Infant feeding in the UK

BHIVA/CHIVA Guidelines Writing Group

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1) 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[1] at delivery.
2) Current BHIVA/CHIVA pregnancy management guidelines include HAART, the option of managed vaginal delivery for women with an undetectable HIV viral load on HAART, pre-labour caesarean section for women with a detectable viral load and exclusive formula feeding from birth[2].
3) HIV transmission can occur through breast-feeding, with continuing risk throughout the breast-feeding period, whilst there is no risk of HIV transmission from mother-to-child if the infant is not breastfed [3-5].
4) The long-term effects of exposing infants, the vast majority of whom will be uninfected, to HAART through breast-milk, are unknown.
5) **Therefore BHIVA/CHIVA advises that, in the UK, refraining from breastfeeding from birth should continue to be recommended for all infants of mothers known to be HIV infected regardless of maternal viral load and antiretroviral therapy.**
6) **All HIV positive mothers should be supported to formula-feed their infants. This means that formula milk and appropriate equipment (including sterilisers and bottles) must be freely available as part of the package of care to prevent mother-to-child transmission.**
7) New data emerging from observational cohort[4-9] and randomised controlled studies[10;11] in Africa, in settings where refraining from breast feeding is less safe than in the UK, show low rates (0 - 3%) of HIV transmission during breast-feeding in mothers on HAART.
8) **BHIVA/CHIVA acknowledges that, in the UK, the risk of mother-to-child transmission from a woman who is on HAART and has a consistently undetectable HIV viral load is likely to be low but has not yet been quantified.**
9) Therefore, although formula feeding is still the best and safest option in the UK to prevent mother to child transmission of HIV, **if a woman is on effective HAART and chooses to exclusively breast-feed having carefully considered the aforementioned advice, she should be supported to do so as safely, and for as short a period, as possible.**
10) **Maternal HAART should be continued until one week after all breast-feeding has ceased.**
11) **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 month[10] there are currently insufficient safety date 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 2-4 weeks as currently recommended for post exposure prophylaxis is not advised[12].

12) There are no data comparing HIV transmission rates related to mixed feeding compared with exclusive breast-feeding, in women on HAART with an undetectable viral load. **Therefore, if the baby is to be breastfed in the circumstance outlined in point 9, exclusive breast-feeding is recommended**.

13) **Intensive support and monitoring of the mother and infant is recommended during any breast-feeding 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.

Reference List

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