US HEALTHCARE PROVIDERS SURVEY ON BREASTFEEDING AMONG WOMEN LIVING WITH HIV

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Background

- WHO guidelines recommend breastfeeding (BF) for women living with HIV (WLHIV)[1]
  - *Consistent with recent evidence from trials such as Mma Bana and PROMISE, where MTCT from breastmilk was 0.3% with up to 6 months of BF in the setting of cART*
- US DHHS Perinatal Guidelines recommend complete avoidance of BF by WLHIV[2]
  - *Regardless of UND (undetectable) VL (viral load) and cART (combined antiretroviral therapy)*
  - *Similar to other high-income countries*
- Many US WLHIV inquire about BF[3]
  - *Some BF despite current recommendations*

1. **World Health Organization**, United Nations Children's Fund. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: 2016.
2. **Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/PerinatalGL.pdf. Accessed [2/5/17]**
3. **Levison J**, Weber S, Cohan D. Breastfeeding and HIV-infected women in the United States: harm reduction counseling strategies. Clin Infect Dis 2014;59:304-9.

Objective

Determine US HCP (healthcare provider) experiences, beliefs, and attitudes regarding BF by WLHIV

Methods

- **Mixed-methods:**
  1. Anonymous online survey
     - pilot-tested for validity
     - 28 closed-ended and 8 open-ended questions
     - Univariate analysis and thematic analysis with Excel
  2. Qualitative HCP interviews
     - Currently ongoing
- **Population**
  - Inclusion criteria:
    - HCP caring for WLHIV or HIV-exposed infants
  - Exclusion criteria:
    - Must practice in the US
      - 10 excluded for not currently practicing in US
    - Have not counseled a mother regarding breastfeeding in the past 2 years
      - 13 excluded for no BF counseling within past 2 years
  - Survey sent to all members of international repro-ID-HIV listserv
    - **83 eligible participants** from 106 responses

RESULTS (%)

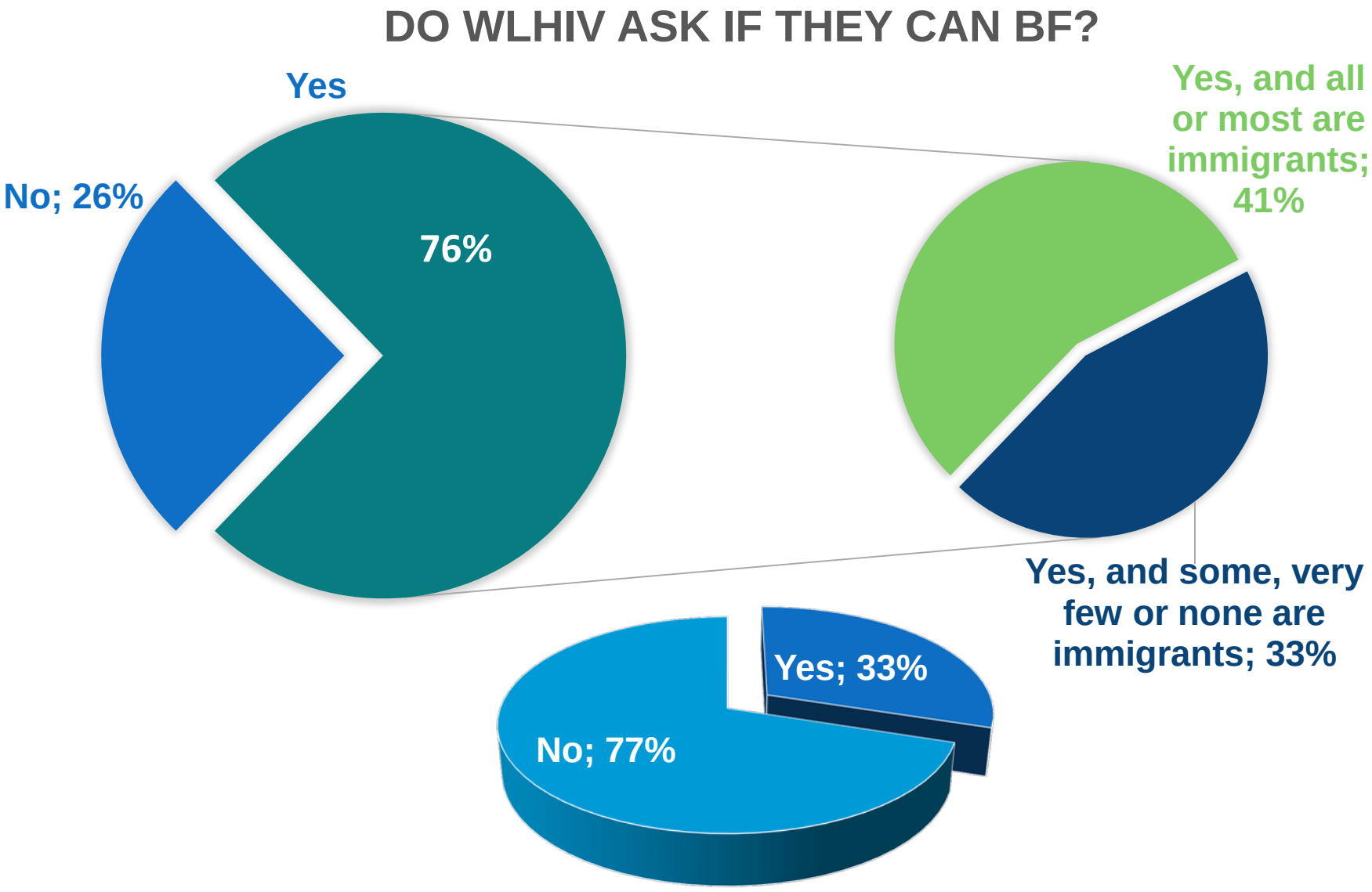
DEMOGRAPHICS

RACE/ETHNICITY	White	65
	Black	11
	Other	24
GENDER	Female	87
	Male	12
	Trans	1
AGE	20-29	1
	30-39	34
	40-49	30
	50+	34
MEAN YEARS IN PRACTICE	15, SD 10	
HAVE CHILDREN?	No	31
	Yes	69
BF YOUR CHILDREN?	Yes	93
	No	7

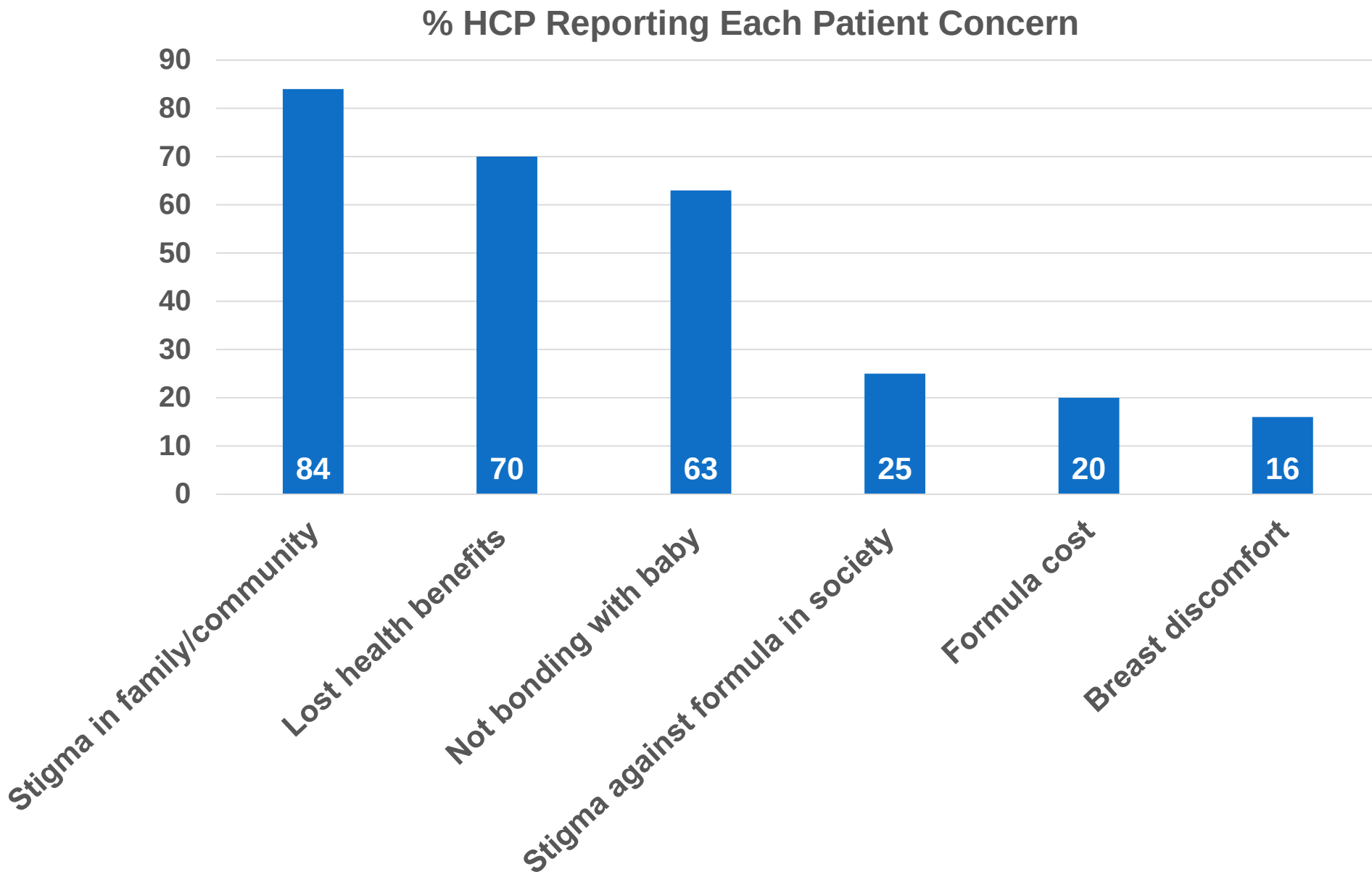
PRACTICE SETTING

PRACTICE TYPE	Academic	72
	Community	22
	Other	6
PRACTICIONER TYPE	MD	72
	RN/APP	16
	Other	12
PRACTICE AREA	OB/GYN	48
	Adult HIV Medicine	29
	Pediatrics	14
	Other	9
REGIONAL DISTRIBUTION	Northeast	25
	South	42
	Midwest	13
	West	35

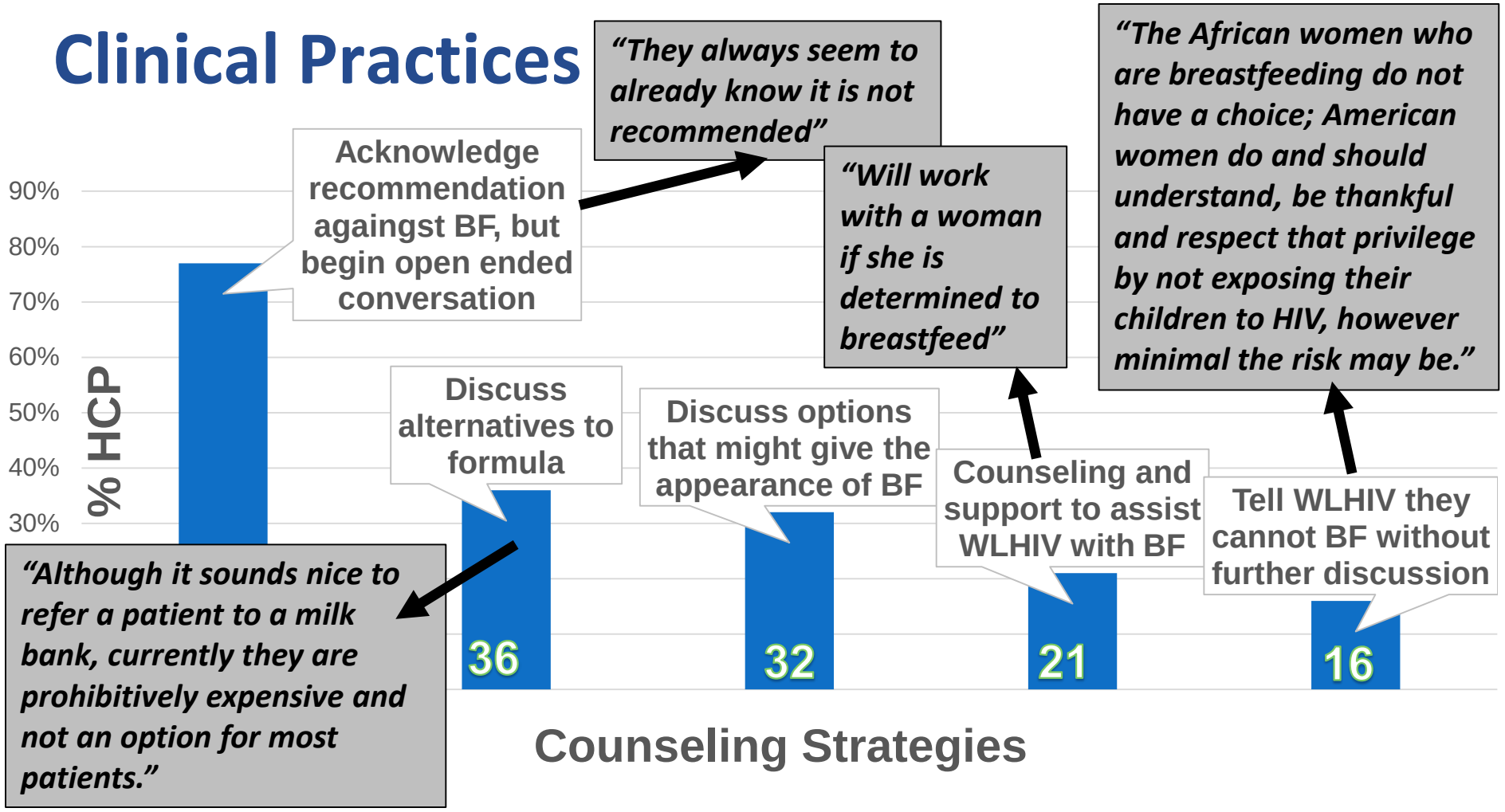
BF Interest


DO WLHIV ASK IF THEY CAN BF?
Yes
No; 26%
76%
Yes, and all or most are immigrants; 41%
Yes, and some, very few or none are immigrants; 33%
Yes; 33%
No; 77%
Do you have patients with HIV who BF despite recommendations?

Patient Concerns about Not BF



Clinical Practices



39% of HCP have had to explain why a patient should not BF to her family

- Some aware of HIV status

"HIV can be transmitted through breastfeeding"

- Often provide alternative explanation to help conceal status

"Mother is on blood pressure or diabetes medicine that can reach the infant via breastmilk…or that baby couldn't latch on well or wasn't growing well"

Diverse perspectives on current policy and HCP's role in infant-feeding decisions

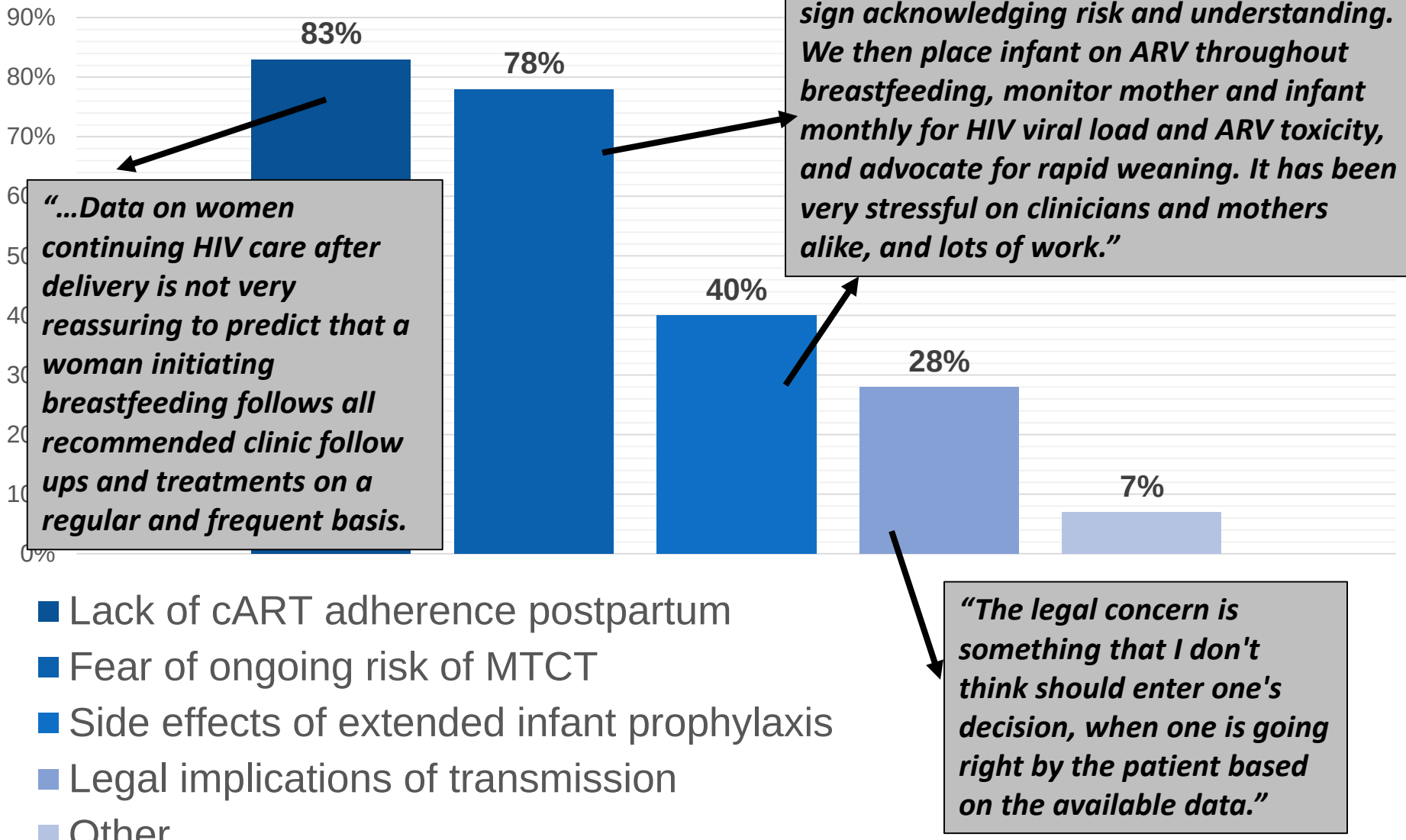
HCP as decision-maker:
prohibit BF to avoid risk

"I am against breastfeeding (with maternal HIV) in areas where formula feeding is safe because there will always be some risk of HIV transmission. The baby cannot make an informed choice of whether or not to breastfeed. The role of the pediatrician is to advocate for the child and prevent illness in the child, not to acquiesce to the wishes of the parent."

Shared decision-making:
support informed patient decisions in light of personal context and culture

"My hope is to provide the research, options, risks and benefits of breastfeeding and letting the mother/couple decide…We need to get pediatricians on board for their fear is so high and women are not given the option."

HCP Concerns about Their Patients BF



"…Data on women continuing HIV care after delivery is not very reassuring to predict that a woman initiating breastfeeding follows all recommended clinic follow ups and treatments on a regular and frequent basis.

"We developed a detailed counseling guide which we review with mom and ask her to sign acknowledging risk and understanding. We then place infant on ARV throughout breastfeeding, monitor mother and infant monthly for HIV viral load and ARV toxicity, and advocate for rapid weaning. It has been very stressful on clinicians and mothers alike, and lots of work."

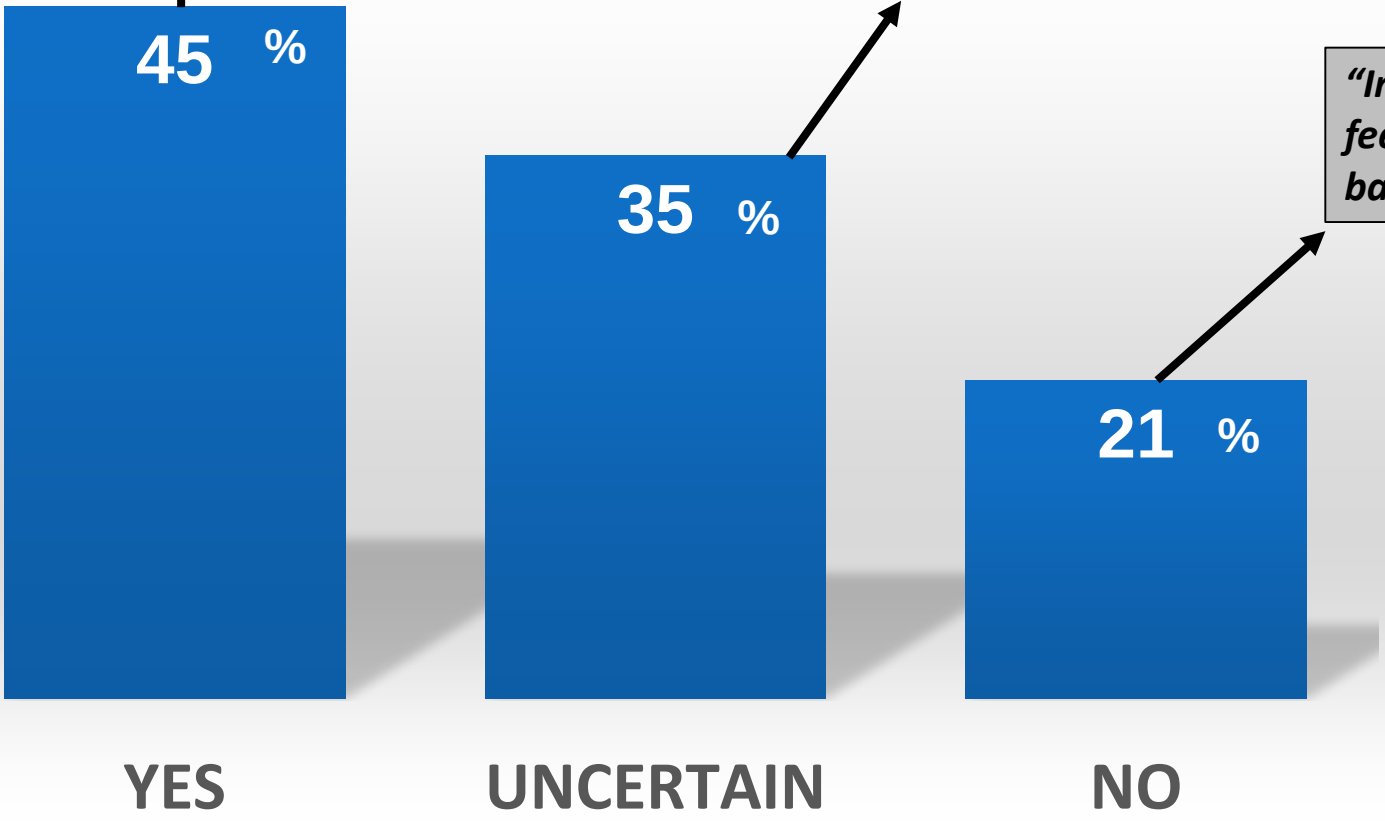
"The legal concern is something that I don't think should enter one's decision, when one is going right by the patient based on the available data."

HCP Willingness to Offer BF to US WLHIV with UND VL

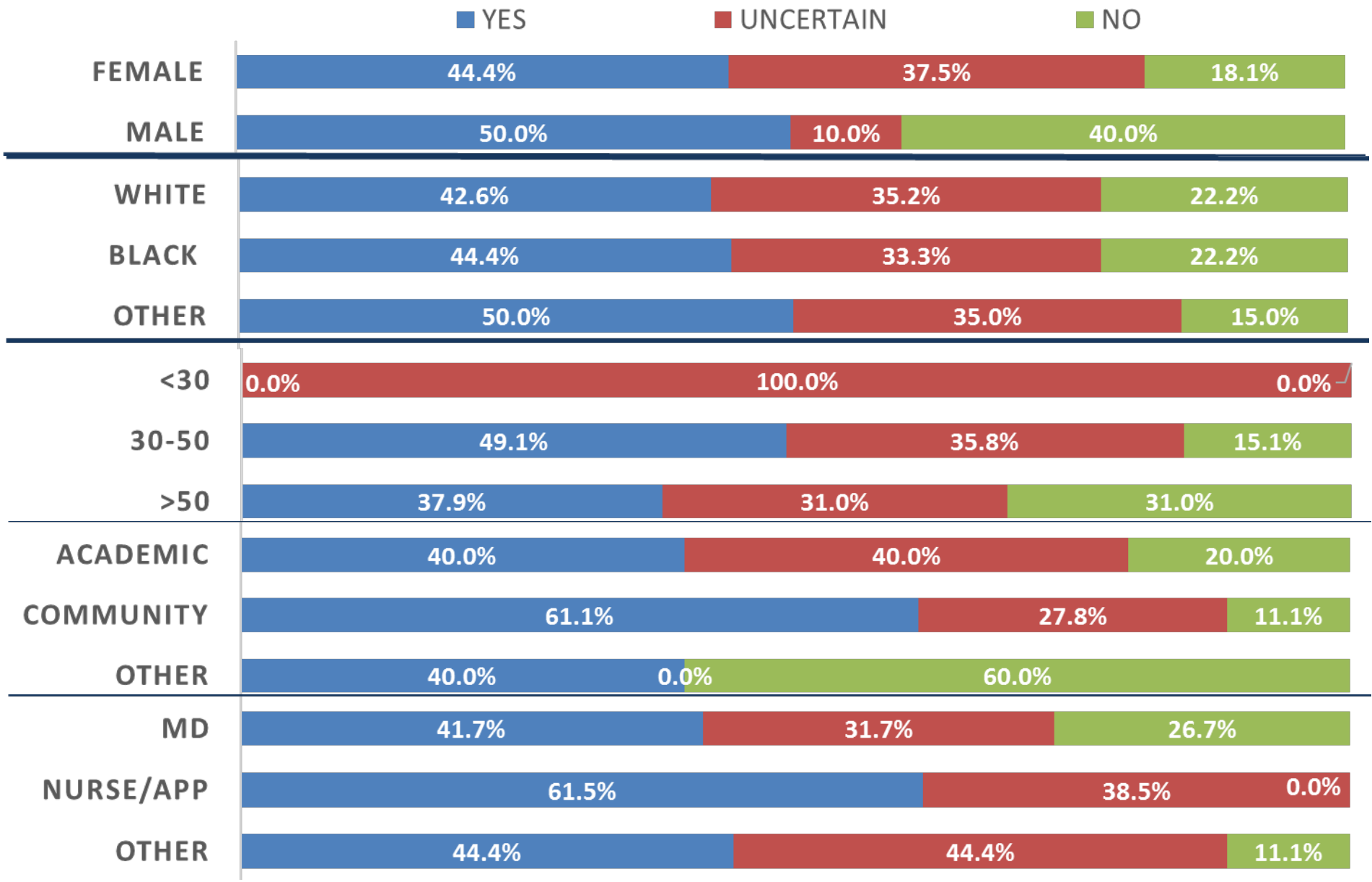
"If they decide to breastfeed that is their prerogative and I would assist them despite disagreeing with them"

"I think it depends on the mother's status - many of our patients have chaotic lives and, often through no fault of their own, poor adherence with antiretroviral therapy."

"In the US where formula feeding carries no risk to baby there is no threshold."



Providers Willingness to Consider BF with UND VL



Trends in HCP views on offering BF

No statistically significant association between willingness to offer BF and:

- ***Age***
- ***Race/ethnicity***
- ***Gender***
- ***US region***
- ***Specialty (OB, Peds, ID)***
- ***Practice setting***
- ***Provider type***

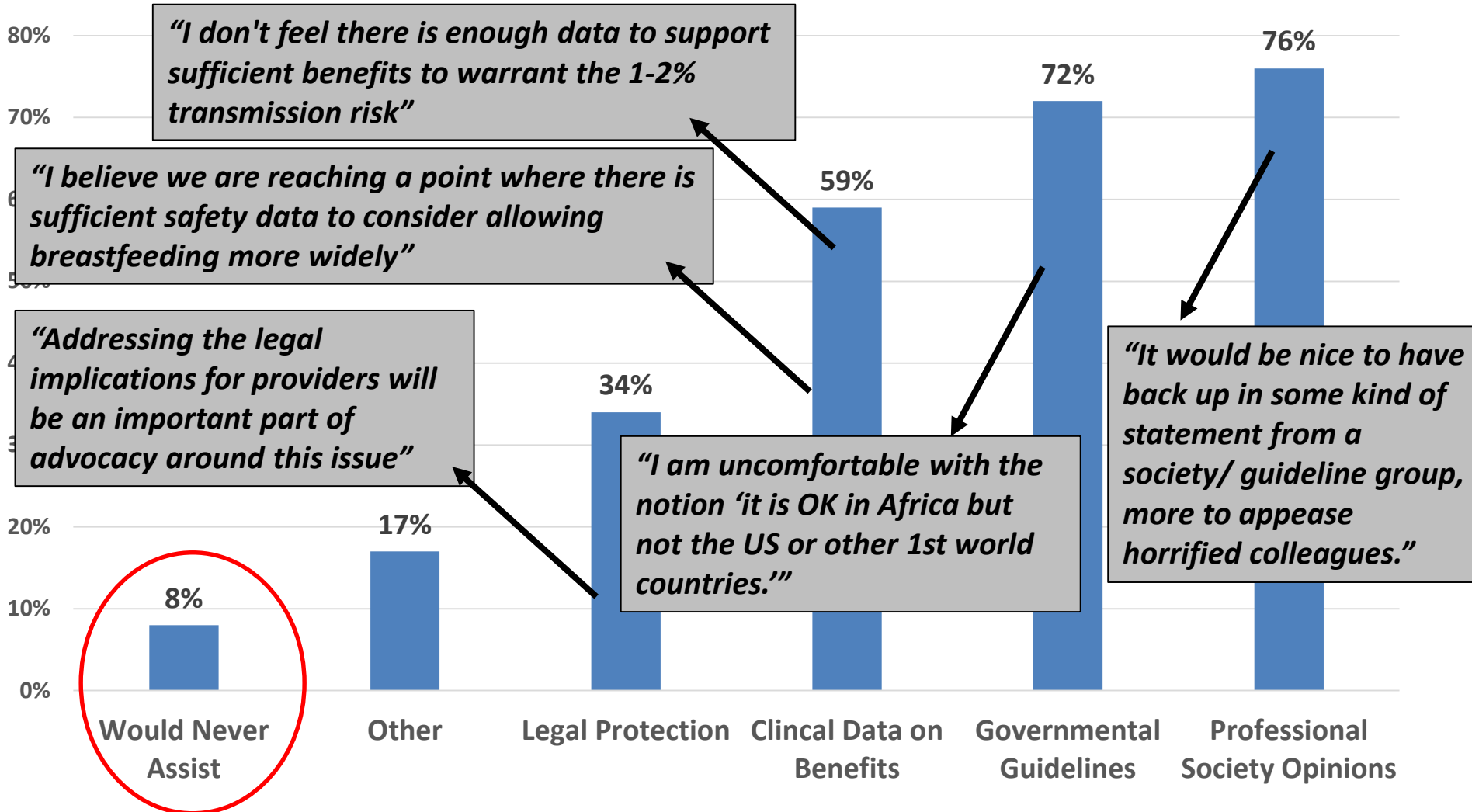
Number of years in practice was significant

(p-value 0.04 in preliminary data)

Willing to offer BF: median 12 years, interquartile range 5-21

Not willing to offer BF: median 21 years, interquartile range 11-26

Mechanisms which would have to be in place for HCP to assist WLHIV with consistently UND VL to BF



Limitations

1. Low survey response rate
2. Repro-ID-HIV listserv: may not be representative of all HCP who care for US WLHIV
3. Not enough representation from Pediatricians

Conclusions

1. US WLHIV commonly ask about BF, and many have concerns about the recommendation to avoid BF
2. Some BF against current medical advice
3. Nearly 1/2 of HCP would consider offering BF for WLHIV with undetectable VL
   - ***Regardless of specialty***
   - ***Longer time in practice = less likely to be willing to offer BF***
4. Guidance from professional and governmental organizations would be helpful

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Thank you!

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