

RECOMMENDATIONS ON FEEDING INFANTS OF HIV POSITIVE MOTHERS

WHO, UNICEF, UNAIDS Guidelines

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1. INTRODUCTION

Since 1992, WHO and UNICEF, and since 1995 when it was formed, UNAIDS, have been working to develop policies and guidelines concerning the safest method of feeding for infants of HIV-positive mothers. The first policy statement put forward in 1992 was made on epidemiological grounds. In countries with high infant mortality rates due to infection, often compounded by malnutrition, women were to be advised to breastfeed, as the risk of death from not breastfeeding was likely to be greater than the risk of acquiring HIV through breastmilk. In other settings, with low infant mortality rates, where the risks of artificial feeding were less, women were to be advised not to breastfeed. These recommendations were seen as reflecting a double standard – one for the rich and one for the poor – and proved unworkable as a basis for the development of globally relevant guidelines.

Throughout the 1990s, the influence of the human rights perspective on health policy steadily increased. The second policy statement on HIV and Infant Feeding put forward jointly by WHO, UNICEF and UNAIDS in 1997 reflected this in its rights based approach, which called for women in

all settings to make a fully informed decision about feeding their infants. Women would not be told or advised what to do, but would be enabled to make a decision appropriate to their particular circumstances and situation, and supported in their choice of feeding method.

2. WHO/UNICEF/UNAIDS HIV AND INFANT FEEDING GUIDELINES

On the basis of this policy, it became possible to develop “Guidelines for Decision Makers” and “A Guide for Health Care Managers and Supervisors”, which had universal applicability. These were issued in 1998^{1,2}, and sought to clarify the direction for implementation, as well as to identify gaps in understanding, and unresolved questions that required further research. There were many serious underlying concerns. While it was recognised that breastfeeding can transmit HIV to an infant, the exact risk of transmission remained uncertain, and appeared to vary with a number of factors including the mother’s health and viral load, the condition of her breasts and of the infant’s oral and intestinal mucosa. Artificial feeding of infants was also recognised to have serious risks, particularly in those countries most severely affected by the HIV epidemic. The term “replacement feeding” was coined to refer to alternative feeding of an infant of an HIV-positive mother, to draw attention to the need for full nutritional support throughout at least the first two years of life, during which time an infant would normally receive a significant proportion of high quality nutrients in the form of breastmilk. Replacement feeding is defined as “the process of feeding a child who is not receiving any breastmilk from birth to two years with a diet that provides all the nutrients that the child needs”. A common assumption that an infant only needed to be provided with breastmilk substitutes for the first six months of life was inappropriate. Many complementary diets are inadequate to support satisfactory growth even if breastmilk is provided. Replacement feeds could consist of commercial infant formula, or home-prepared infant formula in families where animal milk or powdered full cream milk are more readily available. Micro-nutrient supplements would be needed with home-prepared formula, and nutrient-rich complementary foods ensured as part of all replacement feeding from about 6 months of age. The guidelines also make clear that replacement feeding is not the only alternative: modified forms of breastfeeding, such as expression and heat treatment of the mother’s breastmilk, wet-nursing by an HIV-negative wet-nurse, use of uncontaminated donor breastmilk, and exclusive breastfeeding for a few