**MANAGEMENT OF HIV INFECTION IN PREGNANCY AND POSTPARTUM**

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The 2015 National PMTCT and ART guidelines address comprehensive care for women who are pregnant, breastfeeding or within the first year postpartum. This talk will concentrate on the most important management issues, highlighting what is new.

**Repeated HIV testing in Pregnancy and Postpartum:**
Around 4% of HIV negative women in South Africa seroconvert during pregnancy or breastfeeding. Early detection of seroconversion is important: there is a high risk of vertical transmission due to the associated high maternal viral load, and lack of preventative measures. Repeated HIV testing throughout pregnancy and breastfeeding is therefore essential, and should be routinely performed at least 3 months. HIV testing should also be repeated for all women who present with medical problems, particularly if TB is suspected.

**Increased eligibility for HAART:**
The 2015 Guidelines have increased eligibility for HAART for all adults and adolescents with CD4 counts < 500 cells/$mm^3$, irrespective of clinical stage. This means that many more women of reproductive age should be on HAART and virologically suppressed prior to pregnancy.

In addition all pregnant, breastfeeding and postpartum women are now eligible for lifelong HAART. This includes all women up to 1 year postpartum, irrespective of method of feeding, pregnancy outcome, and CD4 count.

**Viral load monitoring in pregnant and breastfeeding women:**
Virological suppression on HAART is essential both to prevent vertical transmission and to prevent maternal morbidity and mortality. During pregnancy and breastfeeding, more frequent viral load monitoring is indicated; the 2015 guidelines have addressed this issue for the first time.

Women already on HAART at booking should have a viral load test the same day; women initiating HAART in pregnancy need a viral load test after 3 months. If there is virological suppression (VL < 1000 copies/ml), then the viral load is repeated after 6 months. If the viral load is unsuppressed (VL > 1000 copies/ml), comprehensive adherence counselling must be implemented, and the viral load repeated after a month. If there is adequate suppression within this time (VL undetectable or ≥ 1 log drop), then women on first line HAART should continue the same regimen. If there is < 1 log drop, changing to second line HAART is indicated. The reason why a 1 log drop over a month is used to assess adequate virological suppression in pregnant and breastfeeding women is to avoid the need to wait 3 months before repeating the viral load, with ongoing risk of transmission. Guidelines should be consulted to ensure that algorithms are properly followed.

**Infant prophylaxis:**
While detailed protocols for infant prophylaxis are outside the scope of this talk, it is important for obstetricians to have a basic understanding of the management of HIV exposed infants. All infants at increased risk of transmission need an HIV PCR at birth, to detect in utero infection. All infants are given 6 weeks of nevirapine for post-exposure prophylaxis. High risk infants are given additional prophylaxis, with AZT and nevirapine for 6 weeks. Infant prophylaxis should be continued until the mother is virologically suppressed, and nevirapine may be extended for 12 weeks if this has not yet been achieved.

The 2015 National Consolidated Guidelines can be accessed at:

http://sanacws.org.za/resources/national-consolidated-guidelines-for-pmtct/

Provincial guidelines should also be consulted. The Western Cape guidelines can be accessed at:

https://www.westerncape.gov.za/sites/www.westerncape.gov.za/files/westerncape_consolidatedguidelines_hivtreatment2015.pdf