TOWARDS ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV

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OUTLINE

• Burden of HIV in PMTCT
• Mechanism and timing of Mother to Child Transmission (MTCT)
• Four Prongs of PMTCT
• Kenya PMTCT Guidelines
• Management of HIV-exposed infants.
• Other maternal services
INTRODUCTION

• Vertical transmission of HIV is the primary mode of acquisition of HIV in children worldwide is through MTCT, which can occur during pregnancy, labor, delivery, and breastfeeding.

• More than 90% of Pediatric HIV infections are acquired through MTCT.

• Risk of HIV transmission without interventions is 20-45%.

• With the implementation of current WHO recommendations, risk of MTCT can reduce to <5% and <2% in the breastfeeding and non-breastfeeding populations respectively.
INTRODUCTION.... cont

- In 2016, UNICEF estimated 2.1 million children under 15 years of age were living with HIV worldwide. Out of this, 18.8 million were women and girls.
- There are an estimated 420,000 new pediatric infections every year (UNAIDS 2017)
- The 2012 Kenya AIDS Indicator Survey reported the HIV prevalence among pregnant women to be 6.5%.
- With an estimated 1.5 million pregnancies annually, the number of women in need of PMTCT services is estimated at 80,000 every year.
- HIV is a leading cause of maternal and infant mortality in Kenya.
Transmission patterns in breastfeeding and non-breastfeeding populations assuming no PMTCT interventions

<table>
<thead>
<tr>
<th>Timing</th>
<th>No Breastfeeding</th>
<th>Breastfeeding through 6 months</th>
<th>Breastfeeding through 18 to 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>During pregnancy</td>
<td>05 to 10</td>
<td>05 to 10</td>
<td>05 to 10</td>
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<tr>
<td>During labour</td>
<td>10 to 20</td>
<td>10 to 20</td>
<td>10 to 20</td>
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<tr>
<td>Through breastfeeding</td>
<td>0</td>
<td>05 to 10</td>
<td>05 to 10</td>
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<tr>
<td>Early (first 2 months)</td>
<td>0</td>
<td>05 to 10</td>
<td>05 to 10</td>
</tr>
<tr>
<td>Late (after 2 months)</td>
<td>0</td>
<td>01 to 05</td>
<td>05 to 10</td>
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<tr>
<td><strong>OVERALL</strong></td>
<td><strong>15 to 30</strong></td>
<td><strong>25 to 35</strong></td>
<td><strong>30 to 45</strong></td>
</tr>
</tbody>
</table>

*De Cock 2002*
**WHO FOUR-PRONGED STRATEGY FOR MTCT**

**Prong 1:** Prevention of HIV among women of reproductive age within services related to reproductive health such as antenatal care, postpartum and postnatal care, the entry point is HIV testing and counseling.

**Prong 2:** Providing appropriate counselling and support, and contraceptives, to women living with HIV to meet their unmet needs for family planning and spacing of births, and to optimize health outcomes for these women and their children.
Prong 3: Access to the antiretroviral drugs for pregnant women living with HIV and their exposed infants to prevent HIV infection from being passed on to their babies during pregnancy, labour and delivery and breastfeeding.

Prong 4: HIV care, treatment and support for women, children living with HIV and their families.
Comprehensive approach to virtual elimination

**Childbearing Women**
- Women living with HIV

**Prevent new infections**
- Prevention of unintended pregnancies

**Pregnant women living with HIV**
- Prevent MTCT

**HIV-infected children**

Preferred Partner for Health Solutions

www.chskenya.org
Reduce HIV incidence in Women of Reproductive Age (WRA) (15-49 yrs) by 50%  

Reduce unmet FP need to 0% among all women (especially HIV positive women)  

Reduce number of new child HIV infections by 90% and 50% of the HIV attributable deaths in children  

Reduce HIV-related maternal deaths up to 12 months postpartum by 90%
GLOBAL PLAN TOWARDS THE ELIMINATION OF NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND KEEPING THEIR MOTHERS ALIVE

2011-2015

Preferred Partner for Health Solutions
GUIDING PRINCIPLES

- HIV testing should be offered to all pregnant and breastfeeding women
- HIV positive pregnant and breastfeeding mothers should get lifelong ART
- Treatment Monitoring for efficiency of ART—Viral load
- Early infant diagnosis with effective prophylaxis to be provided during the breastfeeding period
- Infant and young child nutrition (IYCN) as per WHO
- Comprehensive services such as reproductive health, NCDs management, mental health screening and gender based violence services should not be left out
Care and Treatment for the women
HIV TESTING GUIDELINE

• Testing for all pregnant women at first ANC visit- unless known HIV positive, and repeat testing in the third trimester

• At labour and delivery, testing all women with unknown HIV status or not tested in the third trimester

• Repeat test at 6 weeks and 6 months for all women who tested HIV negative during ANC, labour and delivery, thereafter test as per risk category

• All newly identified HIV positive women should have a confirmatory HIV test. However, repeat testing should not delay ART initiation.
MATERNAL ART

• Lifelong ART is recommended for all positive pregnant and breastfeeding women, regardless of WHO staging and CD4 count.
• Recommended regimen: TDF/3TC/EFV (300/300/600 mgs).
• Early ART initiation (preferably at first contact) reduces risk of vertical transmission.
• Patients already on ART, continue with regimen but evaluate for co-morbidities and optimize
VIRAL LOAD MONITORING

• For newly initiated ART in pregnant and breastfeeding women, obtain VL 6 months after initiation.

• For HIV positive women on ART for > 6 months, obtain a VL as soon as pregnancy is confirmed.

• If \( \geq 1,000 \) copies/ml, intensify adherence, repeat the VL after 3 months.

• If still \( \geq 1,000 \) copies/ml, change to an effective regimen.

• If \(< 1,000 \) copies/ml, repeat viral load every 6 months until end of breastfeeding then follow-up as for general population.
HIV Exposed Infants Management
INFANT HIV TESTING <18 months

• Establish HIV exposure of all infants at point of contact – Immunization, IPD, OPD

• DNA PCR at 6 weeks and if negative at 6 months and 12 months. Final antibody test should be done at 18 months.

• All Infants with an initial positive HIV DNA PCR result should be presumed to be HIV infected and started on ART.

• Do a confirmatory HIV DNA PCR and take baseline viral load sample at the time of ART initiation

• ART initiation is based on the first result.
• Children less than 18 months may present to hospital with severe illness and a rapid antibody test confirms HIV exposure.

• In case there is no immediate availability of HIV DNA PCR results to confirm infection, a presumptive diagnosis may be made to avoid delay in starting lifesaving ARVs.

• If symptomatic with 2 or more of the following: oral candidiasis/thrush, severe pneumonia, severe sepsis Or any of the following; Any WHO clinical Stage 4 condition or recent maternal death or advanced HIV disease in mother.
INFANT PROPHYLAXIS

• All HIV exposed infants regardless of time of identification should receive prophylaxis for a minimum of 12 weeks from birth or time of diagnosis.
• For mothers on ART; give AZT+NVP for 6 weeks, followed by NVP for 6 weeks.
• Provide 6 weeks of AZT+NVP, followed by daily NVP until 6 weeks after complete cessation of breastfeeding for infants whose mothers refuse ART.
• Discontinue NVP ONLY after maternal viral suppression is confirmed.
• Infant cotrimoxazole prophylaxis should be started from 6 weeks.
INFANT AND YOUNG CHILD NUTRITION

• Exclusive breastfeeding for the first 6 months of life
• Introduce appropriate complementary foods at 6 months and continue breastfeeding up to 12 months for HEI.
• BF should ONLY stop once a nutritionally adequate and safe diet without breast milk can be provided and supported for all.
• All HIV infected infants should EBF for the first 6 months of life, complementary feeding from 6 months, and continue breastfeeding up to 24 months and beyond.
• All HEI should be immunized as the national schedule with an additional measles vaccination at 6 months.
Other Maternal Services
Family Planning

• All women should be counselled on safe resumption of sex after delivery
• Pregnancy intention screening should be done on an ongoing basis.
• All HIV infected women should be offered *dual contraception 6 weeks* after delivery or first contact thereafter.
• HIV infected women who desire pregnancy should have sustained VL suppression prior to conception

Cervical Cancer Screening

• All HIV infected women should be offered cervical cancer screening 6 weeks after delivery then annually.
Gender Based Violence Services
• Assessment, counselling, referral and management for GBV services.

Pre-Exposure Prophylaxis
• PrEP should be considered in HIV uninfected pregnant and breastfeeding women who are at an ongoing risk of HIV acquisition.
• Pregnant and breastfeeding women who want to discontinue PrEP should continue for at least 28 days after last potential exposure.

Mental Health Services
• Assessment and referral for management of postpartum or any other kind of depression.
Non-communicable diseases.
• Screening and management

Adolescent PMTCT services
• Provision of adolescent friendly services.
• Psychosocial support to address HIV and pregnancy related stigma leading to improved Adherence, Retention and Suppression. OTZ +
• Economic empowerment through linkage to community and legal services
  – vulnerabilities lead them to become “Key Populations”.
Comprehensive approach to virtual elimination

*Childbearing Women*

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  - Women living with HIV

- Prevention of unintended pregnancies
  - Pregnant women living with HIV

- Prevent MTCT
  - HIV-infected children

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Acknowledgement

- CHS
- CDC
- Ministry of health - NASCOP
- KPA
- All Stakeholders
MTCT FREE “Maisha” INITIATIVE IN KENYA

Asante Sana!
Thank you!

Centre for Health Solutions – Kenya

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