Implications of the new WHO guidelines on HIV and infant feeding for child survival in South Africa

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Abstract The World Health Organization released revised principles and recommendations for HIV and infant feeding in November 2009. The recommendations are based on programmatic evidence and research studies that have accumulated over the past few years within African countries. This document urges national or subnational health authorities to decide whether health services should mainly counsel and support HIV-infected mothers to breastfeed and receive antiretroviral interventions, or to avoid all breastfeeding, based on estimations of which strategy is likely to give infants in those communities the greatest chance of HIV-free survival. South Africa has recently revised its clinical guidelines for prevention of mother-to-child HIV transmission, adopting many of the recommendations in the November 2009 World Health Organization's rapid advice on use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. However, one aspect of the new South African guidelines gives cause for concern: the continued provision of free formula milk to HIV-infected women through public health facilities. This paper presents the latest evidence regarding mortality and morbidity associated with feeding practices in the context of HIV and suggests a modification of current policy to prioritize child survival for all South African children.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

In April 2010 the South African Department of Health and the National AIDS Council released revised clinical guidelines for the prevention of mother-to-child transmission of HIV (PMTCT).[1] These revised guidelines contain many promising changes including: highly active antiretroviral therapy (HAART) for all HIV-infected pregnant women with CD4 counts of ≤ 350 cells/μl; 6 weeks of antiretroviral (ARV) prophylaxis with nevirapine for all HIV-exposed infants; continued infant nevirapine prophylaxis until 1 week after complete cessation of breastfeeding for HIV-exposed breastfed infants whose mothers are not on HAART; and HAART for all confirmed HIV-positive infants from as early as 6 weeks of age. These changes provide the opportunity for South Africa to get back on track towards meeting the United Nations Millennium Development Goals 4, 5 and 6 through significant reductions in HIV transmission and mortality.

While these new guidelines are to be welcomed, one aspect is somewhat disappointing. This concerns the issue of infant feeding in the PMTCT programme. The new guidelines recommend the continued provision of free formula milk through public health facilities for women opting not to breastfeed (Box 1). This policy comes 5 months after the World Health Organization's (WHO) revised principles and recommendations for HIV and infant feeding were released in November 2009.[2] A key WHO recommendation is that national or subnational health authorities estimate which feeding strategy is likely to provide the greatest chance of HIV-free survival for infants based on several factors, including background levels of infant mortality and the leading causes of infant mortality. Authorities should then decide whether health services should mainly counsel and support HIV-infected mothers to breastfeed and receive ARVs, or instead avoid all breastfeeding.

WHO's recommendations are based on accumulated programmatic evidence and research conducted over the past few years in African countries. In keeping with these recommendations, the new South African PMTCT guidelines state that the programme adopt an approach to infant feeding that maximizes child survival and not only the avoidance of HIV transmission. However, it appears that no determination has been made about which feeding practice will maximize HIV-free survival nationally. A choice between two feeding options (exclusive breastfeeding or exclusive feeding with free formula milk) is still recommended. The continued provision of free commercial infant formula is an incentive that can cloud feeding decisions. Research from South Africa[3] has already shown that women are opting for formula feeding despite not meeting WHO AFASS (acceptable, feasible, affordable, sustainable and safe) conditions.

This paper presents the latest evidence regarding mortality and morbidity associated with feeding practices in the context of HIV infection and highlights the lack of a clear infant feeding policy for South Africa in the context of changing evidence. It questions the ongoing provision of free formula milk through the public health system and recommends a change in policy that prioritizes child survival for all South African children.

Benefits of breastfeeding

The single most effective intervention to save the lives of millions of young children in developing countries is the promotion of exclusive breastfeeding.[4] Approximately 1.3 million child deaths per year (13% of deaths of children aged less than 5 years) could be prevented if universal coverage of exclusive breastfeeding were increased to 90% among infants aged less than 6 months.[4] Compared with the use of breast-milk substitutes, breastfeeding has been consistently shown to reduce infant morbidity and mortality associated with infectious diseases in both resource-rich

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(*Submitted: 25 May 2010 – Revised version received: 7 July 2010 – Accepted: 9 July 2010 – Published online: 22 November 2010*)

and resource-poor settings, particularly in the first months of life. The Bellagio Child Survival Group summarizing accumulated international research evidence states: "Infants aged 0–5 months who are not breastfed have seven-fold and five-fold increased risks of death from diarrhoea and pneumonia respectively, compared with infants who are exclusively breastfed. At the same age, non-exclusive rather than exclusive breastfeeding results in a more than two-fold increased risk of dying from diarrhoea and pneumonia."[5] Recent estimates of proportional causes of under-5 mortality in South Africa put diarrhoea and pneumonia third and fourth respectively – behind HIV/AIDS and neonatal causes.[6] Moreover, most deaths of HIV-infected children are due to supervening infections, most commonly diarrhoea and pneumonia.

Formula feeding

Over the past several years, evidence has been accumulating from Africa on the increased mortality associated with formula feeding in various PMTCT research studies. The MASHI study in Botswana[7] was a randomized controlled trial that compared the efficacy of exclusive breastfeeding combined with a course of 6 months of infant zidovudine (ZDV) prophylaxis versus formula feeding combined with 1 month of infant ZDV. Cumulative HIV transmission rates at 7 months were 5.6% in the formula-fed group and 9.0% in the breastfed plus ZDV group. The cumulative incidence of infant death by month 7 was significantly higher in the formula-fed group than in the breastfed plus ZDV group (9.3% versus 4.9%; $P = 0.003$). This supports earlier findings from Kenya of increased early mortality among formula-fed infants.[8,9] However, in the MASHI study, by 18 months there were no significant differences between the formula-fed and breastfed plus ZDV group in the combined outcome of HIV infection or mortality (13.9% versus 15.1%; $P = 0.60$). Both strategies therefore resulted in comparable HIV-free survival at 18 months.

Evidence of the dangers of formula feeding in non-research settings have also been documented in Botswana. Between November 2005 and February 2006 there were unusually heavy rains and flooding which led to an increase in infant diarrhoea incidence and mortality. The United States Centers for Disease Control and Prevention was brought in to investigate the outbreak. It found widespread contamination of the public water supply in four northern districts of the country. The most significant risk factor for diarrhoea was not breastfeeding (adjusted odds ratio, AOR: 50; 95% confidence interval, CI: 4.5–100). Most of the deaths were among HIV-exposed infants whose mothers were receiving free formula milk through the PMTCT programme. Among hospitalized infants, 51% had poor growth before the illness.[10] Recent evidence from Malawi has also found that not being breast-fed was significantly associated with declines in nutritional status as evidenced by decreased mean length-for-age, weight-for-age and weight-for-length *z*-scores.[11]

In South Africa, research from routine PMTCT sites has found that an inappropriate choice to formula feed (without WHO AFASS conditions being met) carries a greater risk of HIV transmission or death than breastfeeding.[3] In another study from the predominantly rural district of Hlabisa, Kwa-Zulu Natal, South Africa, cumulative 3-month mortality in exclusively breastfed infants was 6.1% (95% confidence interval, CI: 4.74–7.92) versus 15.1% (95% CI: 7.63–28.73) in infants given replacement feeds (hazard ratio: 2.06, 95% CI: 1.00–4.27, $P = 0.051$),[12] despite the fact that the women opting not to breastfeed were of higher socioeconomic status. By 18 months of age, the probability of survival was not significantly different for HIV-uninfected infants, whether they were breastfed or formula-fed from birth, despite these mothers and infants receiving excellent support to make and practice appropriate infant feeding choices.[13] Therefore, as in the MASHI study, the avoidance of breastfeeding incurred no survival gain for these infants.

A small study in South Africa that assessed contamination of milk bottles at clinics and in the home found high levels of contamination with faecal bacteria (67% of clinic samples and 81% of home samples). The study also found evidence of poor formula preparation with over-dilution occurring among 28% of clinic samples and 47% of home samples.[14] In Botswana and South Africa, the supply of formula through public health facilities is frequently unreliable.[10,15]

Box 1. **Infant feeding recommendations in the 2010 South African clinical guidelines on prevention of mother-to-child HIV transmission**[1]

For all mothers:

- Counselling on infant feeding must commence after the first post-test counselling session in pregnancy.
- Infant feeding should be discussed with women at every antenatal visit.
- Mixed feeding during the first 6 months of life should be strongly discouraged as it increases the risk of childhood infections.
- Provide nutritional support for ALL breastfeeding HIV-positive mothers and for formula-feeding mothers with food insecurity.

Breastfeeding HIV-positive women:

- All mothers who are known to be HIV-infected either on lifelong ART or not, who exclusively breastfeed their infants should do so for 6 months, introduce appropriate complementary foods thereafter and continue breastfeeding for the first 12 months of life.
- Trained health-care personnel should provide high quality, unambiguous and unbiased information about risks of HIV transmission through breastfeeding, ART prophylaxis to reduce this risk, and risks of replacement feeding.
- Mothers who are known to be HIV-infected, and not on lifelong ART, who decide to stop breastfeeding at any time should do so gradually during one month while the baby continues to receive daily NVP and should continue for one week after all breastfeeding has stopped.

Formula feeding HIV-positive women:

- Free commercial infant formula will be provided to infants for at least 6 months.
- Women should receive practical support, including demonstrations on how to safely prepare formula and feed the infant.
- At 6 months of age, infants with – or at risk of – poor growth should be referred for continued nutritional monitoring and dietary assistance.
- An appropriate formula milk product for the infant's age and circumstances should be chosen.
- In cases in which commercial formula is provided free of charge at health facilities, managers, supervisors and health care personnel should ensure an uninterrupted supply at clinic level. A reliable procurement and distribution system should be put in place.

ART, antiretroviral treatment.

The South African PMTCT guidelines recommend that every antenatal visit include counselling on infant feeding (Box 1), yet several studies in South Africa have found that the quality of this counselling is poor[16–18] and that AFASS conditions are not taken into account.[3] In the context of weak counselling and unclear messages, availability of free formula provides an incentive to choose this option, even when it is not appropriate, since free formula might be viewed as a cash transfer to poor households.

The provision of free commercial infant formula through the public health system may also reinforce the common practice of mixed feeding in the general population, i.e. among HIV-negative women.[19] Data from the Good Start cohort study in South Africa show that formula use among HIV-negative women was significantly higher than formula use among breastfeeding HIV-positive women at all measured time points.[20] Key principle 7 in the WHO *Guidelines on HIV and infant feeding 2010* states that counselling and support to mothers known to be HIV-infected, and health messaging to the general population, should be carefully delivered so as not to undermine optimal breastfeeding practices among the general population.[21]

Cost of feeding options

A recent analysis undertaken for WHO for southern African countries found that the cost per 10 000 HIV-positive mothers would be US$ 522 542 with the option of breastfeeding plus maternal HAART for women with a CD4 count ≤ 350 or breastfeeding with infant nevirapine prophylaxis for women with a CD4 count > 350. In comparison it would cost US$ 2 063 100 per 10 000 HIV-positive mothers provided with maternal HAART and 6 months of formula milk for women with a CD4 count ≤ 350 or for 6 months of formula milk for women with a CD4 count > 350.[21] The study concluded that "any feeding strategy that includes free provision of infant formula to HIV-infected mothers, even for a limited period of 6 months, is between two and six times more costly than a strategy that provides ARVs as prophylaxis to reduce postnatal transmission. The costing model took a conservative approach to the cost of providing infant formula with likely underestimates of staff time required to dispense and counsel on formula feeds and the storage costs of tins of formula milk."[21] Furthermore, the costing did not include nutritional support to breastfeeding mothers to provide mothers with the extra nutrients needed for breastfeeding.[22,23]

A new addition in the recently released South African PMTCT clinical guidelines[1] is the provision of nutritional support to HIV-positive mothers. However this support is due to be given to both breastfeeding HIV-positive mothers and formula-feeding mothers with food insecurity (Box 1). It is not clear from the guidelines how food insecurity among formula-feeding mothers will be determined but this option is by far the most expensive (provision of free formula and nutritional support) and is likely to be taken up inappropriately without very clear implementation plans.

More harm than good?

There are encouraging new data that ARV regimens, when given as prophylaxis to the infant, can reduce postnatal HIV transmission to around 5% at 9 months.[24,25] Mothers who receive effective ARVs also appear to be at low risk of HIV transmission, with studies reporting transmission rates of around 5% at 12 months postpartum.[26,27] When ARVs are given to infants as prophylaxis during breastfeeding or as HAART to mothers, the risk of excess mortality from non-HIV causes among uninfected children takes on greater significance, because even small elevations can counteract the now-reduced HIV transmission risk.

In light of the above, and the new clinical PMTCT guidelines in South Africa, an important consideration for the national government is whether the reduction in HIV transmission through avoidance of breastfeeding outweighs the accompanying risks from infectious disease mortality. The latest evidence suggests that, in the context of HAART provision for HIV-positive women or ARV prophylaxis to breastfeeding infants, avoidance of breastfeeding leads to worse outcomes. In the MASHI study in Botswana the combined outcome of HIV-uninfected child deaths or HIV transmission from birth to 6 months was approximately half in the breastfed plus ARVs group compared with the formula-fed group.[28]

One feeding strategy

The thrust of the new WHO guidelines for HIV and infant feeding is that countries should choose one infant-feeding strategy that health services can advise for HIV-positive mothers. In South Africa, exclusive breastfeeding with ARV interventions is an appropriate option since, with its socio-demographic pattern and urban–rural inequities, the majority of the population would not meet the new WHO AFASS criteria for formula feeding.[2] The recent South African Demographic and Health Survey found that access to piped water into a dwelling was 58% for urban residents and 11% for rural residents, 87% of urban residents and 56% of rural residents used electricity for cooking and 74% of urban residents and 5% of rural residents had a flush toilet.[29]

In South Africa, improving exclusive breastfeeding practices is a major challenge as we have one of the lowest rates in the world. The most recent Demographic and Health Survey found that only 8% of infants aged less than 6 months were exclusively breastfed.[29] The reasons for this low rate are complex but almost certainly include longstanding cultural practices, the support of formula milk through the government protein-energy malnutrition scheme,[30] the lack of promotion of breastfeeding due to high HIV prevalence and the provision of free formula milk through the PMTCT programme. Although the recent Human Sciences Research Council national survey report quotes higher exclusive breastfeeding rates (25%), the validity of this data is questionable due to the long recall period and the lack of in-depth feeding questions.[19]

The current policy of presenting HIV-positive women with two "equivalent" options is likely to have contributed to the confusion among both mothers and health workers.[31] Furthermore, the latest evidence presented here establishes that the two options are not equivalent with regard to HIV-free survival of infants. Moving to one fully-supported policy of exclusive breastfeeding will therefore help to reduce confusion and lead to the greatest child survival benefit for the total child population, the majority of whom are not exposed to HIV.

Recommendations

In light of the recent WHO guidelines on HIV and infant feeding,[21] we urge the South African government to decide upon one single infant-feeding practice that will be promoted and supported in general and in particular among HIV-positive women attending public health

facilities. The data presented in this paper and in the recent WHO principles and recommendations[21] support exclusive breastfeeding with ARV prophylaxis. The government should subsequently embark on a gradual process of withdrawing the provision of free infant formula milk as part of the PMTCT programme. This approach does not imply that exclusive breastfeeding is necessarily the most appropriate feeding option for all HIV-positive women in South Africa, given the vast differences in socio-economic status between populations, rural and urban areas and provinces. However, exclusive breastfeeding is an important child-survival strategy in South Africa even among HIV-positive women.

There is still a role for individualized counselling and clear guidelines should be provided on how to identify those women who could avoid breastfeeding. The latest WHO principles and recommendations on HIV and infant feeding[21] define very specifically what is meant by AFASS using common everyday language and outlining six conditions that should be met to make an appropriate decision to formula feed. In these cases, women should be given the choice to purchase formula supplies for their infant, thus eliminating any perverse incentives from within the health services.

A process of formula withdrawal would need to be phased-in and should be accompanied by a vigorous and clear literacy campaign to inform health workers and mothers of the changes in the policy and the reasons and benefits thereof. This will reduce the possibility for further confusion and mixed messages. A similar process was undertaken by the United Nations Children's Fund (UNICEF) in 2002 when a decision was made to withdraw the provision of free formula milk to UNICEF-supported PMTCT pilot sites across Africa.[32] In some countries, distribution of free formula continued for a further year to avoid abrupt cessation of milk supply to those children already in the programme.[32]

A technical group should be convened to work together with the Department of Health to develop a plan for withdrawal of free commercial infant formula, together with a high-level intensive plan to increase rates of exclusive breastfeeding, and to refine strategies or tools that could be used to identify the few women who may "opt out" of breastfeeding. This group needs to monitor the effect of this policy, especially the effect of opting out of breastfeeding, on long-term survival and morbidity in mothers and infants.

Conclusion

The revised South African clinical PMTCT guidelines provide an opportunity to rapidly reduce postnatal HIV transmission by providing ARVs for women who need them and for infants during breastfeeding. Urgent action is needed so that exclusive breastfeeding with ARV prophylaxis is presented as the default feeding option to HIV-positive women. Clear guidelines must be developed to identify those women who are an exception to this default option. The provision of free commercial infant formula milk should be phased out after community-based advocacy activities so that it does not remain a perverse incentive that could negate the child survival gains of the new guidelines. An opportunity is now presented to move beyond a focus on HIV prevention to a focus on child survival through vigorously promoting the practice of exclusive breastfeeding. ■

Competing interests: None declared

الملخص

تأثير الدلائل الإرشادية الجديدة لمنظمة الصحة العالمية عن فيروس العوز المناعي البشري وتغذية الرضّع على بقاء الأطفال على قيد الحياة في جنوب أفريقيا

أصدرت منظمة الصحة العالمية مبادئ وتوصيات جرى مراجعتها حول فيروس العوز المناعي البشري وتغذية الرضّع في تشرين الثاني/نوفمبر 2009. وترتكز التوصيات على البيّنات البرنامجية والدراسات البحثية التي تراكمت خلال السنوات القليلة الأخيرة في بلدان أفريقيا. وتحثّ هذه الوثيقة السلطات الصحية الوطنية ودون الوطنية على اتخاذ القرار في شأن قيام الخدمات الصحية على نحو رئيسي بتقديم المشورة والدعم للأمهات المصابات بفيروس العوز المناعي البشري لإرضاع أطفالهن من الثدي وتلقي التدخلات المضادة للفيروسات القهقرية، أو التجنب التام للإرضاع من الثدي، وذلك بالاستناد إلى التقديرات حول أي استراتيجية منهما ستسعى على الأرجح لإعطاء الرضّع في تلك المجتمعات أفضل فرصة لعدم إصابتهم بفيروس العوز المناعي البشري. وقد راجعت مؤخراً جنوب أفريقيا دلائلها الإرشادية لتوقي انتقال العدوى بفيروس العوز المناعي البشري من الأم لطفلها، وتبنت جنوب أفريقيا الكثير من التوصيات المندرجة في النصيحة السريعة المقدمة من منظمة الصحة العالمية في تشرين الثاني/نوفمبر 2009 حول استخدام الأدوية المضادة للفيروسات القهقرية لمعالجة النساء الحوامل وتوقي إصابة الرضّع بالعدوى بفيروس العوز المناعي البشري. إلا أن إحدى سمات الدلائل الإرشادية الجديدة لجنوب أفريقيا تتسبب في إثارة القلق: وهي الاستمرار في تقديم الألبان الصناعية المجانية للأمهات المصابات بفيروس العوز المناعي البشري عن طريق مرافق الصحة العمومية. وتعرض هذه الورقة آخر بيّنة حول الوفيات والمراضة المتعلقتين بممارسات تغذية الرضّع في سياق فيروس العوز المناعي البشري، وتقترح الورقة إجراء تعديل للسياسات الحالية لإعطاء الأولوية لبقاء الأطفال على قيد الحياة في جنوب أفريقيا.

摘要

WHO《感染艾滋病毒情况下婴儿喂养》新指南对南非儿童生存意义

世界卫生组织于2009年11月公布了《感染艾滋病毒情况下婴儿喂养》的修订原则和建议。这些建议是基于证据和非洲国家过去几年累积的研究成果。这份文件呼吁国家或地区级卫生当局，应基于哪一策略有可能让这些社区的婴儿有最高的存活率并且无艾滋病病毒感染，来决定提供卫生服务时建议并支持感染艾滋病毒的母亲进行母乳喂养并接受抗逆转录病毒干预或者建议避免采用任何方式的母乳喂养。南非最近修改了其预防艾滋病母婴传播的临床指南，采纳了2009年11月世界卫生组织很多关于对孕妇使用抗逆转录病毒药物和防止婴儿感染艾滋病毒的建议。然而，南非新指南其中一个方面令人关注，即继续通过公共卫生机构为感染艾滋病毒的母亲提供免费的配方奶粉。本文展示了艾滋病毒感染情况下婴儿喂养方式相关的死亡率和发病率的最新证据，并建议对现行政策进行修改以优先考虑所有南非儿童的生存情况。

Résumé

Implications des nouvelles lignes directrices de l'OMS relatives au VIH et à la nutrition infantile sur la survie des enfants en Afrique du Sud

L'Organisation mondiale de la Santé a publié des recommandations et des principes révisés pour le VIH et la nutrition infantile en novembre 2009. Ces recommandations reposent sur des preuves programmatiques et des études de recherche rassemblées ces dernières années dans des pays africains. Ce document conseille vivement aux autorités sanitaires nationales ou sous-nationales de décider si leurs services de soins de santé doivent essentiellement soutenir et encourager les mères séropositives à allaiter et à recevoir des traitements antirétroviraux, ou à éviter l'allaitement au sein, selon les estimations de la meilleure stratégie à adopter pour augmenter les chances de survie sans VIH des nourrissons de ces communautés. L'Afrique du Sud a récemment révisé ses lignes directrices cliniques en matière de prévention de la transmission VIH mère enfant, en adoptant les conseils rapides de novembre 2009 de l'Organisation mondiale de la Santé relatives à l'utilisation des antirétroviraux pour le traitement des femmes enceintes et la prévention de la transmission du VIH aux enfants. Toutefois, l'un des aspects que présentent ces nouvelles lignes directrices sud-africaines est préoccupant. Il s'agit de la distribution permanente et gratuite de lait infantile aux femmes séropositives dans les centres de santé publics. Cet article présente les derniers éléments probants en matière de mortalité et de morbidité associées à ces pratiques nutritionnelles dans le contexte du VIH et suggère une modification de la politique actuelle de façon à placer la survie de tous les enfants sud-africains au cœur de ses priorités.

Резюме

Последствия применения новых рекомендаций ВОЗ по ВИЧ и вскармливанию детей грудного возраста для выживания детей в ЮАР

В ноябре 2009 г. Всемирная организация здравоохранения выпустила новую редакцию принципов и рекомендаций по вскармливанию детей грудного возраста в контексте ВИЧ. Рекомендации основаны на материалах научных исследований и опыте осуществления программ, накопленном за последние годы в странах Африки. Этот документ призывает национальные или субнациональные органы здравоохранения определиться в отношении того, ориентировать ли медико-санитарные службы в основном на консультирование и оказание поддержки ВИЧ-инфицированным матерям при осуществлении грудного вскармливания и получении антиретровирусной терапии, или полностью отказаться от грудного вскармливания, опираясь на оценку того, какая из этих стратегий способна дать детям грудного возраста в этих сообществах наилучшие шансы для выживания и предотвращения заражения ВИЧ-инфекцией. Недавно в ЮАР пересмотрены национальные клинические рекомендации по предотвращению передачи ВИЧ-инфекции от матери к ребенку; при этом в них включены многие рекомендации ноябрьского (2009) документа Всемирной организации здравоохранения о неотложном консультировании в отношении использования антиретровирусных препаратов для лечения беременных женщин и профилактики передачи ВИЧ-инфекции детям грудного возраста. Вместе с тем, один из аспектов применяемых в ЮАР новых рекомендаций является предметом озабоченности, а именно продолжение бесплатной выдачи ВИЧ-инфицированным матерям сухих молочных смесей в государственных медицинских учреждениях. В настоящей статье представлены новейшие данные, касающиеся смертности и заболеваемости, связанных с практиками вскармливания, в контексте ВИЧ, и рекомендуется изменить текущую политику с тем, чтобы выдвинуть на передний план общенациональную задачу обеспечения выживания детей.

Resumen

Consecuencias de las nuevas directrices de la OMS sobre el VIH y la lactancia para la supervivencia infantil en Sudáfrica.

La Organización Mundial de la Salud publicó en noviembre de 2009 una revisión de sus principios y recomendaciones relacionados con el VIH y la lactancia. Las recomendaciones se basan en evidencias sistemáticas y en estudios de investigación que se han realizado en los últimos años en el continente africano. Este documento insta a las autoridades sanitarias nacionales o regionales a decidir con carácter urgente si los servicios sanitarios deben asesorar y apoyar a las madres con el VIH para que den el pecho a sus bebés y reciban tratamientos con antirretrovíricos, o si deben evitar cualquier tipo de lactancia materna, en función de las estimaciones sobre qué estrategia permitirá que los lactantes de esas comunidades tengan más posibilidades de sobrevivir sin contagiarse con el VIH. Sudáfrica acaba de revisar sus directrices clínicas para evitar que las madres transmitan el VIH a sus hijos, adoptando muchas de las recomendaciones incluidas en la orientación de noviembre de 2009 de la Organización Mundial de la Salud sobre el uso de antirretrovíricos para el tratamiento temprano de embarazadas y para evitar que los niños de pecho se contagien con el VIH. No obstante, un aspecto de las nuevas directrices sudafricanas resulta especialmente preocupante: el suministro continuado, a través de los sistemas de salud públicos, de leche de inicio gratuita para las mujeres infectadas por el VIH. Este artículo presenta los últimos datos relacionados con la mortalidad y la morbilidad asociadas a la lactancia en los casos de madres con VIH y sugiere una modificación de la política actual para dar prioridad a la supervivencia infantil de todos los niños sudafricanos.

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