Symposium on Breastfeeding and HIV & AIDS

Breastfeeding – Guarding Maternal & Child Health in an HIV & AIDS World
Washington, D.C. USA, July 2, 2005

Introduction

In the world of today where there is increasing awareness of the role breastfeeding plays in the establishment of optimal infant, young child and maternal health, breastfeeding faces increasing risk of losing its importance as the priority shifts more towards the prevention and control of HIV and AIDS. In recognition of this growing worldwide risk to breastfeeding, La Leche League International (LLLI) and the World Alliance for Breastfeeding Action (WABA) jointly sponsored this symposium themed "Breastfeeding – Guarding Maternal & Child Health in an HIV & AIDS World" in conjunction with the LLLI 19th International Conference.

In their introductory remarks, Hedy Nuriel, Executive Director of LLLI, and Prof. Michael Latham, International Advisory Committee (IAC) Co-Chair of WABA, stressed the importance of this event foremost as a stepping stone to build a collaborative effort among those who are concerned with this issue. Prof. Latham further identified many significant challenges to breastfeeding:

- Unethical marketing of breastmilk substitutes that puts profits ahead of the health and well-being of infants
- medicalisation of childbirth and breastfeeding
- increasing need for mothers to work away from home and many societies' unwillingness to facilitate breastfeeding and child care
- accentuation of the breast as a dominant sex symbol
- increasing inequity and poverty globally
- The process of globalization which gives enormous power and influence to corporations
- widespread environmental pollution leading to greater body burdens, and contaminating breastmilk
- major decline in funding for breastfeeding NGOs, BFHI, and within organizations like UNICEF
- "Americanization" worldwide and current hegemonic policies of the US administration

Above all these challenges is the HIV/AIDS pandemic which Prof. Latham identified as the major challenge to breastfeeding in the 21st century.

Symposium Objectives

The major objectives of the Symposium were:

- To bring together groups and individuals who believe in the importance of breastfeeding for optimal infant, young child and maternal health; to forge understanding; to discuss and to collaborate with the aim of protecting, promoting and supporting breastfeeding in the context of HIV and AIDS.
- To brainstorm for progressive actions and common positions (e.g. framing of important messages that would be strategic for collaborations) that could be done through Advocacy, Research and/or Capacity building (ARC)*.

**Note: the concept of ARC was developed at the HIV and Infant Feeding Meeting in Lusaka, Zambia, February 2004.*

Process of the Symposium

As it was a low-budget event and it was envisioned that the symposium would produce a rich discussion and sharing, it was an invited-only event. To make the best use of the short time that the participants would have, an email discussion group was formed prior to the symposium to get acquainted with each other, develop a sense of collaboration, be familiar with the issue and dilemmas, establish common ground, and explore possible solutions.

Most of all, the email discussion aimed to identify the key areas of concern and the challenges that the participants/organisations face in their work that would be used as a basis for discussion at the symposium. The rich and lively email discussion that spanned 12 days resulted in a synthesis that is listed in 26 points. To narrow this down, each participant reviewed and chose five points in order of priority that s/he felt most important or pressing. Based on this voting and the array of issues involved, the issues were clustered accordingly into seven discussion topics (see pages 3-7):

- A – Counselling and risk analysis
- B – Health outcomes
- C – Cessation and complementary feeding
- D – Policy: global, national, community, organizational
- E – Addressing fear and pessimism about breastfeeding
- F – Choice
- G – Social Concerns: mother, family and society

At the symposium, participants were given the opportunity to participate in two discussion topics in two sessions that spanned 50 minutes each. Each discussion group was assigned a facilitator. Focusing their discussions in the three-pronged approaches – Advocacy, Research and Capacity Building – the groups presented the summary of their discussions, and their proposed positions and actions to the symposium (see pages 7-11). Participants then prioritised the positions/activities by voting with coloured stickers

- Red = priority
- Blue = relatively easy and doable
- Yellow = I can do or already doing/done (state name/organization)

The last hour of the symposium was dedicated to observing how the positions/activities were prioritized among the group and discussing the possible actions that participants could take on collectively.

At the symposium, Dr. Arun Gupta presented the latest rapid country assessments in the region of Asia commissioned by WABA. The consultative meetings conducted in Afghanistan, Indonesia, Bangladesh Nepal and Malaysia gave insights on the dilemmas of national breastfeeding groups, and also opened dialogue and forge possible collaborations with their governments. More importantly, this effort also showed other participants that rapid assessments could be done within a period of less than a month on a tight budget. Dr. Arun expressed that his team and WABA would be more than willing to share their experience with groups in other regions to conduct similar assessments. (To get the reports please write to arun@ibfan-asiapacific.org or waba@streamyx.com)

Discussion points of the Symposium

The Symposium "Breastfeeding and HIV and AIDS" looked at the situation of breastfeeding in the context of the global HIV and AIDS agenda and current reality, and discussed possible collaborative efforts for advocacy, capacity building and research to protect, promote and support breastfeeding. Through online discussions and at the symposium, the following were identified as problem and priority areas.

A Counselling and risk analysis

HIV-positive mothers are burdened with the dilemma of weighing the risks involved with different methods of feeding. From UN agencies to the lay person, making an informed choice has been viewed as the pivotal point thus further adding pressure on the mother to make the 'right' choice. However, the definition and implementation of making an informed choice is problematic, such as the possibility of continued breastfeeding with HAART treatment for the mother or the belief that babies who are breastfed by HIV positive mothers are more likely to get sick and die. Participants discussed the techniques / messages / guidance that are available to help explain practical dilemmas early so that an informed choice can be made.

The participants recommended that there be a clear decision tree or algorithm for an **individual risk analysis** for each baby in each one's specific circumstance, particularly if such algorithm needs to be developed.

A model of teaching counsellors on how to provide effective **counselling** regarding infant feeding decisions would be crucial.

The components of the **acceptable, feasible, affordable, sustainable and safe (AFASS)** assessments, i.e. when and how should the assessments be done, and what happens after assessments, are still unclear and are subject to health workers' interpretations. Health workers should know and experience the difficulties of assessing the feasibility of AFASS. Nonetheless, although AFASS has its loopholes it is still far better to have it implemented than not.

Clinical training or mentorship is another issue. Drugs and ART are not the only way to reduce post-natal transmission. It is imperative to increase the capacity of health workers' to help women breastfeed exclusively, and prevent and address breastfeeding problems such as sore nipples, that would help reduce risk of transmission.

Also lacking is the knowledge on the dilemmas and questions that mothers have and how health workers could best answer these questions.

B Health outcomes

Where is the empirical data for the health outcomes of infants, mothers and the population for different infant feeding methods? That was the question that participants had.

Observational data on feeding methods and **infant/child and maternal health outcomes should be collected**. This would give more concrete evidence that could be shown to mothers in their decision making.

What is the evidence that, in terms of infant health outcomes, it is beneficial for HIV+ mothers to use **replacement feeding** under any conditions? Parents and health workers should bear in mind and be warned of the risks of bottle feeding

regardless of HIV status. For example, formula powder by itself is not sterile. Health workers should experience the difficulties of using breastmilk substitutes before starting to counsel. Agencies or health workers that recommend replacement feeding in families should show evidence of positive impacts of replacement feeding in terms of mortality, morbidity, nutritional status etc, rather than just the possible negative impact of breastfeeding.

C Cessation and complementary feeding

There are many possibilities on HIV and infant feeding beyond 6 months of age that have yet to be studied. Participants discussed the feasibility of a win-win situation by reducing risk of transmission while harnessing the benefits of breastmilk with the advantages of its nutritional value, cost (compared with formula or animal milk), and convenience in terms of lactational amenorrhea etc. For example, HIV+ mothers **expressing their breastmilk** to add to baby foods while cooking – to kill the HIV virus, at whatever age their babies cease breastfeeding.

When and how (e.g. rapid or gradual cessation) should an HIV+ mother stop breastfeeding, if at all? There are few best practices available until further evidence is known. The effect on morbidity and mortality of **early cessation** of breastfeeding is still unclear.

If AFASS could not be fulfilled before baby is 6 months of age, it is not realistic to expect the mother/family to get animal-source food and high energy density **food** if breastfeeding is stopped at that critical time in an infant's growth.

D Policy – global, national, community, organisational

The UN Framework for Priority Action states: When replacement feeding is acceptable, feasible, affordable, sustainable and safe (**AFASS**), avoidance of all breastfeeding by HIV-infected mothers is recommended; and otherwise, exclusive breastfeeding is recommended during the first months of life. UN agencies should be accountable to show that AFASS works, that this recommendation is feasible, and be explicit about its shortcomings or show that it does lead to improved outcomes.

Currently there is no systematic information on **national policies or practices**. We do not know which countries require/recommend to those who had tested positive not to breastfeed, what the results of these policies are, whether mothers were tested for HIV, whether there were confirmatory tests available, or if diagnosis was made from symptoms. As a guide, countries could use existing documents and conduct rapid assessments on their country policies. National policy should not become a statement that protects the policy maker (like a **disclaimer**); instead it should protect the infant and mother.

The formulation of policy on HIV and AIDS should be based on collaboration among departments/agencies and be in line with other policies like 6-month exclusive breastfeeding. It is unclear how breastfeeding would continue to be promoted, supported and protected as a public health recommendation in the context of contradictory national policies. Governments should have more accountability in overseeing and ensuring this **collaboration and harmonisation** of policies.

Besides the dangers of using breastmilk substitutes, there is an inadequate appreciation for the **difficulties in sustaining on-going supplies** of formula for replacement feeding (for 3 months, 6 months, 1 year, 2 years?) in continents where

there can be drought, flood, natural and man-made famine, political upheaval and withholding of food, civil war, displacement of people and other dire conditions. Even logistical problems such as foreign exchange shortages, supply, transportation and paperwork would pose extra challenges. In many low-income parts of the world, periodic stock-outs of products are common. Since this is considered a normal part of life, policy makers are unlikely to have realised that in the case of infants dependent on infant formula, such an otherwise undramatic event can be life-threatening. Thus in any such location the "sustainability" component of AFASS simply cannot be fulfilled except for mothers who can afford to travel to distant localities to buy formula when a local stockout occurs. This is an issue of food security for infants and families.

Moreover, the baby food industry could use the public fear of HIV and AIDS and the ambiguity of AFASS guideline as its **marketing strategy**. It could be a platform for them to have public-private partnerships with governments/agencies and an excuse for the re-entry of formula even in Baby Friendly Hospital Initiative (BFHI) facilities. The International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly (WHA) resolutions should be applied; this is even more important in the context of HIV and AIDS.

There should be monitoring to evaluate policies and interventions. The tabulation of mortality outcomes in relationship to the policy implementation for example could help governments assess its effectiveness. To carry out such evaluation, there should be standardized **research protocol** that would primarily use standardized outcome research and definition of infant feeding.

E Addressing fear and pessimism about breastfeeding

Recommendations and decisions on HIV and infant feeding are often fear-based rather than fact-based. There is ill-placed pessimism about the possibility of promoting exclusive breastfeeding.

The **HIV community's** apparent lack of knowledge of breastfeeding or lack of priority given to breastfeeding is reflected in their policies and materials. Do these groups have their plateful of HIV issues to tackle and not able to give time to breastfeeding, or are they really unaware of the consequences of ignoring breastfeeding?

There is an urgent need to break the prevailing cycle where breastfeeding has **to prove its safety** and efficacy, while the high-risk substitute is often considered acceptable until proven otherwise. Challenging this model of "proof" should also be a necessary component of our efforts to protect breastfeeding in the face of HIV.

The use of language and **terminology** could be a way to eliminate this pessimism. The distinction between "breastfeeding" and "infant feeding" should be made clear. Clearer terminology in educational course materials, policy and guideline documents, is needed to make the meaning and intention very clear to avoid ambiguities and euphemisms.

The term 'mother to child transmission (MTCT)' puts the blame on the mother when usually it is the case of 'father to mother to child transmission'. **MTCT** should be reworded in such a way as to not put the responsibility on the mother. Moreover, we do not use the means of transmission to label other diseases. In Latin America,

breastfeeding groups have addressed this by using 'adult to child transmission' in Spanish.

Health workers and professionals may be pessimistic about whether women can breastfeed exclusively or would volunteer in participating in research. Breastfeeding groups should understand where health professionals, researchers and the HIV community are coming from in order to get the message of breastfeeding across more convincingly.

F Choice

In the context of HIV, the concept of **infant feeding choice** as a human right may need to be re-examined. In resource-poor settings and where breastfeeding is the cultural norm, the possibility of alternatives to breastfeeding is unknown. Health-care is not seen as a matter of choice, since nurses expect to recommend and mothers expect to take advice. Presentation of replacement feeding as a choice may therefore be seen as a novel recommendation, creating a loophole for the promotion of formula feeding by trusted and respected people in white uniforms. In addition, choice may mean different things in different contexts; while couples counselled about family planning choices are not barred from having children, mothers counselled about infant feeding choices could be given the impression that breastfeeding is dangerous. In these cases, choice is a "myth".

The difficulty of ensuring true informed-choice is universal, not only in resource-poor areas. The plight/situation of the **HIV positive mother in industrialised countries** may include laws, such as in Sweden, where breastfeeding by HIV+ mothers is prohibited. In countries where no such law is in place, like the United States, a mother still faces the risk of having her baby made a ward of the court and put in foster care if she decides to breastfeed.

The right of the mother to decide on her choice of infant feeding should not absolve the policy maker and counsellors from being responsible for the health consequences for infants and mothers. While the human rights framework should be used to empower mothers to make informed decisions, policy makers should be forthright about the **knowledge gaps** that exist in identifying the route of transmission of HIV (e.g. during pregnancy, birth or breastfeeding) and about the competing risks between breastfeeding and formula feeding for the HIV-exposed baby.

There are ways despite the obstacles to continue the culture of breastfeeding in an HIV and AIDS context, such as using milk banks as a **solution** for HIV+ mothers in Latin America.

G Social concerns: Mother, family & society

In a breastfeeding culture, a mother who feeds her baby on substitutes may immediately and continually be identified as HIV-infected. Non-breastfeeding therefore becomes a known cause of stigma. Fear of stigmatisation could prevent people from going for testing. This results in mixed feeding, which is the worst combination for virus transmission than exclusive breastfeeding. Moreover, mothers who do not know their HIV status may choose to give replacement or mixed feeding due to the fear of transmission in case they are HIV+. The threat of a **spillover** effect of the Prevention of Mother to Child Transmission (PMTCT) programmes is real. We should consider and guard the needs of HIV-negative mothers as well.

We should put women's needs in perspective and be more **gender** sensitive. Often, the mother is seen as responsible for transmitting HIV (e.g. MTCT), yet drugs and help that are given do not have her interest as a prime consideration. Women are blamed instead of being seen as the victims of a larger social problem. When drafting solutions to prevent transmission, we need to understand that she is first a woman: her reproductive cycle exists in relation to her health, choices and needs. Our advocacy strategy/messages should include prevention of HIV of the mother, instead of being concerned with just her pregnancy, safe motherhood and infant feeding.

Proposed Positions and Actions

During the group discussions, participants considered positions and actions that could be taken and arranged their ideas according to Advocacy, Research and Capacity Building. Participants then prioritised the positions/activities by voting with coloured stickers

- Red = priority
- Blue = relatively easy and doable
- Yellow = I can do or already doing/done (state name/organization)

Proposed Positions and Actions	Red	Blue	Yellow
A. Counselling and risk analysis *Facilitator: Mimi de Maza*			
<u>Capacity building</u>			
1. Develop capacity to health personnel to effectively counsel mothers on infant feeding options.	7	1	2 (ILCA website, Linkages)
a. Use WHO HIV-IF (2000) module only in combination with breastfeeding counselling as done by BPNI/IBFAN's 3-in-1 training course.	3	-	4 (BPNI, IBFAN, ILCA, Linkages)
b. Develop booklet for health professionals on exclusive breastfeeding.*			
<u>Advocacy</u>			
1. To advocate for WHO to partner with LLLI, WABA and ILCA (not with industry).	2	1	2
2. To CDC/WHO/UNICEF; who promote "general module" – 10-day module for training counsellors (2004) for PMTCT to include infant and young child feeding in context with HIV in the curriculum.	2	1	1 (NACO, India)
3. Revise/update the 2000 HIV module.	5		
4. Use India example.			
<u>Research/Action</u>			
1. Develop an evidence-based algorithm to apply the AFASS criteria to be used individually for each mother.	15	2	1 (BPNI/ drafting)
2. Survey to determine and examine the decision points for each question.	3		
B. Health Outcomes *Facilitator: Sallie Paige*			
<u>Advocacy</u>			
1. Compile the research, challenge status quo to address	3	1	

fact that current CEDC (and others') recommendations are not justified.			
2. Call on CDC and all national standard setting bodies to: revisit current recommendations based on newest research; eliminate persecution of physicians who support breastfeeding or women who choose to breastfeed; to make recommendations that women be able to choose.	4	3	
<u>Research/Action</u>			
1. Create research proposals to study infant feeding patterns in PEPFAR and other on-going trials.	7	1	
2. Advocate for studies using mother volunteers to enhance basic knowledge re. HIV transmission in milk, over time, & under different conditions.	2	1	
3. Lobby for use of standardized definitions and outcome measures to be used in all HIV/infant feeding studies.	4		
4. Carry out a cost effectiveness of introducing formula for all vs. supporting EBF for all in least-developed countries settings (based on Ross/Piwoz and available cost data)*			
5. ACTION: Prepare a briefing document re: the above points.		2	
C. Cessation & Complementary feedings *Facilitator: Karen LeBan*			
<u>Capacity Building</u>			
1. Health workers need to understand the risk of transmission.	4		1 (Linkages)
2. Need to be able to teach manual expression.		4	1 (ILCA)
3. Need to understand the risk of **<u>not</u>** breastfeeding.	6	3	1 (IBFAN)
<u>Advocacy</u>			
1. Region-specific meetings re: policy		1	
2. The existing linear progress tool for decision-making on when to stop breastfeeding according to local foods availability (i.e. create existing tool into advocacy presentation).	4		
3. Promotion of breastmilk into complementary foods.	2	5	
<u>Research</u>			
1. Impact of **<u>not</u>** breastfeeding at different ages and different environments.	7		
2. Transmission rates with mixed feeding after birth, and beyond three months of exclusive breastfeeding.		4	
3. Determine effective ways of doing AFASS for HIV+ mothers who choose to stop breastfeeding.	8		
4. Feasibility and effectiveness of treating breastmilk of HIV+ mothers*			
D. Policy *Facilitator: Judy Canahuati*			
<u>Capacity Building</u>			

1. Implement a participatory process for			
a. Inventory of extant national policies and their implementation.			1 (BPNI)
b. Assessing the implications of AFASS as National Policy (for mother/child health outcomes, economy, etc.)	3	7	
2. Linkages with HIV/AIDS organizations (Gov/NGO) for training, counselling for infant feeding.	3		
3. Strengthening national policy makers to have tools to focus health outcomes.			
4. Funding	1		
<u>Advocacy</u>			
Note: National policy-makers as target audience		2	
1. Creation and dissemination of evidence-based guidelines.	6	1	
2. Use required national reporting as opportunity for advocacy (e.g. WHA reporting for Global Strategy for Infant and Young Child Feeding)			
3. Strong presence of breastfeeding NGOs at HIV/AIDS policy conferences.	3	9	
4. Funding.	3	1	
5. Advocate for accountability of UN agencies towards demonstrating the effectiveness of their policies*			
<u>Research</u>			
1. Develop and implement a standardised research protocol to measure/report infant and mother health outcomes as a means to support informed choice by the mother.	9		
2. Compile case studies of national AFASS implementation (e.g. Botswana)	2	7	1 (UNICEF)
E. Addressing Fear and Pessimism about Breastfeeding			
Facilitator: Betty Sterken			
<u>Capacity Building</u>			
1. Address fear and tunnel vision			
2. Basic breastfeeding			
3. Focus on breastfeeding as part of global strategy and not HIV; example, breastfeeding is “doable.”	2	7	3 (LLLI, IBFAN, LLL SA PCP)
4. Bring other professional associations to the breastfeeding table and HIV, and child survival.	1	3	1
<u>Advocacy</u>			
1. Keep focus on child survival.	5	2	1
2. Bring money into the message.	1	1	
<u>Research</u>			
1. Show that certain terminologies could create negative images and assumptions; example: negative assumptions on breastfeeding			

2. Positive role of breastfeeding in reducing infant mortality. 3. Impact of fear on infant feeding.	2	4	2 (ILCA)
F. Choice *Facilitator: Marian Tompson* <u>Position:</u> There is a double standard. In developed countries, women have no choice. Alternative feeding is recommended as public health measure. In developed countries, choice is invoked *but* breastfeeding – which would raise public health – is not supported. There should be a globally applicable standard. Choice must be based on information.			
<u>Capacity Building</u> 1. Train counsellors to present "safer breastfeeding" – including EBF, breast health, and safer sex – in balance with replacement feeding. 2. Counsellors need to know *how* to teach safer breastfeeding methods as well as replacement feeding methods. 3. Counsellors need means to assess individual mother/baby risk.	5 3	1 1	1 2 (ILCA, BPNI)
<u>Advocacy</u> 1. Present double standard as a medical ethics issue. 2. In the U.S., frame it as an issue of "family values." 3. Get institutions/schools of public health to see similarities between "choices" for women in developed as well as developing world. 4. Keep the *mother* in the discussion – a. losing her doubles baby's risk of death. b. and for the mother's own sake.	1 1 1 4	 2	1 4 (LLLI)
<u>Research</u> 1. Study the milk of HIV+ mothers on HAART and not on HAART. Does infection occur? 2. Study outcomes/choices for the cessation of breastfeeding.	7 5	1	
G. Social Concerns *Facilitator: Jean Ridler* <u>Capacity Building</u> 1. Restructure our messages and strategies to respond to change in the context, as a result of current policies. a. e.g. safer breastfeeding practices for *all*! b. support the mother (nutrition/health resources)	7 1 2	4	1
<u>Advocacy</u> 1. Change terminology from PMTCT to "Adult to Child Transmission" (ACT)	1		2

2. Provide universal messages and include:	3	4	
a. men's responsibilities; make them partners.			
b. empowering messages to mothers.	2	1	4

** Additional ideas for proposed positions and actions obtained post-symposium.*

Strategic approach: Ideas for immediate "do-able" actions

From the discussions and the list of proposed positions and actions, there are three ways the ideas and suggestions could be used:

- Messages: compile the key messages that we think could make the difference
- Questions: compile the urgent questions that need to be answered
- Actions: list out the actions that we could do together as a group

The rationale for compiling the messages and questions is to ensure the rich ideas generated are not left out when it comes to carrying out the activities. These lists would be helpful to remind ourselves on the important stance and questions in our work and when we talk to other people. Thanks to Miriam Labbok and George Kent who first mooted this idea.

Key Messages:

1. Health Outcomes: Focus on survival and infants' health outcomes, not just the absence of HIV.
2. Safe breastfeeding practices for all!: Exclusive and continued breastfeeding is an essential global public health strategy, regardless of parents' HIV status.
3. UN recommendation: In the absence of acceptable, feasible, affordable, sustainable and safe (AFASS) replacement feeding, the UN recommendation is exclusive breastfeeding.
4. AFASS: If AFASS could not be fulfilled before baby is 6 months of age, it is not realistic to expect the mother/family to get animal-source and high energy density food after 6 months.
5. Breastmilk Substitutes?: Breastfeeding has to constantly prove its safety and efficacy, while the high-risk substitute is often considered acceptable until proven otherwise. (p/s: Powdered commercial milk formulas are not sterile and may be contaminated.)
6. HIV+ Mother: Keep the mother in the focus, for her own sake too. There is no additional mortality risk conveyed to the HIV-positive woman by breastfeeding.
7. Mother-to-child-transmission (MTCT): MTCT puts the blame on the mother. We do not use the means of transmission to label other diseases.
8. The myth of "Choice": There are cases wherein nurses are expected to recommend and mothers are expected to comply – both where AFASS is achievable and not. There should be a single globally applicable standard when it comes to informed choice.
9. Food Security: Breastfeeding ensures food security in HIV-prevalent and resource-poor areas and following natural and man-made disasters which prevent continuous supply of replacement feeding products to babies who are not breastfed.

10. Threat of spillover: Women whose HIV status is negative or unknown may decide not to breastfeed due to fear or misinformation about HIV transmission, and expose their infants to a greater risk of contracting other life-threatening illnesses.

Key Questions:

1. Any research should include at least 2 years of follow-up, so that HIV-survival can be ascertained.
2. Research is needed to show if HIV transmission an be reduced by carefully monitoring breast health and providing early treatment when problems occur; by encouraging and supporting exclusive breastfeeding; by including mother's CD4 count in AFASS assessments and through counselling.
3. Studies are needed to show that exclusive breastfeeding, followed by breastfeeding, may be safer in terms of HIV-free survival, in settings where child mortality rates are high from other infectious diseases.
4. Research is needed to determine whether women on HAART can safely breastfeed their children.

As for the action for the group, task groups and timeline need to be ascertained. Keeping in mind for action – several strategic actions from the list generated by the group (see above); the voting; the Advocacy/Research/Capacity Building (ARC) framework; and covering every level of meta, macro, meso and micro – the group is interested to move forward with the HIV and breastfeeding agenda. LLLI and WABA had volunteered to facilitate the process following the Symposium to get it started, and will be sending out another email regarding our action plan as a group.

Conclusion

The symposium ended on a high note with enthusiasm and optimism that participants could move forward with some of the activities proposed. All in all, the event was a stepping stone for breastfeeding and HIV and AIDS groups to begin collaboration and strategise in facing the challenges ahead. LLLI and WABA thank all participants who make this initiative possible and worthwhile.

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Attachments:
1. Participants list
2. Glossary of terms

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