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- iv) Miscellaneous Issues Surrounding Implementation of Perinatal HIV Prevention and Management Recommendations
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- i) Human Immunodeficiency Virus Screening -- American Academy of Pediatrics and American College of Obstetricians and Gynecologists 104 (1) 128 -- AAP Policy.htm"

- ii) "Human Milk, Breastfeeding, and Transmission of Human Immunodeficiency Virus Type 1 in the United States -- Read and Committee on Pediatric AIDS 112 (5) 1196 -- AAP Policy.htm"

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# California Perinatal Quality Care Collaborative (CPQCC)

## Perinatal HIV Prevention Toolkit

### Introduction

Women are the fastest growing group of persons with new diagnoses of HIV infection. This number is growing most rapidly in young minority women. Eighty percent of the approximately 150,000 HIV infected women in the United States are of childbearing age. Approximately 7,000 HIV infected women give birth every year.

While the number of perinatally transmitted cases of HIV has declined, up to 40% of HIV-infected infants are born to women who were not known to be infected prior to the delivery. Prenatal or even intrapartum treatment with antiviral medications has been shown to significantly decrease the incidence of perinatal transmission of the virus. It should therefore be our goal to eliminate perinatal HIV infection.

Toward this goal, the state of California has adopted legislation that adds HIV screening to the Obstetric laboratory panel. While women have the option to “opt out” of screening, literature suggests that fewer women make this choice, increasing the overall number of women screened for HIV infection during pregnancy. The state has made it clear that a patient’s HIV status (positive, negative or declined testing) be noted on prenatal records for all women. In addition, those women who choose to decline testing should be offered testing throughout the pregnancy and at the time of hospital admission.

There is no cure for HIV infection; however, using combination highly active antiretroviral therapy (HAART) to decrease maternal viral loads during pregnancy can significantly decrease the likelihood of perinatal HIV transmission. Maternal treatment of HIV infection and perinatal HIV pathogenesis continues to evolve rapidly. Recommendations for combination highly active antiretroviral therapy during pregnancy are constantly evolving. It is important that pregnant women who are HIV positive be referred to those specializing in the treatment of HIV infection for optimal management.

Obstetricians and other healthcare providers caring for pregnant women who are HIV positive should be aware of what delivery plan to offer based on serial HIV RNA viral loads throughout the pregnancy.

#### **Office Testing**

Goal: 100% screening

“Say it right”

“Testing for HIV and syphilis exposures is part of the prenatal laboratory panel because treatment during pregnancy can prevent transmission of these infections to the fetus. We test all of our patients unless they decline to be tested.”

Repeat offers to decliners.

Repeat testing for those at highest risk.

#### **Office Care**

Referral for treatment.

- Need referral resources.

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- Mechanism for rapid referral to HIV centers and treatment. Medications should be started in the second trimester.
- Even known HIV positive women who previously have not required antiretroviral treatment should be offered treatment during pregnancy to decrease the risk of perinatal transmission to the fetus.
- Treatment of concomitant infections
- Smoking cessation

### Delivery plans:

- Elective Cesarean delivery is indicated for women with detectable HIV viral loads.
- If Viral load is not known at the time of early labor and previous undetectable viral loads have not been documented, a Cesarean delivery should also be offered.
- Little benefit is derived from Cesarean delivery of those women whose viral load is undetectable.
- Little benefit is derived from Cesarean delivery for women with a known detectable viral load who arrive in active labor and are likely to deliver rapidly.
- Little benefit is derived from Cesarean delivery for women with known detectable viral loads if rupture of membranes has occurred greater than four hours prior to admission

### **Medical Records/Prenatal record**

- Goal: 100% HIV test results transmitted to Labor and Delivery units.  
100% of positive women have delivery plans sent to Labor and Delivery

### **Rapid Testing**

- Goal: All patients with undocumented HIV status have a rapid HIV test during any hospital visit during which they may deliver.

### **Labor and Delivery**

- AZT-containing regimen
- Avoid scalp electrodes
- Avoid episiotomies (if possible)
- Avoid any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions.

### **Postpartum/Discharge Follow-up**

- Discourage breastfeeding
- Normal mother/baby nursing care unless other medical problems

### **Ancillary Services:**

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Social Services/Case Managers

- Available community resources
- Evaluate support structure
- Partner notification
- Risk behaviors

Pharmacy

- Availability of antiretroviral agents in labor and delivery and nursery
- Availability of discharge oral AZT for newborn, if possible.

Specialists in HIV treatment to manage those tested positive in pregnancy.

- Combination highly active antiretroviral treatment (HAART)
- HIV RNA Viral load
- CD4 cell count

Pediatric HIV specialists to accurately treat and follow potentially exposed newborns.

- Medication regimens with oral zidovudine
- Follow-up testing with HIV DNA PCR

## **California Perinatal Quality Care Collaborative 2008 Standards of Care for the Prevention of Perinatal HIV Transmission**

Perinatal HIV transmission can be greatly reduced in California. This document summarizes the current U.S. Public Health Service Human Immunodeficiency Virus (HIV) Testing and Treatment Recommendations and is designed to assist health care providers to offer HIV information, prenatal HIV testing and care. Mother-to-child HIV transmission can be reduced to the lowest possible level through a comprehensive approach that includes:

- Universal access to prenatal care and routine HIV counseling and testing with each pregnancy
- HIV counseling and rapid testing of women presenting for labor and delivery with no prior prenatal care, HIV testing, or evidence of a negative HIV test result
- Referral of all HIV-positive women to centers with expertise in HIV, perinatal care, women's specialty care, and pediatric HIV
- Access to antiretroviral therapy during pregnancy, at delivery, and postpartum
- Availability of intra-partum antiretroviral medication in all labor and delivery programs
- Education about treatment options and regimen adherence
- Support services for women, children and families that offer case management, mental health services, patient education, counseling, and community education <sup>1</sup>
- HIV results readily available on mothers and baby's chart

### **Background**

- Perinatal HIV transmission can occur during pregnancy, birth, and breastfeeding
- Since 1994, perinatal HIV transmission has been greatly reduced among HIV-positive women who receive therapy before and at delivery, and their infants are treated with 6 weeks of zidovudine.
- As a result of increases in testing and care, perinatal HIV transmission in the U.S. has been reduced from 25% to 2%. <sup>2</sup>
- Transmission continues to occur among women who do not seek prenatal care, were not tested, or were tested late in pregnancy. <sup>2</sup>
- The US Public Health Service, CDC, American College of Obstetricians and Gynecology and American Academy of Pediatrics recommend universal HIV testing for pregnant women. <sup>2,3,5</sup>

### **Legislation and Reporting**

- California legislation currently mandates that all prenatal providers draw blood for HIV testing as a part of prenatal labs. AB 1676, Dutra (chaptered 11/03) amends Section 125085 of the Health and Safety code to require provision of HIV information to the pregnant patient and collection of blood (when Blood type / Hepatitis B serology is performed). AB 682 (chaptered 10/07) simplified the HIV testing and documentation requirements. Providers are to utilize the "opt-out" (routine voluntary HIV testing with the right to decline) rather than the "opt-in" (non-directive patient choice) methodology. As always, women have the right to accept or refuse the HIV test under this law. Information regarding HIV testing of pregnant women may be given by people providing prenatal or intrapartum care. This means that staff other than physicians may provide education and document any refusal of the testing in either the prenatal or hospital setting.

## **California Perinatal Quality Care Collaborative 2008 Standards of Care for the Prevention of Perinatal HIV Transmission**

- The State of California has developed HIV education forms in English and 11 other languages, which provide information about pregnancy and HIV testing<sup>6</sup>. (<http://www.cdph.ca.gov/pubsforms/forms/Pages/AIDS.aspx>)
- HIV infection is a reportable disease and health care providers are required to report positive HIV tests to their local Public Health Department.

### **Recommendations for HIV Screening of Pregnant Women**

- All pregnant women should be tested for HIV infection.
- HIV screening is mandated as a routine part of prenatal care for all women. All health care providers should inform their pregnant patients about HIV testing as part of prenatal testing, pointing out the substantial benefit of knowledge of HIV status for the health of women and their infants. Even with the “opt-out” approach, women may decline HIV testing if their doctor does not recommend and encourage it.<sup>7</sup>
- HIV testing should be performed in women as early as possible in the pregnancy. If a patient declines an HIV test (opting out), it should be re-offered at regular intervals throughout the pregnancy. Retesting in the third trimester, preferably before 36 weeks of gestation, is recommended for women known to be at high risk for acquiring HIV.
- Rapid HIV testing should be offered to all women who present in labor with no available HIV test results. Rapid testing information is available from the Centers for Disease: <https://www.cdc.gov>.
- HIV testing should always be voluntary and free of coercion, although it should always be the standard of care. Discussing and addressing reasons for reluctance (e.g., lack of awareness of risk or fear of the disease, partner violence, potential stigma, discrimination) promotes health education and trust, and encourages some women to accept testing at a later date. Reiterate that women who opt out of HIV testing will not be denied care either for themselves or their infants.
- Before HIV testing, health care providers should provide the following minimum information. Although a face-to-face counseling session is ideal, other methods can be used, (e.g., brochure, or video) if they are culturally and linguistically appropriate.
  - HIV is the virus that causes AIDS.
  - HIV is spread through unprotected sexual contact and injection drug use. Approximately 25% of HIV infected pregnant women who are not treated during pregnancy can transmit HIV to their infants during pregnancy, during labor and delivery, or through breastfeeding.
  - A woman can be at risk for HIV infection even if she has had only one sex partner.
  - Effective interventions (e.g., highly active combination antiretrovirals) for HIV infected pregnant women can protect their infants from acquiring HIV and improve the health and survival of these mothers and their children.
  - Services are available to help women reduce their risk for HIV infection and transmission. Medical care and social services are available to those who are in need. See page 12 for a list of community HIV resources.

### **Management of HIV Positive HIV Tests during Pregnancy**

- HIV post-test counseling for women who test positive should include:

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- information about the availability of highly active antiretroviral therapy (HAART) for treatment of HIV and prevention of perinatal HIV transmission;
- psycho-social support,
- information about testing of other family members,
- immediate referral to an HIV program/provider that provides specialized HIV services.

### **Treatment of HIV Infection during Pregnancy**

- Providers who have limited expertise in maternal-pediatric HIV care should immediately seek consultation and refer the HIV-infected pregnant woman to an HIV specialist for treatment and/or consultation. The National Perinatal HIV Consultation and Referral Service at **888-448-8765** is available to provide free 24-hour clinical consultation and referral services.
- All pregnant HIV infected women should be offered highly active antiretroviral therapy (HAART) to maximally suppress viral replication, reduce the risk of perinatal transmission, and minimize the risk of developing resistant virus.
- Women for whom combination antiretroviral therapy would be considered optional (HIV RNA viral load <1,000 copies/mL) and who wish to restrict their exposure to antiretroviral drugs during pregnancy, monotherapy (controversial) with the three-part (this is controversial and most experts will treat with triple nucleosides -trizivir twice a day- , see new perinatal guidelines attached, page 15) zidovudine (ZDV) prophylaxis regimen (or in selected circumstances, dual or triple nucleosides) should be offered. In these circumstances, the development of resistance could be minimized by limited viral replication (assuming HIV RNA levels remain low) and the time-limited exposure to ZDV.
- Monotherapy with ZDV does not suppress HIV replication to undetectable levels in most cases. Theoretically, such therapy might select for ZDV resistant viral variants, potentially limiting future treatment options.
- All treatment considerations should be discussed with the pregnant woman.
- Recommendations for resistance testing for HIV infected pregnant women are the same as for non-pregnant patients: acute HIV infection, new diagnosis of HIV infection of unknown duration, virologic failure, sub-optimal viral suppression after initiation of antiretroviral therapy, or high likelihood of exposure to resistant virus based on community prevalence or source characteristics.

### **General Principles of Perinatal HIV Treatment**

- The pregnant woman, HIV specialist, and obstetrician must communicate and collaborate regarding her care and treatment.
- After assessing the woman's HIV disease status, the HIV specialist should assess, recommend, and prescribe antiretroviral treatment or modify the current antiretroviral regimen.
- Decisions regarding the use and choice of antiretroviral drugs during pregnancy involve several competing risk and benefit factors. The woman should decide to accept or decline antiretroviral drugs during pregnancy only after discussion with the HIV specialist and obstetrician regarding the known and unknown benefits and risks of HIV therapy during pregnancy and the potential effect of antiretroviral therapy on the fetus and newborn.

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- Use of the three-part zidovudine<sup>8</sup> (ZDV) chemoprophylaxis regimen, in combination with other antiretrovirals, should be discussed with and offered to all HIV infected pregnant women to reduce the risk for perinatal HIV transmission.
- Discussion of treatment options should be non-coercive with the final decision regarding the use of antiretroviral drugs the responsibility of the woman.
- A long-term treatment plan should be developed after discussion between the woman and health care providers. This discussion should emphasize the importance of adherence to any prescribed antiretroviral regimen, prenatal care and risk reduction.

**CLINICAL SITUATIONS AND RECOMMENDATIONS FOR ANTIRETROVIRAL THERAPY**

**SCENARIO # 1 HIV infected pregnant women who have not received prior antiretroviral therapy<sup>2</sup>**

1. Pregnant women with HIV infection must receive standard clinical, immunologic, and virologic evaluation. Recommendations for initiation and choice of antiretroviral therapy should be based on the same parameters used for persons who are not pregnant, although the known and unknown risks and benefits of such therapy during pregnancy must be considered and discussed.
2. The three part ZDV chemoprophylaxis regimen<sup>8</sup> initiated after the first trimester, should be recommended for all pregnant women with HIV infection regardless of antenatal HIV RNA copy number to reduce the risk of perinatal transmission.
3. The combination of ZDV chemoprophylaxis with additional antiretroviral drugs for treatment of HIV infection is recommended for infected women whose clinical, immunologic, or virologic status requires treatment or who have HIV RNA of more than 1000 copies/mL regardless of clinical or immunologic status.
4. Women who are in the first trimester of pregnancy may consider delaying initiation of therapy until after 10-12 weeks gestation.

**SCENARIO # 2 HIV infected women receiving antiretroviral therapy during the current pregnancy<sup>2</sup>**

1. HIV-infected women receiving antiretroviral therapy in whom pregnancy is identified after the first trimester should continue therapy. ZDV should be a component of the antenatal antiretroviral treatment regimen after the first trimester whenever feasible.
2. Women receiving antiretroviral therapy in whom pregnancy is recognized during the first trimester should be counseled regarding the benefits and potential risks of antiretroviral administration during this period, and the continuation of therapy should be considered. If therapy is discontinued during the first trimester, all drugs should be stopped and reintroduced simultaneously to avoid the development of drug resistance.
3. Regardless of the antepartum antiretroviral regimen, ZDV administration is recommended during the intrapartum period and for the newborn.

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**SCENARIO # 3 HIV infected women in labor who have had no prior therapy<sup>2</sup>**

Several effective regimens are available:

1. Intrapartum intravenous ZDV followed by six weeks of ZDV for the newborn;
2. Oral ZDV and Lamivudine (3TC) during labor, followed by one week of oral ZDV-3TC for the newborn;
3. A single dose of nevirapine at the onset of labor followed by a single dose of nevirapine for the newborn at age 48 hours; and
4. The two-dose nevirapine regimen combined with intra-partum intravenous ZDV and six week ZDV for the newborn.
  - In the immediate postpartum period, the woman should have appropriate assessments (e.g., CD4+ count and HIV RNA copy number) to determine whether antiretroviral therapy is recommended for her own health.

**SCENARIO # 4 Infants born to mothers who have received no antiretroviral therapy during pregnancy or intrapartum<sup>2</sup>**

1. The six-week neonatal ZDV component of the ZDV regimen should be discussed with the mother.
2. ZDV should be initiated as soon as possible after delivery, preferably within 6-12 hours of birth.
3. Some clinicians may choose to use ZDV in combination with other antiretroviral drugs, particularly if the mother is known or suspected to have ZDV resistant virus. However, the efficacy of this approach for prevention of transmission has not been proven in clinical trials and appropriate dosing recommendations for neonates are incompletely defined for many drugs.
4. The infant should undergo early diagnostic testing so that if HIV infected, treatment can be initiated as soon as possible

**Antiretroviral Drug Precautions during Pregnancy**

- Efavirenz (Sustiva) and hydroxyurea should be avoided during pregnancy because of their teratogenicity.
- Avoid use of stavudine (d4T) and didanosine (ddI) in combination because of the risk of lactic acidosis-related maternal mortality.
- Do not combine zidovudine (ZDV) with stavudine (d4T)

**Treatment Discontinuation during Pregnancy**

- Women who must temporarily discontinue therapy because of pregnancy-related hyperemesis should not reinstitute therapy until sufficient time has elapsed to ensure the drugs will be tolerated. To reduce the potential for emergence of resistance, if therapy

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requires temporary discontinuation for any reason during pregnancy, all drugs should be stopped and reintroduced simultaneously.

### **Prenatal Care**

- All HIV positive pregnant women should receive care and/or consultation from providers who have expertise in the management of HIV during pregnancy, and delivery.
- In addition to routine prenatal care, all HIV+ women should receive:
  - Comprehensive HIV care, appropriate lab evaluations and prophylaxis
  - Information about the availability of antiretroviral therapy for the treatment of HIV and prevention of perinatal HIV transmission; access to treatment, education about risk reduction; and safer sexual practices
  - Psychosocial support, comprehensive health education and assistance with the testing and care of family members.
  - Invasive prenatal diagnostic procedures such as chorionic villus sampling or amniocentesis should not be performed without a discussion with the patient regarding potential risks versus benefits.

### **Perinatal HIV Transmission and Mode of Delivery**

- Optimal medical management during pregnancy should include highly active antiretroviral therapy (HAART) to suppress plasma HIV RNA to undetectable levels.
- Labor and delivery management of HIV-infected pregnant women should focus on minimizing the risk for both perinatal transmission of HIV and the potential for maternal and neonatal complications.
- In caring for the HIV-infected pregnant woman, provide the most complete and current information regarding use of antiretroviral therapy, mode of delivery, and other issues and allow her to make her own decisions. The woman's autonomy in decision-making should be respected.
  - AZT-containing regimen
  - Avoid scalp electrodes
  - Avoid episiotomies (if possible)
  - Avoid any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions.
- A Cesarean section should be offered to women with HIV RNA viral load over 1,000 copies/mL, unknown viral load, or to women who are untreated during pregnancy and arrive prior to active labor or rupture of membranes.

### **Timing of Scheduled Cesarean Section**

- If the decision is made to perform a scheduled cesarean delivery to prevent HIV transmission, the American College of Obstetrics and Gynecology recommends that it is scheduled at 38 weeks of gestation using clinical and first or second trimester ultrasonographic estimates of gestational age. Amniocentesis should be avoided for fetal lung maturity testing.
- Patient should be counseled to come to hospital quickly if in labor prior to scheduled Cesarean section time

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**MODE OF DELIVERY CLINICAL SCENARIOS**

The following guidelines are based on scenarios that may be encountered in clinical practice. These scenarios are not all inclusive and present only recommendations; flexibility should be exercised according to the patient's individual circumstances.

**Case #1 HIV positive woman, not on antiretroviral therapy, presents after 36 weeks. Viral load and CD4 are pending and not available before delivery.**

**Therapy:**

- Options should be discussed in detail. Begin combination antiretroviral therapy
- Consultation with a HIV specialist is highly recommended

**Delivery:**

- Scheduled Cesarean section is likely to reduce transmission to infant.
- Discuss anesthesia and surgical risks.
- Schedule Cesarean section at 38 weeks based on best available clinical information.
- Avoid amniocentesis, scalp electrodes and other invasive monitoring if possible.

**Intrapartum Treatment:**

- IV ZVD 2 mg/kg for 1 hour, followed by 1 mg/kg/hour continuous infusion beginning three hours before surgery until delivery.
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**Case #2 HIV positive woman who began prenatal care in the third trimester and is responding to treatment, but viral load is well over 1000 copies/mL at 36-week gestation.**

Therapy:

- Continue antiretroviral regimen.
- Counsel that she is responding to therapy, but it is unlikely that her HIV RNA level will be below 1000 copies/mL before delivery.

Delivery:

- Scheduled Cesarean section may provide additional benefit in preventing intrapartum transmission of HIV
- Discuss anesthesia and surgical risks.
- If she chooses Cesarean section, it should be performed at 38 weeks gestation according to best available dating parameter; counsel patient to come in early if in labor prior to scheduled Cesarean section time
- Scalp electrodes and other invasive monitoring should be avoided, if possible

Intrapartum Treatment:

- As the previous case.
- If already on antiretroviral regimen that includes ZDV, recommend continuation of the outpatient regimen without interruption.

**Case #3 Woman on antiretroviral therapy with an undetectable HIV RNA level at 36 weeks gestation**

Therapy:

- Continue antiretroviral regimen
- Counsel her that her risk of perinatal transmission of HIV with undetectable HIV RNA level is low; 2% or less.

Delivery:

- There is no information to evaluate whether a scheduled Cesarean delivery will lower risk of transmission further.
- Balance uncertain benefit with risk of Cesarean section vs. vaginal delivery
- Scalp electrodes and other invasive monitoring should be avoided, if possible

Intrapartum Treatment:

- IV ZDV 2 mg/kg for one hour, followed by 1 mg/kg/hour continuous infusion until delivery
- If already on antiretroviral regimen that include ZDV, recommend continuation of the outpatient regimen without interruption.

**Case #4 HIV positive woman scheduled for elective Cesarean delivery presents in early labor or shortly after rupture of membranes.**

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**Delivery:**

- If labor progressing rapidly, delivery vaginally.
- If a long period of labor is anticipated, may load with ZDV and proceed with Cesarean delivery.
- May also provide pitocin augmentation, if clinically appropriate, to expedite delivery.
- Scalp electrodes and other invasive monitoring should be avoided, if possible.

**Intrapartum Treatment:**

- As previous.
- If already on antiretroviral regimen that included ZDV, recommend continuation of the outpatient regimen without interruption.

**Case #5 Woman with no prenatal care presents to L&D in labor. Rapid HIV testing accepted and returns with a positive result**

**Consultation with a specialist is highly recommended**

**Counseling:**

- Discuss results of HIV screen and the confirmatory test being run by lab.
- Provide opportunity to decrease perinatal transmission through intrapartum treatment.
- Discuss privacy issues, defining who is to learn about this test result.

**Delivery:**

- Minimize invasive procedures, if possible.
- Vaginal or Cesarean birth per patient wishes after discussion of risks/benefits.

**Intrapartum Treatment:**

- IV ZDV 2mg/kg for 1 hour, followed by 1 mg/kg/hour continuous infusion until delivery.

**Newborn Care for Infants Born to HIV Positive Mothers**

The following care should occur for all HIV exposed newborns, whether or not their mothers received therapy.

- Refer for Pediatric Infectious Disease consultation (Refer to Resource list).
- Discuss the recommended neonatal regimen with the mother and begin: ZDV syrup 2 mg/kg orally every six hours for six weeks and other medications as indicated.
- Consult with a Pediatric HIV Specialist in regards to appropriate dosage for Lamivudine and lopinavir/ritonavir administration
  - These agents (other than zidovudine) have not been tested in premature infants, therefore the dose in premature infants is unknown
- Explain the potential for mother-to-child transmission via breastfeeding and, if begun, breastfeeding should be discontinued.
- Perform CBC (with differential and platelet count) before discharge and again at 6 weeks of age to monitor ZDV toxicity.
- Screening: Perform HIV DNA PCR within 48 hours after birth.
  - If HIV DNA PCR is positive, confirm with repeat PCR as soon as possible after positive test results.

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- If HIV DNA PCR is negative, repeat PCR at age 2 weeks, 6 weeks and at 4 months.
- Before discharge, refer the infant for follow-up care:
  - Contact pharmacy to order oral AZT for infant after discharge.
  - Refer to regional Pediatric HIV center (See Resource List)
  - Arrange a case manager and public health nurse.
  - Provide a copy of the discharge summary to the primary care provider
- If a mother is discharged before the result of the infant's HIV test is available, the provider should obtain accurate contact information for follow-up before she is discharged. The provider will then be able to reach the woman for immediate treatment of the infant with a positive result.

### **HIV Antibody Tests for Infants and Children**

- The HIV antibody test (ELISA) is not used to screen infants of HIV positive mothers because positive antibody results may reflect maternal HIV status of antibodies passively transferred to infant and do not diagnose infection in children at less than 18 months of age.
- All children born to an HIV infected mother should be screened for HIV:
  - Use HIV DNA PCR test for infants < 18 months of age;
  - Use HIV antibody test, (ELISA) for children >18 months of age.

### **Breastfeeding**

- It is strongly recommended that women planning to breastfeed be tested for HIV prenatally.
- It is strongly recommended that HIV positive women NOT breastfeed.
- If the HIV positive mother has been breastfeeding, she should be counseled to discontinue.

### **Postpartum HIV Follow-up for Women**

- All women should receive comprehensive HIV medical care services. Continuing antiretroviral treatment is especially critical and must be ensured when such treatment is required for the woman's HIV infection.
- Providers should facilitate referrals - HIV specialist, medication refills, Case Manager, Public Health Nurse

### **Community Resources**

- Refer to Resource List of HIV centers.
- Provide HIV medications for uninsured individuals. (Is this where the Ryan White centers should be listed?)
- **Medi-Cal - (866) 262-9881**
  - Medi-Cal funds medical services for children and adults with limited income and resources. Call the toll-free number for an appointment.

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