HIV AND INFANT FEEDING

UPDATED WHO GUIDELINES, 2016

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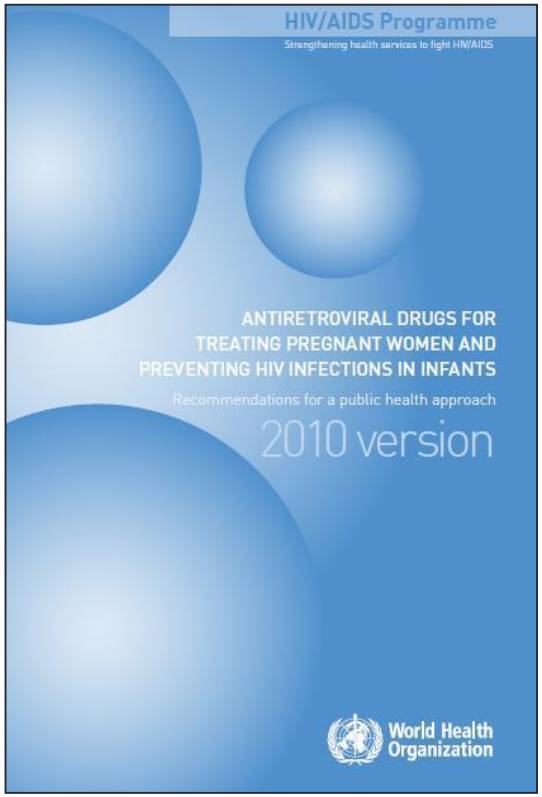
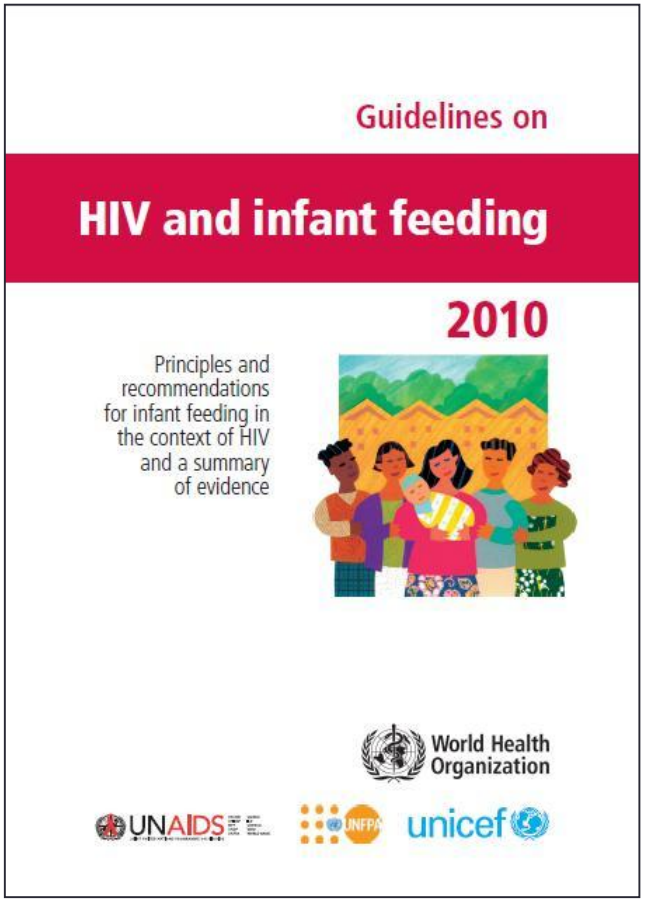
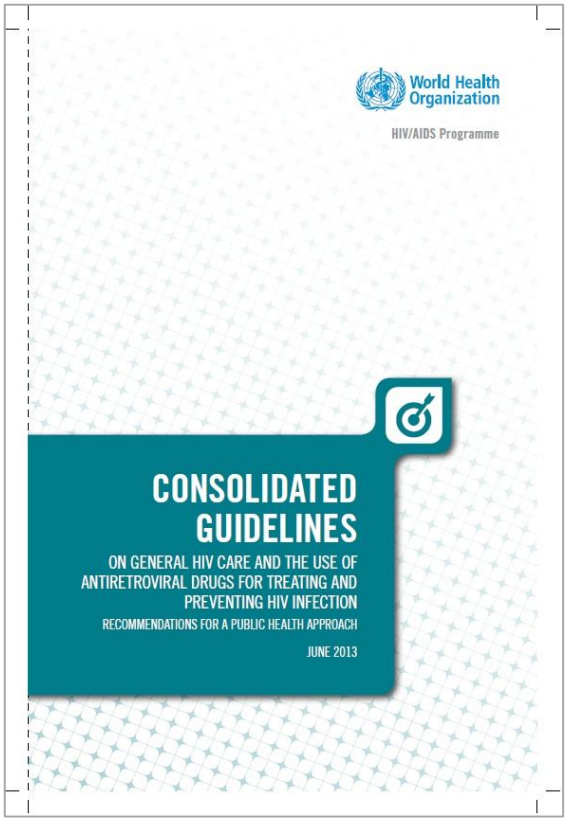
WHO guidelines

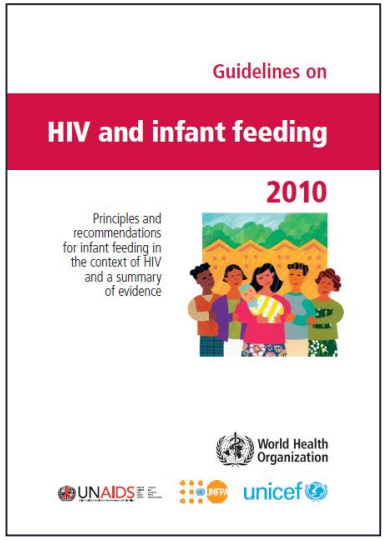






http://www.who.int/hiv/en/

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.**

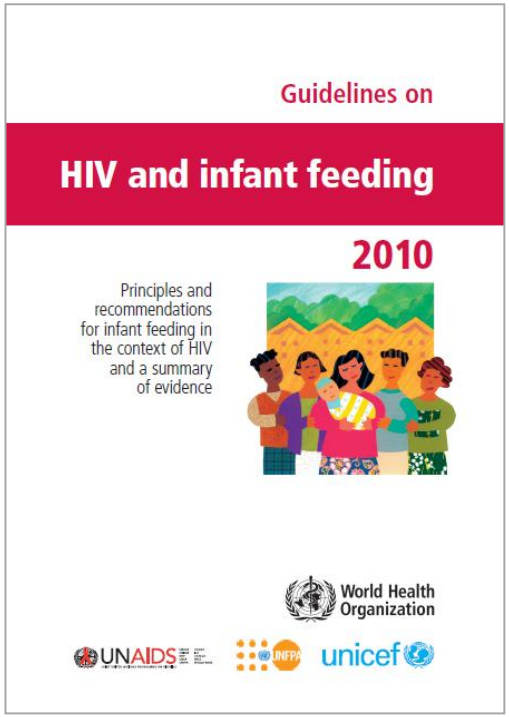
This decision should be based on international recommendations and consideration of the socio-economic and cultural contexts of the populations served by Maternal and Child Health services, the availability and quality of health services, the local epidemiology including HIV prevalence among pregnant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

… in settings where national authorities decide to promote and support BF and ARVs …

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

Updated (2016) guideline on HIV and infant feeding

Four areas prioritised for review, resulting in …

- Two Recommendations
- Two Guiding Practice Statements
- Two programmatic areas highlighted for special consideration

1. For how long should a mother living with HIV breastfeed her infant?
(in settings where BF and ART is recommended)

Recommendation 1

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

  (*Strong recommendation; Quality of evidence: up to 12 m – Low; to 24 m – Very low*)

Framing statement / Additional note

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

- *See WHO consolidated guidelines for interventions to optimize adherence*

Rationale and programmatic issues (1)

Rationale

- ART very effective at reducing transmission risk
- Longer durations of breastfeeding are beneficial for mother and infant though the survival benefits are maximal 0-12 months
- Yet, there is a risk of late transmission if poor adherence to ART
- Harmonizing recommendations for mothers living with HIV with those for the general population has advantages for implementation and reducing stigma

Programmatic issues *(Implications for programmes and research)*

- Need to optimise ART adherence and retention in care (shared agenda)
- Recommendation is permissive and does not obligate duration of breastfeeding
- Clear messages (and accurate data) for health care workers and communities
- Updated guidance needed on timing of HIV testing

2. Infant feeding support for mothers living with HIV

Recommendation 2

- 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*)

Rationale and programmatic issues (2)

Rationale

- High quality evidence (from breastfeeding support intervention studies) showing benefits of proactive support to increase EBF rates
- Assume the same for improving safe replacement feeding practices
- Interventions that combine health facility and community activities even more effective at increasing exclusive breastfeeding rates
- Highly acceptable and will improve breastfeeding practices in general population – win, win
- Supports long term health and development of HEU infants

Programmatic issues *(Implications for programmes and research)*

- A long term view needed of benefits including child development vs. short term focus on prevention of transmission.
- Prioritisation and resources in an ART-driven environment
- Consider new goal of 'HIV-free survival and development'

3. When mothers living with HIV do not exclusively breastfeed

Guiding practice statement 1

- Mothers living with HIV and healthcare workers can be reassured that ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs

(*Guiding practice statement in settings of sub-optimal practices*)

Rationale and programmatic issues (3)

Rationale

- While most studies promoted EBF, few measured EBF rates. Assumed to be slightly better than general population
- Transmission data from intervention studies did not disaggregate by EBF and MBF. Yet still low rates of transmission when ART adherence is high
- A guiding practice statement is made to encourage action or clarify an issue of concern. It addresses an area of suboptimal practice and provides a contingency and guidance to health workers regarding how to respond to a specific challenge
- Should not be seen as an endorsement of mixed feeding

Programmatic issues *(Implications for programmes and research)*

- How best to avert mixed messages. EBF is still the best, but for non-HIV outcomes
- Clear messages needed for health care workers and communities
- Guidance needed on use of infant prophylaxis and BF as interim/contingency measure

4. When mothers living with HIV plan to breastfeed for less than 12 months

Guiding practice statement 2

- 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 practice statement in settings of sub-optimal practices*)

Rationale and programmatic issues (4)

Rationale

- High quality data from general population re. value of any breastfeeding and child outcomes
- If HIV transmission risk is addressed, then should aim for similar benefit for HEU infants and children

Programmatic issues *(Implications for programmes and research)*

- Health workers need support to apply the recommendations. Often take things to the letter of the law (can be good but may have down side as well)
- Opportunity to link with recommendations for general population and support improved practices among all

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 in September 2016. WHO, Geneva

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

Barriers to implementing WHO's exclusive breastfeeding policy for women living with HIV in sub-Saharan Africa: an exploration of ideas, interests and institutions

by Eamer, GG and Randall, GE

Int J Health Plann Manage. 2013 Jul-Sep;28(3):257-68

'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.'