

British HIV Association (BHIVA) and Children's HIV Association (CHIVA) Position Statement on Infant Feeding in the UK

BHIVA/CHIVA Writing Group on Infant Feeding in the UK

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To prevent the transmission of HIV infection during the postpartum period, BHIVA/CHIVA continue to recommend the complete avoidance of breastfeeding for infants born to HIV-infected mothers, regardless of maternal disease status, viral load or treatment.

Recent data from studies among women in Africa who exclusively breastfed while taking highly active antiretroviral therapy (HAART), or during treatment of the infant with nevirapine for 6 months, have shown low (0–3%) rates of HIV transmission. In the light of these findings, WHO has published new infant feeding guidelines applicable to settings where the avoidance of breastfeeding is not acceptable, feasible, affordable, sustainable or safe [1]. WHO now recommends the use of postpartum antiretroviral therapy, either maternal HAART or infant nevirapine, to reduce the risk of HIV transmission during the period of breastfeeding.

Since the WHO guidelines are not generally applicable to the UK setting, BHIVA/CHIVA have reviewed the data with a view to providing guidance to both people living with HIV and to healthcare providers with regard to the safety of different feeding practices and the related safeguarding issues.

The summary guidance presented below takes into account the substantial number of responses to a public consultation on an earlier draft of this advice, incorporating diverse and often conflicting views and data interpretations. The Writing Group reconvened to address these issues, particularly the concerns expressed by many that any new recommendations should not undermine the extensive and highly successful work to reduce mother-to-child transmission of HIV by complete avoidance of breastfeeding.

With current interventions, mother-to-child HIV transmission in the UK is now very low, being ~1% for all women diagnosed prior to delivery, and 0.1% for women on HAART with a viral load <50 HIV copies/ml plasma [2] at delivery.

Current BHIVA/CHIVA pregnancy management guidelines include HAART, the option of managed vaginal delivery for women with an undetectable HIV viral load on HAART at term, pre-labour caesarean section for women with a detectable viral load, and exclusive feeding with infant formula milk from birth [3].

Mother-to-child HIV transmission can occur through breastfeeding, with an ongoing infection risk throughout the breastfeeding period; by contrast, there is no risk of post-natal HIV transmission if the infant is not breastfed [4–6].

The long-term effects of exposing infants to HAART through breast-milk are unknown.

- 1. For these reasons, BHIVA/CHIVA continue to recommend that, in the UK, mothers known to be HIV infected, regardless of maternal viral load and antiretroviral therapy, refrain from breastfeeding from birth.**

While all other interventions to prevent mother-to-child HIV transmission are provided through HIV commissioned services, it is recognised that infant formula milk is not universally provided and that this lack of provision can be a barrier to the successful implementation of this recommendation. BHIVA/CHIVA therefore recommend that:

2. All HIV-positive mothers in the UK should be supported to formula-feed their infants. This means that:

- a. HIV-positive women should be informed to formula-feed their infants and advised on access to infant formula milk and appropriate equipment (including sterilisers and bottles).
 - (i) A starter pack (infant formula milk and appropriate equipment) should be freely available as part of the package of care to prevent mother-to-child transmission.
 - (ii) Ongoing infant formula milk supply will depend on individual circumstances:
 - (1) Women on low income and eligible for Healthy Start should be informed about how to purchase infant formula milk with their vouchers (see Appendix 1).
 - (2) For women without independent means and not eligible for Healthy Start, provision should be negotiated at a local level (see Appendix 2).
- b. In the case of women with HIV, whose immigration status is uncertain or who are applying for asylum, who have refrained from breastfeeding and whose babies are being fed with infant formula milk, it should be recognised that removal of the infant from the UK to a setting where continued formula-feeding is not feasible, affordable, sustainable and safe would represent a direct threat to the health and life of the child.

Guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS (EAGA) [7] states: 'Under exceptional circumstances, and after seeking expert professional advice on reducing the risk of transmission of HIV through breastfeeding, a highly informed and motivated mother might be assisted to breastfeed.'

New data emerging from observational cohort [8–11] and randomised controlled studies [12,13] in Africa, in settings where refraining from breastfeeding is less safe than in the UK, show low rates (0–3%) of HIV transmission during breastfeeding in mothers on HAART. BHIVA/CHIVA acknowledge that, in the UK, the risk of mother-to-child transmission through exclusive breastfeeding from a woman who is on HAART and has a consistently undetectable HIV viral load is likely to be low but emphasise that this risk has not yet been quantified. Therefore, avoidance of breastfeeding is still the best and safest option in the UK to prevent mother-to-child transmission of HIV.

BHIVA/CHIVA recognise that occasionally a woman who is on effective HAART and has a repeated undetectable HIV viral load by the time of delivery may choose, having carefully considered the aforementioned advice, to exclusively breastfeed. Under these circumstances, child protection proceedings, that have until now been appropriate, must be carefully considered in the light of the above and emerging data. While not recommending this approach, BHIVA/CHIVA accept that the mother should be supported to exclusively breastfeed as safely, and for as short a period, as possible. Thus,

3. In the very rare instances where a mother in the UK who is on effective HAART with a repeatedly undetectable viral load chooses to breast feed, BHIVA/CHIVA concur with the advice from EAGA [7] and do not regard this as grounds for automatic referral to child protection teams. Maternal HAART should be carefully monitored and continued until one week after all breastfeeding has ceased. Breastfeeding, except during the weaning period, should be exclusive and all breastfeeding, including the weaning period, should have been completed by the end of 6 months.

The 6-month period should not be interpreted as the normal or expected duration of breastfeeding in this setting but as the absolute maximum, since exclusive breastfeeding is not recommended beyond this period under any circumstances. The factors leading to the maternal decision to exclusively breastfeed should be regularly reviewed and switching to replacement feeding is advocated as early as possible, whether this be after one day, one week or 5 months. It is acknowledged that this strategy will result in a period of mixed feeding and that there are no data to describe the risk related to this during fully suppressive maternal HAART. The Writing Group, however, considered this to be preferable to continuing exclusive breastfeeding to 6 months followed by weaning over a period of several weeks, recognising that less than 1% of mothers in the UK are exclusively breastfeeding at 6 months [14].

4. Prolonged infant prophylaxis during the breastfeeding period, as opposed to maternal HAART, is not recommended.

Whilst serious adverse events were not reported in the infants given nevirapine for up to 6 months [12], there are currently insufficient safety data to advocate this approach given the particular safety concerns regarding the use of nevirapine in adults uninfected by HIV. The use of nevirapine for longer than the 2–4 weeks currently recommended for post-exposure prophylaxis is not advised [15].

5. Intensive support and monitoring of the mother and infant are recommended during any breastfeeding period.

To ensure continued antiretroviral efficacy we recommend monthly maternal viral load testing. To identify any drug toxicity or HIV transmission in the infant, monthly assessment is advised. The timing of follow-up testing for the infant to exclude HIV infection must be adjusted according to the time of last possible exposure. Education to identify factors that might increase the risk of transmission, despite HAART (e.g. mastitis, cracked nipples), should be given and the resources to enable switching to safe alternatives should be in place.

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Appendix 1. HIV and infant feeding: access to financial assistance

1. Where financial reasons are identified as a barrier to avoiding breastfeeding, financial assistance may be available to women/families depending on their circumstances.

Asylum seekers

2. *Pregnant women and children under 3*: Expectant women and young children between 1 and 3 years old who are in receipt of support from the UK Border Agency under section 95 of the Immigration & Asylum Act 1999 (the '1999 Act') are eligible to receive an additional £3 per week. Children under the age of 1 will receive an additional £5 per week. These payments are intended to allow supported asylum seekers to purchase healthy food. Families who are applying for support do not need to request the payment for dependant children separately, as this will be issued automatically when support is allocated. Women who are pregnant need to apply in writing to the UK Border Agency, enclosing confirmation of the pregnancy together with the child's estimated due date of delivery (EDD).
3. *Maternity payment*: Pregnant women, who are supported under section 95 of the 1999 Act, may be eligible to apply for financial support (a single payment of £300) to assist with the costs associated with the birth of a new baby. Applications must be made to the UK Border Agency in writing, signed by the applicant and include the appropriate documentary evidence to confirm the pregnancy and the EDD.
4. Following the birth of the child, a request for the dependant to be added to the support application should be made to the UK Border Agency in writing, signed by the applicant, and should include the original full birth certificate. If it is decided that the applicant should be added to the support application, the family's support will be increased to include the appropriate rate for a child under the age of 16 and the additional payment of £5. The additional payment of £3 to the new mother will cease.
5. *Asylum seekers who are recognised as refugees*: Asylum seekers granted refugee status qualify for Department for Work and Pensions' benefits.
6. Useful information:
 - UK Border Agency Asylum Support Customer Contact Centre on 0845 602 1739

- Policy Bulletin 78: Additional payments to pregnant women and children aged under 3
www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumsupportbulletins/accesstosupport/pb78?view=Binary
- Policy Bulletin 37: Maternity payment
www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumsupportbulletins/accesstosupport/pb37?view=Binary

Low income pregnant women and families, and pregnant women under 18 years old

7. Women at least 10 weeks pregnant and children under four years old in families getting one of a range of benefits or tax credits, and women under 18 years old (unless subject to immigration controls) qualify for support from Healthy Start. The current qualifying benefits and tax credits are:
 - income support
 - income based jobseekers' allowance
 - income related employment and support allowance
 - child tax credit (without working tax credit unless working tax credit run-on only is in payment) AND an annual family income of £16,190 or less (2010/11).
8. Healthy Start offers vouchers that can be put towards the cost of milk, fresh fruit and vegetables, and infant formula milk in participating shops. It also offers coupons that can be swapped through the NHS for Healthy Start vitamin supplements.
9. Potential applicants can request a copy of the application leaflet from the Healthy Start helpline 0845 607 6823, and may also be able to collect them from GP surgeries or Children's Centres. Organisations can make bulk orders of application leaflets and other Healthy Start resources using the DH orderline on www.orderline.dh.gov.uk or 0300 123 1002.

Other routes to accessing infant formula

10. *Sale of Goods for Mothers and Children (Designation and Charging) Regulations 1976*: Under these regulations, Trusts and Health Boards may sell infant formula to the general public through baby clinics or other venues at cost price plus 10%. However, there is no legal obligation on them to sell infant formula this way and many have chosen not to do so. In Scotland, the National Health Service (Supply of Goods at Clinics etc.) (Scotland) Regulations 1976 apply.

Appendix 2. *Provision of infant formula milk: case study*

1. The Infant Formula Milk Scheme (IFMS) is funded by Lambeth PCT on behalf of the Three Boroughs (Lambeth, Southwark and Lewisham).
2. The management of the budget, co-ordination and monitoring the usage of the IFMS sits within the role of the HIV Clinical Nurse Specialist (CNS) Service Manager.
3. Paediatric CNS sees all the antenatal HIV pregnant women at around 30 weeks for a discussion about prevention of mother-to-child transmission including avoidance of breastfeeding. At this point, their starter kit (comprising steam steriliser, four bottles and four tins of formula) is dispensed.
4. The criteria for the scheme are that the women have to live in the boroughs of Lambeth, Southwark or Lewisham and be attending a treatment centre in those boroughs.
5. Only those women with no recourse to public funds are eligible for the ongoing milk scheme, which provides infant formula milk for the first year of life. They have to have evidence of inability to access public funds; evidence of being an overseas student; or a letter stating that their passport is lodged at the home office to gain ILTR (asylum seekers and refugees).
6. The Paediatric CNS dispenses infant formula milk monthly from paediatric outpatients for those accessing the 'ongoing infant formula milk scheme'.

Contact: robyn.cross@gstt.nhs.uk for more details and advice on the scheme.