

**WHO HIV and Infant Feeding Technical Consultation  
Held on behalf of the Inter-agency Task Team (IATT) on Prevention of HIV  
Infections in Pregnant Women, Mothers and their Infants  
Geneva, October 25-27, 2006**

**CONSENSUS STATEMENT**

Researchers, programme implementers, infant feeding experts and representatives of the IATT<sup>1</sup>, UN agencies, the WHO Regional Office for Africa and six WHO headquarters departments<sup>2</sup> gathered in Geneva in order to review the substantial body of new evidence and experience regarding HIV and infant feeding that has been accumulating since a previous technical consultation in October 2000<sup>3</sup>, and since the Glion<sup>4</sup> and Abuja<sup>5</sup> calls to action on the prevention of mother to child transmission of HIV. The aim was to establish whether it is possible to clarify and refine the existing UN guidance<sup>6</sup>, which was based on the recommendations from the previous meeting.

After three days of technical and programmatic presentations and intensive discussion, the group endorsed the general principles underpinning the October 2000 recommendations and, based on the new evidence and experience presented, reached consensus regarding a range of issues and their implications. This statement presents a preliminary summary pending publication of the full report.

**New evidence on HIV transmission through breastfeeding:**

- Exclusive breastfeeding for up to six months was associated with a three to four fold decreased risk of transmission of HIV compared to non-exclusive breastfeeding<sup>7</sup> in three large cohort studies conducted in Côte d'Ivoire, South Africa and Zimbabwe.

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<sup>1</sup>Academy for Educational Development, Catholic Medical Mission Board, Columbia University, Elizabeth Glaser Pediatric AIDS Foundation, UNAIDS, UNFPA, UNICEF, US Agency for International Development and the US Centers for Disease Control.

<sup>2</sup> Child and Adolescent Health and Development, Nutrition for Health and Development, HIV/AIDS, Reproductive Health Research, Making Pregnancy Safer and Food Safety, Zoonoses and Foodborne Diseases.

<sup>3</sup> WHO. New data on the prevention of mother-to-child transmission of HIV and their policy implications. Conclusions and recommendations. WHO technical consultation on behalf of the UNFPA/UNICEF/WHO/UNAIDS Inter-agency Task Team on mother-to-child transmission of HIV. Geneva, 11-13 October 2000. Geneva, WHO 2001, WHO/RHR/01.28.

<sup>4</sup>UNFPA and WHO. The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children, 3-5 May 2004.

<sup>5</sup> Call to Action: Towards an HIV-free and AIDS-free Generation. Prevention of mother-to-child transmission high-level global partners forum, Abuja, Nigeria, December 3, 2005.

<sup>6</sup> For current guidance, please see documents and tools at [http://www.who.int/child-adolescent-health/NUTRITION/HIV\\_infant.htm](http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm); and Guidelines for the Safe Preparation, Storage and Handling of Powdered Infant Formula.

<sup>7</sup> In Côte d'Ivoire, non-exclusive breastfeeding included any other liquids or foods; in South Africa, it included non-human milks or other liquids, with or without solids; in Zimbabwe, it included feeding non-breast milk foods and liquids.

- Low maternal CD4+ count, high viral load in breast milk and plasma, maternal seroconversion during breastfeeding and breastfeeding duration were confirmed as important risk factors for postnatal HIV transmission and child mortality.
- There are indications that maternal HAART for treatment-eligible women may reduce postnatal HIV transmission, based on programme data from Botswana, Mozambique and Uganda; follow-up trial data on the safety and efficacy of this approach, and on infant prophylaxis trials, are awaited.

### **New evidence on morbidity and mortality**

- In settings where antiretroviral prophylaxis and free infant formula were provided, the combined risk of HIV infection and death by 18 months of age was similar in infants who were replacement fed from birth and infants breastfed for 3 to 6 months (Botswana and Côte d'Ivoire).
- Early cessation of breastfeeding (before 6 months) was associated with an increased risk of infant morbidity (especially diarrhoea) and mortality in HIV-exposed children<sup>8</sup> in completed (Malawi) and ongoing studies (Kenya, Uganda and Zambia).
- Early breastfeeding cessation at 4 months was associated with reduced HIV transmission but also with increased child mortality from 4 to 24 months in preliminary data presented from a randomized trial in Zambia.
- Breastfeeding of HIV-infected infants beyond 6 months was associated with improved survival compared to stopping breastfeeding in preliminary data presented from Botswana and Zambia.

### **Improving infant feeding practices**

- Improved adherence and longer duration of exclusive breastfeeding up to 6 months were achieved in HIV-infected and HIV-uninfected mothers when they were provided with consistent messages and frequent, high quality counselling in South Africa, Zambia and Zimbabwe.

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<sup>8</sup> HIV-exposed refers to children born or breastfed by women living with HIV.

## **New programme data**

- UN HIV and infant feeding guidance is available and increasingly used in policy-making in countries, but challenges in implementation remain.
- Coverage and quality of the full range<sup>9</sup> of interventions to prevent mother-to-child transmission of HIV, including those related to infant feeding counselling and support, is disturbingly low.
- Weak and poorly organized health services affect the quality of infant feeding counselling and support. Inaccurate, insufficient, or non-existent infant feeding counselling has led to inappropriate feeding choices by both HIV-infected and HIV-uninfected women.
- Scaling-up quality infant feeding counselling and support and related interventions needs sustained and strong commitment and support from international agencies and donors working in concert with Ministries of Health.
- The sharp increase in deaths from diarrhoea and malnutrition in non-breastfed infants and young children during a recent diarrhoeal disease outbreak in one country emphasizes the vulnerability of replacement-fed infants and young children, and the need for adequate follow-up for all infants.
- Increasing access to early infant diagnosis in the first months of life and to paediatric ARV treatment provides new opportunities for postnatal infant feeding assessment, counselling, and follow-up nutritional support.
- Multidisciplinary research, from basic science through clinical trial and operational research, is still needed on identified priority issues, including ways of making infant feeding options safer for HIV-exposed infants.

## **Recommendations:**

The following recommendations for policy-makers and programme managers are intended to supplement, clarify and update existing UN guidance and do

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<sup>9</sup> The full range of interventions includes: primary prevention of HIV infection in women; prevention of unintended pregnancies in women living with HIV; prevention of transmission from women living with HIV to their infants; and provision of care, treatment and support for women living with HIV and their families.

not replace it. Based on this consultation, a technical update of the relevant UN guidance will be forthcoming.

- The most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, including her health status and the local situation, but should take greater consideration of the health services available and the counselling and support she is likely to receive.
- Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.
- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.
- At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.
- Whatever the feeding decision, health services should follow-up all HIV-exposed infants, and continue to offer infant feeding counselling and support, particularly at key points when feeding decisions may be reconsidered, such as the time of early infant diagnosis and at six months of age.
- Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding.
- Governments and other stakeholders should re-vitalize breastfeeding protection, promotion and support in the general population. They should also actively support HIV-infected mothers who choose to exclusively breastfeed, and take measures to make replacement feeding safer for HIV-infected women who choose that option.
- National programmes should provide all HIV-exposed infants and their mothers with a full package of child survival and reproductive

health interventions<sup>10</sup> with effective linkages to HIV prevention, treatment and care services. In addition, health services should make special efforts to support primary prevention for women who test negative in antenatal and delivery settings, with particular attention to the breastfeeding period.

- Governments should ensure that the package of interventions referenced above, as well as the conditions described in current guidance<sup>11</sup>, are available before any distribution of free commercial infant formula is considered.
- Governments and donors should greatly increase their commitment and resources for implementation of the Global Strategy for Infant and Young Child Feeding and the UN HIV and Infant Feeding Framework for Priority Action in order to effectively prevent postnatal HIV infections, improve HIV-free survival and achieve relevant UNGASS goals.

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<sup>10</sup>See: WHO. Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants in resource-limited settings. Geneva, 2006; WHO. The World Health Report: Make every mother and child count. Geneva, 2005.

<sup>11</sup> See [http://www.who.int/child-adolescent-health/NUTRITION/HIV\\_infant.htm](http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm).