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Supported breastfeeding among women with diagnosed HIV in the UK- the current picture

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Background

- The HIV vertical transmission (VT) rate was 0.28% (95% CI 0.08%, 0.71%) among births to diagnosed women living with HIV (WLHIV) in the UK and Ireland in 2015-2016
- The **British HIV Association (BHIVA) recommends formula-feeding infants born to WLHIV** to eliminate risk of postnatal transmission but states that **virologically-suppressed treated women with good adherence wishing to breastfeed may be clinically supported to do so** (see BHIVA guidelines, right))
- The objective of this work was to estimate the prevalence of breastfeeding (BF) among WLHIV in the UK and describe current clinical practice

Methods

- **National Surveillance of HIV in Pregnancy and Childhood (NSHPC)** is part of Public Health England's Infectious Diseases in Pregnancy Screening Programme
- **All pregnancies to women living with HIV in the UK/Ireland are actively reported,** along with their HIV-exposed infants and any children diagnosed with HIV (<16yrs age)
- Data on supported breastfeeding has been collected since 2012
- **Enhanced surveillance of mother-infant pairs where BF was reported (planned/occurred) since August 2018**
- **Eligible population:** livebirth deliveries to diagnosed women 2012-19

BHIVA 2018 guidelines for management of supported BF

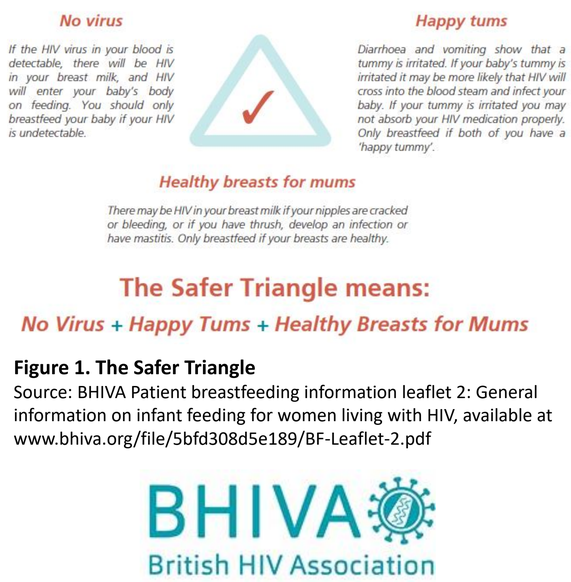

Figure 1. The Safer Triangle
Source: BHIVA Patient breastfeeding information leaflet 2: General information on infant feeding for women living with HIV, available at www.bhiva.org/file/5bfd308d5e189/BF-Leaflet-2.pdf

BHIVA British HIV Association

- **Mother and infant should be reviewed monthly** for HIV RNA testing during BF and for two months after stopping BF
- **Maternal cART** rather than infant pre-exposure prophylaxis advised
- **Infant HIV antibody testing for seroreversion** at age 18-24 months
- **BF for as short a time as possible**
  - exclusively for the first 6 months
  - cease if: signs of breast infection/mastitis, mother or infant has gastrointestinal symptoms or if maternal virus becomes detectable (the Safer Triangle)

Source: BHIVA guidelines on the management of HIV in pregnancy and postpartum 2018 (2019 interim update), available at www.bhiva.org/pregnancy-guidelines

NSHPC enhanced data collection

Enhanced surveillance: additional data collected by phone for **all reported cases of planned/supported breastfeeding** from NSHPC paediatric and maternity respondents. Questions included:

- Reasons for wanting to breastfeed
- Whether the woman's partner and GP knew her HIV status
- Duration of breastfeeding
- Whether any mixed feeding occurred before 6 months of age
- Maternal and infant test results during breastfeeding
- Maternal cART during breastfeeding
- Infant confirmatory antibody tests (18-24 months)

Results

Among 7187 livebirth deliveries, **135 (1.9%)** were reported as **planned and/or supported to breastfeed**

- **93%** (125/135) were births to women **diagnosed before pregnancy**
- **83%** (112/135) were pregnancies to women **born abroad**
- **13%** (18/135) were in women supported to BF >1 infant
- Median maternal age at delivery was 35 years (IQR: 31,40)

Enhanced data collection on 102 supported BF cases: BF ongoing in 9/102 and 3/102 were lost to follow-up.

Current case status among cases where BF was reported to have stopped (90/102):

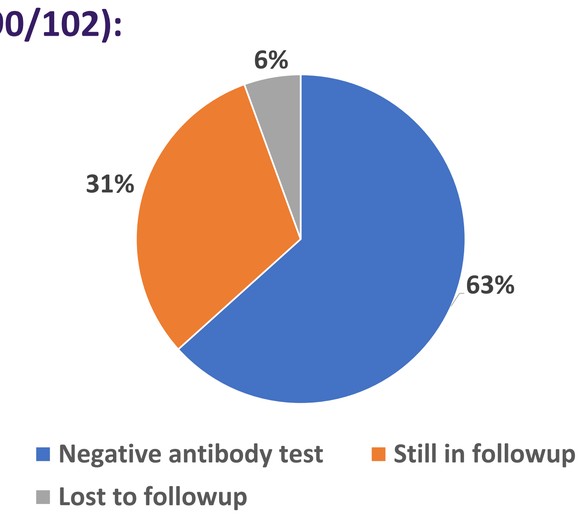

Figure 2: Infant follow-up (where BF stopped), *n* = 90

In 4/90, BF was reported to have stopped due to maternal VL rebound

- » 2 confirmed negative
- » 2 awaiting confirmatory antibody

In 3/90, ≥1 detectable VL was reported during BF period

- » 1 had negative antibody
- » 1 still in follow-up
- » 1 lost to follow-up

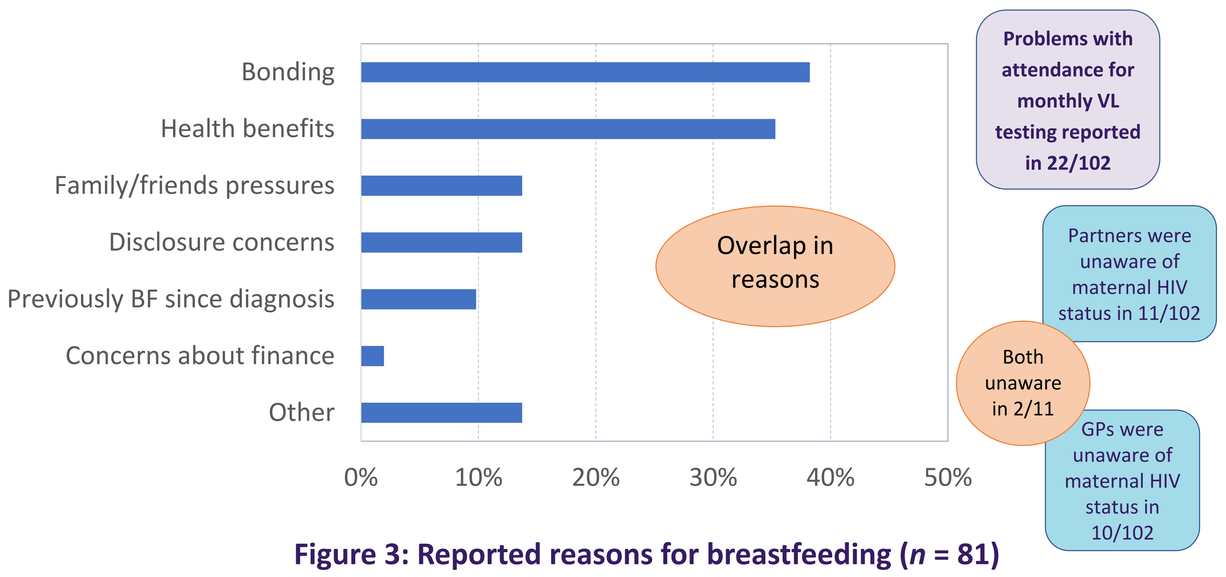

Figure 3: Reported reasons for breastfeeding (*n* = 81)

- Duration of BF ranged from 1 day to 2 years; median duration: 7 weeks (IQR: 3, 16)
- Reasons for stopping BF included: part of a plan to stop (36), mastitis (3), VL rebound (4), problems latching (6), hospitalisation of mother and/or infant (2)
- Mixed feeding before 6 months of age in 10/90 cases
- Mastitis reported in two cases where breastfeeding continued

Conclusions

BF reports reflect guideline updates, the current 'U=U' era and continued strides towards normalising maternity experiences for WLHIV. Cases to date have been few but diverse, underscoring the **need for careful monitoring to allow early identification and management of VL blips**. Although results show no VTs among supported BF cases so far, a postnatal transmission likely attributable to covert BF by a woman who had undetectable VL throughout pregnancy was reported in 2016. **Further insights enabled by national surveillance have the potential to guide policy and practice**.

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