A RESPONSE TO DR. CLAUDIO SCHUFTAN

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Dr. Claudio Schuftan's response to my article advocating that HIV-positive mothers in resource-poor settings bottle-feed according to acceptable, feasible, affordable, sustainable and safe (AFASS) criteria rather than breastfeed their infants employs the same line of reasoning used in the late 1990s to not treat HIV-positive Africans with antiretroviral drugs. In fact, we can see his argument unfold below by replacing the terminology about bottle-feeding (crossed out) with ART (antiretroviral therapy, indicating access to triple therapy) terminology (added in *red italics*):

* "Economic access to six or more months ~~of infant formula supplies~~ *ART* is not realistic for ~~poor mothers~~ *people living with AIDS* in poor countries — nor, either, is access to clean water."
* "Of course we need to set the same human rights objectives for ourselves in the global South as those set in the North. However, as ~~public health nutrition~~ *infectious disease experts*, it is our obligation to acknowledge the local reality of HIV and AIDS affecting important segments of the poor population in our respective milieus. That reality shows us that economic access to ~~infant formula~~ *ART* does not exist for vast numbers of affected women people living with AIDS."
* "But the choice of whether to ~~bottle-feed~~ *take ART* or not is not really at the forefront for a ~~woman~~ *person living with AIDS* who cannot afford adequate food, has no adequate housing or access to safe water and sanitation, employment and education, let alone a right to ~~gender equality~~ health care."

At that time, this was the same type of controversy, with good people and good intentions on both sides of the discussion. But thank goodness we didn't listen to the majority of those who believed that the lack of financial resources and lack of education would prevent Africans from being able to take their ART medication correctly. We can now see that in fact these same uneducated, poor Africans are more adherent than Western populations. History has proven that the faithful activists, who believed that lack of financial resources was no excuse for providing substandard care, were right.

I am sure now that people living with HIV in Africa are thankful to those activists who fought for their lives. Even though it was not easy to implement in the beginning, in the long-term and for the majority of people it has been beneficial and life-saving.

All tools that may stop the transmission of HIV should be seen as medicine — for example, condoms in HIV-discordant couples. In the same spirit, we must see infant formula according to AFASS criteria as a medicine. Bottle-feeding should be discussed when it can be done safely for the child. Although breastfeeding is an option where there is no plan for

bottle-feeding, there are some who say implementing bottle-feeding in resource-poor countries is criminal. No, only implementing without proper preparation is criminal. And at the same time, to ignore bottle-feeding when AFASS criteria are fulfilled as a best practice for HIV-positive mothers is also criminal.

The financial argument developed by Dr. Schuftan does not make sense and again is similar to the debate about providing ART medications to Africa. There is no African living with AIDS at the community level who can afford to purchase a lifetime supply of ART. There is also no African mother living with HIV at the community level who can afford infant formula to bottle-feed for her child's first six months. The world has found a solution for providing access to ART through the Global Fund, PEPFAR, international foundations, and NGOs. The same can be done for bottle-feeding with AFASS criteria if we are willing to actually implement and put it into practice, and if people will stop shouting that this is not practical (like they did for ART). Rwanda has found a way to address the financial obstacles of providing antiretroviral therapy through global solidarity. Now over 70% of those in need are on treatment. Certainly having all HIV-positive mothers bottle-feed according to AFASS criteria will increase costs. But what is the cost of incorporating bottle-feeding into prevention protocols versus the cost of the percentage of children infected by HIV through breastfeeding and their treatment for life? We have found it acceptable to provide ART treatment for all children infected with HIV through breastfeeding; why is it unacceptable to find ways to provide appropriate, safe bottle-feeding?

Having limited access to clean water should also not be an excuse to provide this essential medicine to HIV exposed infants. We expect that HIV-positive children will take their medicine with the same water early in life and for life. This means teaching caregivers the importance of boiling water and using clean water. It is a matter of education. If we believe mothers can give clean water for children to take their medicine, it is not that much harder to believe they can be educated to clean a bottle as well. And as they know how to add proper proportions of hot water in flour or millet or couscous to cook for their family, they will easily learn how to do the same for formula milk.

Dr. Schuftan also argues that promoting bottle-feeding will fill the pockets of the milk industry, who are already rich. Of course, providing ART to the poor does not hurt pharmaceutical companies that make a profit off of this! This is no excuse to not provide this essential medicine. This argument should have zero impact on whether or not HIV-positive mothers should bottle-feed. It makes no sense to say that because the milk industry will benefit, these mothers should not be allowed to prevent HIV transmission to their infants.

Dr. Schuftan states that the Rwandan study which showed that bottle-fed children were no more susceptible to diarrhea or acute malnutrition than the general population demonstrated these findings only because these children had better follow-up. This only indicates that better follow-up is needed for all children in the world. It is not an argument against bottle-feeding. Having good follow-up should be the standard practice that we fight for. If good follow-up is needed to bottle feed children, then this should be implemented, especially if it means we will reduce the HIV transmission rate to infants.

In summary, Dr. Schuftan's argument is to not implement bottle-feeding in resource-poor settings because: it will cost too much money, it will make the milk industry richer, and women are too uneducated to learn how to bottle feed properly . Although well-intentioned, these are extremely similar to the arguments in the 1990s for not giving another essential treatment to Africans: ART. A human rights paradigm demands that we implement best practices for preventing mother-to-child transmission for all HIV-positive mothers, just as it requires us *to provide all people the same enjoyment of basic human rights.*