

# Report

## Community Perspectives on Infant Feeding and HIV in the Context of PMTCT in Zimbabwe

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## **Abstract**

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## **1. Introduction**

HIV continues to be the major public health problem affecting Zimbabwe. In Zimbabwe, 9-10% of newborn babies are becoming infected with HIV through mother to child transmission yearly<sup>1</sup>. Although the majority of transmissions are occurring before and during childbirth (70%), a significant proportion of HIV transmission to infants is as a result of breastfeeding (30%).<sup>2,3</sup>

HIV positive mothers to be are counseled on infant feeding options they can take so as to reduce the risk of HIV transmission through breastfeeding. The infant feeding options discussed during the PMTCT counseling sessions are exclusive and sustained breastfeeding, modified breastfeeding (which includes early cessation of breastfeeding, and expressing and heat-treating breast milk), and replacement feeding (which is use of modified animal milk and infant formula feeding).<sup>4</sup> Very little is known about the acceptability and feasibility of the infant feeding options that are being recommended through the PMTCT programme.

Zimbabwe is a breastfeeding nation with 98% of the mothers breastfeeding their babies for up to one year<sup>5</sup>. Many of these women, especially in rural and commercial farming settings, breastfeed for 24 months and beyond. Breastfeeding taboos and cultural issues surrounding infant feeding and care still influence infant feeding practices in the general population<sup>6</sup>. The infant feeding options being discussed in the PMTCT programme are not familiar to both mothers and the general community.

## **2. Review of literature and other existing information**

The coming of the HIV/AIDS epidemic has challenged the breastfeeding culture. It is no longer questionable that HIV is transmitted through breastfeeding. Maternal and infant factors contributing to the risk of MTCT through breastfeeding are still poorly understood and not well researched.<sup>7,8</sup> However, factors that have been identified as contributing to MTCT through breastfeeding include; mother's breast health (*e.g.* cracked nipples, mastitis etc), condition of baby's mouth (*e.g.* oral thrush), mother's nutritional and immune status, including viral load, duration of breastfeeding, mixed feeding and smoking, substance abuse and vitamin A deficiency<sup>2, 3,7,8</sup>.

Breastfeeding is deeply engrained within the societal values of many cultures globally and among Zimbabweans<sup>9</sup>. While breastfeeding is a norm in many cultures, infants are given different foods pre-lacteal and during the breastfeeding course depending on the culture.<sup>9, 10, 11</sup> Breastfeeding not only provides infant nutrition but also provides psychosocial support for both mother and child<sup>6</sup>.

As a result of HIV/AIDS, infant feeding strategies that include exclusive breast feeding, modified breast feeding and exclusive replacement feeding have been suggested. Women are less optimistic and express great concern on the social consequences of not breastfeeding but also question the safety of exclusive breastfeeding.<sup>12</sup> Low adherence to

infant feeding strategies that differ from local norms has been observed and also shown to reduce the effectiveness of MTCT<sup>7,13</sup>. The importance to assess the acceptability, feasibility, affordability, safety and sustainability of the infant feeding options being offered in the PMTCT programme becomes relevant.

### **What is known about exclusive breastfeeding?**

Exclusive breastfeeding has been shown to be safer with regards to early infant morbidity and mortality than replacement feeding.<sup>14,15,16,17</sup> In different settings in Southern Africa exclusive breastfeeding rates range between 19% and 76%<sup>7, 18, 19</sup>.

Where properly supported, there can be a significant improvement in exclusive breastfeeding<sup>18</sup>. In a PMTCT programme in Ndola, Zambia, exclusive breastfeeding rates rose from 56% to 76%<sup>18</sup>. With appropriate counseling, women not only maintained, but also increasingly adopted good breastfeeding practices.

Some studies have shown that HIV positive women opt to breastfeed as a result of financial constraints, poor hygienic conditions, and risk of social repercussions which include partner influence and fear of losing confidentiality.<sup>20, 21</sup>

### **What is known about early cessation of breastfeeding?**

PMTCT programmes in Botswana, Uganda, Zambia showed that early cessation is possible though it presents problems to the mother and infant.<sup>7, 22</sup> The problems that are faced by the infants include, dehydration, anorexia, later behaviour problems,

malnutrition and death.<sup>7</sup> The mother has problems of breast engorgement, mastitis, increased risk of getting pregnant, depression, stigma, and possible reversion to breastfeeding.<sup>7,22</sup> From the experiences of early cessation of breastfeeding among HIV infected women in Kampala, Uganda, mixed feeding was practiced by 45% and exclusive breastfeeding with early cessation was practiced by only 6%.<sup>22</sup>

The impact of early cessation on infant morbidity and mortality is unknown.<sup>7,23</sup> Early cessation of breastfeeding poses a threat to the nutritional status of infants especially in poor resource settings. Breast milk provides more than half the total intake of many macro and micronutrients at 6-8 months and at 9-11 months of age respectively.<sup>7</sup> The contribution of breast milk to total nutrient intake is considerable in the second year of life.<sup>7</sup>

### **What is known about expressing and heat-treating breast milk?**

Heat-treating breast milk for 12-15 minutes has been shown to inactivate HIV in the milk. However there is no data on the feasibility of this practice.<sup>7</sup> Few studies done in Zimbabwe and Tanzania have shown this option as not being acceptable and viable.<sup>11,12</sup>

### **What is known about modified animal milk?**

Modified animal milk (including that which has micronutrient supplementation recommended by WHO/UNICEF) has a good protein energy balance, but does not meet the needs for all estimated micronutrients and essential fatty acids required for infant growth and development of infants aged <6months.<sup>7,25,18</sup> Very little is known about the

feasibility of this option. A study done in Tanzania showed that women perceived this method as the most feasible infant feeding alternative method.<sup>12</sup> Another study done in India showed that about 44% of the HIV- positive women intended to use modified cow's milk which they referred to as 'top milk.'<sup>20</sup> These women were more likely to disclose their HIV status to their families<sup>20</sup>.

### **What is known about infant formula feeding?**

There are high levels of acceptance and adherence to formula feeding in some PMTCT programmes. Manuel de Paoli et al showed that 82% of Tanzanian women were confident of choosing infant formula feeding their infants.<sup>12</sup> In studies done in South Africa, acceptance of formula feeding was higher in urban settings than in rural settings.<sup>7</sup> The Botswana PMTCT study showed that the adherence to exclusive formula feeding may be higher than the adherence to exclusive breastfeeding.<sup>26</sup> Use of this method of infant feeding is hindered by stigma attached to not breastfeeding.<sup>7</sup> At the same time, safe formula feeding requires access to safe water, proper instructions and access to health care should children become sick with diarrhoea or fail to thrive.<sup>16,25</sup> ZVITAMBO study in Zimbabwe showed that mothers in urban settings needed half their incomes to purchase infant formula.<sup>27</sup> Impact of cultural values including that husbands have the final say regarding breastfeeding poses a challenge to practicing formula feeding.<sup>16</sup>

### **3. Statement of objectives**

#### **Broad Objective**

To explore the acceptability and feasibility of different infant feeding options offered in the PMTCT programme in urban and rural communities in Zimbabwe.

#### **Specific Objectives**

- I. To determine the knowledge levels concerning PMTCT in the community
- II. To determine infant feeding practices of women.
- III. To determine the acceptability of infant feeding options offered by PMTCT in the community.
- IV. To assess the feasibility of using the different infant feeding options in the community.
- V. To determine the methods of infant feeding used in rural communities for an orphaned infant.
- VI. To assess health workers knowledge on infant feeding within the PMTCT context.

### **4. Methodology**

#### **Research Methodology**

We conducted a cross-sectional survey in 2 purposively selected districts with PMTCT programmes. In one district the PMTCT programme had been running

for at least 12 months and in the second district the programme had just started. The following study sites were chosen, Makoni and Tsholotsho district. The study population was women with children below 1 year of age.

In each district 7 health centre catchment areas implementing PMTCT were randomly selected. In each of the health centre catchment areas village health workers registered all women with children below 1 year. This registers was used to randomly select women into the study. The sample for each catchment area was weighted on the projected population of children below 1 year in the different areas. The calculated sample size for this study was 400 women with children below one year. The following assumptions were made, uptake of PMTCT among women attending ANC of 40% with a 5% margin of error at 95% confidence level.

Three groups of people; key informants, women above 45yrs and married men were purposively selected to participate in separate focus group discussions. The number of participants in each focus group discussion was between 8 and 10 individuals.

Health workers from the two district hospitals and from selected health centres were interviewed.

To collect data from the women with children below 1year, interviewer administered structured questionnaires with both coded and non-coded responses

were used. A focus group discussion guide was used to collect information during focus groups. The questionnaires and focus group discussion guides were pre-tested in Seke rural district which operates PMTCT.

The following variables were assessed; **Demographic characteristics** (age, sex, source of income, amount, assets, family size, parity, religion, age of body, close family with children under 2 years, marital status); **knowledge** (HIV, modes of transmission (MTCT), knowledge of PMTCT programme, knowledge of components of PMTCT, knowledge on infant feeding methods) ; **acceptability of infant feeding options**; **feasibility** (uptake of PMTCT in the community, knowledge of HIV-status, frequency of disclosures, infant feeding counseling, cost, beliefs and taboos, community acceptability, barriers, perceptions, availability of formula and animal milk); and **infant feeding practices** (frequencies of exclusive BF, formula, modified animal milk, mixed feeding, expressing, early cessation and other infant feeding practices);

Permission to carry out the research was sought from the Ministry of Health and Child Welfare and the relevant local authorities in which the study took place. Before administering the questionnaire the respondent will be asked to sign a consent form if willing to participate in the study. The study was also approved by the Medical Research Council of Zimbabwe. Confidentiality of information collected was guaranteed to the respondents. Trained research assistants collected data.

Data was entered in Microsoft access and analysed using EPI 2002. Simple descriptive statistics were used for presentation of the summarized data.

### 3 Results

#### 3.1 Demographic Characteristics

We interviewed 421 women with babies below 1 year of age. In Makoni District 201 women were interviewed and in Tsholotsho we interviewed 220 women. Table 1 shows the demographic characteristics of the survey participants by district.

**Table 1 Demographic variables**

Variable	Category	Makoni District		Tsholotsho District	
		n	%	n	%
Age of babies	<6 months				
	>6 months				
Place of residency	Urban	89	44.3%	2	0.9
	Rural	88	43.8	217	98.6
	Resettlement	19	9.5	0	0
	Growth Point	3	1.5	1	0.5
	Farming	2	1	0	0
Marital Status	Married	182	91	131	60
	Not Married	19	9	89	40
Education	None	1	0.5	2	1
	Primary	57	28	77	35
	Secondary	136	68	139	63
	Tertiary/Vocational	7	3.5	2	1
Main source of income	Remittances	0	0	91	41
	Farming	63	31	72	32
	Wages	76	38	19	9
	Pension/Grants	2	1	0	0
	Own business	42	21	27	12
	Casual labour	10	5	6	3
	Other	8	4	5	2
Religion	vapostori	75	37	4	2
	Christian	122	61	93	41
	Traditional	1	1	5	2
	Zion	2	1	94	42
	Other	1	1	24	11
Source of water	safe	177	88	197	85
	Not safe	24	12	33	15
Distance to water source	Near	154	77	163	74
	Far	47	23	57	26
Source of energy	Electricity	73	36	3	1

	Firewood	127	63	212	99
	Gas	0	0	0	0
	Paraffin	1	1	0	0

The median age of the study participants (women with babies aged <12 months) in Makoni was 24 years(20, 28) and in Tsholotsho 23 years (20, 28). The median age of the babies of the women in the study was – (), --() in Makoni and Tsholotsho respectively. Both in Makoni and Tsholotsho the participants had an average of 3 meals per day.

Over 99% of the participants in both Makoni and Tsholotsho had attained at least primary education. The main source of income in Makoni (76; 38%) was wages and in Tsholotsho (91; 41%) remittances. The majority of the participants in the survey had access to safe water, Makoni (154; 77%), and Tsholotsho (163; 74%).

### **3.2 Knowledge on HIV, PMTCT and Infant feeding**

Table 2 shows the respondents knowledge on HIV transmission. Knowledge that HIV is transmitted through sexual intercourse was high in both Makoni and Tsholotsho.

Knowledge that HIV transmission is transmitted from mother to child was low; in Makoni 17% (34) and 12% (27) in Tsholotsho. However when mothers were prompted in Makoni, 90% (181) mothers knew that HIV is transmitted through mother to child. Those who sited mother to unborn child were 46% (93), breastfeeding 74% (150), during delivery 46% (92). In Tsholotsho, 86%(190) mothers knew that HIV is transmitted from mother to child. Those who agreed for mother to child were 46% (102), breastfeeding 68% (150) and during delivery 25% (55).



**Table 2 Respondant's Knowledge on HIV transmission**

<b>Variable</b>	<b>District M</b>		<b>District T</b>	
<b>HIV is transimitted through:</b>				
Sexual intercourse	189	94	211	96
Kissing	12	6	10	5
Touching	13	7	9	4
Staying in the same room with an infected person	3	2	4	2
Mother to unborn child	34	17	27	12
Breastfeeding	60	30	52	24
During delivery	45	22	25	11
Other (sharps)	93	46	128	58
All HIV positive mothers who breast feed cause HIV infection in their babies	85	42	142	65

Table 3 shows the respondents knowledge on the PMTCT programme. In Makoni District, 78% (156) of the participants had heard about the PMTCT programme. In Tsholotsho, 45% (99) of the participants had heard about the programme. In both districts the majority of the participants had heard from the health centre 86% (134), and 88% (87) respectively in Makoni and Tsholotsho. In both Makoni 72% (113) and Tsholotsho 63% (62) less participants had heard about counseling on infant feeding options as part of the package offered in the programme.

**Table 3 Knowledge on the PMTCT Programme**

Variable	District M		District T	
	156	78	99	45
Knowledge of the PMTCT Programme				
<b>I heard about the programme from: (N=156), (N=99)</b>				
Health Centre	134	86	87	88
Relatives	3	2	3	3
Media	14	9	10	10
Other	7	5	7	7
<b>I heard the following about the PMTCT programme:</b>				
HIV testing	151	97	103	
Counseling	137	88	67	68
Drugs at delivery	136	87	75	76
Infant Feeding options	113	72	62	63

**Figure 1 Knowledge on infant feeding options among women who had heard about the PMTCT programme**

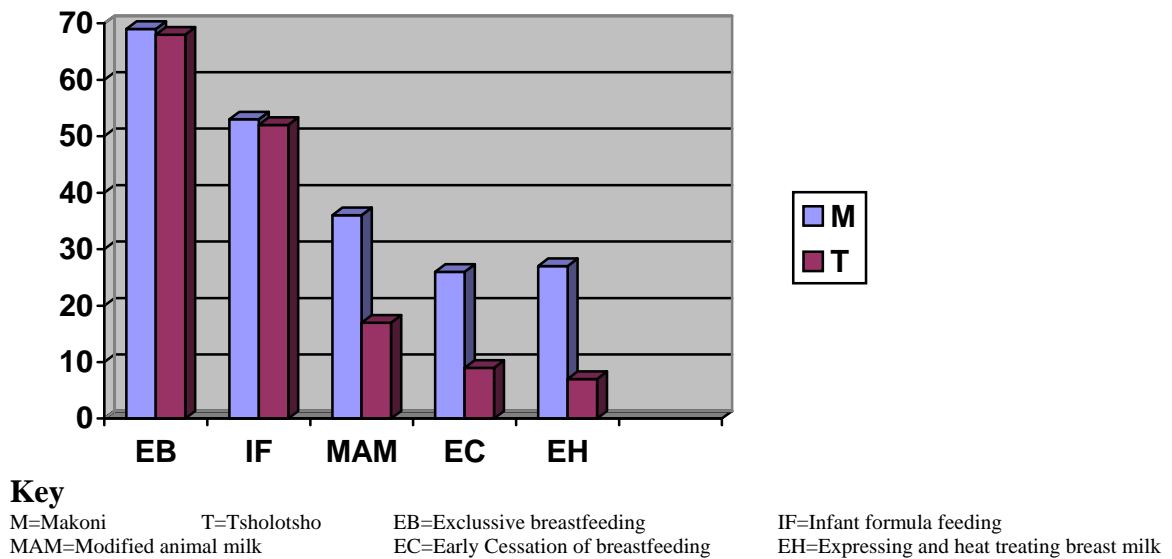


Figure 1 shows the respondent’s knowledge on infant feeding options. In both districts (69% Makoni and 68% Tsholotsho), most of the participants knew about exclusive

breastfeeding as an option. The least known option was early cessation in Makoni 26% and expressing and heat-treating in Tsholotsho 7%. Generally the percentage of women who had knowledge on the different infant feeding options was lower in Tsholotsho than in Makoni.

Table 4 shows respondents knowledge on breastfeeding. Correct knowledge on exclusive breastfeeding was low in Tsholotsho (58%). In both Makoni (30%) and Tsholotsho (35%) a considerable number of participants had the misconception that breastfeeding protects a baby from getting HIV.

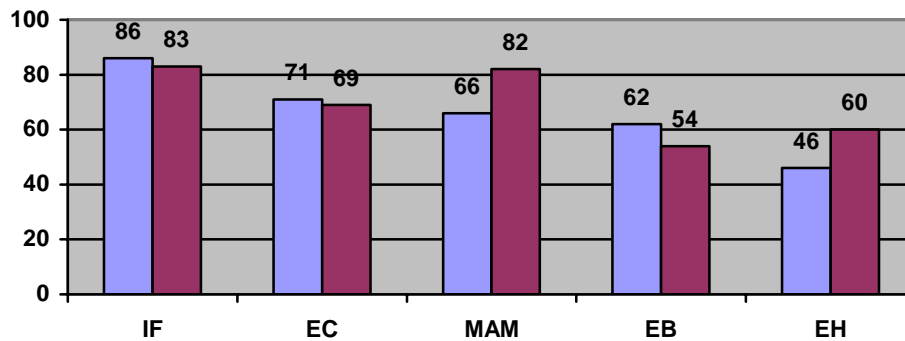
**Table 4 Knowledge on Breastfeeding**

Variable	District M		District T	
	N	%	n	%
Correct knowledge on exclusive breastfeeding	137	68	127	58
Correct knowledge on when other foods and drink should be introduced to babies	148	74	112	51
Breastfeeding protects a child from getting HIV	61	30	77	35
Correct knowledge on length of breastfeeding period for a baby	2	1	9	4

### 3.3 Acceptability of different infant feeding options

Figure 2 presents data on acceptability of different infant feeding options to the participants in the survey. Figure 3 presents the perceptions of acceptability of the different infant options in the community.

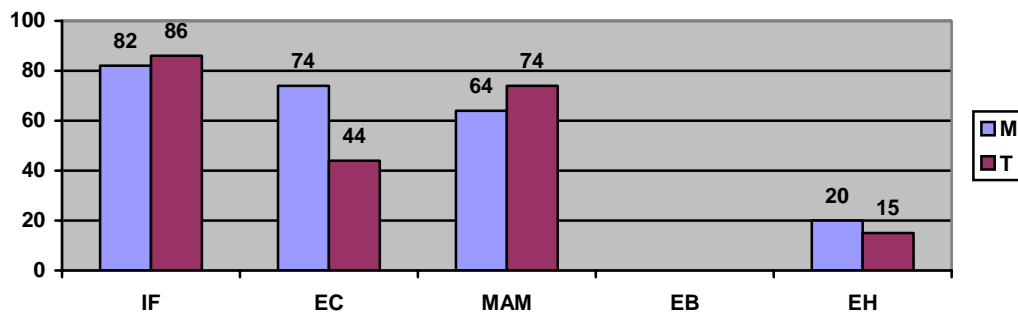
**Figure 2 Acceptability of infant feeding options to women**



**Key**

M=Makoni      T=Tsholotsho      EB=Exclusive breastfeeding      IF=Infant formula feeding  
MAM=Modified animal milk      EC=Early Cessation of breastfeeding      EH=Expressing and heat treating breast milk

**Figure 3 Perception of acceptability of infant feeding options in community**



**Key**

M=Makoni      T=Tsholotsho      EB=Exclusive breastfeeding      IF=Infant formula feeding  
MAM=Modified animal milk      EC=Early Cessation of breastfeeding      EH=Expressing and heat treating breast milk

The most acceptable infant feeding option in both districts was infant formula feeding; Makoni 86% and Tsholotsho 83%. The least acceptable infant feeding option was expressing and heat treating in Makoni and exclusive breastfeeding in Tsholotsho. Figure 3 shows that the women in the study perceived expressing and heat-treating as the least

acceptable infant feeding option in the community in both Makoni (20%) and Tsholotsho (15%).

### 3.4 Feasibility of different infant feeding options in the community

**Exclusive Breastfeeding**

**Early Cessation**

**Expressing and Heat-treating**

**Modified animal milk**

**Exclusive breastfeeding**

**Table 2 Availability of livestock and use of milk**

Variable	District M		District T	
	n	%	n	%
Cows available	64	32	118	54
Use cows milk	173	86	58	26
Milk always available	40		10	5
Goats available	59	29	130	59
Use goat' milk	15	8	57	26
Milk always available	13	7	19	9

**Table 5 Practises in the PMTCT Programme**

Variable	District M		District T	
	n	%	n	%
Attended ANC	195	97	213	97
Told About the PMTCT programme	142	73	69	
Tested for HIV	52		21	
Able to share results: N=52, 18	42		13	
Positive N=41,	6		1	
Negative	33		12	
Did not collect them	4		0	

**Table 6 Infant Feeding Counseling Received**

Variable	Category	District M		District T	
Received infant feeding counseling	Yes	20		6	
	No	27		9	
Infant feeding options discussed	Exclusive Breastfeeding	18		2	
	Early Cessation	10		3	
	Expressing and Heat treating	8		3	
	Modified animal milk	8		3	
	Infant formula	9		6	
	None	2		2	
Infant Feeding option chosen	Exclusive Breastfeeding	14		2	
	Early Cessation	2		0	
	Expressing and Heat treating	1		0	
	Modified animal milk	4		0	
	Infant formula	3		0	
	None	3		5	
Received educational material on infant feeding		5		2	

**Peer Support Networks**

The women in the study from Makoni District indicated the they would want the following support from health workers in terms of infant feeding; Health Education (116, 59%), Supplementary food for mothers (39, 20%), infant formula (15, 8%), supplementary food for the babies (6, 3%). The women in the study from Tsholotsho District indicated the they would want the following support from health workers in

terms of infant feeding; health education (74, 35%), Supplementary food for babies (57, 27%), Infant formula (25, 12%), and supplementary food for mothers (17, 8%)

**Table 7 Women’s perception of risks associated with breastfeeding**

Variable	District M		District T	
	n	%	n	%
<i>Increase chances of baby contracting HIV if I:</i>				
Breastfeed when I have mastitis	185	92	182	85
Breastfeed when nipples are cracked	184	92	198	90
Don’t use a condom when having sex in the breastfeeding period	175	87	186	85
Breastfeed when baby has mouth thrush	164	82	177	81
Breastfeed for long time	172	86	185	84
Mix feed	131	65	138	63
Breastfeed when I am feeling very sick	178	89	197	90

**Table 9 Infant Feeding Practices**

<b>Variable</b>	<b>District M</b>		<b>District T</b>	
	<b>N</b>	<b>%</b>	<b>n</b>	<b>%</b>
Exclusive Breastfeeding				
Early Cessation	1	1	3	
Expressing and Heat treating	0	0		
Modified animal milk	0	0		
Infant formula	2	1		
Mixed Feeding	32	16	99	

**Table 12 Benefits of Exclusive Breast Feeding**

Variable	District M		District T	
	n	%	n	%
Provides good nutrition	136	68	164	75
Protects baby against diseases	140	70	146	30
Helps delay pregnancy	37	18	12	6
Cost less	70	35	42	19
Always available	71	35	23	11
Don't Know	17	9	20	9

**Table Barriers of Exclusive Breastfeeding**

Variable	District M N=201		District T N=213	
	n	%	n	%
Child may contract HIV	78		25	
All babies should get water	12		1	
Beliefs	8		18	
Fear	0		80	
Breastmilk is inadequate for the baby	25		0	
Lack of knowledge	1		1	
When one has breast problems difficult to breastfeed	5		5	
Costly	2		2	
Baby crying	6			
<b>Inadequate milk</b>	31		23	
Family pressure	1		1	
Time	1		0	
Don't know	7		20	
No barriers	23		36	

**Table Benefits of Early Cessation**

Variable	District M		District T N=	
	n	%	N	%
<b>Provides good nutrition</b>	1	0.5	7	3
Protects baby from disease	0	0	1	0.5

Cheap	4	2	0	0
Child maybe protected from HIV	160	80	135	62
Improve's child health	1	0.5	4	2
Prevents mixed feeding	1	0.5	0	0
Not acceptable	1	0.5	0	0
None	27	13	47	22
Don't know	6	6	19	9

**Table 13 Barriers of early cessation**

Variable	District M		District T	
	n	%	n	%
Breastmilk contains HIV	7	4	10	5
Baby cries	1	1	1	1
Beliefs	1	1	9	4
Breast problems	0	0	1	1
Child prone to disease	9	5	5	2
Child too young to stop breastfeeding	20	10	3	1
Community fears	18	9	38	18
Cost	53	26	107	50
No food for baby after weaning	38	18	9	4
Early pregnancy	1	1	4	2
Baby refuses food substitutes	2	1	0	0
Growth retardation of child	20	10	1	1
None	25	12	12	6
Unacceptable	1	1	0	0
Don't know	4	2	14	7

**Table 14 Benefits of modified animal milk**

Variable	District M		District T	
	n	%	n	%
Animal milk available	27	13	6	3
Acceptable	1		3	1
Good nutrition	65	32	60	28
Cheap	33	16	6	3
Protects baby from HIV	33	16.4	95	44
Safe	3	2	3	1
Similar to mother's milk	0	0	3	1
None	31		25	12
Don't know	8		12	6

**Table 15 Barriers of modified animal milk**

Variable	District M		District T N=215	
	n	%	n	%
beliefs	2	1	14	7
Fears	0	0	3	1
Cost	63	31	84	39
Cow may be diseased	4	2	1	1
Difficult to prepare	5	3	0	0
Insufficient nutrients	27	13	3	1
Not suitable for infant feeding	23	11	11	5
Does not protect child form HIV	1	1	0	0
No bonding	1	1	0	0
<b>Not acceptable</b>	7	4	0	0
Milk not always available	34	17	54	25
Poor preparation	18	9	7	3
Poor knowledge	0	0	1	1
Child becomes prone to disease and allergies	6	3	2	1
Baby may refuse animal milk	0	0	1	1
None	9	4	28	13
Don't know	1	1	6	3

**Table 16 Benefits of Expressing and heat treating**

Variable	District M		District T	
	n	%	n	%
Heat treating kills HIV	113	56	130	60
available	7	4	4	2
Cheap	13	7	2	1
Good for those with cracked nipples	1	1	0	0
Child can feed even when mother is away	1	1	0	0
Same as breast milk	8	4	2	0
Inadequate milk	1	1	0	0
Good nutrition	0	0	13	6
None	46	23	53	25
Don't know	11	6	11	5

**Table 17 Barriers of Expressing and heat-treating**

Variable	District M		District T	
	n	%	n	%
Beliefs	1	1	67	31
Breastfeeding is best			1	
Taboo	2	1	0	0
stigma	8	4	1	0
Difficult	12	6	7	3
Time consuming	12	6	1	
Fear of relatives, neighbours and community	18	9	71	33
Ignorance	2	1	0	0
Inadequate breastmilk	12	6	4	2
Inadequate food for mother to produce enough milk	3	1	0	
Mother ill	1		1	
Milk contains HIV	17	9	13	6
No bonding with mother	1		1	
Other nutrients destroyed	6	3	5	2
Poor hygiene and preparation	55	27	3	1
Temptation to breastfeed	1	1	0	
Unacceptable	13	6	3	
Not practiced	14	7	0	
None	20	10	23	11
Don't Know	2	1	13	6

**Table 18 Benefits of formula feeding**

Variable	District M		District T	
	n	%	n	%
Approved	41	20	11	5
Available	6	3	2	1
Best option	4	2	1	1
Convenient	2	1	0	0
Easy to prepare	8	4	3	1
Prevents baby from HIV infection	31	15	84	39
<b>Provides good nutrition</b>	61	30	70	33
Safe	28	14	9	4

Similar to breast milk	2	1	6	3
Protects baby from diseases	0	0	2	1
None	14		18	8
Don't know	4	2	9	4

**Table 19 Barriers of formula feeding**

Variable	District M		District T N==216	
	n	%	n	%
<b>Expensive</b>	161	80	185	86
Not suitable for infant feeding	12	6	2	1
Does not prevent child hood illnesses	2	1	1	1
Inferior to mother's milk	3	2	1	1
Instructions difficult to follow	6	3	1	1
Might have expired	1	1	0	0
Poor hygiene	9		0	0
Poor storage	3	1	0	0
Beliefs			2	1
Fears			10	5
Time consuming	1	1	0	0
Not acceptable	2	1	0	0
None			11	5
Don't know	1	1	3	1