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HIV and formula milk policy revisited

HIV, infant feeding, and implementation failure: advancing policies for women with HIV infection and attaining the Millennium Development Goals

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Coutsoudis et al. 1 offer a viewpoint on the WHO guidelines on HIV and infant feeding that suggests that the use of infant formula among HIV-positive women in the developing world is, to a large extent, currently untenable. The article has many valid arguments: it is well known that promotion of formula feeding among HIV-positive women within the context of inadequate community support, unreliable formula supply and contaminated drinking water can result in excess infant mortality. 2 However, empirical data exist that counter some of the authors’ views. It has been demonstrated that formula feeding among HIV-positive women in a context with counselling support and education, access to clean water and uninterrupted availability of breast-milk substitutes can offset the risk of infant mortality. In Côte d’Ivoire, there were no differences in risks of diarrhoea, respiratory infection, malnutrition, hospitalization or death in breastfed versus formula-fed infants of HIV-positive women. The authors of this study suggest that offering safer conditions (clean water, free formula) and a more supportive environment (replacement feeding counselling and education) were elements that reduced the potential threat of mortality among formula-fed infants. These findings were sustained after a two-year follow-up period. 3
With safe formula feeding, the vertical HIV transmission rate can be reduced to less than 2%; this is an attainable goal in a resource-limited setting as indicated by results from a preliminary study in Rwanda.\textsuperscript{4} In addition to a low transmission rate, the mortality rate reported was modest (21/1000 person-years) among those infants enrolled at birth in the Inshuti Mu Buzimana prevention of mother-to-child transmission programme in rural Rwanda that were offered free formula, materials, education and support through community health workers.

Evidence from South Africa offers a more complex picture of infant feeding outcomes in the context of HIV. There, formula feeding demonstrated a protective effect on HIV transmission/death among those living in households with piped water [hazard ratio (HR) = 0.51; 95% confidence interval (CI): 0.31–0.84]. Among those who had piped water and fuel and who disclosed their HIV status, the protective effect of formula was greater (HR = 0.32; 95% CI: 0.16–0.62). However, among women who did not have piped water or fuel and did not disclose their HIV status, formula feeding conferred an increased risk of HIV transmission/death by 3.5 fold (HR = 3.45; 95% CI: 1.89–6.32).\textsuperscript{5} These findings suggest that contextual factors are critical when considering the appropriate feeding option for HIV-positive women in resource-poor settings, indicating that in some settings the provision of formula would result in increased child mortality as Coutsoudis et al.\textsuperscript{1} argue.

However, these findings also suggest that aggressive measures to improve water quality and access to other resources may reduce the risk of child mortality associated with provision of infant formula. In fact, improving access to potable water may be the most critical element in offering safe feeding alternatives to HIV-positive women with infants in developing countries and should not be considered an unattainable goal. One of the eight Millennium Development Goals (MDGs) is to “ensure environmental sustainability” (Goal 7) and one of the targets is to “reduce by half the proportion of people without sustainable access to safe drinking water”.

Although addressing the global water crisis may not be immediate, as indicated by the MDGs, targets for improving access to potable water must be set and attained for the near future. One should not lose sight of the fact that progress has been made in the past 20 years: since 1990 approximately 1.6 billion people have gained access to safe drinking water. During this period, the child mortality rate for developing countries declined from 103 to 80/1000 live births, suggesting improvement with respect to MDG Goal 4 of reducing child mortality.\textsuperscript{6} Therefore,
despite the suggestion that “poverty is not easily or quickly reversed”¹, a positive, goal-directed outlook can offer results more quickly.

If programmes reducing mother-to-child transmission of HIV through formula feeding are deemed not feasible in a large majority of settings throughout the developing world, thousands of infants will continue to die due to the presumed inability to offer access to clean drinking water and a safe environment for formula feeding. However, in settings where women are offered a safe and supportive environment, the potential for child mortality can be offset and the risk of HIV transmission can be dramatically reduced. The fight against HIV/AIDS can serve as an entry point to demonstrate to families in remote areas that access to clean water and reduction in HIV transmission as well as child mortality are attainable goals as we work collectively towards reaching the MDGs.

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