HIV AND INFANT FEEDING

UPDATED WHO GUIDELINES, OCTOBER 2015

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Maternal, Newborn, Child and Adolescent Health
WHO guidelines

http://www.who.int/hiv/en/
Setting national recommendations for infant feeding in the context of HIV

National (or sub-national) health authorities should decide whether health services will principally counsel and support mothers known to be HIV-infected to:

- breastfeed and receive ARV interventions, or,
- avoid all breastfeeding,

as the strategy that will most likely give infants the greatest chance of HIV-free survival.

This decision should be based on international recommendations and consideration of the socio-economic and cultural contexts of the populations served by Maternal and Child Health services, the availability and quality of health services, the local epidemiology including HIV prevalence among pregnant women and main causes of infant and child mortality and maternal and child under-nutrition.
Which breastfeeding practices and for how long?

Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first 6 months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life.

Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
22 UNAIDS priority countries (2012)

- The vast majority have adopted Breastfeeding with ARVs as policy
Questions raised

Can a country recommend exclusive breastfeeding and ARVs to HIV-infected mothers even when rates of EBF are low?

Do HIV-infected mothers really need to stop breastfeeding, especially if they are on lifelong ART?

Do ARVs reduce transmission if the mother does not exclusively breastfeed?

Is it important to promote exclusive breastfeeding if ARVs are effective even when mothers mix feed?

How to give health workers confidence to want to recommend HIV-infected mothers to breastfeed while receiving ART/ARVs?
'Findings suggest that WHO Guidelines on preventing vertical transmission of HIV through exclusive breastfeeding in resource-limited settings are not being translated into action by governments and front-line workers because of a variety of structural and ideological barriers.'
Mma bana study

2 randomised arms and one observational
Mothers not eligible for ART received either:
lopinavir/ritonavir and combivir } for 6m
or  abacavir/AZT/3TC } while BF
Mothers eligible for ART – outcomes observed

1248 pregnant women referred
to study sites. After counselling
about study interventions, 110
(8.8%) declined enrolment as
preferred to give formula feeds.
Where we want to be

- Where HIV-infected mothers do not need to think about their status when they feed their infants.
  - Zero risk of HIV transmission
  - HIV-infected mothers have confidence in the benefits of BF and can benefit from all social and health aspects of breastfeeding
  - Health workers have confidence to promote and support BF
  - Breastfeeding does not have any negative connotation
  - Where HIV investment to promote and support breastfeeding among HIV-infected mothers, can also support breastfeeding among the general population and *vice versa*

- *Where HIV-free survival and development is the metric of success*
Guideline process

• **Four areas reviewed**
  (mainly with respect to countries where BF is recommended and ART is provided)
  • For how long should a mother living with HIV breastfeed her infant/child if she is being supported with ART?
  • Should women living with HIV be supported in their infant feeding practices?
  • If mothers living with HIV are mixed feeding, are ARVs still protective against postnatal transmission?
  • If mothers with HIV plan to return to school/work, should she breastfeed for shorter than recommended (e.g. 12 months) or never breastfeed at all?

• **Three additional discussion points**
  • What to recommend in emergencies and humanitarian disasters?
  • What are the implications for routine M&E?
  • How should updated guidelines be disseminated in order to improve IFP in HIV prevalent settings incl. opportunities to improve practices in the general population
WHO recommendations on ART

• 2010 Guidelines on HIV and infant feeding are intrinsically linked to updated recommendations on ART

• WHO recommendations on antiretroviral treatment between 2010 and 2015 evolved from

  • Lifelong treatment only for pregnant women and mothers fulfilling specific immunological or clinical criteria AND antiretroviral drug prophylaxis either to breastfeeding infants (option A) or to lactating mothers (option B), TO

    • Lifelong treatment for all pregnant women and mothers, TO

    • Lifelong treatment for all, from whenever diagnosed.
For how long should a mother living with HIV breastfeed her infant?
(in settings where BF and ART is recommended)

• In settings where health services provide and support lifelong antiretroviral therapy, including adherence counselling, and promote and support breastfeeding among women living with HIV, the duration of breastfeeding should not be restricted.

• Mothers living with HIV should breastfeed for at least 12 months and can continue breastfeeding for up to 24 months or longer (as for the general population) while being fully supported for ART adherence.

(Strong recommendation; Quality of evidence: up to 12 months – low quality; to 24 months – very low quality)
Infant feeding support for mothers living with HIV

- National and local health authorities should actively coordinate and implement services in health facilities and activities in workplaces, communities and homes to protect, promote and support breastfeeding* among women living with HIV.

(Strong recommendation; Quality of evidence: high quality)
When mothers living with HIV do not exclusively breastfeed

- Mothers living with HIV and healthcare workers can be reassured that ARV treatment is effective at reducing the risk of postnatal HIV transmission in the context of mixed feeding and that mixed feeding in itself is not a reason to stop breastfeeding.

(Guiding statement in settings of sub-optimal practices)
When mothers living with HIV plan to breastfeed for less than 12 months

- Mothers living with HIV and healthcare workers can be reassured that shorter durations of breastfeeding less than 12 months are better than never initiating breastfeeding at all.

(Guiding statement in settings of sub-optimal practices)
Questions / clarifications

- New recommendations / guiding statements

Principle (2010)

- National (or sub-national) health authorities should decide whether health services will principally counsel and support mothers known to be HIV-infected to:
  - breastfeed and receive ARV interventions, or,
  - avoid all breastfeeding,

as the strategy that will most likely give infants the greatest chance of HIV-free survival.
Implications for responses in humanitarian disasters and emergency settings

- Principles of response discussed
  - Conflict / (recurrent) disasters / fragile states
- Major challenge to collect data in these settings
- Need to adapt existing recommendations to emergency context and develop principles for decision making re. how to respond according to context and nature of setting
- Formal consultation planned at WHO, Geneva – Q4
Dissemination

• Build on existing programmes and link with systems designed around ART
• Communication strategy needed for communities and health workers
• Need to engage professional associations
• Engaging and working with networks of mothers living with HIV
Next steps (1)

- Disseminate main points
  - Regional workshops and information dissemination
  - IATT webinar
- Update training materials
- Translate into relevant languages (French, Spanish, Russian)
Breastfeeding 2

Why invest, and what it will take to improve breastfeeding practices?

Nigel C Rollins, Nita Bhandari, Nemati Hajebehoy, Susan Horton, Chessa K Lutter, Jose C Martines, Ellen G Piwoz, Linda M Richter, Cesar G Victora, on behalf of The Lancet Breastfeeding Series Group*

Despite its established benefits, breastfeeding is no longer a norm in many communities. Multifactorial determinants of breastfeeding need supportive measures at many levels, from legal and policy directives to social attitudes and values, women’s work and employment conditions, and health-care services to enable women to breastfeed. When
Implications for M&E systems

- What do we need to know?
  - National data
    - Retention
    - BF duration and method
  - Child HIV infections
  - Child mortality
  - Maternal mortality
  - Viral load
  - Routine program data
    - Infant and maternal nutrition status
    - ARV coverage
    - (Morbidity)
- Implications for global estimates of paediatric infections
Next steps(?): reinstate IFP as a priority and focus for HIV programmes

- Systematic collection of high value data
  - BF practices and ART cover among mothers living with HIV
  - Establish sentinel sites in 4-5 countries
- Strategic engagement with 2-3 countries to mark the direction of things to come (feasibility and outcomes) and normalise BF. E.g.
  - East and Southern Africa e.g. Botswana, Kenya and South Africa
  - Haiti
  - Tajikistan, Kyrgyzstan
- Engage networks of mothers living with HIV
- Strategy to engage, and win hearts and confidence of health professionals (incl. associations) and communities
- Convene a meeting to review infant feeding principles and responses in HIV prevalent emergency settings