its nutritious value. But they were all giving their baby formula in order to avoid transmission. They could not provide a quantitative estimation of the risk of contamination through breastfeeding, or thought it to be 100%. This is in line with popular representations of transmission through blood and blood products (milk being considered one of them). A minority (3 women) was not afraid of explaining family members and neighbors why they were not breast-feeding. For all the others confidentiality was an issue and they resorted to a wide range of expedients to defuse suspicion about the origin of their supplies and the reason for using infant formula. They made it clear that for them the biological risk (contamination of the child) was more important than the social risk (discrimination of the mother) and they had chosen what they thought would best protect their child.

## ***Typology of choices***

Although the national policy encourages exclusive breast-feeding, due to the extremely low record of VCT for pregnant women in the public sector, it has not been possible to meet any mother who would have chosen to breast-feed. But it has been found that two different, opposite types of feeding counseling were provided within this public sector.

- In the settings of the National Mother and Child Health Center, mothers were advised to practice exclusive breast-feeding "and if they chose differently, the counseling was repeated". Within this institutional framing, information was molded by the conviction that mothers opting for formula do not fully understand what it implies. Hence, it was considered that they needed some help to make a better choice. But we met 4 women who were encouraged to practice exclusive breast-feeding. They told us that they had decided, on the contrary, to use formula, because the medical information did not fit with what they had heard about vertical transmission elsewhere.
- The Antenatal Care services of the teaching hospital receive together a more affluent clientele and a small number of very poor ones attended by an NGO. There, HIV positive mothers were told not to breastfeed. It was assumed that they could afford to buy formula or that the NGO would provide it free. Some mothers who had come in order to get Nevirapine prevention did not dare to divulge their economic situation and struggled to bear the cost of replacement feeding.

In both cases counseling had become "guidance", and the personnel speech and attitude was shaped by institutional policy. Furthermore, in any case, it appears that selection of a feeding method was not linked to counseling, but to access to a PMTCT program, and before that, to test availability. It cannot be said then, that these women had exercised their right to choose. If so, at which level, how and why, had the decisions been taken?

### ***One policy for the rich***

The option found in the Cadres Hospital can be viewed as following policies devised for middle-income countries, in societies where mothers are strongly encouraged to opt for milk substitutes. Risk-reading has focused on HIV transmission, and the biological risk given prominence over the social risk.

- Transmission rates are considered high and the danger of diarrhoeal disease or the economic burden associated with formula feeding seen as irrelevant or of a less concern. This latest point stands partly on a strong identification of the staff with the mothers (coming from the middle and upper-class) or the assumption that the NGO will take care of all the contingencies.
- Suspicion and stigma are not perceived as an issue because (although the hospital aims at getting a Baby Friendly label and promotes breastfeeding) it is known that "rich mothers prefer to give the bottle".

### ***One policy for the poor***

The promotion of exclusive breast-feeding favored by the health authorities and international agencies in Cambodia is based on opposite premises which are:

- A reverse risk-reading where the figures for HIV transmission are set up against the rates of non-transmission ("Most mothers will NOT transmit").
- A ranking of biological risks that put diarrhoeal disease on the top of the list.
- The belief in a social contamination phenomenon where use of formula milk spreads to the general population ("spill-over"). No studies have been found to support this view.
- An extrapolation of African data, where discrimination of women using bottles has been called upon.
- A non-identification with the "target", seen through gender and class bias as uneducated, helpless and backwards ("poor women have no hygiene").

In order to implement this vision international donors and local authorities have released in late May 2004 a new series of TV ads, one of which promoting exclusive breast-feeding in ALL circumstances. Grass-roots organizations have not been consulted. Observers report confusion and bewilderment from the public and child health specialists.

## **Conclusion and propositions**

Public health measures, supposedly based on scientific rationale, can be viewed as social constructs, supporting different, sometimes conflicting logic. In Cambodia, the multiplicity of actors and the lack of a strong coordination body lead to divergent policies. Class factors are the most important obstacles to PMTCT programs. HIV positive mothers do not get unbiased information on how to feed their children. In order to do so, they should be given the fullest possible information on which to base their decision and appropriate support for the course of action they choose. So far this can only be seen in the premises of one or two private charities.

Questions and recommendations include:

- A call to policy-makers to review the principles and conditions of "informed choice";
- A discussion about the role of NGOs in the field of PMTCT: those with a better grasp of social practicalities or already engaged in feeding programs should be given a prominent voice

- Ways to better coordinate private initiatives and national policies.