PREVENTING MOTHER TO CHILD TRANSMISSION OF HIV (PMTCT)

Why is it important?

- Prevention is better, there is no cure

**1 in 3 babies born to HIV-infected mothers will be infected with HIV during pregnancy, delivery and via breast milk, without intervention.**

Nevirapine given correctly to mothers and babies almost halves the risk of HIV transmission.

*(More complex ARV regimens can reduce transmission to less than 2%.)*

- The BEST practice is to reduce the mother’s viral load to as low a level as possible prior to delivery
- Most transmission occurs during delivery so good obstetric management is vital, apart from ARVs
- Don’t forget the father – prevention and/or treatment of HIV infection, and planning for future parenthood

**Determine the mother’s HIV status**

- Ask every pregnant woman if she knows her status at the time of confirmation of pregnancy (check this for private sector patients as well)
- If YES, ask if she has ever taken / is taking ARVs
- If NO, recommend VCT as soon as possible

**ALL mothers should be offered voluntary counselling and testing for HIV during antenatal care**

**Plan for the HIV-infected mother**

**During pregnancy**

- Regular, careful antenatal care (especially if mother’s CD4 < 200)
- It is very important to discuss **feeding choice** with the mother, either:
  - exclusive breast for 4-6 months, OR
  - exclusive replacement/formula feeding, if mother has access to clean water and is able to sterilise bottles etc
- The CD4 level is important: if < 200 cells/mm³, mother should be started on HAART
- if > 200 cells/mm³, mother should receive PMTCT according to provincial protocol

**NEVIRAPINE (NVP) for mother:**

Nevirapine 200mg PO stat at onset of labour, OR when membranes rupture, OR prior to Caesarean section.

NVP must be taken between 72 and 2 hours before the birth

REMEMBER to give the nevirapine to the mother when she is 34 weeks pregnant

**During delivery**

- Do an elective C/S if the viral load high at 37 weeks AND before the onset of labour
- Do not artificially rupture membranes
- Do not do invasive procedures (eg scalp pH monitoring of baby)
- Avoid episiotomy, if possible

**Post partum**

- REMEMBER to implement the feeding choice the mother made antenatally
- Ongoing HIV care for mother including ARVs, prophylaxis for opportunistic infections and contraception

**EXCLUSIVE FEEDING is essential – either breast (i.e. nothing else, not even water) OR formula.**

When WEANING, make the switch from breast to formula as quickly as possible, to minimise the period of mixed feeding (i.e. breast AND formula), which is the most risky for HIV transmission.
Plan for the HIV-exposed infant

Antiretrovirals

- Determine what ARVs mother received
  - if single dose nevirapine was given between 2 hours before birth and 72 hours after birth, give a single dose of nevirapine to baby between 12-72 hours after birth
  - if single dose nevirapine was given to mother < 2 hours before birth or > 72 hrs after birth: give immediate dose nevirapine to baby (within 6 hours of birth) and a repeat dose 12-72 hours after birth

<table>
<thead>
<tr>
<th>NEVIRAPINE (NVP) for baby:</th>
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<tr>
<td>Birth weight &gt; 2kg, give 0.6ml PO stat</td>
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<tr>
<td>Birth weight &lt; 2kg, give 0.2ml/kg PO stat</td>
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- if baby’s mother is on the HAART regimen, baby will need 2 drug therapy (AZT + 3TC for 4 weeks) – DISCUSS with consultant

Feeding choice

- This must be an informed choice based on the specific social circumstances of each individual woman, and ideally with the full support of her family
- The choice should best be made antenatally (see “Plan for the HIV-infected mother”)
- Document the feeding choice clearly on the neonatal record (Form Paed/01)

Follow up

- Document all HIV information and plans in all designated places on the “Newborn Care Record” (Form Paed/01)
- Regular monthly clinic visits are essential for:
  - growth monitoring
  - feeding support
  - treatment of intercurrent illnesses
- COTRIMOXAZOLE prophylaxis should be started from 6 weeks (single daily dose of 2,5 ml given Monday - Friday)
- Immunisation should be given according to SA EPI schedule, unless baby has signs suggestive of AIDS
- HIV testing
  - PCR must be done for definitive diagnosis at 6 weeks
  - ELISA from 18 months, and at least 3 months after cessation of breast feeding

Pregnancy is often the first time when women become aware of their HIV status – maximise this opportunity for education, care, support and good medical treatment