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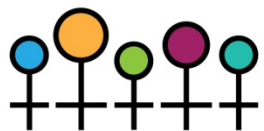
Pregnancy and HIV

Together, we can change the course of the HIV epidemic...one woman at a time.

#onewomanatatime

www.thewellproject.org

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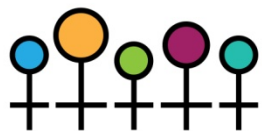
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Pregnancy and HIV

Many women living with HIV are ***living longer, healthier lives...***



...As they think about their futures, ***some are deciding to have the babies they always wanted***

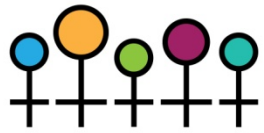


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The Good News

Advances in HIV treatment have ***greatly lowered chance that a mother will pass HIV on to her baby***

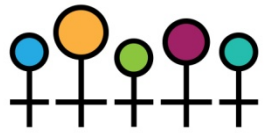
- Known as **perinatal**, "**mother-to-child**" or **vertical** HIV transmission
 - World Health Organization (WHO): HIV perinatally transmitted in as many as 45% of cases when mother is not taking HIV drugs
 - U.S. Centers for Disease Control and Prevention (CDC): chance of transmission can be **<1 in 100** if mother takes HIV drugs, is virally suppressed
 - Being pregnant will not make HIV progress faster in mother
- **Antiretroviral Pregnancy Registry** documents how HIV drugs affect pregnancy; pregnant women living with HIV encouraged to register (through their providers) at www.APRegistry.com
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Before Getting Pregnant

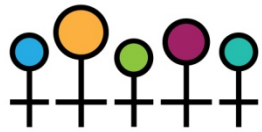
- Discuss plans with HIV care provider
 - Confirm woman is on the right treatment plan for her own health and to reduce risk of perinatal transmission
- Find an obstetrician (OB) or midwife who is familiar with HIV care
 - Can explain best options for getting pregnant
- Ask HIV provider and your OB/midwife to talk to each other, coordinate care before/during pregnancy



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Before Getting Pregnant

- Screen for STDs/STIs, hepatitis B/C, tuberculosis
- Try to give up smoking, drinking, drugs
 - Can be bad for your/your baby's health
- Start taking prenatal vitamins that contain folic acid
 - Can reduce rates of some birth defects
- Put together support network of people who are caring, non-judgmental, well educated about HIV and pregnancy
 - Can include providers, counselors, other women living with HIV who are considering pregnancy or who have had children

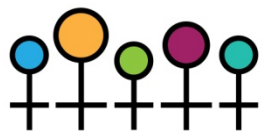


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Pregnancy Guidelines

Recommendations of expert groups on care/treatment for women with HIV who are/may become pregnant:

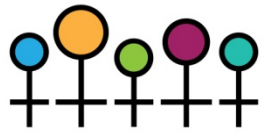
- **U.S. Department of Health and Human Services (DHHS):**
 - Thorough check up to find out about health, status of HIV infection
 - HIV drugs recommended for all pregnant women regardless of CD4 count and viral load
 - Drugs must be taken just as prescribed to have best chance of working
 - Also reduces chance of transmitting HIV to sexual partners
 - Continue taking after baby's birth, regardless of CD4 count



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HIV Drugs and Pregnancy

- According to DHHS, ***some drugs to avoid or use with caution:***
 - Videx (didanosine, ddl) + Zerit (stavudine, d4T)
 - Zerit + Retrovir (zidovudine or AZT)
 - Viramune (nevirapine) should not be started in women living with HIV who have CD4 cell counts >250
- Discuss risks/benefits of HIV drugs with health care provider to decide which treatments are best for mother and baby



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Regimens for Pregnant Women

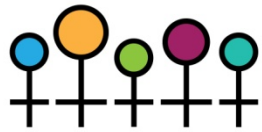
- Efavirenz (Sustiva; also in Atripla) during pregnancy:
 - Some past debate regarding safety of efavirenz during pregnancy
 - US DHHS guidelines as of October 2016 match WHO:
 - Efavirenz safe to take during pregnancy, including the first trimester (12 weeks)
 - Women who become pregnant, and are on a successful treatment regimen (virally suppressed) that includes efavirenz, should continue on efavirenz throughout pregnancy



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Tests, Procedures, and Delivery

- Invasive prenatal tests or delivery procedures that ***may increase risk of HIV transmission to baby*** (talk to your provider if you need these tests)
 - Amniocentesis
 - Chorionic villus sampling (CVS)
 - Umbilical blood sampling
 - Forceps- or vacuum-assisted delivery
- DHHS recommends women have CD4 counts checked every 3 months during pregnancy
 - Pregnant women whose viral loads remain consistently low can get CD4 counts checked every trimester (12 weeks)

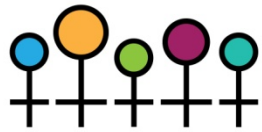


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Types of Delivery

- **C-Section**

- Not necessary unless for women living with HIV unless they:
 - Have an unknown viral load
 - Have a viral load $\geq 1,000$ copies at 36 weeks of pregnancy
 - Need a C-section for reasons other than preventing HIV transmission
- Done before labor begins and mother's "water" breaks
- Reduces baby's contact with mother's blood
- May reduce risk of transmission in certain cases
- Women who have C-sections more likely to get infections than those who give birth vaginally



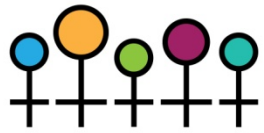
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Types of Delivery

Vaginal Delivery

- For a woman on combination HIV treatment with a low viral load (less than 1,000), a C-section has not been shown to further reduce her already very low risk of transmitting HIV

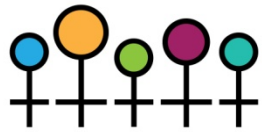
Decision of which type of delivery is best should be ***discussed with health care provider early in pregnancy***



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After the Baby Is Born

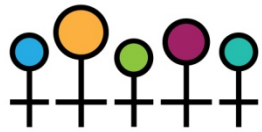
- During 1st 4-6 weeks, baby will need to take HIV meds
- Blood test called **complete blood count (CBC)** done on newborn baby as baseline
- Baby will also need to take medication to prevent pneumonia after finishing HIV meds
 - Unless there is adequate information to confirm that infant does not have HIV
 - Taking these medications does not mean the baby is sick
 - Precaution to decrease chance of getting HIV, other illnesses



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After the Baby Is Born

- Baby will receive test for ***HIV viral load***:
 - HIV viral load test looks for HIV virus, not antibodies; babies carry mothers' antibodies for up to 18 months
 - HIV testing done at one and four months
 - If baby tests negative at one and four months: HIV-negative
 - If the baby tests HIV positive, start HIV treatment immediately

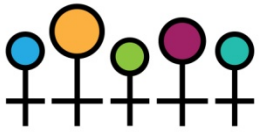


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Breastfeeding

Possible to *transmit HIV through breast milk*

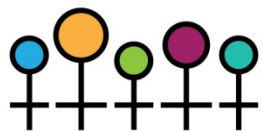
- Guidelines advise not to breastfeed, in U.S. and other high-resource countries
 - Water safe; formula available, affordable
 - ***Can still have strong bond with baby*** even if you bottle feed
- If safe water is not easy to get:
 - Risk to your baby of life-threatening conditions from formula feeding with unsafe water may be higher than risk of HIV infection through breastfeeding
 - Formula may also be too expensive or not regularly available
 - Better to feed your baby on breast milk alone, take HIV drugs



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Breastfeeding

- Breast milk contains many ***antibodies to keep baby healthy***
- Found to have protein Tenascin-C that helps neutralize HIV
- Possibility of transmission less if you are on HIV drugs and viral load is undetectable
- Mixed feeding (baby given breast milk + other liquids – formula, sugar water, gripe water) ***not recommended***
 - May damage lining of babies' stomachs, make them more likely to get HIV when exposed to it in breast milk
 - If you cannot feed your baby on formula alone, use breast milk alone
- Do not feed your baby food that has been pre-chewed by someone who is living with HIV
 - Can spread HIV to your child



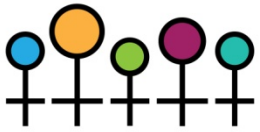
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In Conclusion

Deciding to have a baby is a ***big step for any woman***; for a woman living with HIV, it is even more complicated.

Talk to HIV health care provider and OB or midwife before trying to get pregnant.

With planning, there are ***many things women can do to protect their health and the health of their baby***



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Learn More!

- To learn more, and for links to articles featuring more details, please read the full fact sheet:
 - [Pregnancy and HIV](#)
- For more fact sheets and to connect to our community of women living with HIV, visit:
 - www.thewellproject.org
 - www.facebook.com/thewellproject
 - www.twitter.com/thewellproject