

et al caution on the risks of opening the door to breastfeeding advocates; perhaps this framework is the opportunity to begin a dialogue with breastfeeding advocates and lactation consultants to understand how we can best support women living with HIV in remaining engaged in care and managing the stigmas associated with HIV and/or not breastfeeding. The data simply do not support a platform to advocate for women living with HIV in resource-rich settings to breastfeed. Understanding the details of each woman's history of adherence to antiretrovirals, her motivation to breastfeed, and her understanding of the risks to her child illuminates what strategies may be useful to support her in keeping her baby free of HIV.

We agree that the desires of the mother may be in conflict with rights of the child. Like other challenging scenarios faced by obstetric providers, balancing the rights of the mother and infant requires a collaborative team effort. For this reason, we value a multidisciplinary, team approach to supporting a woman to remain engaged in care and counseling her about what is known and not known about lactational HIV transmission. In this regard, co-managing this topic with a pediatrician or pediatric infectious disease specialist prior to delivery is advised. Pediatric infectious disease specialists are, appropriately, very cautious in discussing this topic and, in our experience, the vast majority of women ultimately choose replacement feeding following this risk reduction counseling model.

Although there may be drawbacks to generalizing data from resource-limited settings to North America, we expect that the risks in our setting are lower

than in areas of limited resources. In the few cases where a woman has opted to breastfeed and remained in care, we continue women on antiretrovirals while breastfeeding (World Health Organization [WHO] Option B), and the pediatricians have simultaneously maintained breastfeeding infants on antiretrovirals until fully weaned (WHO Option A).

The community event described by Kennedy et al is to be commended and is inspiring. We look forward to their forthcoming systematic review on this subject and to continuing this conversation.

Note

Potential conflicts of interest. All authors: No potential conflicts of interest.

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Reply to Kennedy et al

TO THE EDITOR—We thank Kennedy et al [1] for their thoughtful response to our article on a harm reduction approach to breastfeeding among human immunodeficiency virus (HIV)-infected women in the United States [2]. This is just the type of dialogue we hoped to inspire with our proposed framework. We agree that formula feeding is often a foregone conclusion in high-resource settings; we have concerns that, if not discussed, women may intermittently breastfeed, which—as pointed out—is a higher-risk scenario for lactational HIV transmission. Kennedy