**Neonatal Care**

**Give all HIV-exposed newborns ARV prophylaxis.**

- Infant prophylaxis regimens are based on HIV transmission risk. See intrapartum management for more information.
- Standard ARV prophylaxis: ZDV syrup 4 mg/kg po BID as soon as possible and within 6-12 hrs. of birth, through 6 wks. A 4-week prophylaxis regimen can be considered if the mother has received standard cART during pregnancy with consistent viral suppression and there are no concerns related to maternal adherence.
- Combination ARV prophylaxis: ZDV syrup (4 mg/kg) and/or 3 doses of NVP (at birth, 48 hrs after first dose, and 96 hrs after the second dose).
- Neovirgin ZDV is recommended regardless of maternal ARV or resistance history but consult an expert if considering combination therapy based on maternal resistance history.
- Consult Perinatal Guidelines for ZDV/NVP dosing in premature or SGA infants.

**FOLLOW-UP CARE For Infants Born to Mothers with HIV Infection**

- Educate mother about neonatal ARV prophylaxis and discuss recommendation to avoid breastfeeding.
- Perform VL at baseline and then monthly for hematologic abnormalities; consult Perinatal Guidelines for timing.
- HIV DNA PCR is the preferred virologic assay.
- HIV virologic testing is recommended within 14–21 days of birth, at 1−2 months, and at 4−6 months.
- Confirm first positive virologic test with a second virologic test soon as possible.
- HIV is diagnosed by 2 positive HIV virologic tests on separate blood samples.
- HIV infection can be presumptively excluded in a non-breastfed infant with 2 or more negative virologic tests: one obtained at age > 14 days and one at ≥ 1 month.
- Definitive exclusion of HIV infection is based on 2 or more negative virologic tests performed at > 1 month and ≥ 3 months.
- Third-line HIV infection is confirmed, refer to pediatric HIV care for ongoing treatment and care.
- TMP-SMX for PCP prophylaxis should be started at 4–6 wks of age for infants exposed to HIV who are determined to be presumptively uninfected.

**To obtain the most current recommendations, visit www.aidsinfo.nih.gov**

**Perinatal HIV Care**

- National Perinatal HIV Consultation and Referral Service offers healthcare providers around-the-clock advice on testing and care of HIV-infected pregnant women and their infants and provides referrals to HIV specialists and regional resources.
- 1-888-448-8765 • 24 hours a day • 7 days a week

**Guidelines for Use of HIV Antiretroviral Therapy in Pregnancy**

- The full perinatal guidelines are available at http://www.aidsinfo.nih.gov/
Perform expedited/rapid HIV testing, scheduled C/S not routinely
If a pregnant women presents late to care,
All HIV-infected women and/ or infants should receive postpartum ARV drugs to
receive postpartum ARV drugs to
be tailored to specific needs, which
Approaches, including the use of
A, HBV, influenza, pneumococcus,
optimization of chronic medical
Continued antepartum ARVs on
whether an HIV-infected woman
HIV-2 infection should be suspected
Perform 3rd trimester repeat HIV
HIV-2 infection is recommended for all preg
Obtain an early ultrasound to
Conduct HIV resistance testing if detectable
Obtain VL initially, at 2-4 weeks after starting or changing ARVs,
If positive, start cART immediately,
If delivering vaginally, attempts should
Provide contraceptive counseling to
Obtain HIV resistance testing before start
Obtain VL and/or CD4 results for results of supplemental testing.
HIV RNA/VL near delivery. All HIV+ women
on maternal VL and mode of delivery.
HIV+ women and C/TARPs should be considered for countermeasure therapy in consultation with a product expert based
on the diagnosis and treatment of HIV 2 infection in pregnancy.
HIV+ women on cART not on the diagnosis and treatment of HIV 2 infection in pregnancy.
HIV+ women on cART not on
HIV-2 infection in pregnancy.
Kaur S et al. 39 weeks gestation. If a
All HIV+ women in labor with no
HIV 2 infection in pregnancy.
Frequent monitoring is necessary
HIV+ women without a known
HIV-2 infection in pregnancy.
HIV infection in pregnancy.
without knowledge of the status of
The goal of treatment is to achieve a
ARV for the prevention of perinatal HIV transmission is recommended for all preg
women with HIV infection regardless
symptoms of HIV disease, opportunistic
ART in pregnancy is recommended for all preg
women as non-pregnant
Guidelines for management of C/TARPs in pregnancy is recommended for all preg
ARV for pregnant women listed in
case, empiric cART should be initiated
HIV resistance testing is detectable
viral suppression (VL ≤1000 copies/mL).
Kaur S et al. 39 weeks gestation. If a
HIV RNA/VL near delivery. All HIV+ women
prime-positive ARV therapy. Since
preliminary evidence supports
HIV+ women with a known
HIV infection status who present in labor
HIV+ women in labor with no prior ARVs
no prior ARVs. Start ZDV without waiting
months or Q6 months if woman is
empiric cART should be initiated until
Stop infant ARV prophylaxis.
HIV resistance testing is detectable
C/TARPs should be considered for
on schedule 6-week prophylaxis.
HIV+ women in labor with no prior ARVs
infection.
HIV+ women on cART not on
HIV infection in pregnancy.
Women with no history (h/n) of ARVs (ARV-naive)
start ZDV, or 2-4 weeks after stopping or changing ARVs,
HIV RNA/VL (viral load) or CD4 count.
among the standard regimens for
Conduct HIV resistance testing if detectable
Obtain VL and/or CD4 results for results of supplemental testing.
HIV infection status who present in labor
HIV+ women on cART not on
HIV+ women without a known
HIV infection status who present in labor
HIV+ women in labor with no prior ARVs
HIV+ women with a known
HIV infection status who present in labor
HIV+ women in labor with no prior ARVs
HIV+ women with a known
HIV infection status who present in labor
HIV+ women without a known
HIV infection status who present in labor
HIV+ women in labor with no prior ARVs
HIV infection in pregnancy.
with knowledge of the status of
HIV infection status who present in labor
HIV+ women in labor with no prior ARVs
HIV infection in pregnancy.
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HIV infection in pregnancy.
with knowledge of the status of
HIV infection status who present in labor
HIV+ women in labor with no prior ARVs
HIV infection in pregnancy.