SECTION 3: Interventions to maximise mother and child health and survival

This Section reviews risk factors for transmission of HIV to infants and outlines the up-to-date research underpinning current interventions to improve the health of HIV-positive mothers and maximise HIV-free child survival.

- Appropriate and effective maternal/infant antiretroviral regimens lead to:
  - Improved health and longer survival of HIV-positive mothers.
  - An extremely low risk of postnatal transmission (during breastfeeding).
- Exclusive and continued breastfeeding to six and 12 months respectively reduces postnatal transmission and maximises infant HIV-free survival.
- Replacement feeding, while eliminating postnatal transmission of HIV, increases overall rates of malnutrition and infant mortality.

Ironically, the HIV epidemic may be the best thing that ever happened to breastfeeding… our efforts to ameliorate its effect on children provided an ethical opportunity to observe what happens when large number of infants living in conditions of poverty are not breastfed. If these observations lead to stronger breast-feeding policy and programming that in turn reduce the 1.4 million child deaths occurring each year due to suboptimal breastfeeding, we will have created one of the epidemic’s very few silver linings.

– Jean Humphrey, The Risks of Not Breastfeeding, 2010

Risk Factors for Transmission of HIV to Infants

When does transmission of HIV to infants occur?
With no interventions, such as giving ARV drugs or avoiding breastfeeding – 30 – 40% of infants born to HIV-positive mothers may be infected during:
- a) pregnancy,
- b) birth,
- c) after birth, during breastfeeding.

It is important to remember, though, that even without any intervention, most babies are not infected. More than half of infants of HIV-positive mothers who become infected themselves (approximately 15 – 25%) are infected before and during birth; somewhat less than half (5 – 20%) will become infected through breastfeeding.

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Factors which Increase the Risk of Vertical Transmission

**Pregnancy**
If the mother:
- Is already HIV-infected, but remains untreated, as shown in the diagram below.
- Has a high viral load and/or low CD4 count.
- Becomes newly infected/seroconverts during pregnancy.

Risk of Mother-to-child Transmission (infant HIV DNA positive at 4 – 6 weeks) among Women Receiving HAART before or During Pregnancy Compared with those Receiving Single-dose Nevirapine or no Maternal Prophylaxis

Birth Practices which Increase the Risk of Vaginal Secretions Infecting the Baby During Delivery
- Rupture of membranes longer than four hours,
- Assisted delivery with vacuum extractor or forceps,
- Episiotomy, or other breaks in the woman’s skin,
- Fetal monitoring that breaks the infant’s skin,
- Suctioning the newborn.

---


Maternal factors which increase the amount of virus in breastmilk during breastfeeding

If the mother:
- Has a high viral load, (e.g., >3500 copies/mL) due to:
  - Primary infection with HIV during late pregnancy or during the breastfeeding period.
  - A very long-standing HIV-infection, with a low CD4 count (<225 cells/mm³) which indicates active AIDS.
  - Short duration of antiretroviral (ARV) therapy, facilitating ongoing seeding of the milk by viruses from the blood.
- Suffers breast pathology, also more likely with a low CD4 count:
  - Inflamed or infected breasts (mastitis, abscess);
  - Bacterial or fungal nipple infection.

Infant factors which increase the risk of infection during breastfeeding

If the child:
- Has oral thrush, though this may also be a proxy for immunosuppression, a symptom of an already-infected infant whose immune system has already been severely compromised by early HIV-infection.
- Has damage to the intestinal mucosa, caused by mixed-feeding (breastfeeding plus other foods or fluids before the age of six months); exclusive breastfeeding protects the integrity of the gastrointestinal tract, presenting a more effective barrier to HIV. Conversely early introduction of solid foods and animal milks increases HIV transmission risk compared with exclusive breastfeeding from birth.

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Interventions to Prevent Pediatric HIV Transmission

In recent years, significant programmatic experience and research on the use of ARVs have accumulated. In developed countries, rates of vertical transmission of HIV have been reduced to 1% to 2% by the combined strategies of:
- Routine prenatal testing.
- Maternal/infant ARV prophylaxis or treatment.
- Caesarean section, however, it should be noted that given the lack of clear evidence of benefit in industrialized countries, HIV-infected women with a viral load < 50 copies/mm$^3$ are now able to choose vaginal delivery.
- Breastfeeding avoidance.

Similar interventions have been promoted in resource-poor settings, but have required adaptation to local conditions, e.g.,
- HIV-testing is not always available or acceptable.
- ARV prophylaxis has often been short (e.g., single-dose perinatal maternal/infant NVP or short-course AZT) and if longer regimens were provided to the pregnant HIV-positive mother, these may have been withdrawn after delivery of the baby.
- Caesarean section is unlikely to be readily available in many developing country settings where HIV prevalence is high.
- More focus has been directed at postnatal PMTCT efforts, including promotion of maternal choice about:
  - Type of breastfeeding, e.g., exclusive or mixed.
  - Replacement (formula) feeding, either
    - From birth, or
    - With premature weaning (also known as early cessation).

Interventions to Reduce the Risk of Transmission Through Breastfeeding

Since the discovery in 1985 that HIV could be transmitted during breastfeeding and in recognition that the risk of HIV transmission continues throughout the breastfeeding period, various interventions to reduce postnatal transmission have been employed in different countries, including:
- Modifying infant feeding:
  - Complete avoidance of breastfeeding from birth, i.e., replacement of breastmilk with formula.
  - Early cessation of breastfeeding at 3–6 months to reduce the length of time that the infant is exposed to the virus in breastmilk.

Interventions to maximise mother and child health and survival

Modifying infant feeding
- Most industrialised countries, where uptake of breastfeeding was already low, issued the recommendation that HIV-positive women should not breastfeed. 23, 24
- In resource-poor settings, where breastfeeding was the normal mode of infant feeding, there was acknowledgement of the competing risks of infant morbidity and mortality from causes other than HIV when breastfeeding was withheld. 25

Original framework for facilitating maternal infant feeding choice
In developing country settings initiatives for reducing postnatal transmission of HIV using breastmilk substitutes (known as “replacement feeding”) included:
- A WHO-UNAIDS-UNICEF Technical Consultation in 1998 to develop guidelines on HIV and infant feeding, recommending a selection of infant feeding options for HIV-positive mothers and support for their choice, whether they chose breastfeeding or replacement feeding. 26
- Support from UNICEF in planning and/or implementing PMTCT programmes in 54 countries by December 2002 27 to provide:
  - counselling and HIV testing of pregnant women,
  - improved health care,
  - ARVs,
  - counseling on infant feeding options,
  - provision of formula, with high uptake (60% in Zambia, 87% in Uganda, and 89% in Botswana). 27
- Introduction of the AFASS criteria in 2003 28 acknowledging research showing that artificial feeding represented a risk to child health and survival, 29, 30 and suggesting:
  “when formula-feeding is acceptable, feasible, affordable, sustainable and safe, then avoidance of all breastfeeding by HIV-infected mothers is recommended, otherwise exclusive breastfeeding for the first few months of life is recommended, but should be discontinued as soon as feasible.”

References:
Development in 2005 of guiding principles for feeding infants over six months to acknowledge the risks of early weaning. 21,31
Clarification in 2006 of the unsuitability of home-modified animal milk for feeding infants under six months of age. 32

Challenges of Facilitating Maternal Infant Feeding Choice
The task of weighing the risks and benefits of various feeding methods created considerable difficulties for policy-makers and for health-care workers in the field. 33 From 1998 to 2010 the responsibility for assisting HIV-positive women to make an infant-feeding choice rested with nurses and lay counsellors. 34 Participants at the La Leche League International/WABA Symposium on HIV and Breastfeeding held in July 2005 voted “counselling” as the major problem to be addressed. 35 Those counselling mothers experienced unforeseen problems: 37
Understaffing, high staff turnover, 36 lack of time and burnout, 37
Uncertainty over national HIV and infant feeding guidelines, 38 lack of printed materials 37 and changing recommendations 39, 40
Misunderstanding of various feeding methods, due to incorrect information, ambiguous training or incomplete evidence from which to deduce the safety of locally recommended infant feeding options. 37, 41, 42

References
34. Doherty T, Chopra M, Nkonki L, Jackson D, Greiner T. Effect of the HIV epidemic on infant feeding in South Africa: ‘When they see me coming with the tins they laugh at me’. Bull World Health Organ 2006; 84:90–96.
Mixed messages related to implementing ‘AFASS’ counseling, resulting in poor counselling, especially relating to assessments of home circumstances and inappropriate decision-making by HIV-positive mothers. Counselor bias, particularly in favour of replacement feeding. Conflicts about how to support client autonomy without compromising the health of infants. Loss to follow-up of clients tested and accepted into PMTCT programmes. Low uptake of maternal/infant ARV prophylaxis. Low client adherence to chosen feeding method, resulting in high rates of mixed feeding.

Health Outcomes for Replacement Feeding vs Continued Breastfeeding

Despite reductions in postnatal HIV-transmission, replacement feeding by HIV-positive mothers, either from birth, or after a shortened period of breastfeeding, was associated with:

- No overall advantage in terms of HIV-free survival compared to continued breastfeeding in studies conducted under close supervision and follow-up in urban settings in Kenya and Côte d’Ivoire.
- Reduced HIV-free survival in randomised trials in Kenya, Botswana and Zambia.

47. Rollins NC et al. Infant feeding, HIV transmission and mortality at 18 months: the need for appropriate choices by mothers and prioritization within programmes. AIDS, 2008, 22(17):2349–2357
Increased infant morbidity and mortality in programmatic settings in India, Malawi, South Africa, Uganda, and Botswana.

Extremely high infant mortality rates (217 per 1,000 live births) mostly in the first six months of life in Haiti.

Increased morbidity due to spillover of formula-feeding to the general population in Botswana where 97% of homes had piped water but one-third of all infants under six months were not breastfeeding during a serious diarrhoea outbreak in 2006.

Increased opportunistic infections and a shortened life-span for HIV-infected infants in Botswana, Uganda and Malawi.

Increased rates of malnutrition, serious infections, including pneumonia and diarrhoea, growth faltering and death for uninfected infants who avoided postnatal transmission.

Increased morbidity and mortality after weaning with early cessation of breastfeeding. Though stopping breastfeeding after 4 – 6 months reduces the length of time that the infant is exposed to HIV in breast milk, there is increased mortality after weaning compared to continuing breastfeeding for the normal span of time.

References:

Interventions to maximise mother and child health and survival

3.

Rates of Diarrhoea-Related Hospital Admission or Death Among HIV-exposed Uninfected Infants by Actual Breastfeeding Practice and by Age

Source: Fawzi et al, 2016

Thus, for most of the developing world, the risks of increased morbidity, mortality and malnutrition due to replacement feeding exceed the risks of HIV-transmission due to breastfeeding, especially when breastfeeding is exclusive in the first six months of life and when appropriate ARVs are provided. (see below).

Benefits of Early Weaning for HIV Prevention are Counterbalanced by Risks of Uninfected Mortality in Resource-Poor Countries. Hence, There is no Benefit for HIV-free Survival of Early Weaning in Such Settings.

Source: Kuhn & Aldrovandi, 2010

Exclusive breastfeeding

With increasing recognition that replacement feeding is neither affordable, feasible, acceptable nor, most importantly, either safe or sustainable in most developing countries, alternative research has focused on ways to make breastfeeding safer so as to maintain its important general health benefits.


Support of exclusive breastfeeding is a standard part of usual lactation management. Outside the context of HIV, increased rates of diarrhoea and respiratory infections have been associated with the early introduction of non-human milks and solid foods (mixed feeding) compared to exclusive breastfeeding. Exclusive breastfeeding facilitates normal physiological regulation of milk production and helps to prevent milk stasis which underlies the development of avoidable breast problems especially necessary when a mother is infected with HIV.

The first studies showing that exclusive breastfeeding was protective against HIV-transmission compared to mixed feeding were published in 1999 and 2001 with a further study confirming these results published in 2005. For HIV-positive mothers exclusive breastfeeding compared to mixed or replacement feeding in both research and programme settings was associated with:

- A 3-4-fold decreased risk of HIV transmission in the first six months of life in three large cohort studies.
- Reduced infant morbidity.
- Reduced infant mortality.

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Components of breastmilk which protect against HIV

- Human milk, rich in immunoglobulin-secreting B cells that originate in the gastrointestinal-associated lymphoid tissue \(^{88,89,90}\) has long been known to possess antimicrobial properties which protect newborns from enteric pathogens. \(^{91,92}\)

- Specific identified protective factors against HIV in human milk include: Secretory IgA, IgG, IgM, chondroitin sulphate, β defensins (1-3), lactoferrin, lipids (unsaturated fatty acids and monoglycerides), lysozyme, milk cells, mucin (muc-1; milk fat globulin membrane), ribonuclease and secretory leukocyte protease inhibitor. \(^{93}\)

- Anti-HIV IgG and IgA antibodies have been identified in colostrum from HIV+ women, but not from HIV- women. \(^{94}\)

- The specificity and function of these mucosal antibodies may be distinct from those in plasma. \(^{88,95,96}\)

- It has been suggested that HIV-1 IgM in breastmilk could be protective against postnatal transmission of the virus in three ways: \(^{91,97}\)
  - By compensating for a defective secretory IgA response and behaving in a similar way by directly coating viral particles,
  - IgM antibodies are strong potentiators of complement-mediated cytotoxicity, of which at least nine components have been identified in human milk, and
  - specific IgM could take part in the lysis of infected cells by a mechanism of antibody-dependent lymphocyte cytotoxicity.

- Human milk also contains a glycosamine which is able to inhibit the binding of HIV [gp 120] to CD4, blocking the first step for infection of a target cell. This inhibitory activity was found in colostrum and mature milk samples from both HIV+ and HIV- populations of women. \(^{98,99}\)

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A recent study isolated B cells from colostrum of an HIV-infected lactating woman. These represent two of the first mucosally-derived antibodies to HIV yet to be reported:

- Colostrum monoclonal Antibody (mAb) CH07 is a highly-autoreactive, weakly-neutralising gp140-specific mAb that binds to linear epitopes in the gp120 C5 region and gp41 fusion domain.
- In contrast, colostrum mAb CH08 is a nonpolyreactive CD4-inducible (CD4i) gp120-specific mAb with moderate breadth of neutralisation.

These novel HIV-neutralizing mAbs provide protection against virus acquisition at mucosal surfaces. This may help explain why the majority of nursing infants of HIV-infected infants are protected against HIV-1 acquisition, despite chronic, daily mucosal HIV-1 exposure.

A further recent study demonstrates for the first time highly reproducible transmission of multiple HIV strains in bone marrow/liver/thymus humanised mice in the oral cavity and GI tract, which can be prevented with antivirals. This research offers the first in vivo demonstration that human milk can inhibit oral transmission of cell-free and cell-associated HIV.

Immunologically active carbohydrates called human milk oligosaccharides (HMOs), the third most abundant component of breastmilk, become concentrated in the mucosal surfaces of the infant’s gastrointestinal tract. HMOs are not digestible and act as prebiotics, promoting the growth of desirable bacteria, or probiotics, to protect from HIV transmission. HMOs resemble sugar chains called glycans that are normally found on epithelial cell surfaces and can serve as “decoy” receptors to inhibit HIV binding.

The Baby Who is Already HIV-infected

Approximately 20% of babies of untreated mothers with HIV are born already infected. In most circumstances feeding decisions are made prior to knowledge of the child’s HIV status. Babies with HIV have an increased risk of acquiring opportunistic infections such as pneumocystis carinii (jirovecii) pneumonia which healthy babies do not get. As well as being a good source of nutrition, breastmilk contains immune factors which provide protection against opportunistic infections, and delay HIV disease progression. Breastfeeding, particularly exclusive breastfeeding, greatly increases the life expectancy of HIV-infected infants. Current guidance is that mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to breastfeed exclusively for the first six months and to continue for two years or beyond.


Heat-treated Expressed Breastmilk

Mothers who are HIV-positive and who choose not to breastfeed because of the risk of HIV transmission to their infants would be well served if the possibility of using their own heat-treated expressed breastmilk could be made possible. There seems no good reason why, in the near future, it could not be a realistic option; clearly, feeding expressed breastmilk is very much superior to infant formula, the product is locally manufactured, the procedure will have benefits to the mother’s health and will reduce her likelihood of an early pregnancy.

– Latham and Kisanga 2000

Research conducted since before 2000 has shown that home-pasteurisation methods can inactivate HIV in breastmilk. It is possible for mothers to express their breastmilk and heat-treat it using simple methods at home so that they can safely feed it to their babies and thus eliminate all risk of postnatal transmission.

Protocols for how to achieve home-pasteurization are set out in Section 4.

Benefits to the Baby of Receiving the HIV-positive Mother’s Own Heat-treated Breastmilk

Heat-treated expressed breastmilk:
- Is physiologically normal and non-allergenic.
- Is nutritionally adequate (some components slightly changed).
- Inactivates HIV and bacteria.
- Is a free and feasible infant feeding method.
- Retains some immunological protection.


Is likely to maintain a normal maternal postpartum hormonal profile, to:
- Promote maternal-infant bonding.
- Facilitate lactational amenorrhea/reduced fertility.
- Remains within the mother’s control regarding supply/sustainability/baby’s food security. 112,113
- Can be safely stored after pasteurisation for eight hours at room temperature. 108
- Causes no risk of HIV-transmission if used as a mixed feeding method, since HIV is inactivated.
- Can be used from birth, or
- May be particularly valuable as a short-term feeding strategy during times of high risk such as:
  - if the baby is low birth weight or sick and unable to breastfeed,
  - if the infant has oral thrush,
  - if the mother has mastitis, or damaged/abraded nipples
  - to assist mothers to cease breastfeeding, and/or
  - if ARVs are temporarily unavailable.

Antiretroviral Interventions
Various drugs to treat HIV and prevent vertical transmission have been employed in the last 25 years.

**Estimated Number of Children Newly Infected with HIV 1990 – 2010, and ARVs Used in Relevant PMTCT Clinical Trials**

Source: Cavarelli M and Scarlatti G, 2011 114

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**Interventions to maximise mother and child health and survival**

**ARV interventions to reduce HIV-transmission during pregnancy and birth**
The first clinical trial of ARVs to reduce vertical HIV-transmission was conducted in 1994. Treatment with the drug AZT reduced HIV transmission from HIV-positive mothers to their infants during pregnancy and birth by two-thirds. Following this research, between 1994 and 1999 the number of babies born with HIV in developed countries dropped 78%.

**Short-course ARV interventions to reduce postnatal transmission**
Subsequent protocols that could be implemented in breastfeeding populations in resource-limited settings were found to reduce vertical transmission by half. A less expensive regimen such as single-dose nevirapine (sdNVP) administered to the mother in labour and to the infant within 72 hours of birth also reduced postnatal transmission by 50%, even when breastfeeding continued. Single-dose NVP has been the mainstay of ARV prophylaxis in most countries, but maternal HAART has since been shown to reduce postnatal HIV transmission four-fold compared to sdNVP even in times of severe socio-economic crisis. Thus, WHO guidelines since 2006 have progressively recommended shifting away from sdNVP towards more effective alternatives.

**Long-term ARV interventions**
In the USA and Europe, where HIV-positive women have been treated with a combination of ARVs from early in pregnancy, longer treatment duration has been found to be significantly more effective than shorter regimens in reducing viral load, reducing the risk of transmission during pregnancy and delivery to as low as 1–2%.

In developing countries, postnatal prevention has taken two different approaches:
- Triple drug combination ART to the breastfeeding woman to maximise her health and suppress HIV viremia in blood and breast milk, or
- ARV prophylaxis for the breastfeeding infant.

For breastfeeding mothers, a combination of ARVs used earlier in pregnancy had greater efficacy in preventing transmission than the same combination starting during labour and delivery. Viral load at enrolment and shorter duration of HAART

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before delivery were significantly associated with infant infection, whereas extended maternal or infant treatment or prophylaxis showed reduced postnatal HIV transmission through breastfeeding even up to 12 months.

Very improved results from the Kesho Bora, and other trials, underpinned WHO’s 2010 decision to revise international guidelines for ARV use by pregnant and breastfeeding women. From this time, maternal triple ARV prophylaxis starting from the second trimester of pregnancy until all exposure to breastmilk ended was recommended. The unifying principle of the new guidelines was that an effective maternal or infant antiretroviral-based prophylaxis to prevent MTCT was required in all instances.

**Long-term ARV prophylaxis for infants**

In 2008, results from two randomised clinical trials demonstrated that providing daily NVP to the breastfeeding infant offered protection against HIV infection. However, once NVP was withdrawn, transmission risk returned unless mothers were receiving HAART. With increased duration of prophylaxis, extended NVP administered to breastfeeding infants for 6, 14 or 28 weeks was shown to result in reduced postnatal transmission at 6-9 months:

- To 6 weeks - 6.9%
- To 14 weeks - 5.2%
- To 28 weeks - 1.1%

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Thus, NVP for breastfed infants was recommended as an alternative prophylactic strategy for women with moderate to high CD4 cell counts who did not require long-term HAART for their own health, administered as follows: 120

- Maternal zidovudine prophylaxis from the second trimester of pregnancy until delivery, and
- Daily oral nevirapine to the breastfed infant until all breastfeeding has ceased.
- Either maternal and/or infant prophylaxis was recommended to be continued until one week after all breastfeeding has ceased. 21

**Comparison of long-term maternal and infant ARVs**

The HPTN 046 trial results 32 confirm that long-term infant NVP offers no additional benefit in infants born to women receiving HAART. A recent modelling paper computes that if women receive HAART while breastfeeding, the monthly postnatal transmission risk is assumed to be reduced by 80%. If the mother does not receive HAART while breastfeeding, but the infant receives extended nevirapine prophylaxis, the rate of transmission is assumed to be reduced by 60%. 4

**Long-term ARV interventions and exclusive and continued breastfeeding (ART+EBF)**

The results from eight studies outlined in the following Table show that the risk of postnatal transmission during the period of exclusive breast can be reduced to 0% – 1% when:

- Mothers and/or their babies receive appropriate ARVs from early/mid pregnancy and throughout the breastfeeding period, and
- Breastfeeding is exclusive for up to six months.

A further recent study, the first of its kind, where maternal HAART was initiated at 14-30 weeks of pregnancy and continued to 12 months postpartum, while infants were exclusively breastfed to 6 months and continued breastfeeding with complementary feeding from 6-12 months, resulted in postpartum HIV transmission rates of 1.3% at 6 months and 2.2% at 12 months respectively. 124
Table Adapted from Morrison P et al, AIDS 2011

Studies of Postnatal HIV Transmission Rates <1% at Six Months
(inclusion criteria: mother or child received ART and infants were exclusively breast fed. Breastfeeding-associated transmission was defined as excluding transmission occurring in the first month postpartum)

<table>
<thead>
<tr>
<th>Ref Author Year</th>
<th>Duration of Exclusive Breastfeeding</th>
<th>Antiretroviral treatment and/or prophylaxis</th>
<th>Postnatal transmission</th>
<th>Determined by first infant HIV+ test result between…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palombi 2007 134</td>
<td>6 months</td>
<td>Maternal HAART from 25 weeks gestation until weaning: infant sdNVP after birth</td>
<td>0.8% (2/251)</td>
<td>1 – 6 months</td>
</tr>
<tr>
<td>Kilewo 2008 135</td>
<td>18 weeks</td>
<td>Maternal ZDV &amp; 3TC from ~34 weeks gestation to 1 week postpartum; Infant: ZDV &amp; 3TC from 0-1 week, then 3TC alone during breastfeeding</td>
<td>1% (4/398)</td>
<td>6 weeks – 6 months</td>
</tr>
<tr>
<td>Kilewo 2009 136</td>
<td>For a maximum of 6 months</td>
<td>Maternal HAART from 34 weeks gestation to 6 months postpartum: Infant ZDV &amp; 3TC to 1 week of age</td>
<td>0.9% (4/441)</td>
<td>6 weeks – 6 months</td>
</tr>
<tr>
<td>Marazzi 2009 137</td>
<td>6 mo; mothers advised to start weaning by 6 months ending within 2 months, but likely some breastfeeding 6-12 months;</td>
<td>Maternal HAART from 15 weeks gestation to 2 months post weaning. Infant sdNVP after birth + AZT for 1 week</td>
<td>0.6% (2/341)</td>
<td>6 weeks – 6 months</td>
</tr>
<tr>
<td>Marazzi 2009 137</td>
<td>6 mo; mothers advised to wean at 6 months;</td>
<td>Maternal HAART from 28 wk gestation to 7 mo postpartum; Infant sdNVP after birth + ZDV for 1 week</td>
<td>0.6% (2/239)</td>
<td>6–12 months</td>
</tr>
<tr>
<td>Peltier 2009 138</td>
<td>6 mo; mothers advised to wean at 6 months;</td>
<td>Maternal HAART from 28 wk gestation to 7 mo postpartum; Infant sdNVP after birth + ZDV for 1 week</td>
<td>0.44% (1/227)</td>
<td>6 weeks – 9 months</td>
</tr>
<tr>
<td>Shapiro 2010 127</td>
<td>EBF for 93% of infants to weaning: 71% breast fed &gt;5months; &lt;1% &gt;6 months</td>
<td>Randomised and varied HAART regimens for mothers from 18-34 wk gestation until weaning; all mothers also received supplemental AZT during labor: Infant sdNVP after delivery plus 1 mo AZT</td>
<td>0.3% (2/709)</td>
<td>1 – 6 months</td>
</tr>
<tr>
<td>Homys 2010 63</td>
<td>EBF for 92% for 4 months, weaned at 5 months</td>
<td>Maternal FDC, median duration 5.2 - 20.3 mo preceding delivery and during breastfeeding: Infant sdNVP post birth or sdNVP + ZDV 1 wk</td>
<td>0% (0/109)</td>
<td>6 weeks of age – 6 weeks post weaning</td>
</tr>
<tr>
<td>Thomas 2011 139</td>
<td>6 months</td>
<td>Maternal HAART from 34 weeks gestation to 6 months postpartum: infant sdNVP at birth</td>
<td>0.8% (4/487)</td>
<td>6 weeks – 6 months</td>
</tr>
</tbody>
</table>

133. Morrison P, Greiner T, Israeli-Ballard K, Informed choice in infant feeding decisions can be supported for HIV-infected women even in industrialized countries. AIDS 2011; 25:1807–1811
Thus, there is enough evidence for WHO to recommend ARVs while breastfeeding. Appropriate long-term ARV maternal/infant treatment and/or prophylaxis while breastfeeding and beyond has the potential to:

- Reduce viral load and improve the health of HIV-positive mothers in the short-term.
- Extend the life-span of HIV-positive mothers to almost normal.
- Effectively reduce vertical transmission of HIV during pregnancy, birth and breastfeeding for 12 months.
- Reduce the risk of horizontal transmission in sero-discordant couples where the male partner is not HIV-infected.

The findings of increased morbidity and mortality associated with replacement feeding and research showing extremely low rates of postnatal HIV-transmission during breastfeeding when mothers and infants receive appropriate ARVs have profound implications for the health of HIV-positive mothers and HIV-exposed babies, and for those counselling them. Together, these findings underpin the current guidance. Effective use of antiretroviral drugs can now reduce transmission to such low levels that there are few circumstances in developing countries where artificial feeding can be justified.

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**HIV-free Survival, Different ART Regimens and Feeding Methods**

- **White babies – Uninfected by any route**
- **Blue babies – HIV-infected through pregnancy & birth**
- **Red babies – HIV-infected through breastfeeding**
- **Black babies – Babies who die from causes other than HIV**

**Source:**


Current ART Recommendations for Pregnant Women

In 2010 the following recommendations were made for all pregnant women in need of ART for their own health:

- Every effort should be made to ensure that all women who require ART have access to it.
- ART significantly reduces HIV disease progression and decreases morbidity and mortality in pregnant women.
- ART is also the most effective method of preventing vertical HIV-transmission and, by improving the health of the mother, improves the chances of survival of her child, particularly for a woman with advanced disease and a higher risk of transmission.
- The benefits of ART for the health of the mother outweigh any potential risks for the well-being of the fetus and of potential drug toxicity, drug resistance and additional cost.
- The criteria for initiating ART for pregnant women are the same as for non-pregnant women.
- The 2010 recommendations also contained additional information about ART eligibility for HIV-infected pregnant woman according to CD4 cell counts and WHO clinical staging.

However, in April 2012 WHO announced that it has begun a comprehensive revision of all ARV guidelines, including guidance on ARVs for pregnant women. The revision is planned for release in early 2013. In the meantime a programmatic update confirms that substantial clinical and programmatic advantages can come from adopting a single, universal regimen both to treat HIV-infected pregnant women and to prevent vertical HIV transmission.

The current recommendation is not only to provide triple ARV drugs to all HIV-infected pregnant women beginning in the antenatal clinic setting but also to continue this therapy for all of these women for life. Important advantages include:

- further simplification of regimen, service delivery and harmonization with ART programmes,
- protection against vertical transmission in future pregnancies,
- a continuing prevention benefit against sexual transmission to serodiscordant partners,
- avoiding stopping and starting of ARV drugs.

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Interventions to maximise mother and child health and survival

3.

Current infant feeding recommendations for resource-poor settings

Rather than presenting breastfeeding as an option, breastfeeding is now recommended for HIV-positive mothers in resource-poor settings:

- Enabling breastfeeding with ARV interventions to continue to 12 months.
- Providing additional developmental and other health benefits of breastfeeding for infants who do not become HIV-infected.
- Eliminating replacement feeding as the sole way to avoid postpartum transmission of HIV.
- Avoiding increased rates of infant morbidity and mortality due to withholding breastfeeding.
- Avoiding the complexities associated with stopping breastfeeding and attempting to provide a safe and adequate diet without breast milk to the infant 6 – 12 months of age.
- Facilitating the greatest likelihood of infant and young child HIV-free survival.

Current infant feeding recommendations for resource-rich settings

In 2009/10, the British HIV Association and Children’s HIV Association held a consultation to respond to concerns about the appropriateness of HIV and infant feeding recommendations for the majority of HIV-positive mothers in the UK. As a result, their 2008 guidelines were revised. Their current published Position Paper recognises in paragraph 3 that an HIV-positive woman already receiving triple ART, with a repeated undetectable viral load at delivery may, after careful consideration, choose to exclusively breastfeed for the first six months of her baby’s life. In such a scenario, the current guidance recommends:

- Continuing maternal triple ART treatment and short-term infant prophylaxis.
- Exclusive breastfeeding for six months.
- Frequent follow-up.
- Careful monitoring of maternal adherence until 1 week after weaning.
- Monthly checks on maternal viral load and infant HIV status.

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146. Lunney KM et al. HIV-positive poor women may stop breast-feeding early to protect their infants from HIV infection although available replacement diets are grossly inadequate. Journal of Nutrition, 2008,138(2):351-357
HIV-positive women may have concerns or experience constraints regarding how to feed their infants to give them the best chance of survival. Breastfeeding needs to be protected so that breastfeeding mothers can be supported in feeding their infants optimally, with the help of the healthcare system and the wider community, and unhindered by the inappropriate marketing of infant formula.

Section 4 discusses some these concerns and the process of counselling.

References and further reading are listed in Section 6.
3. Interventions to maximise mother and child health and survival

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Understanding International Policy on HIV and Breastfeeding

The World Alliance for Breastfeeding Action (WABA) is a global network of individuals and organisations concerned with the protection, promotion and support of breastfeeding worldwide. WABA action is based on the Innocenti Declaration, the Ten Links for Nurturing the Future and the Global Strategy for Infant & Young Child Feeding. WABA is in consultative status with UNICEF and an NGO in Special Consultative Status with the Economic and Social Council of the United Nations (ECOSOC).