Session I: think pair share – answers

The purpose of this exercise is for participants to think through some of the challenges and adaptations related to HIV and IYCF-E in Emergencies.

***This activity is based on: WHO (2018) HIV & IFE Operational Guidance***

|  |  |
| --- | --- |
| Duration | 30 minutes |
| Activity Type | Think pair share |
| Materials | Per participant: 1 question (activity materials) |
| Preparation | 1. *Print and cut activity materials* |
| Trainers | 1 – 2 |

**INSTRUCTIONS:**

1. Randomly distribute questions to participants (1 question per participant) ​
2. Instruct participants to thinking about the question on their own: What are the implications? What actions should be taken?  (3 minutes)​
3. After 3 minutes, pair up with a participant with the same question ​
4. Discuss the question as a pair (5 minutes)​
5. Bring students together as a group to discuss in plenary​
6. Ask a pair to present their answers and ideas (2 minutes) ​
7. Ask other pairs with the same question to complement the answer already provided ​
8. Repeat this for each of the 5 questions​

**ANSWERS**

**Question 1: What if there are no antiretroviral drugs available? What is the recommended duration of breastfeeding without antiretroviral drugs?​**

In general, when ARVs are not available, mothers should be advised and supported to breastfeed as

per the general population, that is, exclusive breastfeeding for the first 6 months of life and continued

breastfeeding until 2 years of age or beyond.

Principle 4 of the 2010 HIV and infant feeding guideline *(4)*, which is still valid, states that “When ARV drugs are not (immediately) available, breastfeeding may still provide infants born to mothers living with HIV a greater chance of HIV-free survival”. In addition, it states that in circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended, to increase survival.

Infant prophylaxis should be considered where interruption of ARV supply continues. In the absence of ARVs, the risk of HIV transmission through breastfeeding is cumulative with longer durations of breastfeeding and the risk depends on the clinical status of the mother; this needs to be balanced with the risk of other infectious diseases, malnutrition and death if breastfeeding ceases in an emergency-affected population.

The dangers of not breastfeeding are greater among infants aged less than 6 months; the younger the infant, the more vulnerable he or she will be. For older infants and young children, a decision on stopping breastfeeding will depend on the child’s general health, age, availability of and access to a nutritionally safe and adequate diet, counselling services and other support available, and the risk of other infectious diseases, malnutrition and death if breastfeeding ceases.

*For further information see Question 2, Page 19.*

**Question 2: What if there are no antiretroviral drugs available? What change in support (counselling, follow-up schedule, nutritional supplements to mothers) is needed in the absence of antiretroviral drugs?​**

When ARVs are not available, additional counselling should be given to mothers to maintain confidence in the importance of breastfeeding for child survival, on how to make breastfeeding safer and on maintaining their own health, and supplementary foods, screening and treatment for opportunistic infections, and prophylactic co-trimoxazole may be provided.

Whether ARVs are available or not, mothers with infants aged under 6 months need support to exclusively breastfeed. Conditions of the breast or of the child’s mouth are factors that can affect MTCT. Therefore, prioritizing access to skilled breastfeeding support is particularly important for this group.

General health screening and evaluation of the mother for opportunistic infections should be conducted. Treatment for opportunistic infections should be provided whenever available, as well as prophylactic co-trimoxazole. An assessment of whether a woman should continue breastfeeding may be carried out if her overall health is changing or she has developed specific complications, such as mastitis. Progression in clinical staging may be correlated with increased HIV transmission to the infant, and thus would indicate a higher priority for introducing BMS if resources and safe conditions are in place. Mental health support should be introduced when resources are available.

Nutritional status should be assessed on a frequent basis, where possible. Supplementary foods for mothers may be needed, given the extra metabolic demands of breastfeeding and HIV.

*For further information see Question 3, page 20.*

**Question 3: What if HIV testing is not available? Can wet nursing still be recommended?​**

Wet-nursing in emergencies can be life-saving, providing an immediate source of breast milk for infants, and is likely to carry a small risk of HIV transmission.

In the absence of testing, an HIV risk assessment of the wet-nurse should be undertaken, if feasible. An assessment should consider the HIV status of current or previous partners, the practice of unprotected sex, the history of sexually transmitted disease, and whether the woman appears to be in good health. The decision on an infant feeding practice requires a balance of risk factors that influence HIV-free survival of the child. In addition to the above assessment of the wet-nurse, this will include consideration of the prevalence of HIV, the likely duration of wet-nursing, the HIV test history of the wet-nurse (e.g. during previous pregnancy), and other factors such as the risks of not breastfeeding and the feasibility and safety of artificial feeding in the specific circumstance.

*For further information, see Question 9, page 22.*

**Question 4: How can complementary feeding for HIV-positive and HIV-exposed infants be supported?​**

Mothers living with HIV should be supported in the same way as other mothers in the general population regarding complementary feeding for their HIV-positive and HIV-exposed infants.

Non-breastfed children have heightened nutrient needs *(12)*. If a mother living with HIV is considering stopping breastfeeding, or the national policy is replacement feeding, a key question should be whether there is adequate available and affordable replacement feeding and complementary food in the setting.

HIV-positive children from 6 months of age have increased energy needs.

*For further information, see Question 20, page 25.*

**Question 5: What if artificial feeding is the national policy and an emergency happens? ​**

Once provided, BMS should continue to be supplied for as long as the infant needs it. WHO recommends that ART should be initiated in all pregnant and breastfeeding women living with HIV. It is possible for a non-breastfeeding mother to re-lactate, but she will require skilled breastfeeding support. The re-establishment of breastfeeding is an important management option in emergency situations. There may be a period of mixed feeding (increases risk of transmission if ARVs not available).

In emergency situations where there is no suitable BMS, the recommendation for HIV-exposed neonates

should be to breastfeed, with provision of maternal and/or infant ARVs if possible. For infants already being fed BMS but where supplies of safe water are not available, RUIF is the preferred BMS. Re-lactation by the mother may be possible . In some settings, wet-nursing by a family member or close friend may be an alternative. If a human milk bank and safe transportation mechanisms for the milk exist, these services can be used.

*For further information, see Questions 5 – 8, page 21 and 22.*