



Position Paper on HIV and Infant Feeding

The value of human milk

- Exclusive breastfeeding for six months followed by continued breastfeeding with complementary foods and fluids for up to age two years and beyond (the World Health Organization standard) is the normal, optimal way of feeding infants and the foundation of health and development, except in rare circumstances (1).
- *Artificial feeding* (use of substitutes for human milk) increases infants' risks of acute illness, chronic disease, and slower cognitive development, and increases mothers' risks of cancer (2).
- It is estimated that yearly, at least one million infants die due to lack of optimal breastfeeding. A three-country World Health Organization analysis of infant mortality data showed a six-fold greater risk of death from infectious disease for infants who were not breastfed in the first two months of life (3). A 17-country study carried out by MACRO, International found that a four-fold risk continued through about eight months.
- Globally, over 90% of deaths among children one month to five years are due to causes other than HIV/AIDS. Malnutrition is an underlying cause of about 60% of these deaths. Lack of exclusive breastfeeding, complementary feeding that begins too early or too late, inadequate quality or quantity of complementary foods, and challenges in safely preparing, serving and storing such foods all contribute to malnutrition (1).
- Among newborn infants testing HIV-positive within 48 hours after birth, approximately 50% die within six months, primarily due to infectious diseases such as pneumonia (75%) and diarrhea (40%) (4), diseases which are known to occur more frequently and with more severe consequences when infants are not exclusively breastfed.
- Any replacement of breastfeeding must be acceptable, feasible, affordable, sustainable, and safe (AFASS), or it will increase risks to infant survival, regardless of exposure to HIV (5). Infant feeding counseling must comprehensively address changing circumstances surrounding replacement feeding, acknowledging the difficulties of reestablishing a mother's breastmilk supply.

Current state of knowledge about HIV transmission and infant feeding

- Women living with HIV may transmit the virus to their infants during pregnancy, birth, or breastfeeding. The exact mechanism for HIV infection of an infant during the perinatal period and breastfeeding remains unclear (6). Definitive determination of HIV+ status for an infant cannot be done until at least six months of age. Infection may also occur through non-sterile procedures in the health setting and other routes besides the mother. Therefore, it is extremely difficult to accurately identify the mode of primary infection.
- Without treatment, the assumed risk of pediatric HIV infection during pregnancy and birth is estimated to be approximately 20%. Maternal conditions which increase the risk of transmission include a high viral load due to recent primary infection or during the terminal phases of AIDS; a low CD4+ cell count; malaria; prolonged labor; and vaginal birth. Interventions such as anti-retroviral (ARV) treatment during pregnancy and elective cesarean section can reduce the risk of mother-to-child-transmission (MTCT) to as low as 3-6% (7).
- The risk of HIV transmission via breastfeeding is difficult to accurately measure. Estimates using comparisons between breastfeeding and non-breastfeeding populations give a transmission rate ranging from 5 – 20% (8). Approximately 75% of all breastfeeding-assumed pediatric HIV infection is estimated to occur within the first six months of life. The relative risk of infection increases with the overall duration of breastfeeding (9).
- Maternal factors that may increase the risk of transmission via breastfeeding include a low CD4+ count, high HIV-1RNA levels in breastmilk, and a high viral load in blood (10). Sub-clinical mastitis, which is common during changes in breastfeeding, and clinical episodes of mastitis may increase the viral load in the milk (11).
- *Exclusive breastfeeding* by an HIV-infected mother, when compared to partial breastfeeding or mixed feeding, has been shown to be associated with a reduced risk of transmission in the early months postpartum, and may confer a continued lower risk of transmission in babies continuing to breastfeed from 6-18 months (12, 13).

- Theoretically, abrupt cessation of breastfeeding at 6 months should shorten exposure and may lessen the overall risk of transmission. However, no evidence and little experience exists to show that premature weaning can be achieved without adverse effects for mother and infant (9). In many settings, the risk of infant morbidity and mortality due to malnutrition and infectious disease may be higher than that due to HIV when infants are no longer breastfed (1). In at least one study, mortality among HIV positive infants at 24 months was not significantly different between those breastfed and formula fed (14).
- When appropriately heat-treated, expressed milk of HIV-positive mothers will not transmit HIV and remains economically, nutritionally and, possibly, immunologically superior to infant formula (15,16). Other treatment options for expressed milk are also being investigated (17). Issues concerning acceptability, feasibility, affordability, sustainability and safety will also apply to feeding infants expressed, heat-treated milk (18).

ILCA affirms the rights of mothers and infants

Women of childbearing age comprise an increasing proportion of people living with HIV/AIDS worldwide. Gender inequalities in social and economic status as well as other factors often limit women's access to adequate, timely, and confidential testing. Therefore, the actual proportion of women living with HIV may be significantly higher than reported numbers.

ILCA affirms the importance of human rights law and principles as the basis for sound policies related to HIV prevention and treatment and infant feeding. These rights, which are not reduced by a person's age, gender, economic status, schooling, marital status, sexual orientation, reproductive status, or HIV status, are understood to include:

- Each child has the right to the highest attainable standard of health.
- Every person has a right to voluntary and confidential HIV counseling, testing, and appropriate treatment.
- Every mother has a right to full and objective information on all infant feeding options,* in a form she can understand and apply in her own situation.
- Every mother has a right to protection from coercion, stigma, and commercial influences in making her own decisions about infant and young child feeding.
- Every mother has a right to skilled assistance from lactation consultants or other trained health care workers, and to appropriate care and supportive conditions regardless of her infant feeding decisions.

- Each country and each society, in affirming these human rights, has a responsibility to enable the fulfillment of these rights.

These rights are affirmed in key international documents concerning HIV and infant feeding from the WHO and UN Agencies (1,6,19).

**These options include exclusive breastfeeding, continued partial breastfeeding with other fluids or foods past six months, heat-treated expressed mother's own or donor human milk, wet nursing, partial or complete replacement of human milk with home-prepared, generic, or commercial formula, and information on how and when to move from one option to another. Feeding options also include how and whether to hand-express or machine-express milk, and whether to feed milk by bottle, cup or any other technique.*

Therefore the International Lactation Consultant Association:

- Advocates continued protection, promotion, and support of exclusive and continued breastfeeding for the vast majority of mothers and children, regardless of the prevalence of HIV infection in their community or country. Where women do not have access to testing, counseling, and treatment, exclusive breastfeeding remains the safest and healthiest form of infant feeding.
- Advocates for universal access to care and treatment for HIV-positive women and their infants, especially long-term access to antiretroviral therapies and other effective treatments, recognizing that a child's survival depends on the survival of the mother.
- Continues to advocate for policies that support exclusive breastfeeding, including the Baby-Friendly Hospital Initiative and the Global Strategy for Infant and Young Child Feeding.
- Urges training of health and community workers to practice evidence-based infant feeding counseling and lactation management skills in order to best serve mothers' needs and changing circumstances, including becoming International Board Certified Lactation Consultants.
- Emphasizes the need to regulate marketing of all artificial infant feeding products in all countries, in accordance with the *International Code of Marketing of Breast-milk Substitutes* and subsequent World Health Assembly Resolutions, with special attention to settings where HIV is endemic, and where marketing must not interfere with proper counseling decisions.

- Urges ethical and standardized research on all strains of HIV and infant feeding, including operations research, monitoring and evaluation at all levels, and dissemination of findings, with particular focus on decreasing the risk of transmission via breastfeeding, on the timing and mechanism of primary infection via breastfeeding, long-term morbidity and HIV-free survival associated with various breastfeeding patterns, human milk processing, early cessation of breastfeeding, and the use of ARV therapy and other treatments to decrease the risk of HIV transmission and improve the survival of the breastfed HIV-positive infant;
- Urges national and international analyses free from commercial influences of long and short-term costs, benefits, and outcomes comparing free/low-cost replacement feeding with short and long-term HIV treatment strategies, especially among families in resource-poor settings.
- Advocates for urgent public dissemination of such research results and their use by policy makers and governments to promote effective use of scarce resources to maximize the overall health and survival of children of HIV-infected mothers.
- Urges investigation of spillover trends and how to reduce them. (Spillover occurs when women whose HIV status is negative or unknown decide not to breastfeed due to fear or misinformation about HIV transmission.)

Members of ILCA in their professional roles are encouraged to:

- Protect, promote, and support exclusive breastfeeding for six months and appropriate complementary feeding thereafter as the international standard for the general population of infants, including those whose HIV status is unknown.
- Advocate for the primary prevention of HIV-infection, addressing all routes of transmission.
- Encourage women and men to have voluntary, confidential HIV counseling and testing done throughout their reproductive lives.
- Advocate for and implement the Baby-Friendly Hospital Initiative as a proven method for establishing exclusive breastfeeding and linking mothers to support and assistance to maintain exclusive breastfeeding.
- Protect breastfeeding by adhering to the *International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions and advocating for legal implementation and enforcement.

- Help women to breastfeed exclusively, to prevent and treat breast and nipple problems that may increase the risk of viral transmission due to blood exposure or mastitis, to effectively express and handle their own milk as desired, and to diminish lactation with care if they decide to stop breastfeeding.
- Be familiar with the current research and policy on infant feeding and HIV, and be skilled in its application to clinical practice.
- Provide non-commercial information and counseling regarding all infant feeding choices, and provide skilled help with all options, throughout the course of infant feeding.
- Advocate for supportive care and appropriate treatment for HIV-positive women regardless of their infant feeding decisions.

Review Committee

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