BREAST FEEDING RISKS FOR HIV POSITIVE MOTHERS AND ALTERNATIVE INTERVENTIONS IN KENYA: LEGAL PERSEPECTIVE

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Abstract

The Aids pandemic has been devastating to humanity. The World Health Organization has been on the forefront encouraging all manner of approaches that can reduce the risk of HIV transmission. One such approach that has gained prominence especially in Luo Nyanza is male circumcision. It is believe that circumcised male stand less risk of contracting HIV. One approach that has not received much emphasis is the role of commercial infant formula in reducing the risk of mother to child transmission as a result of breastfeeding.

This article considers the juridical framework of reducing HIV transmission through improving choices for HIV positive mothers who opt not to breastfeed. It considers that breastfeeding is compulsory for every infant if good health is to be guaranteed against the challenge of HIV transmission to the child. It advances the argument that every child has the right to life and knowingly putting the life of a child at risk of death is a violation of this cardinal right to life. It argues that the government not only has a legal but also a moral responsibility to protect the life of minors against the risk of HIV transmission.

It anchors the debate on who is responsible to shoulder the burden of commercial infant formula purchases. Should it be the parents or the State? It recommends that good public administration would demand that the State to step in and provide commercial infant formula to HIV positive mothers who may not wish to breastfeed. The choice is narrow. It is either exclusive breastfeeding or exclusive commercial infant formula. The financial implications of the later could negate the choice and therefore compromise an alternative intervention towards HIV prevention, management and control.

The article introduces the subject, then considers whether the government has a positive duty to mitigate HIV transmission in context of breastfeeding. It then considers case studies in South Africa and United States of America. It considers what Kenya has done and concludes by giving recommendations on what Kenya ought to do.

Introduction

It has been argued forcefully that breast feeding is compulsory for every infant to ensure good immunity against common childhood diseases. This position has been maintained even in the case of HIV positive (HIV +ve) mothers(1). It is also conceded that breast feeding by an HIV +ve mother may advance the risk of mother to child transmission. Commercial infant foods formula have been brushed aside as being too expensive for resource impoverished mothers. Since such mothers cannot afford to pursue an exclusive infant diet of commercial formula they have been urged to breast feed notwithstanding the risk of transmission to the infant(2). A critical legal issue that arises is whether pursuing a policy of non intervention would be in the best interests of the child. Should the government intervene to ensure that risk of HIV transmission to innocent infants is minimized? Collateral to this legal issue would be the accessible intervention strategies

1. See for example Consensus Statement, "WHO HIV and Infant Feeding Technical Consultation Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants" Geneva, October 25-27, 2006.

2. The Consensus Statement made a preliminary summary that exclusive breastfeeding for up to six months was associated with a three to four fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding in three large cohort studies in Cote d'Ivoire, South Africa and Zimbabwe. On the other hand low maternal CD4+ count, high viral load in breast milk and plasma, maternal seroconversion during breastfeeding and breastfeeding duration were confirmed as important risk factors for HIV transmission and child mortality.

Context

This article explores this legal dilemma and advances the debate that the government has a legal responsibility to intervene through policy formulation and appropriate coercive measures to ensure that risk of HIV transmission to innocent infants is minimized. It analyses and evaluates the juridical regime in Kenya for Children rights and makes a comparison with existing government policy and international norms. It highlights shortcomings of existing government policy and proceeds to compare best practices from other jurisdictions.

The theme of the article revolves around testing the hypotheses (1) that there is a positive legal duty on the government to pursue policies that advance welfare of infants born to HIV+ve mothers and (2) that there is no positive obligation on the government to provide nutritional support or commercial infant formula. The methodology adopted is analysis of existing literature and drawing conclusions taking into account limitations of the study such as lack of scientific proof that breastfeeding by HIV infected mothers automatically leads to infant HIV infection(3). The proposition supported by some studies that women on ARV therapy suffer less risk of transmitting HIV to their infants and the overall benefit of breastfeeding to infants(4). It is expected that the article will improve government understanding of its responsibility in this area. With a view to engineering a policy shift in favour of commercial infant formula for infants born to HIV infected mothers who opt not to breastfeed.

Mother To Child HIV transmission

Breastfeeding is the primary feeding option for every mother. Apart from the nutritional benefit that accrues to the child in the long run it is psychologically boosting to the mother and makes the mother feel whole. However, serious challenges have arisen in the wake of HIV. Experience has shown that infants born to HIV infected mothers stand a high chance of HIV infection either during pregnancy, delivery or through breastfeeding. The actual scientific mechanism through which the transmission occurs is well beyond the scope of this article which primarily looks at the issue from a legal perspective. Empirical evidence is however clear that the risk is real and the government through the Ministry of Health has put into place mechanisms for early diagnosis of the status of women visiting antenatal clinics.

Every pregnant woman is encouraged to undergo HIV screening in order to determine her status. The objectives are twofold. First it is important to know the status of the mother so as to recommend ARV treatment in the event of positive results. On the other hand holds a positive result would put the health officers on the alert as to the mode of delivery to reduce the risk of HIV transmission to the infant.

At this stage it becomes necessary to examine the National Policy on Infant and Young Child Feeding Practices. A summary of the statement from the Ministry of Health states as follows:

Every facility providing Maternal and Child Health (MCH) services should:

- Adhere to the National Infant Feeding Policy, which should be routinely communicated to all health staff and strategically displayed;
- Train all health care staff in skills necessary to implement this policy;
- Provide information to all pregnant women and lactation mothers and their parents on the benefits and management of breastfeeding;
- Assist mothers to initiate breastfeeding within the first 30 minutes of birth;

3. See the Consensus statement 4. See the Consensus statement

- Give newborn infants no food or drink other than breast milk unless medically indicated (see specific guidelines on HIV Infected mother)
- Show mothers how to breast-feed and to maintain lactation even if they should be separated from their infants;
- Practice rooming-in, allow Infants to remain together with the mother 24 hours a day;
- Encourage breastfeeding on demand;
- Encourage and actively promote exclusive breastfeeding for Infants up to six months;
- Provide information and demonstrate to mothers how to introduce and prepare appropriate and nutritious complementary foods to their infants after six months;
- Encourage mothers to breast-feed for at least 24 months (see guidelines for HIV infected mothers)
- Foster the establishment of breastfeeding support groups and other support groups and refer mothers to them on discharge room hospital or clinic;
- Not accept any free samples and supplies of breast milk substitutes;
- Not give any feeds using bottles or teats.

The Guidelines on HIV and Infant Feeding Practices are as follows:

Every institution providing maternal and child health services should ensure that its personnel disseminates the following information to mothers.

- ♦ Information on benefits of breastfeeding;
- ♦ Prevention and management of breastfeeding problems;
- ♦ Appropriate complimentary feeding
- ♦ Promote good maternal nutrition and self care
- ♦ Provide Vitamin A supplements iron folic and Zinc
- ♦ Counsel on child spacing
- ♦ Prompt treatment of infections
- ♦ Reduction of HIV infections
- ♦ Risk of mother to child transmission (MTCT) of HIV
- ♦ Information on voluntary counseling and testing
- ♦ Reinforcing risk reduction to couple

Enforcement of risk reduction measures

The government recommends voluntary HIV counseling and testing. The objective is to reinforce risk reduction and promote breast feeding for mothers who are not infected. For HIV +ve mothers the policy is as follows:

i. To provide information on feeding options,
ii. cost of the options
iii. Information and skills on how to reduce/avoid MTCT
iv. Allow the mother & partner to make informed choice.

The policy of the government for HIV +ve mothers who choose to breastfeed is as follows

i. Support and encourage exclusive breastfeeding
ii. Prevention & management of breastfeeding problems
iii. Discourage breastfeeding if cracked nipples, mastitis or abscess
iv. Provide relevant antiretroviral.

HIV +ve mother who choose not to breastfeed should be treated as follows

i. Demonstrate safe preparation & storage of chosen milk
ii. Demonstrate cup and spoon feeding
iii. Counsel on the care of breasts to avoid engorgement
iv. Provide reliable family planning method by 4 weeks.

It is clear that there is no proactive policy on the part of the government to empower HIV +ve mothers who choose not to breastfeed . Accordingly, the choice of mothers

mothers who choose not to breastfeed. Accordingly, the choice of mothers who may wish not to breastfeed but lack resources for commercial infant formula is compromised. Does this violate the right of infants by unnecessarily exposing them to HIV infection? This question calls for an examination of the juridical regime of children and their right to life.

Positive duty to mitigate HIV transmission

Looking at the policy of the government as a whole it is apparent that there is a positive duty to reduce HIV transmission to infants during and after child birth. Why is the government concerned with reducing HIV transmission from HIV +ve mothers to infants? Maybe the question may be reframed as why does the government provide ARV free of charge to HIV +ve persons? Is it because it is legally obligated to do so? It is the duty of government to protect human rights which specifically applies to children as per the Constitution of Kenya 2010.

The government provides relief food during famine, it evacuates during floods and protects citizens from internal and external aggression. Does the duty spring from the right to protect life guaranteed by section 71(5) of the Constitution of Kenya?

ARVs do not guarantee life but only delay the effects of HIV which is AIDS. The postponement of this terminal stage is the policy objective of ARVs. The government is yet to conduct a study to determine which of the two policy alternatives; breastfeeding or breastfeed substitutes is more viable in the long run to the life of infants. However, one thing is clear and acknowledged by the government.

There is high risk of transmission of HIV if breastfeeding option is chosen and not practiced exclusively for first six months. Who determines what is in the best interests of the child? Should the decision be left with the HIV +ve mother? Can it be assumed that the mother will always make a decision that is in the best interests of the child? These issues are weighty and deserve critical review.

Let us start by looking at the responsibility of the government towards the child. Section 3 of the Children Act (6) provides as follows:

- The Government shall take steps to the maximum of its resources with a view to achieving progressively the full realization of the rights of the child set out in this Part.

The rights of the child set out in Part II of the Act include

(a) Survival and best interests of the child(7)

This section imposes a positive obligation on the Government and family to ensure the survival and development of the child. In matters affecting the child the first and paramount consideration is the best interests of the child.

(b) Non discrimination(8)

(c) Right to parental care(9)

(d) Right to education(10)

Every child shall be entitled to education the provision of which shall be the responsibility of the government and family. In furtherance of this obligation the Government has implemented free primary and secondary education according to section 7(2) of the Act. It expressly enacts that each child shall be entitled to free basic education which shall be compulsory in accordance with Article 28 of the United Nations Convention on the Rights of the Child.

(e) Right to religious education (11)

(f) Right to health care(12)

5. No person shall be deprived of his life intentionally save in execution of sentence of a court in respect of criminal offence under the law of Kenya of which he has been convicted. 6. Act No. 8 of 2001. 7.See section 4 of the Act. 8. See section 5 of the Act 9. See section 6 of the Act 10. See section 7 of the Act 11. See section 8 of the Act 12. See section 9 of the Act.

Every child shall have a right to health and medical care the provision of which shall be the responsibility of the parents and the Government.

(g) Protection from child labour and armed conflict(13)

(h) Right to name and nationality(14)

(i) Disabled child privileges(15)

(j) Protection from abuse(16)

(k) Protection from harmful cultural rites(17)

No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development.

(l) Protection from sexual exploitation(18)

(m) Protection from drugs(19)

(n) Right to leisure and recreation(20)

(o) Protection from torture and deprivation of liberty(21)

(p) Right to privacy(22)

Section 20 of the Act provides twelve months or to fine not exceeding fifty thousand or to both.

An exhaustive reproduction of the rights of the child under the Children Act was necessary to show that the Government has a positive duty towards the child. Child means any human being under the age of eighteen years(23). The right to health and health care are relevant for our analysis. A positive duty is cast on the government to protect life and provide for health care needs of the child.

It is beyond argument that it is in the best interests of a HIV-exposed(24) child to lead a life free from HIV infection. Circumstances that may infect a child with HIV should be avoided. In terms of feeding options of the child how does the government come in? The cost of commercial infant formula is well beyond the reach of many HIV +ve mothers. Due to their impaired heath condition most of them are normally not in gainful employment.

This dilemma has led them to chose breast feeding for lack of alternative viable option. If it is assumed that commercial infant formula for infants born to HIV +ve mothers is preferable to breastfeeding taking into account degree of risk to HIV infection, then it would follow that commercial infant formula should be encouraged and promoted as the alternative to breastfeeding. On the other hand the benefits of exclusive breastfeeding for mothers who can afford nutritious diet cannot be ignored.

The next issue would be who bears the burden of providing commercial infant formula? It is proposed that the government should shoulder this responsibility. Commercial infant formula should be provided as a matter of course to all HIV +ve mothers. The choice of feeding option should be improved through alternatives. As a policy it should be made clear that all HIV +ve mothers are free to use commercial infant formula at no cost.

The benefits of this approach should be communicated to the parents. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV infected mothers is recommended. (25)

The rationale for imposing the duty to provide commercial infant formula on the government arises from the duty to protect life and provide for health care of the child.

13. See section 11 of the Act 14. See section 12 of the Act 15. See section 13 of the Act 16. See section 14 of the Act 17. See section 15 of the Act 18. See section 16 of the Act 19. See section 17 of the Act 20. See section 18 of the Act 21. See section 18 of the Act 22. See section 19 of the Act 23.See section 2 of the Children Act.
24. HIV-exposed refers to children born or breastfeed by women living with HIV.
25. WHO. Recommendations on the prevention of mother-to-child transmission of HIV and their policy implications. WHO, 2001. www.who.int/reproductive-health/publications .

We can also draw from international human rights agreement is the *Convention on the Rights of the Child (26)*. Article 24 imposes an obligation on state parties to recognize the right of the child to the highest attainable standard of health and to take appropriate measures to combat disease and malnutrition through provision of adequate nutritious foods, clean drinking water, and health care.

The duty to prevent HIV infection in infants is correlated to ARV provision. Through reducing the number of infants likely to be affected by HIV the government indirectly reduces the burden of providing ARVs. It is a perfect case of walking the extra mile. This view is reinforced by best practices gathered from other jurisdictions.

The Case of South Africa

South Africa has implemented a robust prevention of mother-to-child transmission of HIV (PMTCT)(27). The primary aim of the PMTCT programmme was to decrease the number of HIV infected babies born to HIV +ve mothers. Primary prevention of HIV infection particularly among women of childbearing age has always been the backbone of the programme.

A comprehensive package of interventions were developed and implemented, including routinely offered voluntary counseling and testing (VCT), counseling on infant feeding practices, safe non-invasive obstetric procedures, single dose nevirapine and the provision of infant formula feeding

Under the infant commercial formula programme, free commercial infant formula is provided for at least six months. Women receive practical support, including demonstrations on how safely to prepare the formula and feed the infant. At 6 months infants at risk of poor growth are referred for continued nutritional monitoring and dietary assistance. An appropriate infant milk product for the infant's age and circumstances is chosen. Infants weighing less than 2 Kgs receive a special low birth weight formula until the infant weighs at least 2 Kgs, thereafter infant formula for a term infant is given.

In situations where commercial formula is being provided free of charge through health facilities, managers, supervisors and health care personnel should ensure an uninterrupted supply at clinic level. This is achieved through efficient procurement procedures and adherence to Code of Marketing of Breast milk substitutes, resolutions and South Africa regulations.

The case of United States of America

The United States Special Supplemental Nutrition Program for Women, Infants and Children (WIC) distributes infant formula to deserving mothers at no cost (28). WIC program was launched in 1974 and is administered by the Food and Nutrition Services (FNS) of the US Department of Agriculture. It was authorized by the Child Nutrition Act of 1966. The WIC program "serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care(29).

What has Kenya done?

Kenya has taken the following steps to reduce HIV infection transmission. It has encouraged routine voluntary counseling and testing and provision of ARVs for those infected.

26. Convention on Rights of the Child, entered into force in 1990.
27. See Policy and Guidelines for the implementation of PMTCT Programme, National Department of Health, 11th February 2008.
28.George Kent, "WIC'S Promotion of Infant Formula in the United States", International Breastfeeding Journal, 2006.
29. The existence of the WIC programme has empowered HIV infected women in their choice not to breast feed.

It has however, failed to assist HIV +ve mother in achieving infant freedom from hunger while choosing not to breastfeed. This is the shortcoming that we urge the government to address. Apart from providing information on feeding options and the cost of the options, it should be alive to the government that it has a duty to contribute to meeting the costs of commercial infant formula. This would emancipate resource impoverished women who would like to forego breastfeeding as feeding option in favour of exclusive non-breastfeeding to improve the chances of negative infection of HIV to their infants.

The HIV and Aids Prevention and Control Act(30) was enacted to address matters related to prevention and control of HIV. Any person who is aware of being infected with HIV or is carrying and is aware of carrying the HIV virus is under an obligation to take all reasonable measures and precautions to prevent the transmission of HIV to others(31). He is also required to inform in advance any sexual contact or person with whom he shares needles of his HIV status (32).

A person who is aware of being infected with HIV or who is carrying and is aware of carrying HIV shall not, knowingly and reckless, place another person at the risk of becoming infected with HIV unless that other person voluntarily agrees to run the risk after being informed of HIV status(33). Knowing and reckless transmission of HIV is a criminal offence attracting a fine not exceeding Kshs. 500,000 or imprisonment for a term not exceeding seven years or to both such fine and imprisonment(34).

The statutory framework therefore upholds preventive effort of HIV transmission. The Act, however, does not deal expressly with mother-to-child-transmission (MTCT) in the context of HIV. However, it is submitted that an infected mother who knowingly and recklessly places a child at risk of contracting HIV commits an offence. This is the policy of the law.

The obligation as regards infants or children is absolute. The child has no capacity to determine whether to run the risk. As a matter of fact no consultation takes place in situations of MTCT. Using alternative feeding options falls under the obligation to take reasonable measures and precautions to prevent the transmission of HIV to others.

Another front has been the Kenya National Aids Strategic Plan III launched by the Minister for State for Special Programmes, Dr. Naomi Shaban(35). The vision plan is expected to be operational as from July 2009. The strategic goals of the vision plan are:

i. HIV incidence reduced
ii. HIV-related morbidity and mortality reduced.
iii. Kenyans infected and affected have access to adequate and equitable social protection services.

The new strategic plan will aim to achieve Kenyans universal access targets for quality integrated services at all levels to prevent new HIV infections, reduce HIV-related illness and deaths and mitigate the effects of the epidemic on households and communities. Special attention will be given to preventing new HIV infections and securing an Aids competent Kenyan society in the long term.

The proposed strategic thrusts and approaches of the new plan are:

i. Provision of cost effective services informed by an engendered Rights Based Approach for Universal Access to prevention, treatment, care and support. This means saving lives, averting more new infections and saving life-time medical care costs with available funds;

30. Act No. 14 of 2006 31. Section 24(1)(a) of the HIV Prevention and Control Act. 32. Section 24(1)(b) of the HIV Prevention and Control Act. 33. Section 24(2) of the HIV Prevention and Control Act. 34. Section 24(3) of the HIV Prevention and Control Act. 35. See www.nacc.or.ke accessed on 8/6/2009

ii. Targeted community based programmes supporting Universal Access and social transformation for an Aids-competent society supported in all communities.
iii. Long term programmes addressing both the root causes and effects of HIV mainstreamed key sectors; and
iv. All stakeholders operating within a nationally owned harmonized and aligned framework at all levels supporting mutual accountability.

It is clear from the Kenya National Aids Strategic Plan III vision that it is not a strategic goal for the government to empower HIV infected mothers in their choice of adopting alternative feeding options for the infant. The vision is more concerned about universal access which in short means providing ARVs to all infected. The government has not embraced the right to assist infants who suffer from lack of options in terms of feeding policy. An infected mother who cannot afford commercial infant formula has no option but to breastfeed. The recommended approach of exclusive breastfeeding may not be adhered to thus endangering the health of the infant. Therefore, instead of reducing new infections it may instead increase new infections. The cost benefit analysis would seem to lie in favor of empowering infected mothers in implementing feeding options.

Conclusion and recommendations

The way forward for the government is to realize its duty in improving the infant feeding alternatives of HIV infected mothers. It is a positive duty owed to the infants. If the infants could speak for themselves they could choose an option of feeding that least exposes them to HIV infection. The government has a duty to act on behalf of the children. It is a statutory duty that has basis in the Children Act and the *Convention on Rights of the Child*. Free primary and secondary education has been realized it only takes political goodwill to realize free commercial infant formula. For starters the numbers are manageable. The proportion of children born to HIV infected mothers can be estimated and those found positive during antenatal clinics factored in. Partnerships can be forged with businesses producing commercial infant formula for subsidized rates. The utility of the product does not encourage the drive of profits as factor influencing production. But rather the need to save the lives of innocent infants and to empower HIV infected mothers in their choice of feeding alternatives. It's the least that a government can do for its future generations.

References

1. *Children Act, Act No. 8 of 2001*

2. *Consensus Statement, "WHO HIV and Infant Feeding Technical Consultation Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV Infections in Pregnant Women, Mothers and their Infants", Geneva, October 25-27, 2006*

3. *George Kent, "WIC'S Promotion of Infant Formula in The United States", International Breastfeeding Journal, 2006.*

4. *National Department of Health, Policy and Guidelines for the implementation of PMTCT, 11th February 2008.*

5. *The Constitution of Kenya, 2010, promulgated on 8th August 2010.*

6. *United Nations Convention on the Rights of the Child, 1990*

7. *WHO, Recommendations on the prevention of mother-to-child transmission of HIV and their policy implications, WHO, 2001.*

8. *www.nacc.or.ke, accessed on 08/06/2009*