24. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV INTERVENTION

24.1 Overview of PMTCT interventions

Prevention of mother-to-child transmission (PMTCT) of HIV is one of the key HIV prevention strategies in Zimbabwe’s national response to the HIV/AIDS epidemic. Mother-to-child transmission (PMTCT) of HIV is the most significant source of HIV infection in children below the age of 15 years. Over 90% of HIV infection in infants and children is due to PMTCT.

About 30 to 35% of pregnant women are HIV positive. Without any PMTCT intervention, about a third of the HIV infected women will pass the virus to their babies. It is estimated that about 20% of the infected babies become infected during pregnancy, 60% during labour and delivery, and 20% after birth through breast-feeding. Most infections therefore occur during labour and delivery.

The goal of Zimbabwe PMTCT is to reduce PMTCT of HIV infection, thereby leading to reduction of infant morbidity and mortality.

The Four Main Strategies for PMTCT in Zimbabwe are:

- Primary prevention of HIV infection in Women of childbearing age and their partners.
- Prevention of transmission of HIV to the infant during pregnancy and breastfeeding
- Prevention of unwanted pregnancies in HIV infected women.
- Care and Psychosocial support to HIV infected women and their families

PMTCT practices need to be carried out during the antenatal period, labour and delivery and post-natal period including after hospital / clinic discharge.
24.2 Summary of antenatal care practices

All pregnant women offered VCT

Carry out individual pretest counselling

Informed consent for HIV testing?

YES -> Proceed to HIV rapid testing

NO -> Continue routine ANC
Offer VCT at subsequent visits

Post Test Counselling

NEGATIVE

- Discuss window period, offer further HIV test in 3 months if ‘high risk’
- Offer partner VCT and encourage involvement
- Discuss safer sex and give condoms
- Encourage breastfeeding

POSITIVE

- Give Nevirapine
- Counselling on infant feeding
- Offer partner counselling
- Discuss “safer sex” and offer condoms
- Look for signs and symptoms
- Discuss positive living

Continue routine ANC and reinforce messages at each visit
24.3 Summary of practices during labour and delivery

- Woman presents to labour ward in “labour”
- Establish that it’s true labour
- Ensure Nevirapine has been taken
- HIV status
- Carry out labour and delivery using SAFE OBSTETRIC PRACTICES:
  - Use of the partogram
  - Avoid ARM where possible
  - Avoid unnecessary episiotomy
  - Minimise trauma from instrumental delivery and routine suctioning of baby’s mouth/nostrils
  - Clamp cord immediately after birth and do not “milk”
  - Dry baby and keep warm immediately after birth
  - Apply baby friendly practices

- If false labour replace Nevirapine and discharge
- If HIV status is POSITIVE:
  - Give baby 0.6ml NVP syrup immediately after birth AND repeat at 72 hours
  - Routine postnatal care of infant

- If HIV status is NEGATIVE OR UNKNOWN:
  - Establish that it’s true labour
  - If false labour replace Nevirapine and discharge

- Mother did not take NVP OR took NVP less than 2 hours before delivery
- Give baby 0.6ml NVP syrup immediately after birth AND repeat at 72 hours
- HIV exposed baby
24.4 Summary of post natal practices

Woman has delivered her baby

Educate/counsel mother on the following issues:
• Good hygiene/cord care
• Signs and symptoms of infection in both herself and her baby.
• Importance of good nutrition
• Family planning (dual protection)
• Importance of follow up visits
• Encouragement to seek health care promptly if problems arise in herself or baby
• Encourage safe sex
• Encourage VCT for partner

Establish HIV Status

Positive
- Support chosen infant feeding method
- If unwell, refer
- Give Nevirapine to baby at 48 – 72 hrs
- Complete Child Health Card including PPTCT code

Negative
- Support breast feeding

DISCHARGE mother and infant
Give date of first follow up visit (ten to fourteen days post delivery)
24.5 Summary of long term follow up & care

**Schedule of visits for mother/infant follow up:**
- 10 – 14 days
- 6 weeks
- Monthly up to 18 months

**INFANT:**
- Counselling on infant feeding and address any problems.
- Encourage exclusive breast feeding for 6 months followed by rapid weaning
- For non-breastfeeding, ensure hygienic preparation and adequacy of feeds including micro nutrient supplementation
- Monitor growth
- Monitor development
- Follow routine immunisation schedule
- Give cotrimoxazole prophylaxis and increase dose according to age*
- Monitor signs and symptoms of HIV infection and refer appropriately

**MOTHER:**
- Monitor mother’s weight and give nutritional advice
- Cotrimoxazole prophylaxis if indicated*
- Refer appropriately if ill
- Discuss and provide family planning, emphasis on dual protection
- Referral for psychosocial support

**Check HIV status at 18 months**
- Discharge from PMTCT follow up
  - Continue cotrimoxazole prophylaxis *
  - Continue nutrition and growth monitoring

**INFANT COTRIMOXAZOLE PROPHYLAXIS DOSES**
- 6 wks – 5 months: 2.5ml OD
- 6 – 18 months: 5ml OD
- 18 months – 3 yrs: 7.5ml OD
- 3 yrs onwards: 10ml OD
  (10ml = 1 tablet)

**MOTHER COTRIMOXAZOLE PROPHYLAXIS DOSES**
- 2 tablets OD

* For mothers with WHO stage III or IV HIV or CD4 count ≤ 350 cells/mm³.