FACT SHEET
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New guidance on prevention of mother-to-child transmission of HIV and infant feeding in the context of HIV

2010 guidelines on antiretroviral drugs for treating pregnant women and preventing HIV infections in infants

- Since WHO issued revised guidelines in 2006, important new evidence has emerged on the use of antiretroviral (ARV) prophylaxis for the prevention mother to child transmission of HIV (PMTCT), and on safe feeding practices for HIV-exposed infants.

- At AIDS 2010, WHO is releasing new guidelines on PMTCT and infant feeding practices. If widely implemented, these guidelines will provide the basis for more effective PMTCT interventions in resource-limited settings, and will virtually eliminate the number of new paediatric HIV infections. For the first time, the elimination of mother-to-child transmission of HIV (MTCT) is considered a realistic public health goal.

- The PMTCT and infant feeding guidelines were developed in coordination with the new WHO guidelines on adult and adolescent ART and paediatric ART.

Key recommendations

- The key recommendations of the new guidance on ARV drugs for treatment of pregnant women and prevention of HIV in infants are as follows:

  - Earlier antiretroviral therapy (ART) for a larger group of HIV-positive pregnant women to benefit both the health of the mother and prevent HIV transmission to her child during pregnancy and breastfeeding.

  - Longer provision of antiretroviral (ARV) prophylaxis for HIV-positive pregnant women with relatively strong immune systems who do not need ART for their own health. This would reduce the risk of HIV transmission from mother to child.

  - Provision of ARV prophylaxis to the mother or child to reduce the risk of HIV transmission during the breastfeeding period. For the first time, there is enough evidence for WHO to recommend ARVs while breastfeeding.

  - The 2010 revised PMTCT guidelines refer to the following two key approaches:

    - 1. Lifelong ART for HIV-infected women in need of treatment for their own health, which is also safe and effective in reducing mother to child transmission of HIV (MTCT).

Eligibility for treatment

- The **2006 guidelines** recommended starting lifelong ART for pregnant women with a CD4 count equal to or below 200 cells/mm$^3$, usually the stage at which the immune system is no longer strong enough to prevent opportunistic diseases.

- The **2010 guidelines** promote starting lifelong ART for all pregnant women with severe or advanced clinical disease (stage 3 or 4), or with a CD4 count at or below 350 cells/mm$^3$, regardless of symptoms. The new ART eligibility criteria, which are the same as those for adults in general, emphasize the need for access to CD4 testing.

- Both the previous and new PMTCT ARV guidelines recommend that HIV-positive pregnant women in need of treatment for their own health should start ART irrespective of gestational age and should continue with it throughout pregnancy, delivery, during breastfeeding and thereafter.

- In both sets of guidelines, the timing of ART initiation for HIV-positive pregnant women is the same as for non-pregnant women, i.e. as soon as the eligibility criteria are met.

**What ART regimen to initiate**

- The **2006 guidelines** recommended AZT + 3TC + NVP

- In the **2010 guidelines**, the recommended first-line regimens for pregnant women are:
  - AZT + 3TC + NVP or AZT + 3TC + EFV or TDF + 3TC (or FTC) + NVP
  - TDF + 3TC (or FTC) + EFV

- The expanded number of recommended treatment options in the 2010 guidelines will enable countries to choose the treatment option that is most suited to their national circumstances and the needs of their populations.

ARV prophylaxis

- The **2006 guidelines** proposed starting ARV prophylaxis in the third trimester (28 weeks) of pregnancy. They recommended a regimen of twice daily zidovudine (AZT), single-dose nevirapine at onset of labour, a combination of AZT+3TC during delivery and one week postpartum, as well as infant prophylaxis for one week after birth.

- The **2010 guidelines** include two options, both of which should start earlier in pregnancy, at 14 weeks or as soon as possible thereafter. The two options provide significant reduction in MTCT with equal efficacy in this group of women who are not eligible for ART.

  - Option A. Twice daily AZT for the mother and infant prophylaxis with either AZT or NVP for six weeks after birth if the infant is not breastfeeding. If the infant is breastfeeding, daily NVP infant prophylaxis should be continued for one week after the end of the breastfeeding period.
  
  - OR
  
  - Option B. A three-drug prophylactic regimen for the mother taken during pregnancy and throughout the breastfeeding period, as well as infant prophylaxis for six weeks after birth, whether or not the infant is breastfeeding.

2010 Guidelines on HIV and infant feeding

- In many countries, both health services and individual mothers have not been able to adequately support and provide safe replacement feeding. HIV-positive mothers have faced the dilemma of either giving their babies all the benefits of breastfeeding but exposing them to the risk of HIV infection, or avoiding all breastfeeding and increasing the risk of death from diarrhoea and malnutrition.

- At the time of the **2006 PMTCT guidelines**, there were insufficient data supporting the use of ARVs to prevent HIV transmission from mother to baby during breastfeeding.
Since then, several clinical trials have shown the efficacy and acceptability of prophylaxis either to the mother or to the infant during breastfeeding. The new PMTCT recommendations outlined above reflect this exciting breakthrough.

The 2010 guidelines on HIV and infant feeding build on the new recommendations for lifelong ART and the two prophylaxis options for HIV-positive women who breastfeed and are not taking ART - see Options A and B as above.

The effectiveness of ARVs to reduce transmission through breastfeeding has resulted in two major changes from previous guidelines:

1. National health authorities should decide whether health services will principally counsel and support HIV-positive mothers to either:
   -- breastfeed and receive ARV interventions,
   
or
   -- avoid all breastfeeding, as the strategy that will most likely give infants the greatest chance of HIV-free survival.

2. In settings where national authorities recommend HIV-positive mothers to breastfeed and provide ARVs to prevent transmission, mothers should exclusively breastfeed their infants for the first 6 months of life, introducing appropriate complementary foods thereafter, and should continue breast-feeding for the first 12 months of life.

Benefits and challenges

The 2010 guidelines have great potential to improve the mother’s own health and to reduce mother-to-child HIV transmission risk to 5% or lower in a breastfeeding population, from a background transmission risk of 35% (in the absence of any interventions and with continued breastfeeding).

The new guidelines offer the potential for all countries to virtually eliminate paediatric HIV. Combined with improved infant feeding practices, the guidelines can help to reduce both child mortality and new HIV infections.

PMTCT can also act as a gateway to improved reproductive, maternal and child health services at primary level and, in turn, bolster progress towards achieving the health-related Millennium Development Goals of reducing under-five mortality rates by two thirds, decreasing maternal mortality rates by three quarters, and halting and reversing the spread of HIV/AIDS by 2015.

The new guidelines enable more consistent policies and support for infant feeding practices among both HIV-positive and HIV-negative mothers in the general population. Given the importance of breastfeeding as a child survival intervention, the availability of ARV interventions could make a major contribution to reducing child mortality in the entire community.

The major challenges in scaling-up national PMTCT services and implementing the new guidelines are weak health infrastructure, limited human resources, limited management capacity, and limited funding and support for PMTCT. However there are many hopeful signs that PMTCT now have greater priority both at the national and international level.

Given the confusion in the past around HIV and infant feeding, comprehensive communications strategies are now needed to give health workers confidence to recommend breastfeeding and ARVs and for HIV-positive mothers to want to breastfeed.

The 2010 guidelines on antiretroviral drugs for treating pregnant women and preventing HIV infections in infants and the 2010 recommendations on HIV and infant feeding are on the web: www.who.int/hiv and www.who.int/CAH.

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