Plasma and breast-milk selenium in HIV-infected Malawian mothers are positively associated with infant selenium status but are not associated with maternal supplementation: results of the Breastfeeding, Antiretrovirals, and Nutrition study1–3

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ABSTRACT

Background: Selenium is found in soils and is essential for human antioxidant defense and immune function. In Malawi, low soil selenium and dietary intakes coupled with low plasma selenium concentrations in HIV infection could have negative consequences for the health of HIV-infected mothers and their exclusively breastfed infants.

Objective: We tested the effects of lipid-based nutrient supplements (LNS) that contained 1.3 times the Recommended Dietary Allowance of sodium selenite and antiretroviral drugs (ARV) on maternal plasma and breast-milk selenium concentrations.

Design: HIV-infected Malawian mothers in the Breastfeeding, Antiretrovirals, and Nutrition study were randomly assigned at delivery to receive: LNS, ARV, LNS and ARV, or a control. In a subsample of 526 mothers and their uninfected infants, we measured plasma and breast-milk selenium concentrations at 2 or 6 (depending on the availability of infant samples) and 24 wk postpartum.

Results: Overall, mean (±SD) maternal (range: 81.2 ± 20.4 to 86.2 ± 19.9 μg/L) and infant (55.6 ± 16.3 to 61.0 ± 15.4 μg/L) plasma selenium concentrations increased, whereas breast-milk selenium concentrations declined (14.3 ± 11.5 to 9.8 ± 7.3 μg/L) from 2 or 6 to 24 wk postpartum (all P < 0.001). Compared with the highest baseline selenium tertile, low and middle tertiles were positively associated with a change in maternal plasma or breast-milk selenium from 2 or 6 to 24 wk postpartum (both P < 0.001). With the use of linear regression, we showed that LNS that contained selenium and ARV were not associated with changes in maternal plasma and breast-milk selenium, but maternal selenium concentrations were positively associated with infant plasma selenium at 2 or 6 and 24 wk postpartum (P < 0.001) regardless of the study arm.

Conclusions: Selenite supplementation of HIV-infected Malawian women was not associated with a change in their plasma or breast-milk selenium concentrations. Future research should examine effects of more readily incorporated forms of selenium (i.e., selenomethionine) in HIV-infected breastfeeding women. This trial was registered at clinicaltrials.gov as NCT00164736. Am J Clin Nutr doi: 10.3945/ajcn.113.073833.

INTRODUCTION

The trace element selenium plays an important role in antioxidant defense, cell-mediated immunity, brain and thyroid function, and cardiovascular health (1). Overt selenium deficiency is rare (2). Symptoms in people with very low plasma selenium concentrations include cardiomyopathy, growth retardation, and a greater susceptibility to infection (3). Selenium concentrations tend to be low in HIV-infected individuals and decline as HIV progresses (4–7). It has been hypothesized that selenium becomes depleted in people with HIV because the body uses selenoproteins to suppress viral replication, or the virus uses selenium to create its own selenoenzymes (8), especially in the later stages of the disease (9). Low selenium concentrations have been associated with morbidity and mortality in HIV-infected populations (7, 10, 11). These effects can be limited by slowing the progression of HIV disease through the use of antiretroviral drugs (ARV)4. When...
Plasma selenium concentrations are generally sufficient, HIV-infected individuals who use ARV have maintained an adequate selenium status (12). This effect is likely a result of improved virologic control in individuals taking ARV. In settings in which selenium concentrations are already low at a population level, it may be necessary to combine both ARV and selenium supplementation to attain adequate selenium concentrations in HIV-infected individuals.

The selenium status varies worldwide and is largely dependent on food-selenium concentrations, which tend to reflect the selenium availability in soils (13). Malawi is among the countries with low amounts of selenium in soils and staple foods (14, 15). These low amounts have led to low dietary selenium intakes and low plasma selenium concentrations in Malawian adults (16, 17). HIV-infected Malawan women likely suffer from a double burden of low selenium intakes and increased selenium needs (18). This burden may be further exacerbated by the added micronutrient requirements of pregnancy and lactation (19).

In other countries, such as Finland and Poland, where soil selenium is low, the supplementation of lactating mothers with inorganic and organic selenium has increased maternal plasma and breast-milk selenium concentrations as well as selenium intakes of their breastfed infants (20, 21). The effect of supplementation with inorganic selenium (in the form of sodium selenite) is generally smaller than that of organic selenium (in the form of selenomethionine) (22). The ability of oral selenium supplementation with inorganic or organic selenium to increase selenium concentrations in HIV-infected adults has also been shown (5, 9). In HIV-infected women, the effects of selenium supplementation on maternal and infant selenium status have not previously been reported to our knowledge.

The main aims of the current study were to measure the effects of selenium supplementation and ARV, which are used for the prevention of mother-to-child transmission, on maternal plasma and breast-milk selenium concentrations and to look at the subsequent intervention effects on infant plasma selenium concentrations. We hypothesized that women who received lipid-based nutrient supplements (LNS), which contained 127% of the Recommended Dietary Allowance for selenium during lactation, Antiretrovirals, and Nutrition (BAN) study from 2004 to 2009. Mother-infant pairs were eligible if infants had a birth weight ≥2 kg, and mothers had a CD4 count ≥250 cells/µm³ (≥200 cells/µm³ until July 2006), hemoglobin concentration ≥70 g/L, and no previous ARV use (23).

With the use of a permuted-block method, mothers were randomly assigned by using a 2 × 3 factorial design to 1 of 6 study arms as shown in Figure 1 (see reference 21 for details of the randomization procedure). Because this analysis examined intervention effects on the mother, we combined the infant ARV plus maternal LNS arm with the maternal LNS arm and the infant ARV arm with the control arm, which resulted in the following 4 groups that referred only to maternal interventions: LNS, ARV, LNS and ARV, and control. Assigned interventions began at delivery and continued through 28 wk. Mothers were counseled to exclusively breastfeed from 0 to 24 wk postpartum and wean their infants from 24 to 28 wk postpartum. LNS were designed to meet the energy, micronutrient, and protein needs of lactation. A daily 140 g dose of LNS contained 75 µg selenium in the form of sodium selenite; the complete nutrient content has been described elsewhere (24). Sodium selenite was selected for use in LNS rather than selenomethionine because the producer (Nutriset) uses only vitamins and minerals that are listed in the Codex Alimentarius and approved by the European Union, where the company is based. The maternal ARV intervention consisted of a highly active regimen, including zidovudine and lamivudine as a single tablet (Combivir; GlaxoSmithKline) plus one or more other drugs (25). Mothers were initially given nevirapine as the third drug in their regimen. Nevirapine was discontinued in February 2005 and replaced with nelfinavir (Viracept; Roche). In January 2006, nelfinavir was replaced by lopinavir plus ritonavir (Kaletra; Abbott).

Blood and breast-milk samples were collected during regular study visits at 2, 6, and 24 wk postpartum. Plasma was separated from red blood cells within 60 min and kept at −70°C. Whole breast-milk samples were also frozen. Mothers were asked to report their adherence to LNS and ARV regimens at 1, 4, 8, and 21 wk. A questionnaire on socioeconomic characteristics was administered to mothers during screening.

To measure the effects of interventions on maternal and infant selenium concentrations, we selected a subsample who had breast-milk and maternal and infant plasma samples available at 2 time points, either at 2 and 24 wk (n = 358) or 6 and 24 wk (n = 168) postpartum. We originally planned to use samples from 2 and 24 wk postpartum to determine selenium concentrations as close to the beginning and end of supplementation as possible. We added 6 wk to the baseline group because some infants had inadequate quantities of stored plasma at 2 wk postpartum. We excluded multiple births and infants who were HIV positive. With the selected sample size, we have 83% power to detect an 8-µg/L mean difference in maternal plasma selenium concentrations between study arms.

Subjects and procedures

HIV-1–infected, pregnant women were recruited at antenatal clinics in Lilongwe, Malawi, for participation in the Breastfeeding, Antiretrovirals, and Nutrition study arms as shown in Figure 1 (see reference 21 for details of the randomization procedure). Because this analysis examined intervention effects on the mother, we combined the infant ARV plus maternal LNS arm with the maternal LNS arm and the infant ARV arm with the control arm, which resulted in the following 4 groups that referred only to maternal interventions: LNS, ARV, LNS and ARV, and control. Assigned interventions began at delivery and continued through 28 wk. Mothers were counseled to exclusively breastfeed from 0 to 24 wk postpartum and wean their infants from 24 to 28 wk postpartum. LNS were designed to meet the energy, micronutrient, and protein needs of lactation. A daily 140 g dose of LNS contained 75 µg selenium in the form of sodium selenite; the complete nutrient content has been described elsewhere (24). Sodium selenite was selected for use in LNS rather than selenomethionine because the producer (Nutriset) uses only vitamins and minerals that are listed in the Codex Alimentarius and approved by the European Union, where the company is based. The maternal ARV intervention consisted of a highly active regimen, including zidovudine and lamivudine as a single tablet (Combivir; GlaxoSmithKline) plus one or more other drugs (25). Mothers were initially given nevirapine as the third drug in their regimen. Nevirapine was discontinued in February 2005 and replaced with nelfinavir (Viracept; Roche). In January 2006, nelfinavir was replaced by lopinavir plus ritonavir (Kaletra; Abbott).

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**SUBJECTS AND METHODS**

**Subjects and procedures**

HIV-1–infected, pregnant women were recruited at antenatal clinics in Lilongwe, Malawi, for participation in the Breastfeeding, Antiretrovirals, and Nutrition study arms and collapsed arms used in the analysis. ARV, antiretroviral drugs; LNS, lipid-based nutrient supplements; LNS-ARV, antiretroviral drugs and lipid-based nutrient supplements.

**FIGURE 1.** Randomly assigned Breastfeeding, Antiretrovirals, and Nutrition study arms and collapsed arms used in the analysis. ARV, antiretroviral drugs; LNS, lipid-based nutrient supplements; LNS-ARV, antiretroviral drugs and lipid-based nutrient supplements.
Ethical approval for the study was obtained from the Malawi National Health Science Research Committee and the institutional review boards at the University of North Carolina at Chapel Hill and the US CDC.

Laboratory analysis

Plasma and breast-milk selenium concentrations were measured at the USDA–Agriculture Research Service, Grand Forks Human Nutrition Research Center by using automated electrothermal atomic absorption spectrophotometry with a reduced palladium matrix modifier and an instrument equipped with L’Vov platforms and automated Zeaman-effect background correction (26). A daily calibration set for each batch was prepared by using certified standards (Alfa Aesar; Perkin Elmer). Calibration standards were analyzed at the beginning and end of each daily batch and at a 10% frequency within each batch. Plasma and breast-milk matrix effects were examined by using quantitative standards (National Institute of Standards and Technology) and spiked sample recovery tests. Laboratory tests of the LNS provided to mothers confirmed that the supplement contained the stated quantity (75 μg) of selenium.

Statistical analysis

We used a cutoff of the plasma selenium concentration at <80 μg/L to indicate a low selenium status in mothers. Adults with plasma selenium concentrations ~80 μg/L appear to express major selenoproteins at maximal concentrations (27). We chose to report infant intakes of selenium from breast milk because there is no standard selenium adequacy for this age group. Infant selenium intake from breast milk was calculated by multiplying the mean breast-milk selenium concentration by the estimated breast-milk intake at each age (710 g/d at 2 or 6 wk postpartum and 780 g/d at 24 wk 24 wk postpartum) (28). The proportion with the recommended normative intake from the WHO/FAO (6 μg/d from 0 to 6 mo of age) (3) and adequate intake from the Institute of Medicine (15 μg/d from 0 to 6 mo of age) (19) was determined for each time point.

Our initial analysis tested intervention effects overall. We subdivided the sample into tertiles to determine whether interventions had a differential effect on the change in selenium by the baseline selenium concentration. The LNS used in this study contained selenite, which is not as bioavailable as organic selenium (ie, selenomethionine), and thus, we expected to see the strongest effects of supplementation in mothers with the lowest baseline concentrations. Means and proportions of background characteristics were compared between study arms by using a 2-factor ANOVA for continuous variables and logistic regression for categorical variables. Mean selenium concentrations from 2 or 6 to 24 wk postpartum were compared by using paired t tests. A 2-factor ANOVA was used to test effects of study interventions within tertiles. Multivariable linear regression models, with the timing of the early visit (2 or 6 wk postpartum) controlled for, were used to examine effects of BAN interventions and the baseline tertile on selenium concentrations in maternal plasma and breast milk. All analyses that examined effects of study interventions included LNS, ARV, and the interaction between LNS and ARV in the models. Multivariable models were also used to study associations between maternal and infant selenium concentrations. Statistical analyses were conducted with Stata 12.1 software (StataCorp).

RESULTS

Characteristics of mother-infant pairs generally did not differ by study arm, with the exception of the CD4+ count at 24 wk postpartum (Table 1). As expected, women in study arms that received ARV had a higher median CD4+ count at 24 wk postpartum. We also examined characteristics of mother-infant pairs in the selenium-analysis sample and those of other BAN participants. Mothers in the selenium subsample had a higher mean maternal age (P < 0.01) and lower mean BMI (P < 0.05), and a greater proportion had a CD4+ count <250 cells/μL at

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Characteristics of mother-infant pairs in the selenium subsample by study arm*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control (n = 175)</td>
</tr>
<tr>
<td>Mothers</td>
<td></td>
</tr>
<tr>
<td>Age (y)</td>
<td>26.5 ± 5.2</td>
</tr>
<tr>
<td>More than a primary education (%)</td>
<td>37</td>
</tr>
<tr>
<td>BMI at 2 wk postpartum (kg/m²)</td>
<td>22.6 ± 2.6</td>
</tr>
<tr>
<td>BMI &lt;18.5 kg/m² at 2 wk postpartum (%)</td>
<td>3</td>
</tr>
<tr>
<td>CD4+ at baseline (cells/μL)</td>
<td>421 (324, 570)</td>
</tr>
<tr>
<td>CD4+ at 24 wk postpartum (cells/μL)</td>
<td>463 (319, 665)</td>
</tr>
<tr>
<td>CD4+ &lt;250 cells/μL at 24 wk postpartum (%)</td>
<td>10</td>
</tr>
<tr>
<td>No. of pregnancies</td>
<td>3.3 ± 1.7</td>
</tr>
<tr>
<td>Infants</td>
<td></td>
</tr>
<tr>
<td>Female (%)</td>
<td>47</td>
</tr>
<tr>
<td>Birth weight (kg)</td>
<td>3.0 ± 0.4</td>
</tr>
<tr>
<td>Birth length (cm)</td>
<td>48.3 ± 1.8</td>
</tr>
</tbody>
</table>

*CD4+ counts at 24 wk postpartum included 481 participants. P values represent the overall significance for the difference in characteristics of study arms obtained from the 2-factor ANOVA for continuous variables and logistic regression for categorical variables. Models contained an interaction term for LNS-ARV to represent this study arm. LNS, lipid-based nutrient supplements; ARV, antiretroviral drugs; LNS-ARV, lipid-based nutrient supplements and antiretroviral drugs.

*Mean ± SD (all such values).

*Median; IQR in parentheses.
24 wk postpartum \( (P < 0.01) \), than did the rest of the study sample (see Supplemental Table 1 under “Supplemental data” in the online issue).

Maternal LNS and ARV adherence in the subsample was high. The proportion of mothers who reported eating the full daily dose on the previous day ranged from 87% to 96% at 1, 4, 8, and 21 wk postpartum, whereas the proportion of mothers who reported taking their ARV daily for the past 3 d ranged from 87% to 94% at the same time points.

We showed no differences in the mean change in selenium by study arm within any tertile (Table 2). In regression analyses, LNS that contained selenium and ARV were not associated with a change in the selenium concentration, whereas the trend across tertiles was positively associated with a change in maternal plasma or breast-milk selenium from 2 or 6 to 24 wk postpartum (see Supplemental Table 2 under “Supplemental data” in the online issue). Because there were no intervention effects on maternal selenium concentrations, we did not examine effects of interventions through breast milk on infant plasma concentrations.

Selenium concentrations varied widely at each time point (Table 2). Overall, mean maternal and infant plasma selenium concentrations increased (maternal: 81.2 ± 20.4 µg/L at 2 or 6 wk postpartum to 86.2 ± 19.9 µg/L at 24 wk postpartum; \( P < 0.001 \); infant: 55.6 ± 16.3 µg/L at 2 or 6 wk postpartum to 61.0 ± 15.4 µg/L at 24 wk postpartum; \( P < 0.001 \)), whereas breast-milk selenium concentrations decreased \( (14.3 ± 11.5 \, \mu g/L \text{ at } 2 \text{ or } 6 \text{ wk postpartum to } 9.8 ± 7.3 \, \mu g/L \text{ at } 24 \text{ wk postpartum}; P < 0.0001 \) significantly over time. The direction of change in the selenium concentration differed by baseline tertile across all 3 outcomes, with selenium concentrations increasing in the low tertile and decreasing in the high tertile (Table 2).

On the basis of plasma selenium concentrations, we showed that 50% and 42% of mothers had a low selenium status \( (<80 \, \mu g/L) \text{ at } 2 \text{ or } 6 \text{ and } 24 \text{ wk postpartum, respectively. Mean infant intakes of selenium from breast milk were estimated at } 10.1 ± 8.2 \, \mu g/d \text{ at } 2 \text{ or } 6 \text{ wk postpartum and } 7.7 ± 5.7 \, \mu g/d \text{ at } 24 \text{ wk postpartum, indicating that } 30% \text{ and } 39% \text{ of infants did not achieve the FAO/WHO recommended selenium intake at } 2 \text{ or } 6 \text{ and } 24 \text{ wk postpartum. According to the Institute of Medicine guidelines, } 85% \text{ and } 91% \text{ of infants did not achieve adequate selenium intakes from breast milk at } 2 \text{ or } 6 \text{ and } 24 \text{ wk postpartum.}

Maternal plasma and breast-milk selenium concentrations were strongly positively associated with infant plasma selenium concentrations at 2 or 6 and 24 wk postpartum (Table 3). The change in maternal plasma and breast-milk selenium from 2 or 6 to 24 wk postpartum was positively associated with the change in the infant selenium concentration (both \( P < 0.001 \)) (not shown).

**DISCUSSION**

Despite good adherence to study interventions, we showed that LNS, ARV, and LNS and ARV did not affect maternal plasma or breast-milk selenium concentrations in the whole sample or in women with the lowest baseline selenium tertile. The form of selenium used in the supplement was likely one of the main factors that limited the effect of LNS on maternal selenium status. Inorganic sodium selenite is somewhat less readily absorbed than many food forms of selenium, particularly selenomethionine, which is the dominant one. More importantly, selenite can be incorporated only into selenoproteins. Twenty-five selenoproteins have been identified in humans, but many forms are present in only some tissues [eg, 9 forms are present in breast milk (29)].

In individuals with plasma selenium concentrations \( \geq 80 \, \mu g/L \), selenoproteins, such as glutathione peroxidase-3, are maximally expressed, and supplementation with selenite cannot be effectively incorporated (27). Consequently, selenite treatment produces small increases in concentrations of selenium in the plasma and breast milk of individuals who do not have low concentrations of the element. Unlike selenite, selenomethionine can also be incorporated nonspecifically into general proteins in lieu of methionine; for this reason, sources of selenomethionine produce greater increases in tissue selenium concentrations (20, 21, 29, 30). Good sources of selenomethionine include selenium-enriched yeast, which can be used in supplements, and high-protein foods produced on soils that are not deficient in selenium. When individuals are in a steady state concentration of selenium, the nonspecific component of plasma selenium represents a turning-over pool that releases selenium in the form of selenomethionine for incorporation into selenoproteins (26).

We expected that participants who received ARV would have had higher selenium concentrations because the virus would be suppressed and disease progression would be limited by the drugs (12). The lack of an ARV effect in the current study was likely explained by the high mean CD4 \( ^\text{+} \) counts at 24 wk postpartum across study arms, even in subjects who did not receive drugs. Work by Rousseau et al (31) has indicated that there may be a threshold (eg, CD4 \( ^\text{+} \) count \(<250 \, \text{cells/mm}^3\) below which selenium concentrations begin to decline. This threshold was crossed by few women (\( \sim 8\% \)) included in this analysis.

The direction of change in selenium concentrations in postpartum women and infants has not been consistently established across studies. The decline in breast-milk selenium concentrations in our sample was similar to that in reports from the United States (32), Finland (20), Niger (33), and Burundi (34) but differed from that in studies in Belgium (35) and Japan (36), where there were no changes over time in the selenium concentration of mature human milk. Kumpulainen et al (20) have suggested that a gradual decline in breast-milk selenium concentration is physiologic even when maternal selenium consumption is sufficient. The increase in infant plasma selenium in this study was consistent with the results of other research, which indicated a small decline in selenium concentration from birth to 4 mo of age and an increase through the rest of infancy and to adulthood (37–39). The increase in maternal plasma selenium seen in this sample differed from the results in several other studies, in which maternal plasma selenium remained stable in nonsupplemented women postpartum (21, 32, 40), but was in agreement with results of studies in Niger (33) and Poland (41), where plasma selenium increased during lactation.

Mean maternal plasma and breast-milk selenium concentrations in our sample were within ranges reported in 2 reviews (2, 29). However, this result should not mask the fact that many of the mothers in this study had plasma selenium concentrations below those associated with maximal selenoprotein expression, which suggested the possibility of subclinical deficiency (42). The women also had substantially lower plasma selenium concentrations than HIV-infected women in Kenya (110 \( \mu g/L \) and
Selenium concentrations at 2 or 6 to 24 wk postpartum and the change in selenium over time by baseline tertile and study arm in a subsample of BAN study participants \((n = 526)\)

<table>
<thead>
<tr>
<th>Treatment arm</th>
<th>Control</th>
<th>LNS</th>
<th>ARV</th>
<th>LNS-ARV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome</strong></td>
<td>μg/L</td>
<td>μg/L</td>
<td>μg/L</td>
<td>μg/L</td>
</tr>
<tr>
<td>Baseline tertile</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low tertile</td>
<td>(\leq 71)</td>
<td>58.5 ± 9.0(^2)</td>
<td>73.5 ± 15.2</td>
<td>15.0 ± 15.0</td>
</tr>
<tr>
<td>Middle tertile</td>
<td>71.1–89</td>
<td>57</td>
<td>80.4 ± 5.5</td>
<td>82.4 ± 14.5</td>
</tr>
<tr>
<td>High tertile</td>
<td>&gt;89</td>
<td>57</td>
<td>103.7 ± 10.3</td>
<td>100.3 ± 22.3</td>
</tr>
<tr>
<td>Breastmilk selenium (^\dagger)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low tertile</td>
<td>(\leq 9)</td>
<td>61</td>
<td>4.5 ± 3.3</td>
<td>6.1 ± 5.3</td>
</tr>
<tr>
<td>Middle tertile</td>
<td>9.1–16</td>
<td>53</td>
<td>13.0 ± 1.0</td>
<td>11.2 ± 7.0</td>
</tr>
<tr>
<td>High tertile</td>
<td>&gt;16</td>
<td>61</td>
<td>26.7 ± 11.6</td>
<td>14.1 ± 8.9</td>
</tr>
<tr>
<td>Infant plasma selenium (^\dagger)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low tertile</td>
<td>(\leq 50)</td>
<td>55</td>
<td>40.1 ± 9.3</td>
<td>54.6 ± 12.8</td>
</tr>
<tr>
<td>Middle tertile</td>
<td>50.1–63</td>
<td>54</td>
<td>57.0 ± 3.9</td>
<td>60.4 ± 13.3</td>
</tr>
<tr>
<td>High tertile</td>
<td>&gt;63</td>
<td>66</td>
<td>73.9 ± 7.5</td>
<td>71.0 ± 14.0</td>
</tr>
</tbody>
</table>

\(^1\) Models showed no significant effects of the study arms for maternal plasma selenium or breastmilk selenium (see Supplemental Table 2 under “Supplemental data” in the online issue). The effects of study arms were not tested for infant plasma because there were no effects in mothers, and infants were exclusively breastfed. Overall \(P\) values are reported because there were no significant effects of LNS, ARV, or the interaction between LNS and ARV on the change in selenium within each tertile. \(P\)-trend < 0.001 over tertiles by using multivariable linear regression models with the change in selenium as the outcome and controlling for the timing of the baseline measurement (2 or 6 wk postpartum). \(\dagger\) Calculated by using a 2-factor ANOVA including LNS, ARV, and the interaction between LNS and ARV. ARV, antiretroviral drugs; BAN, Breastfeeding, Antiretrovirals, and Nutrition; LNS, lipid-based nutrient supplements.

\(^\dagger\) Mean ± SD (all such values).
TABLE 3
Association of maternal plasma and breast-milk selenium concentration with infant plasma selenium concentration in a subsample of BAN study participants (n = 526)^1

<table>
<thead>
<tr>
<th>Outcome [infant plasma selenium (μg/L)]</th>
<th>β coefficient (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal plasma selenium</td>
<td></td>
</tr>
<tr>
<td>2 or 6 wk postpartum</td>
<td>0.47 (0.42, 0.53)</td>
</tr>
<tr>
<td>24 wk postpartum</td>
<td>0.41 (0.36, 0.47)</td>
</tr>
<tr>
<td>Maternal breast-milk selenium</td>
<td></td>
</tr>
<tr>
<td>2 or 6 wk postpartum</td>
<td>0.48 (0.37, 0.59)</td>
</tr>
<tr>
<td>24 wk postpartum</td>
<td>0.57 (0.39, 0.74)</td>
</tr>
</tbody>
</table>

^1 Values are from separate linear regression models that examined the association between maternal and infant plasma selenium or breast-milk and infant plasma selenium at baseline or the final measurement. *P < 0.001. BAN, Breastfeeding, Antiretrovirals, and Nutrition.

In conclusion, intervention strategies to reduce the prevalence of a low selenium status in Malawian women’s plasma and breast milk are needed. Recommendations to increase the intake of selenium-rich foods would be difficult in Malawi because the most common source of dietary selenium is maize, which is already eaten in large quantities and contains <7 μg Se/100 g (15, 17). Two other strategies that might be more feasible include the use of selenium-containing crop fertilizers or the use of organic selenium supplements. Fertilizers have proven to be effective in another country with low soil selenium (47), and they are widely used and frequently subsidized in Malawi. Alternatively, organic selenium supplements could be provided to women during antenatal visits and when mothers bring their infants for immunizations. Before choosing an intervention strategy, additional studies in HIV-infected mothers are needed to determine the dosage of selenomethionine in fertilizers or supplements that produces an optimal effect on plasma and milk concentrations.

We thank all the members of the BAN Study Team at the University of North Carolina at Chapel Hill, the CDC, Atlanta, and the University of North Carolina Project in Lilongwe. We are grateful to all women and infants who agreed to participate in the study. We also appreciate the laboratory work carried out by Laura Idso, Craig Lacher, and Setti Shahab-Ferdows. The authors’ responsibilities were as follows—MEB, CSC, DK, GT, DK, APK, DJH, CMvdH, and LSA: designed and conducted the study; EID and AF: were responsible for data management and provided statistical advice; GFC: led the laboratory analysis and contributed to the manuscript; VLF: carried out the analysis, drafted the manuscript, and had primary responsibility for the final content of the manuscript; and all authors: read and approved the final manuscript. Drug companies and nongovernmental entities that donated to or supported this study had no role in the design, implementation, analysis, or interpretation of the data. CMvdH received grant support from Abbott Laboratories and GlaxoSmithKline. VLF, MEB, GFC, CSC, DK, GT, DJH, EID, AF, APK, DJH, and LSA reported no conflicts of interest.

REFERENCES


