HIV AND PREGNANCY

CLINICAL GUIDELINE MCSA.MBC.2.1

The Prevention of Mother to Child Transmission (PMTCT) program consists of four pillars:

Prevention of HIV (especially among women of childbearing potential)	**Prevention of unintended pregnancies among women living with HIV**	**Prevention of HIV transmission from a woman living with HIV to her infant**	**Appropriate treatment, care, and support to women living with HIV, their children, partners and families**

This guideline mainly focuses on the prevention, diagnosis and treatment of HIV during pregnancy and puerperium and is based on the latest (2019) Guideline for the Prevention of Mother to Child Transmission of Communicable Infections published by the South African National Department of Health (DOH Guideline – weblink at end of document)

Prevention of Unintended Pregnancies and achieving Safe Conception for Women living with HIV

Family planning is an integral part of antiretroviral treatment (ART) services, and every encounter with reproductive aged individuals should be used as a window of opportunity to discuss issues around family planning.

Ideally, engage women living with HIV and their partner in a couples-based approach, as the health and commitment of both partners is important for safe contraception and/or conception

1. **Couples currently wanting to conceive**
    - Recommend, discuss, and agree on steps before conception
    - Optimise HIV treatment in the partner living with HIV (sero-discordant couple), or in both partners living with HIV (sero-concordant couple).
        - Continue to use condoms until optimised
        - Document HIV status of both partners
        - Identify and manage co-morbidities, including syphilis and other STIs
        - Initiate or continue ART and support good adherence
        - Maintain an undetectable viral load (VL), ideally for 4-6 months before conception
        - Start folate supplementation and check Hb if clinically pale

        - Consider post exposure prophylaxis (PrEP) for the uninfected partner
        - Initiating Dolutegravir (DTG) in women wanting to conceive now or in the future may carry risks. Counsel the mother on use of Dolutegravir (DTG) in pregnancy and allow her to make an informed choice. See **Dolutegravir in Pregnancy** on page 17 of DOH Guideline
    - Once viral load suppression is achieved in the HIV-infected partner(s), the following additional options are available to make conception safer
        - timed, limited, peri-ovulatory, sex without a condom
        - intravaginal insemination
        - male circumcision
        - intra-uterine insemination
        - sperm washing
        - surrogate sperm donation
    - If pregnancy confirmed, counsel the mother to book an antenatal visit before 14 weeks and to continue using condoms consistently during pregnancy and the breastfeeding period

2. **Couple not currently desiring a child, but may do so in the future**
    - Counsel about options for contraception including long-acting reversible contraceptives (IUCD and implants), and barrier methods
    - Dual method is always recommended
        - A hormonal method (including implants) or intra-uterine contraceptive device to prevent pregnancy
        - A barrier method (male/female condoms) to augment the hormonal method, and prevent STIs and HIV
3. **No desire for a child now or in the future**
    - Counsel about options for contraception including permanent methods (male and female voluntary sterilisation), long-acting reversible contraceptives (IUCD and implants) and barrier methods. If permanent methods are not appropriate, proceed to an alternative dual method as outlined below

- Discuss the different contraceptive options available for use in the women living with HIV
    - Injectable progestins
    - Combined oral contraceptive pills
    - Intra-uterine contraceptive device
    - Emergency contraception
- Counsel women about reduced efficacy of progestin subdermal implants (e.g., Implanon NXT®) with enzyme inducing drugs such as Efavirenz, Rifampicin, and certain epilepsy drugs. Women who are already using an implant should consider an alternative non-hormonal method for contraception e.g. the IUCD and should continue to use condoms correctly and consistently. However, all hormonal methods (including implants and long acting injectables) are safe to use with Dolutegravir.

Testing for HIV during Pregnancy

All pregnant women must be offered screening for HIV, Syphilis, Hepatitis B and Rubella at the first antenatal visit

Provider Initiated Counselling and Testing (PICT) should be provided to all women with unknown or HIV-non-infected status:

- Offer an HIV test at the first antenatal visit to all.
- In regions with a high HIV prevalence: all patients (esp. those deemed to be at high risk of HIV acquisition) should be offered re-testing at each antenatal visit due to high risk for seroconversion
- Offer couple/partner testing to promote prevention, access to HIV care and treatment, and/or manage discordant results (when one partner is HIV-infected and the other partner HIV-non-infected).
- If the woman and/or her partner test HIV-non-infected: provide HIV prevention information (refer to **HIV Prevention** on page 8 of DOH Guideline).
- In women who choose not to be tested: document her reasons clearly and offer 'post-refusal' counselling and counselling for testing at every subsequent visit.
- If a woman tests HIV-infected at any stage: encourage testing of her other children, and linkage to HIV care and treatment as necessary.
- For the HIV testing algorithm, including the management of discrepant HIV test results, refer to the HIV Testing Services (HTS) Guideline.

Always maintain a professional attitude.

Clearly document the result but maintain confidentiality at all times. Be careful not to inadvertently disclose her status to partner or other family

The management is multidisciplinary, with a Specialist Physician and Paediatrician

Consider referring newly diagnosed HIV-infected women to a psychologist.

Encourage the patient to disclose her status to her partner or a confidant

Encourage safe sex practices and condom use, to reduce STI's and HIV re-infection

Recommend a strategy to prevent mother-to-child transmission

Treatment for HIV- infection during Pregnancy

All newly diagnosed HIV-infected pregnant women:

- are eligible for lifelong ART regardless of gestation, CD4 count, or clinical stage.
- serum-Creatinine and CD4 count should be done to determine renal function and the need for prophylaxis (TB, Pneumocystis Pneumonia (PCP) and Cryptococcus Meningitis (CM)).
- TDF, 3TC, and EFV/DTG (as a fixed dose combination) should be initiated on the same day as HIV infection diagnosis, and after contra-indications to ART have been excluded (Refer to **ART Initiation Algorithm** on Page 18 of DOH Guideline).

Pregnant women already on ART:

- should continue their current ART regimen pending the result of their 1st VL (to be done at entry into antenatal care as outlined below).
- if the VL is < 50 c/ml AND the gestation is further than the 1st trimester: offer the option of switching to DTG.
- a switch to DTG needs to be preceded by appropriate counselling on the risk for neural tube defects (NTDs) for subsequent pregnancies, postpartum contraception, and the new side-effects that may be experienced when switching to a new drug (refer to **DTG in pregnancy** on page 17 of DOH Guideline).
- If the VL is ≥ 50 c/ml: manage as per the **VL Non-suppression algorithm** (page 21 of DOH Guideline)

Known HIV infected women, who are not currently on ART, but are ART-exposed (e.g., previous PMTCT, or previous loss-to-follow up on ART):

- should initiate 1st line ART, pending 1st VL result

Late presenters:

- If ART is initiated after 28 weeks gestation (particularly if re-initiated after previous ART exposure): start DTG, FTC/3TC and TDF.
- If DTG is not available: start routine 1st line ART and consult/refer for access to DTG.
- Referral for a third line agent such as DTG normally necessitates the availability of a VL result, which many of these women may not have. This should not be a barrier to access DTG in the context of PMTCT.

- Appropriate ART literacy education should be given to the woman before she leaves the facility. (Refer **Key Adherence Messages** on page 19 of DOH Guideline)
- All women living with HIV should be referred to an appropriate service provider to support adherence, breastfeeding and retention in care pre- and post-delivery.

VL Monitoring and Management during Pregnancy

Newly diagnosed and initiated ART for the first time:

- Do 1st VL at 3 months on ART.
- If VL < 50 c/ml, repeat VL at delivery.

Known HIV-infected women already on ART:

- VL at first/booking visit,
- If VL < 50 c/ml, repeat VL at delivery.

Known HIV-infected women, who are not currently on ART, but are ART exposed

(e.g., previous PMTCT, or ART defaulter)

- Do VL before re-starting ART, but start ART on the same day (no need to wait for VL result)
- Repeat VL in one month
- If more than one log drop in VL is achieved, continue current regimen and repeat VL in two months
- If VL < 50 c/ml, repeat VL at delivery.

If the VL while on treatment is ≥ 50 c/ml in any of the above scenarios, refer to **VL Non-suppression Algorithm** (page 21 of the DOH Guideline).

Screening for TB and other Opportunistic Infections

Screen for TB at every visit (history) regardless of HIV status.

Consider TB Preventative Treatment (TPT) if eligible. The CD4 count threshold for TPT eligibility in pregnancy has been amended from 100 cells/µL to 350 cells/µL

Ensure that any woman diagnosed with TB is adherent to TB treatment and that she is aware that her newborn may require TB prophylaxis (refer to **TB screening and TPT** on page 27 of the DOH Guideline).

Initiate Cotrimoxazole Prophylaxis (CPT) if CD4 count < 200 cells/µL or WHO clinical stage 2, 3, or 4.

If CD4 ≤100 cells/uL the lab should automatically perform a Cryptococcal Antigen test (CrAg). CrAg-positive pregnant women should be offered a lumbar punction (regardless of symptoms) and be discussed with an expert before a decision is made regarding management.

Prevention of transmission of syphilis, Hepatitis B (HB) and other infections

Syphilis:

Test all women for syphilis and screen for other STI's (e.g., gonorrhoea) at their first ANC visit. (see **Syphilis** on Page 31 of the DOH Guideline)

- If the first test is performed before 20 weeks gestation and is negative: repeat the test at 32 weeks.
- Treat all women with a positive syphilis screening test, irrespective of titre.

Hepatitis B Virus (HBV):

All woman living with HIV are automatically treated for HBV when they start routine 1st line ART containing TDF and 3TC/FTC.

- If she should need to switch to 2nd line ART, HBsAg should be checked.
- If HBsAg is positive, TDF should be retained as a fourth drug in her new regimen.
- If a HIV non-infected pregnant woman is known to have HBV infection, she should be referred for further tests to determine eligibility for treatment.

All babies should receive hepatitis B vaccinations in accordance with the immunization schedule.

Malaria:

Although MTCT is rare in non-endemic regions, malaria in pregnancy poses serious risks for both the mother and the baby.

Malaria presents as a febrile illness and is often unrecognised or misdiagnosed with severe consequences. The most important aspect of making a diagnosis of malaria is having a high index of suspicion.

If a woman presents with fever in pregnancy, always ask about her travel history.

Refer any woman with signs of severe illness or danger signs as outlined in PC101.

Comprehensive information on Malaria in Pregnancy is available in the Guideline for Maternity Care in South Africa, and the National Guideline for the Treatment of Malaria SA.

Labour and Delivery

Testing for HIV:

PICT should be provided to all women presenting in labour ward who are not known to be HIV-infected (including those delivered before arrival):

- Offer couples counselling and partner testing. For the management of the discordant couple, refer to **HIV Prevention** section on page 8 of the DOH Guideline.
- Women who choose not to be tested should be offered 'post-refusal' counselling and counselled for a test at every subsequent visit.
- If a woman tests positive at any stage, encourage testing of her other children, and linkage to HIV care and treatment as necessary.
- If a woman has indeterminate or discrepant HIV test results, treat the baby as a high-risk HIV-exposed infant until mother's HIV status can be confirmed. Communicate clearly to the mother and document the results and plan of action in the maternal record.

Antiretroviral therapy at delivery

Pregnant women already on ART: they should continue their current ART regimen at usual dosing times during labour.

Newly diagnosed, or known HIV-infected women not on ART:

- If DTG is not available as routine 1st line ART: give single dose NVP, single dose Truvada and AZT 300mg 3 hourly during labour.
- If DTG is available: give a stat single fixed dose combination tablet of TDF, 3TC and DTG (TLD) and a stat single dose of NVP.
- ART should be initiated the following day after contra-indications to ART have been excluded (refer to **ART Initiation Algorithm** on Page 18 of the DOH Guideline). Provide appropriate counselling on available ART options.
    - If she will be using reliable contraception **TDF, 3TC and DTG (TLD)** can be given.
    - If not, start **TDF, FTC, and EFV (TEE)**.

- Appropriate ART literacy education should be given to the women before leaving the facility. (see **Key Adherence Messages** on Page 19 of the DOH Guideline).
- Mothers must understand and anticipate the adherence challenges that may be experienced in the postpartum period.

VL Monitoring and Management at Delivery

Check if there is a VL result in the last 12 weeks and categorize the risk for the infant:

- VL < 1000c/ml = Low risk
- VL ≥ 1000 c/ml = High risk
- No VL result in the last 12 weeks = High risk

All women must have a VL test done at the time of delivery.

The results of the delivery VL must be checked at the 3-6-day postnatal visit, and the management of the mother-infant pair adjusted accordingly.

Screening for TB and other Opportunistic Infections

- Screen all women for TB at entry to the labour ward
- Initiate TPT for women living with HIV before discharge, if eligible. The CD4 count threshold for TPT eligibility in pregnancy has been amended from 100 cells/μL to 350 cells/μL.
- Initiate Cotrimoxazole prophylaxis before discharge if CD4 count < 200 cells/uL, or WHO clinical stage 2, 3, or 4.

Other care for the mother living with HIV at delivery

Provide routine labour and delivery management according to the Maternity Guidelines of SA, including safe delivery techniques for the HIV infected mother:

- Avoid episiotomy & assisted delivery unless essential.
- Avoid prolonged rupture of membranes.
- Avoid unnecessary suctioning of the infant.
- If C/section required: Provide prophylactic antibiotics for all HIV-infected women according to the Maternity Care Guidelines (2016).

Within 1 hour of delivery: encourage skin-to-skin contact with baby and initiate exclusive breastfeeding. Hospitals and labour wards can support mothers to breastfeed by following the WHO **10 Steps to Successful Breastfeeding** on Page 28 of the DOH Guideline. In addition, counsel mother on **Breastfeeding Plus** on page 29 of the DOH Guideline.

At discharge

- Ensure contraception has been administered after appropriate counselling (see **Contraception and Safe Conception** Page 9 of the DOH Guideline).
- Provide the mother with two-months' supply of ART and six-weeks supply of infant prophylaxis.

- Communicate follow-up appointment dates for the six-day post-natal visit at a named facility. Provide necessary referral letters.
- Provide an ART transfer-out letter, if she will receive her ART at a different facility. However, it is recommended that the mother-baby pair continue to receive integrated care within the maternal and child health stream until the baby is two years old or no longer breastfeeding.

<table>
<tr><th></th><th colspan="5">CARE OF THE MOTHER AFTER BIRTH</th></tr>
<tr><th></th><th>6 DAYS</th><th>6 WEEKS</th><th>10 WEEKS</th><th>6 MONTHS</th><th>18 MONTHS</th></tr>
<tr><td>TESTING for HIV</td><td>Retest the HIV-negative mother if she was not retested in labour</td><td></td><td colspan="3">Retest every HIV-negative mother at the 10-week visit (~ three months postpartum), the 6-month visit, and every 3 months whilst breastfeeding Remember to offer partner testing. If no longer breastfeeding, ensure that the mother receives an HIV test at least every year</td></tr>
<tr><td>Antiretrovirals</td><td colspan="5">Mother to continue ART during the postpartum period and for life.
If she is newly diagnosed during the breastfeeding period, initiate ART after contra-indications to ART have been excluded (Go to ART Initiation Algorithm on Page 18). Provide appropriate counselling on available ART options. If she is/will be using reliable contraception, TDF, 3TC and DTG (TLD) can be given. If not, start TDF, FTC, and EFV (TEE).
This is a high-risk period for poor adherence. Ensure that the mother understands the importance of continued viral suppression for her own health and that of her baby. She must also understand and anticipate the adherence challenges that may be experienced in the postpartum period. Ensure that the mother is retained in care, adherent to ART, and maintains a suppressed viral load.</td></tr>
<tr><td>VL MONITORING and Management</td><td>Check ART adherence
Follow-up on result of delivery-VL. (If not yet available, follow-up again in 1 week. If VL not done at delivery, do VL at this visit)
If VL ≥ 50 c/ml: manage mother as per VL Nonsuppression Algorithm on Page 21.
If VL ≥ 1000 c/ml: manage infant as high-risk i.e., add AZT for 6 weeks, and extend NVP until mother's VL is <1000 c/ml.</td><td>Check ART adherence
Repeat VL if delivery-VL was ≥ 1000 c/ml.
Check mother's ART supply and confirm where she will be receiving her ongoing ART care</td><td>Check ART adherence
Check, record and act on any earlier VL tests
Check mother's ART supply and confirm where she will be receiving her ongoing ART care</td><td colspan="2">Check ART adherence at every visit.
Check, record and act on results of any earlier VL tests
Do a VL for all HIV-positive mothers on ART at 6 months.
Continue VL monitoring every 6 months (at 12,18, and 24 months) whilst breastfeeding.
Ensure that the results of any VL test are checked within 1 week. If VL ≥ 50c/ml:
• Recall the mother-infant pair to the facility
• Manage mother as per VL Non-suppression Algorithm on Page 21
If VL ≥ 1000 c/ml:
• Restart/extend infant prophylaxis if mother is still breastfeeding.
Go to Management of a High Maternal VL after Delivery on Page 25.</td></tr>
</table>

SCREENING for TB and other opportunistic infections	• Routine postpartum care as per the Maternity Care Guideline • TB screening, TPT, and CTMX according to guidelines • Mental Health: Screen for postpartum depression • Contraception and STI screening • Infant feeding counselling and support according to the Infant and Young Child Feeding Policy • Counselling on safe use of water, sanitation and hygiene (WASH) • A papsmear can be done from 6 weeks onwards	• TB screening, TPT, and CTMX according to guidelines • Mental Health: Screen for postpartum depression • Contraception and STI screening • Infant feeding counselling and support according to the Infant and Young Child Feeding Policy • Counselling on safe use of water, sanitation and hygiene (WASH) • Papsmear (if indicated)

Care of the HIV-exposed infant (HEI) at delivery

HIV prevention

All HIV-exposed Infants should receive HIV-PCR at birth to identify HIV transmission that occurred in-utero.

All HIV-exposed Infants should receive a minimum of 6 weeks post exposure prophylaxis with NVP.

Identify the high-risk infants for whom additional prophylaxis must be provided:

- Mother with a VL of ≥ 1000 c/ml at delivery (or most recent VL taken during the last 12 weeks of antenatal care), or
- Mother with no VL result in the last 12 weeks.
- These infants should be provided with high-risk prophylaxis until the result of the delivery-VL can be checked at the 3-6-day postnatal visit. When the delivery-VL result is known, the infant can be re-classified as high/ low-risk and prophylaxis adjusted accordingly.

All high-risk infants who are breastfed should receive additional AZT for 6 weeks AND NVP for a minimum of 12 weeks. NVP should only be stopped when the breastfeeding mother has a VL of less than 1000 c/ml, or until one week after she has stopped breastfeeding.

All high-risk infants who are exclusively formula fed should receive AZT for 6 weeks and NVP for 6 weeks. (see **HEI Prophylaxis Infographic and the NVP and AZT dosing chart** on Page 23 of the DOH Guideline)

Routine vaccinations

Provide oral polio vaccine, BCG and other routine neonatal care as per the Maternity Care and Neonatal Care Guidelines.

Do not give BCG if the infant is TB-exposed

Management of the TB-Exposed Infant

Do not give BCG vaccine

Infant needs to receive TB prophylaxis (see Page 27 of the DOH Guideline).

Syphilis:

Examine and treat the newborn of the RPR positive mother (see Syphilis on page 31 of the DOH Guideline):

Well (asymptomatic) baby: Treat baby with benzathine penicillin 50 000u/kg IM stat only if:

- Mother was not treated, or
- Mother has received < 3 doses of benzathine benzylpenicillin, or
- Mother delivers within 4 weeks of commencing treatment.

Symptomatic baby (hepatosplenomegaly, pseudoparesis, snuffles, oedema, jaundice, anaemia, purpura, desquamative rash -especially involving palms and soles):

- Refer all symptomatic babies for treatment of congenital syphilis
- Procaine penicillin 50 000 u/kg IM daily for 10 days, or
- Benzyl penicillin (penicillin G) 50 000 u/kg/dose 12-hourly IV for 10 days.

Hepatitis B (HBV):

All babies should receive hepatitis B vaccinations in accordance with the immunization schedule.

Breastfeeding by the HIV-infected mother:

- Breastfeeding in the context of ART is recommended for 24 months or longer, in line with recommendations for general population
- Breastfeed exclusively for 6 months, then start complementary feeding
- Breastfeed for 12 months - stop once adequate nutrition and safe diet
- Breastfed high-risk infants at birth: AZT for 6 weeks and NVP for a minimum of 12 weeks.
    - Stop NVP after 12 weeks only if mother's VL is less than 1000 copies/ml.
    - If the maternal VL is not less than 1000 c/ml by 12 weeks: continue NVP until mother's VL is less than 1000 c/ml, or until one week after she is no longer breastfeeding
- If maternal VL increases to > 1000 copies/ml after previously been suppressed: immediately request infant HIV-PCR and start high-risk infant prophylaxis
- Provide guidance for management of the infant of a newly diagnosed mother during breastfeeding
- Provide guidance to the breastfeeding mother who's VL was previously less than 1000 c/ml and is now found to have a VL ≥ 1000 c/ml
- Provide guidance on stopping breastfeeding and indications for formula feeding

- Administer Cabergoline (Dostinex®) or Bromocriptine (if no hypertension or preeclampsia) as soon as possible for mothers who don't intent to breastfeed

<table>
<tr><td></td><td colspan="4">CARE OF THE HIV-EXPOSED INFANT AFTER BIRTH</td><td></td><td></td></tr>
<tr><td rowspan="2">HIV Testing and Early Infant Diagnosis</td><td>3 – 6 DAYS</td><td>6 WEEKS</td><td>10 WEEKS</td><td>6 MONTH</td><td>18 MONTHS</td><td>OTHER TEST (any time)</td></tr>
<tr><td>Follow-up results of birth PCR and manage accordingly. Any HIV positive neonate should be discussed/ referred to a clinician experienced in managing an HIV positive neonate.
ART should be initiated even if the infant weighs less than 2,5 kg.</td><td>Ensure that birth PCR and mother's VL results were checked, recorded and acted upon correctly.</td><td>HIV-PCR for all HIV-exposed infants who previously tested HIV-PCR negative</td><td>Known HIV-exposed infants:
• Do HIV-PCR test at 6 months except in those who previously tested positive and are on ART.

Infants not known to be HIV-exposed:
• At 6 months of age, establish the HIV status of all infants not already known to be HIV-exposed
• Offer an HIV test to the mother. If she tests HIV negative, no infant test is required
• If the mother is not available, or refuses an HIV test, do an HIV rapid test on the infant
• All positive infant rapid tests need to be confirmed with an HIV-PCR.</td><td>Universal HIV testing at 18 months (HIV rapid test for ALL infants regardless of HIV exposure, except in those who previously tested HIV positive and are on ART)</td><td>Do an age appropriate HIV test 6 weeks post cessation of breastfeeding, even if breastfeeding continues beyond 18 months of age. Test a symptomatic child at any age according to IMCI guideline</td></tr>
<tr><td>Confirmatory test for HIV</td><td colspan="4">Any child under two years with a positive HIV-PCR or a positive HIV rapid test should have their HIV status confirmed with a HIV-PCR test on a new sample. At the clinician's discretion, the HIV-PCR may be replaced by a viral load test which has the advantage of both confirming the HIV diagnosis and providing a baseline VL for monitoring the child's response to ART. Any child who tests HIV positive should initiate ART according to the Paediatric ART guideline as a matter of urgency. Do not wait for the confirmatory result before initiating ART but ensure that this result is checked. For the Management of Indeterminate HIV PCR results, go to page 25.</td><td colspan="3"><table><tr><th>AGE OF CHILD</th><th>HIV SCREENING TEST</th><th>HIV CONFIRMATION TEST</th></tr><tr><td>Less than 18 months</td><td>PCR</td><td>PCR</td></tr><tr><td>18 months to 2 years</td><td>Rapid</td><td>PCR</td></tr><tr><td>More than 2 years</td><td>Rapid</td><td>Rapid</td></tr></table></td></tr>
<tr><td>Infant Prophylaxis</td><td>Check adherence/ tolerance NVP (and AZT, if applicable). Ask the mother to explain how she administers</td><td>All HEI's: Start
Cotrimoxazole prophylaxis therapy (CPT), even if birth PCR was negative. Go to Cotrimoxazole Dosing Chart on Page 23</td><td>High-risk infants:
Continue NVP prophylaxis.
Ask mother to return at 12 weeks to evaluate VL result and stop/extend</td><td colspan="3">At every visit, check results of mother's most recent VL. An elevated VL may require high-risk infant prophylaxis (6 weeks AZT twice daily and 12 weeks NVP daily) to be restarted or existing NVP prophylaxis to be extended. Go to Management of a High Maternal VL after Delivery on Page 25.</td></tr>
</table>

<table>
<tr><td rowspan="3"></td><td rowspan="2">the infant's medication.

Check result of mother's delivery-VL.

If necessary re-classify infant as high/low-risk and adjust prophylaxis accordingly.

See the Infant Prophylaxis Infographic and the NVP and AZT dosing chart on Page 23.</td><td rowspan="2">Low-risk infant:

Stop NVP if mother's VL at delivery was <1000 c/ml.

High-risk infants:

• stop AZT,

• continue NVP for a minimum of 12 weeks, or until one week after all breastfeeding has stopped</td><td>NVP as necessary</td><td></td></tr>
<tr><td colspan="2">Stop NVP after 12 weeks only if mother's VL is < 1000 c/ml. If the maternal VL is not suppressed by 12 weeks, continue NVP until mother's VL is <1000 c/ml, or until one week after all breastfeeding has stopped.

Continue cotrimoxazole prophylaxis (CPT) until infant is confirmed HIV negative 6 weeks post cessation of breastfeeding.

For formula fed infants, CPT may be stopped if the infant is confirmed to be HIV negative at the 10-weeks PCR test, provided that no breastfeeding has occurred in the 6 weeks prior to the 10-week PCR test.

If a child tests HIV positive at any stage, stop NVP prophylaxis, initiate ART, do a confirmatory HIV PCR, and continue cotrimoxazole prophylaxis according to guidelines.</td></tr>
<tr><td colspan="3">If the mother is newly diagnosed with HIV after delivery or during the breastfeeding period go to Management of a High Maternal VL (due to HIV Diagnosis) after Delivery on Page 24</td></tr>
<tr><td>Other Routine Care</td><td>Routine growth monitoring, immunisations, nutritional support. Provide advice to support breastfeeding.
Go to Breastfeeding Plus on Page 29</td><td colspan="2">Routine growth monitoring, immunisations, vit A, deworming and nutritional support.
Provide advice to support breastfeeding.
Go to Breastfeeding Plus on Page 29</td></tr>
</table>

Definitions

Term, Acronym or abbreviation	Definition
ART	Anti-retroviral therapy
CM	Cryptococcal meningitis
DTG	Dolutegravir
HBsAG	Hepatitis B Antigens
HEI	HIV exposed infant
IUCD	Intra uterine contraceptive device
LP	Lumbar puncture
LTFU	Lost to follow up
NTD	Neural tube defect
NVP	Nevirapine
OI	Opportunistic Infections
PCP	Pneumocystis carinii pneumonia
PMTCT	Prevention of Mother to Child transmission
PReP	Post exposure prophylaxis
Seroconcordant	Woman positive and her partner also positive

Term, Acronym or abbreviation	Definition
Serodiscordant	Woman positive and her partner negative
STI	Sexually Transmitted Infection
TPT	Tuberculosis prevention treatment
VL	Viral load

References

1. Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (HIV, Hepatitis, Listeriosis, Syphilis and TB). South African National Department of Health. 2019
2. Adam, S. & Soma-Pillay, P. 2018. Obstetric Essentials. 3rd Edition. University of Pretoria
3. The Western Cape Consolidated Guidelines for HIV Treatment: Prevention of Mother-to-Child Transmission of HIV (PMTCT). 2018
4. DOH guideline: https://www.nicd.ac.za/wp-content/uploads/2019/11/Guidelines-for-the-Prevention-of-Transmission-of-Communicable-Diseases-from-mother-to-child_28-October.pdf
5. DOH March 2022 updated guideline: https://www.knowledgehub.org.za/system/files/elibdownloads/2020-05/2019%20ART%20Guideline%2028042020%20pdf.pdf

Authorship

These guidelines were drafted by a clinical team from Mediclinic and were reviewed by a panel of experts from SASOG and the BetterObs™ clinical team in 2019 and revised by the scientific committee of BetterObs™ in 2023. All attempts were made to ensure that the guidance provided is clinically safe, locally relevant and in line with current global and South African best practise. Succinctness was considered more important than comprehensiveness.

All guidelines must be used in conjunction with clinical evaluation and judgement; care must be individualised when appropriate. The writing team, reviewers and SASOG do not accept accountability for any untoward clinical, financial or other outcome related to the use of these documents. Comments are welcome and will be used at the time of next review.

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Author	Version	Details of update	Effective date
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A. Hall	1.2	Rebranded and edited to Mediclinic Clinical Guideline All drug names changed to active ingredient	2020 07 10
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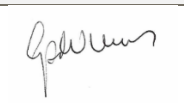
Approval and sign-off

Approved by

Department/ Area/ Group/ Forum	Representative name	Signature	Designation	Date
Clinical Department	Dr Gerrit de Villiers		Chief Clinical Officer	2023 04 26