Early exclusive breastfeeding: still the cornerstone of child survival1–3

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Notwithstanding the HIV/AIDS epidemic ravaging sub-Saharan Africa, exclusive breastfeeding (EBF) for at least the first 6 mo of life remains the cornerstone of child survival. Accumulating evidence indicates that EBF, as compared with predominant or mixed breastfeeding, reduces the risk of HIV infection and increases the likelihood of HIV-free survival among infants born to HIV-infected mothers (1). In the current issue of the Journal, Koyanagi et al (2) show that, in an African setting with high prevalence of HIV/AIDS, EBF also has benefits for infants born to HIV-uninfected mothers, which supports the current World Health Organization (WHO) recommendation for early EBF for all infants.

Koyanagi et al (2) report that EBF between birth and 3 mo of age in infants born to HIV-uninfected mothers was associated with a significant reduction in clinic visits for diarrheal illness. A weaker association was found between EBF and clinic visits for lower respiratory tract infection. The fact that data were collected prospectively from a largely unselected mixed cohort of HIV-infected, HIV-exposed, and HIV-unexposed African infants confers on these findings real relevance for developing world settings in which infant feeding choices and practices are likely to have the greatest effect on health. One might anticipate that the protective effects observed in the study might be even more pronounced in rural African settings, which often lack the tap water and sanitation facilities common to urban settings, such as the one where the study was conducted.

Although the protective effects described may at first glance appear to be modest, the potential economic and public health benefits for an African country such as Zimbabwe (3), with a total annual health expenditure per capita of $147 and a mortality rate of 12.9% in those age <5 y, are immense. It is estimated that diarrheal disease accounts for 12% of all deaths in Zimbabwe in those age <5 y.

In the United States, where rates of mortality from diarrheal disease and other infectious diseases are low and alternative feeding sources are available, HIV-infected women are counseled to forgo breastfeeding (4). These conditions do not exist across most of sub-Saharan Africa, where the HIV/AIDS epidemic has hit hardest and disproportionately affects women of childbearing age. In these settings, neither formula feeding (5, 6) nor early weaning (7) has improved rates of HIV-free survival. It is not yet clear whether maternal antiretroviral therapy will reduce the risk of HIV transmission to the infant via breast milk, although this is the subject of active investigation. Extended antiretroviral prophylaxis administered directly to breastfed infants may lower the risk of postnatal HIV mother-to-child transmission (8). Finding ways to enhance the safety of EBF for mothers and infants without access to safe and affordable feeding alternatives remains an issue of major public health importance across Africa and around the world.

The work of Koyanagi et al (2) and others in sub-Saharan Africa, where the potential value of breastfeeding and rates of HIV/AIDS are greatest, validates the current WHO recommendation for EBF of HIV-exposed and HIV-unexposed infants alike. Counseling of both HIV-infected and HIV-uninfected women can help to promote and sustain EBF (9). Such counseling should be an integral facet of programs designed to reduce child mortality. Additional research is needed regarding strategies to improve the safety and acceptability of EBF for infants of HIV-infected women, including optimal timing of and approaches to weaning.

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REFERENCES

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