



World Alliance for
Breastfeeding Action

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WABA World AIDS Day Statement

Press Release

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KEEP THE PROMISE TO HIV-POSITIVE MOTHERS AND THEIR BABIES

A decade of uncertainty has fuelled an agonizing dilemma about the least risky way to feed HIV-exposed babies. Research presented in 2007 finally points conclusively to the need for renewed protection, promotion and support of breastfeeding.

The Final Report of the 2006 World Health Organization HIV and Infant Feeding Technical Consultation¹ provides welcome revised recommendations. New evidence clarifies that the most appropriate infant feeding option should continue to depend on a mother's individual circumstances, her health status and the local situation, but should take greater consideration of available health services. HIV-positive mothers should breastfeed their babies exclusively for the first 6 months of life, and continue partially breastfeeding after 6 months **unless** conditions are already in place to show that replacement feeding is safe.

Commenting on the dilemma of competing risks between HIV transmission through any breastfeeding vs no breastfeeding, Dr Hoosen Coovadia was quoted this year as saying, *"If you choose breastfeeding, you would of course have HIV infection. You would have about 300,000 per year in the world. But if you avoided breastfeeding, the mortality would be about 1.5 million per year. So on the balance of probabilities for poor women in the developing world, there is no other choice than to breastfeed their infants. You shouldn't devise policies for the rich few. There are some, but the majority of HIV infected women are poor."*² His subsequent paper showed that HIV transmission through 6 months' exclusive breastfeeding by South African mothers was 4%.³ Cumulative 3-month mortality due to replacement feeding was 15.1% vs 6.1% for breastfeeding.

Early weaning vs continued breastfeeding substantially increased morbidity and mortality of infected and uninfected babies in Uganda⁴, Malawi,⁵ Kenya,⁶ and Zambia⁷. Researchers concluded that the risks should be anticipated and PMTCT programmes should strongly encourage breastfeeding into the 2nd year of life.

Specific HIV and infant feeding counselling was less effective than group information, videos and pamphlets in achieving exclusive and extended breastfeeding in Zimbabwe.⁸ Intriguingly, 84.5% of mothers recruited into the ZVITAMBO study did not wish to learn their HIV-status,⁹ thus avoiding a recommendation for early weaning for HIV-exposed babies, leading instead to an extremely high rate of HIV-free survival.¹⁰

Finally, providing antiretroviral therapy (ART) to mothers only during pregnancy and birth begs further scrutiny. While only ~1% of HIV-infected mothers currently receive it, ART for eligible mothers could reduce MTCT in resource-poor settings by over 75%.¹¹ In Rwanda¹² and Tanzania¹³ triple-therapy dramatically reduced transmission of HIV during 6 months exclusive breastfeeding to 0% and <1% respectively. These strategies benefit mothers and babies while avoiding the stigmatisation and risks of artificial feeding.

The cost of formula was the same as the cost of highly active antiretroviral therapy (HAART) for mothers recruited into the DREAM study in Mozambique, Tanzania and Malawi.¹⁴ Acknowledging the difficulty in telling a woman that she can avoid transmitting the infection to her child, but that little can be done for her own health, researchers provided HAART to mothers from the 25th week of pregnancy through 6 months exclusive breastfeeding. Cumulative HIV transmission to infants was similar to rates reported in high-income countries and lower than those of formula-fed babies, being 2.2% and 2.7% respectively, with postnatal rates of 0.8% and 1.8%.

Political will and strong leadership are needed to reverse the decade-long erosion of breastfeeding accompanying the global PMTCT effort. Characterization of formula-feeding as a safe infant feeding option can no longer be justified; contamination of powdered infant formula can occur intrinsically from raw materials, during manufacture

or from extrinsic sources.^{15 16} Its cost has been very high in terms of infant malnutrition and mortality, and in displacement of funding away from treatment for HIV-positive mothers. Rational and humane strategies are needed to simultaneously:

- improve the health and survival of HIV-infected women,
- lift the burden of an impossible choice from mothers as they contemplate how best to feed their babies,
- prevent transmission of HIV to exposed infants, and
- protect food security for young children.

WABA calls on national and international leaders to close the gap between rich and poor countries regarding access to treatment, and to use current evidence to enact universal public health measures fostering overall child survival, both within and outside the context of HIV.

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Endnotes

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