Policy on Breastfeeding and HIV

Revised April 2005

Introduction

In 1990, the New York State Department of Health developed a policy and recommendations regarding breastfeeding and HIV, with the help of a workgroup made up of representatives from the CDC, HRSA, the American Academy of Pediatrics, the Institute of Medicine's Subcommittee on Lactation, and the Commissioner's Prenatal-Perinatal Advisory Council. This document is an update of that policy. The recommendations remain the same; the background section reflects the current evidence base supporting these recommendations.

Background

It is known that breastfeeding is beneficial to both the infant and the mother in many ways; it is the gold standard for feeding newborns. For the infant the benefits of breast milk include providing the best nutrition, strengthening the infant's immune system, and emotional bonding with the mother. Breastfeeding also offers the mother numerous health benefits, including decreased postpartum bleeding, increased spacing between children, and decreased risk of breast cancer and ovarian cancer (American Academy of Pediatrics).

Maternal HIV infection is one of the few contraindications to breastfeeding in the United States. According to a recent article, interviews with post-partum women revealed that although 95% of the women were aware of the risk of vertical (mother-to-child) HIV transmission, only 60% were aware that HIV could be transmitted via breastmilk (Walter, et al.). By following all the current guidelines in the United States (taking antiretroviral drugs during pregnancy and labor, administering a short course of anti-retroviral drugs to the infant, and not breastfeeding) we can reduce the risk of vertical HIV transmission to about 2% (www.avert.org/pregnancy.htm)

There was evidence that HIV could be transmitted via breastmilk as early as the mid 1980's when HIV was cultured from the cell-free component of breastmilk in a laboratory (Thiry, et al.). Multiple epidemiologic studies of mother-to-child transmission of HIV confirmed transmission via breastfeeding. In the early 1990s the European Collaborative Study (ECS) followed a large cohort of infants and showed that breastfeeding was an independent risk factor for transmission of HIV (ECS). More recent epidemiologic studies done since 2000 have shown more definitively that HIV can be transmitted via breastmilk. It has been estimated that in the absence of any antiretroviral treatment, HIV is transmitted to 16% of infants breastfed by HIV positive mothers, with 47% of all perinatal HIV infections due to breastfeeding. (Nduati, et al.) This rate increases with increasing viral loads in the mother, increasing length of breastfeeding, mixed formula feeding and breastfeeding, younger maternal age, higher parity, and breast abnormalities such as mastitis (Read, et al.). There have been no studies of transmission via breastfeeding in women or infants who are receiving perinatal antiretroviral therapy; however, we know that currently available antiretroviral therapy does not completely eliminate the virus in breastmilk. Given that there may be a risk of transmitting HIV to the infant via breastfeeding even with appropriate use of current antiretroviral therapy, formula is the safest and best way for HIV-positive mothers in the United States to feed their infants. There is still debate about the most appropriate method of infant feeding in developing countries, where rates of life-threatening diarrhea and other infectious diseases are much higher, formula is too expensive for most families, and the water supply may not be sanitary.

Recommendations

- Woman who are HIV-positive should be counseled not to breastfeed because of the risk of HIV transmission via breastmilk. In addition, they should be referred for appropriate HIV care.
- The HIV status of a woman should never be assumed; all pregnant women and women planning to have children should be counseled, and testing for HIV should be recommended. The risk of transmitting HIV to the infant needs to be fully explained so that women can make appropriate choices regarding getting HIV tested before and/or during pregnancy.
- At the time of delivery if a woman's HIV status is unknown, expedited testing should be offered. Women should know that even if they refuse testing, there is universal mandatory testing for their newborn. For women without prenatal HIV test results who decline HIV testing during delivery, hospitals in NYS are required to conduct expedited HIV testing of all newborns with the results available within 12 hours of testing using the Oraquick HIV test.
- Women who use IV drugs, or are involved in other high risk behavior for HIV who initially test HIV-negative during pregnancy should be retested at labor.
- Regardless of their HIV status, women who use IV drugs should be counseled against breastfeeding because of their ongoing risk of HIV infection. Transmission rates via breastfeeding are highest at the time of primary HIV infection and seroconversion. In addition to HIV risk, drugs can be transmitted via breastmilk. Counseling and assistance in stopping drug use should be provided.
- Women who are HIV-negative but are involved in high risk sexual behavior should be strongly counseled to use condoms, both to protect herself, and to prevent mother-to-child HIV transmission. Transmission rates via breastfeeding are highest at the time of primary HIV infection and seroconversion.
- Women who are counseled not to breastfeed, should be given appropriate education on the nutritional needs of their infants, and instructed on how to feed their infants with formula.

References

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