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A FURTHER RESPONSE TO DR. BINAGWAHO ON HUMAN RIGHTS FOR INFANTS OF HIV-POSITIVE MOTHERS

Claudio Schuftan (CS) and Ted Greiner (TG)

[Editor's note: this post is the latest and last installment of an ongoing discussion on the merits of exclusive breast feeding versus formula feeding for HIV-positive mothers. Dialogue on this issue began with [an article by Dr. Binagwaho in Health and Human Rights](#), followed by a Perspectives piece by [Dr. Schuftan](#). Dr. Binagwaho continued the exchange with [a post on OpenForum](#), to which Dr. Schuftan and Ted Greiner, PhD, have responded below.]

We are of the opinion that, in her response, Dr. Binagwaho misinterprets the human rights of these newborn infants and somehow tries to turn the tables on the readers of this blog using fallacious arguments. She now tries to directly link my original argument (CS) to the arguments fought around the introduction of ARV treatment in Africa in its early stages. Our disagreement with her now centers around how she uses the AFASS criteria argument (acceptable, feasible, affordable, sustainable and safe) which she, in our view, lightly assumes are realistically achievable in Rwanda. She actually puts the emphasis on the cost-free-distribution- of-infant-formula which she rightly says would in theory be compatible with HR principles.

Human rights activists are used to fighting tough battles, we agree. But to win, it has to be for a human rights cause that is scientifically plausible. Can widespread bottle feeding for children born to HIV-positive mothers be implemented now (“safely for each child”, as she says) when currently “there is no plan for bottle feeding in resource poor countries”? Perhaps there is a good reason for there being no plan . . . UNICEF began supporting the provision of free formula, but stopped within a couple years. I (TG) would be happy to send readers a copy of the document in which they explain their reasons for this.

We do not say bottle feeding “is criminal” (as she implies), but we stand firm on our view that it would be irresponsible at this time “without proper preparation.” It is not about “ignoring bottle feeding if and when AFASS criteria are fulfilled”; it is just that ‘if and when’ is the key consideration for a human rights-based pronouncement in this case.

Bottle feeding will not be made safe just because someone solves a few of the many constraints to its safe use, some of which, like maternal education and the high standards of hygiene and sanitation required,

will take time. (Keep in mind that a non-breastfed newborn is as immune incompetent as many AIDS patients, and thus needs a nearly sterile environment). So, for now, we need to view the aim of bottle feeding these particular infants as something somewhere in the path towards the progressive realization of their right to health.

An additional reason the analogy to the battle won over ART in Africa is fallacious is that the costs and logistics involved are simply not comparable. “The world having found a solution for providing access to ART” does not mean that the same can be done for bottle feeding by somehow ‘providing’ the AF-ASS criteria to families! Exclusive breastfeeding has shown to be the alternative that ultimately saves lives of these infants in the medium term.

Dr. Binagwaho’s assertion that “bottle-fed children were no more susceptible to diarrhea or acute malnutrition than the general population” goes against years of published evidence to the contrary. The only relevant data we know of comes from samples of children living in a large, relatively well-off city in Africa enrolled in a longitudinal study which, for ethical reasons, provided higher levels of follow up and care than infants get even in Northern countries. To date, the only published data on African infants living in a rural area and not receiving such unrealistic levels of follow up (Kagaayi J, et al., [available here](#)) found that formula fed infants were six times more likely to die. I (TG), in talks in various venues in Rwanda, have provided simulation data suggesting that Rwandan babies would achieve higher HIV-free survival by stopping breastfeeding at 12 months rather than the current policy of 6 months. (During the period 6-12 mo, ~8% will be HIV-infected or die if breastfed; 10-18% will die if formula fed.)

Dr. Binagwaho is right that boiling water is a matter of maternal education — but there are also financial and time constraints. It is often assumed incorrectly that the cost of formula and access to clean water are the major constraints. From my research in St. Vincent (TG), where bottle feeding had been taught

for 30 years, I would argue that those factors are perhaps half the problem. Mothers with 10 years of education (extremely rare in Rwanda) often thought sterilizing the bottle once a day (or even just when it was purchased!) was enough. Few could afford bottle brushes, but shook sand in the bottle to try removing the film of milk inside or swirled a rag around in it with a stick, often scratching the plastic and creating an excellent location for further bacterial growth.

A caveat: Neither of us have ever said or implied that “because the milk industry will benefit, these mothers should not be allowed to prevent HIV transmission to their infants.” This was a low blow.

That “good follow-up (for safe bottle feeding) should be the standard practice to fight for” cannot be argued, but how realistic is this except in the far long term? The best approach might be to say that, yes, some day we will succeed in eliminating poverty, at which time Dr. Binagwaho’s approach will make sense. We caution against mixing up long-term and short-term goals — a common error in this discussion, more so when attributing it to a human rights violation. Human rights law does not call for countries to realize all rights immediately; instead, by ratifying UN human rights covenants, countries are supposed to make concrete plans towards achieving them, progressively, to the best of their ability. In the interim, our human rights obligation is towards the right to life, i.e., in this case, to save as many lives as we can given the economic and sanitary realities of the places where we work. A rapid rush toward bottle feeding of infants born to HIV-positive mothers will simply lead to more infant deaths, even if donors pay for it.

In summary, we never implied that, in the long run, bottle feeding should not be considered, because “it will cost too much money”, because “it will make the milk industry richer” or because “women are too uneducated to learn how to bottle feed properly”. Together with Dr. Binagwaho, we agree that “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.*"