Supporting Mothers Living With HIV in the United States Who Choose to Breastfeed

To the editor—Yusuf et al [1] reported outcomes of 10 infants exclusively breastfed (median 4.4 months) by virally suppressed women living with HIV (WLHIV) in the United States who remained HIV uninfected. The infants received antiretroviral drug (ARV) prophylaxis with zidovudine (ZDV), lamivudine (3TC), and nevirapine (NVP) for 4 to 6 weeks, followed by NVP alone through 6 weeks after breastfeeding cessation. In response, 2 editorial commentaries raised discussions about the prospects of offering WLHIV in the United States the choice of breastfeeding [2, 3].

Despite recommendations to avoid breastfeeding by WLHIV [4], WLHIV in resource-rich settings express a desire to breastfeed or have breastfed their infants [5, 6]. At an urban HIV clinic at Children's National Hospital (CNH) in Washington, DC, several WLHIV have chosen to breastfeed their infants. Breastfeeding waivers are not required to avoid additional stigma and the risk of generating medical mistrust. Our current approach to risk-reduction includes ensuring maternal viral suppression with antiretroviral therapy (ART), infant ARV prophylaxis (6 weeks ZDV and NVP), counseling on exclusive breastfeeding during the first 6 months of life, HIV nucleic acid tests (NAT) for infants (1, 2, and 4 months of age; every 3 months through breastfeeding; 1, 3, and 6 months after breastfeeding cessation), and bimonthly maternal HIV NATs. In this letter, we provide our perspective and additional data on breastfeeding among WLHIV in the United States.

Between 2018 and 2021, seven infants born to 6 WLHIV receiving care at CNH were breastfed. Risk-reduction measures were provided to all but one mother who disclosed breastfeeding after her infant's visit at 4 months of age. All WLHIV received ART, 4 were virally suppressed (<20 copies/mL), and 2 had low levels of viremia (30-40 copies/mL) before delivery. Three (50%) WLHIV had breastfed previously. None of the infants received prolonged ARV prophylaxis: one received 4 weeks of ZDV (mother with late breastfeeding disclosure), 3 received 6 weeks of ZDV, 2 received 6 weeks of ZDV and NVP, and 1 received ZDV plus 3TC and NVP for 2 weeks followed by 4 weeks of ZDV. Infant regimens varied depending on maternal/infant provider's decision, accounting for maternal preference/capacity. The duration of exclusive breastfeeding varied between 2 weeks and 6 months. Despite the counseling, all but one WLHIV disclosed some degree of mixed breastfeeding with formula. Three weaned infants are confirmed to be HIV uninfected, while 4 infants (aged 6-15 months) continue to be breastfed with confirmed negative NAT testing to date and suppressed maternal viral load.

Many unanswered medical, ethical, and social questions within the U=U (undetectable=untransmittable) paradigm of breastfeeding among WLHIV remain, including the need for prolonged infant ARVs as a trade-off for breastfeeding with effective modern maternal ART, risks of mixed feeding practices with sustained maternal viral suppression in resource-rich settings, optimal mother-infant dyad testing, and optimal ARV regimens for infants and WLHIV including the future use of long-acting maternal ARVs [1–3]. Our joint experiences highlight the need for studies to find the best risk-reduction approach to allow WLHIV in the US autonomy when choosing to breastfeed their infants.

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