# Infant Feeding in Resource Poor Countries in the face of HIV/AIDS:

*Lessons Learnt*

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Studies have long confirmed that HIV transmission from mother to child can take place intrapartum and postpartum, transmission can take place during pregnancy , during labor and during breastfeeding. BPNI is deeply concerned to improve infant and young child nutrition and to alleviate all forms of malnutrition in India as it affects almost half of babies under three, through improving breastfeeding. While considering policy options for infant feeding in communities in poor countries like India, several issues emerge, and we make an attempt to highlight those here.

The Breastfeeding Promotion Network of India (BPNI) was established in the year 1991 and works to protect, promote and support breastfeeding in India and South Asia. Training of health care providers has been BPNI's major area of work and so is the implementation and compliance with the International Code of Marketing of Breast-Milk Substitutes. Concerned over the HIV situation in India BPNi developed its position statement on HIV in 1999 and revised it in the year 2000 wherein it respects the two major principles , one truly informed choice and application of the Code. It is our ongoing effort to provide technical assistance to several organizations. I was privileged to be invited to be in a panel discussion " Lessons learnt in HIV prevention from Mother to Child Transmission at the International Conference on HIV and ADIS Mumbai 16-19 Dec.2001

The moderator Dr. P. Gurnani from UNICEF shared the results of the study undertaken by the UNICEF and National AIDS Control Organization (NACO) to assess to what extent it had been possible to implement the concept of informed choice in the context of a national programme to prevent mother to child transmission.

This study involved counsellors, mothers and their families. Results showed that 19% women chose to breastfeed, 81% to artificial feeding and he described that the process of information and choices had some bias towards artificial feeding. Further he also showed that among those who chose to give artificial feeding , more than half of them faced economic problems. Although these counsellors knew that women were meant to make informed choices regarding infant feeding, they themselves thought that artificial feeding was the preferred method of alternate feeding to reduce PMTCT, which created a counselling bias. Families were largely poor and illiterate and artificial feeding was not affordable, feasible and sustained for all and nor safe for all infants.

The panel comprised of several renowned panelists form these five centers where the study was undertaken .Each panelist was asked about most crucial lessons learnt. Only relevant to breastfeeding are given here.

*Observations on choice of infant feeding*

During the panel discussion following pertinent observations were made,

- Most mothers who chose artificial feeding returned to mixed feeding in a few days time due to social or economic pressures.
- At least in one center in Bangalore most mothers chose to breastfeed.

*On use of drugs during neonatal period*

During the panel discussions, regarding use of drugs in MTCT and follow up of newborn babies following data/information was shared with the group.

***a.*** HIVNET 023 trails (Oct 2001) have shown that *Nivarapine* could be used in infants for Prophylaxis 0-24 weeks, with single 200 mg tab at labour (onset), which HIV-1 pregnant women self administer and breastfeeding infants born to these mothers were randomized to 3 groups,

once weekly, twice weekly and daily, it was found that daily or twice a weekly dose was effective in building a target trough concentration for the drug *Nivarapine.*

*What information should be provided during antenatal period?*

It is well known that risk of transmission increases with the occurrence of oral thrush in the baby and mastitis. To prevent this from happening it is quite critical to support mothers for good management of lactation , which entails:

- Proper attachment / position for sucking of the baby at the breast
- Frequent emptying of the breast
- Prevention of sore / cracks nipples
- Prevention of engorgement / mastitis

**This would need counseling by trained breastfeeding counselors to *at risk* mothers.**

Components of counselling and Information package should include

*HIV counseling should include*

- Use of condoms during lactation period
- Prompt treatment of any breast problem
- Prompt treatment of thrush in baby's mouth

*Breastfeeding counseling should include:*

– Information about benefits and risks of infant feeding options, Additional advantages of exclusive breastfeeding – child health and survival, colostrum

- Guidance to select the most suitable option.
- Support if women choose to breastfeeding – to be able to practice exclusive breastfeeding for six months
- Explain the risk of artificial feeding including
    1. Higher risk of infant morbidity and mortality
    2. Risk of another pregnancy – another HIV+ve
    3. Economic impact of using infant formula
    4. Ensuring safe water supply and
    5. Ensuring sufficient supplies of formula

**Informed choice**

Mothers should be informed of advantages and disadvantages of each option and fully supported in their decisions and assisted and properly counseled. Counseling should be proper not an advice only as poor compliance to such advice would lead to "mixed feeding" which is not the best option. And all women have the right to proper information. Proper and adequate training would be required to lead to good counselling.

***If we advocate for choice of AF to HIV+ mothers***

The risk of replacement feeding should be less than the potential risk of HIV through breastfeeding, for it to be advocated as an alternative choice. It should not lead to increased number of overall deaths in infants and young children.

In the above mentioned study, in at least one of the hospitals infant formula was given free which also contributed to choice artificial feeding according to the counselors. The infant formula industry's solution that "free infant formula " could be solution to the problem in fact makes it a dilemma for the poor people as money is not only spent on the formula, but other process as well. How long can free formula be sustained before it starts building up an economic pressure, which makes it impossible for poor people to continue and resort to mixed feeding.

***The issue of hygiene*** is another factor. Most mothers who cannot afford formula are not expected to follow the hygienic standards. Who will educate the mothers about safe artificial feeding? Are we going to depend on health care providers, who have little time and willingness to educate women about safer ways of feeding including cup feeding? It seems that choice of artificial feeding would actually lead to increased

rates of mixed feeding and eventually increased transmission of HIV and more deaths.

The dangers of ***stigmatization for mothers*** who do not breastfeed from birth may also be great to affect cultural trust.

While considering artificial feeding, '***spillover' effects*** to the community should also be taken into account.

***Misinformation by inadequately informed media*** is another factor, which destroys breastfeeding as scary news about breastfeeding to a causative factor are flashed. It happened once in Delhi when an afternoon paper flashed a headline, "Breastfeeding causes AIDS" and on contacting them the reporter was not even ready to listen, under the compulsion of preparing another news story. And those who do opt or start to artificially feed are more likely to be turning to mixed feeders in such settings, which have higher risk of transmission.

If we could ensure safe, nutritionally adequate breastmilk substitutes with uninterrupted access; it could be assumed to lead to less risk of illness and death. *The* WHO Report on meta-analysis of the studies conclude, " it will be difficult if not impossible to provide safe Breastmilk substitutes to children from the underprivileged populations"

Since the most of worlds infants are mixed fed; the challenge, therefore is to **reduce mixed feeders in order to increase exclusive breast feeders**, as the risk is less with exclusive breastfeeding than mixed feeding and with additional benefits of exclusive breastfeeding promotion. There is a need to weigh the risks with both options Exclusive breastfeeding for first six months or total artificial feeding. Benefits of exclusive breastfeeding to babies have been established beyond doubt and are possibly more when the poverty levels are higher. It almost guar antees a baby's survival.

**Key issues**

The issues emerging here are :

1. **Health workers skills** and willingness, knowledge, realization of importance of avoiding artificial/bottle feeding,
2. Avoidance of spillover of AF
3. **Conflict of interest** at the research and conferences. The studies, which should be projected properly, are often not. Some studies enjoy more support because of the conflict of interest, which is often not being highlighted at these forums.

**What is BPNI's position?**

- Promote exclusive breastfeeding for all infants for first six months and continued breastfeeding for two years along with appropriate complementary feeding.
- HIV+ve women should be well informed and supported in their decisions, by trained, unbiased or `independent' health worker.
- The policy on HIV should respect the National legislation to protect breastfeeding and the International Code and World Health Assembly Resolutions.

**Recommendations for potential interventions**

1. Treatment of breastmilk – HIV-1 inactivation
2. Exclusive breastfeeding <6 months or more – continued study and impact of different modes of feeding choices.
3. Effect of medications: maternal antiretroviral and neonatal and early infancy prophylaxis
4. Conferences and research should declare conflict of interest if any of the speakers and researchers. Any connections to the Baby food industry and ARV Drugs should be made public.