Overview of 2016 Kenya PMTCT guidelines

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MINISTRY OF HEALTH
National AIDS & STI Control Programme

Kenya Framework for Elimination of Mother to-Child Transmission of HIV and Syphilis

Every Mother and Child Counts
2016-2021

Ministry of Health

GUIDELINES FOR PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HIV/AIDS IN KENYA 4TH EDITION, 2012

MINISTRY OF HEALTH

Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya

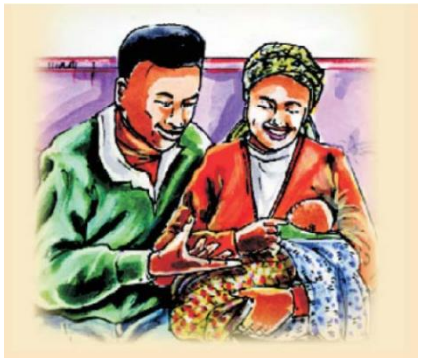
2016 Edition

Strategies to reduce paediatric AIDS

Prevention of unwanted Pregnancies

Prevention of Mother to Child Transmission (PMTCT)

Care for mother and family



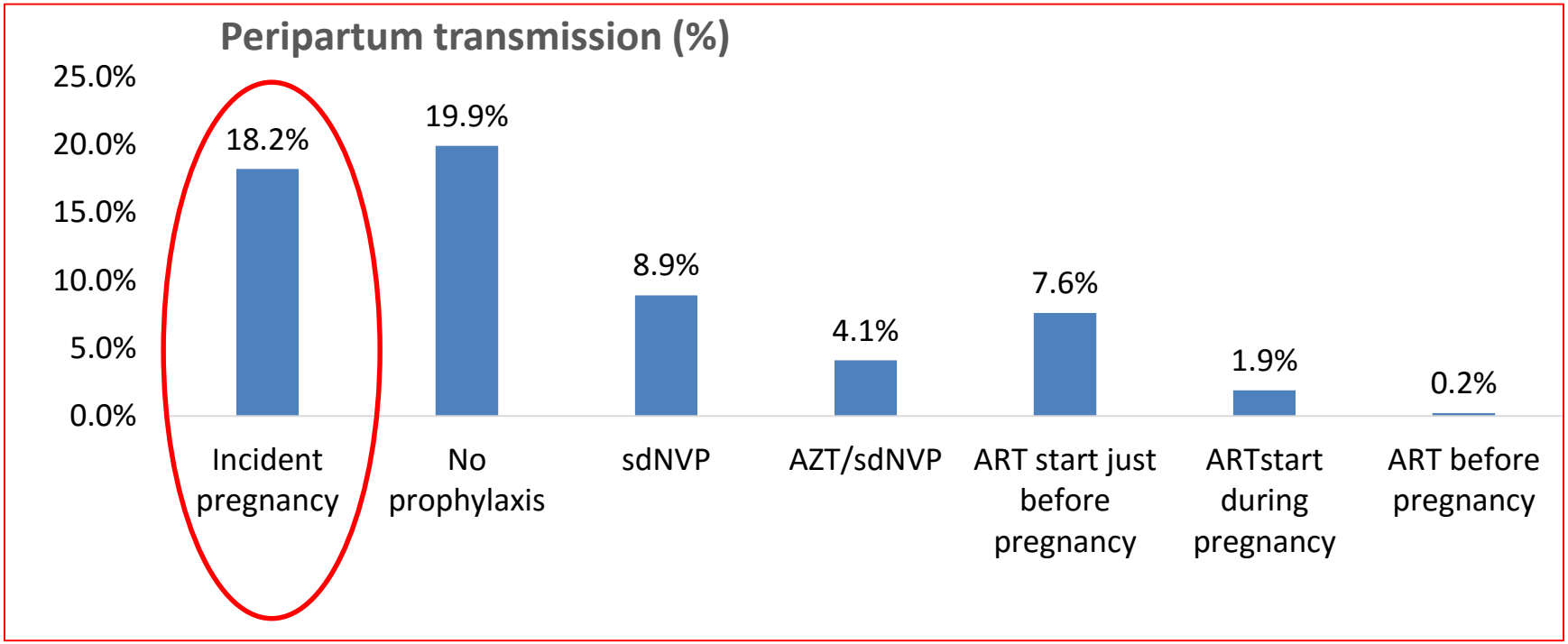
Primary HIV prevention in parents to be

HIV testing

- All women except those known to be HIV infected should be offered HIV testing at 1st antenatal care visit
- Women not tested at 1st antenatal care visit should be offered testing at subsequent visits
- All women should be offered partner and or couple HIV testing

Increased HIV incidence during pregnancy & breastfeeding

- High incidence of HIV during pregnancy and breastfeeding

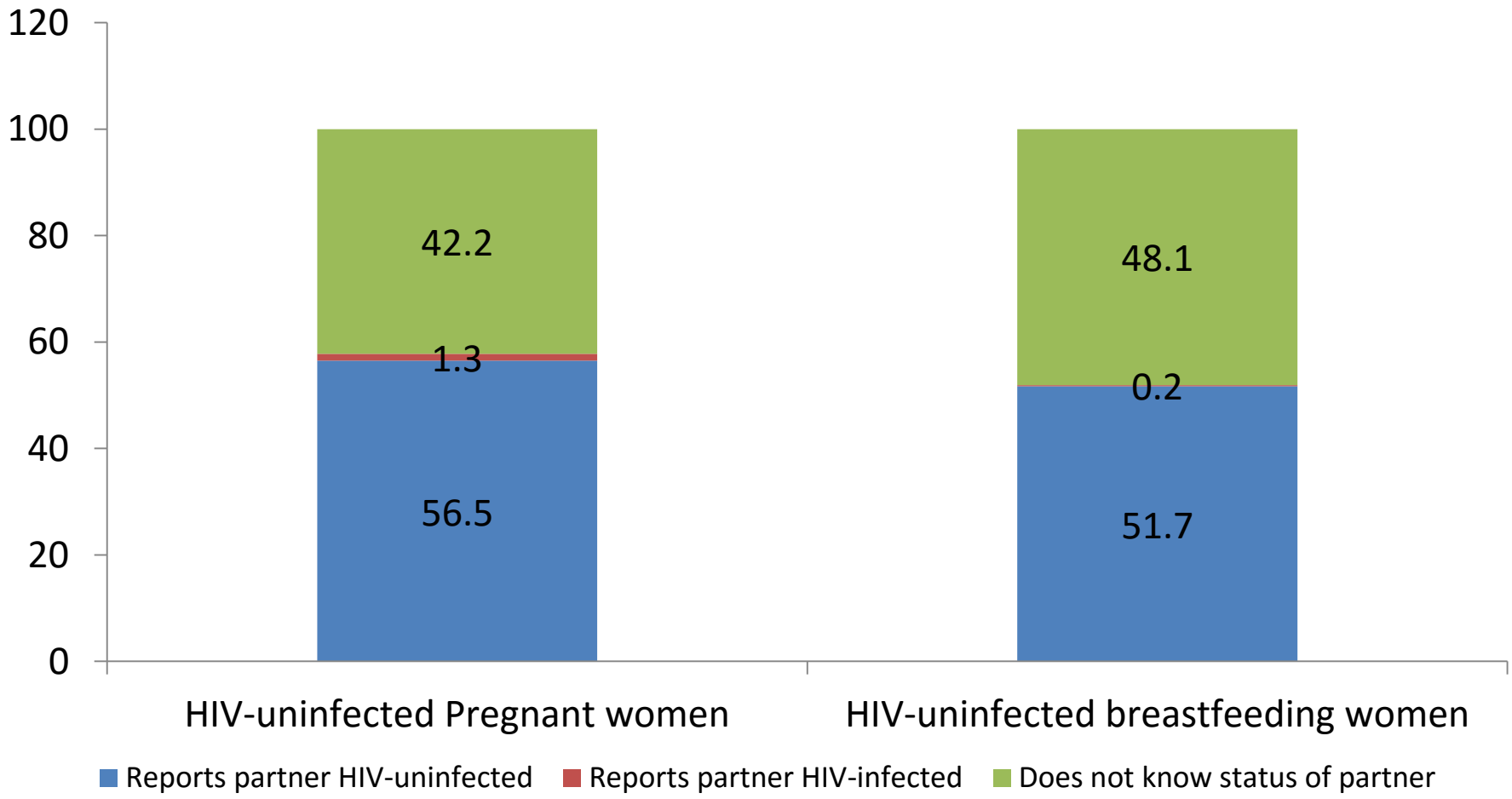


- Increased risk of MTCT in acute HIV infection

HIV retesting

- HIV retesting increases the ability to identify women who seroconvert
- HIV retesting recommended
  - 3rd trimester
  - during labour/delivery
  - 6 weeks & 6 months after delivery
  - thereafter as for the general population considering their risks

Knowledge of partner HIV status is low



KAIS 2012

Partner HIV testing and management

- Offer partner and or couple HIV testing
- To minimize the risk of horizontal transmission among HIV discordant couples
  - HIV infected partner should be initiated on ART
  - couple should avoid unprotected sex
  - HIV uninfected partner should be initiated on PrEP
- HIV negative pregnant and breastfeeding women at risk of HIV should be offered pre-exposure prophylaxis

Screening for sexually transmitted infections

- All pregnant women should be screened STIs
  - particularly syphilis
    - affect the baby's growth and cause congenital anomalies
- Dual HIV/Syphilis screening test recommended at 1st ANC visit to optimize syphilis testing
- Syphilis testing should ideally be performed before 20 weeks of gestation
- All women and their partners diagnosed with syphilis should be offered treatment
  - benzathine benzylpenicillin, 2.4 million IU, by intramuscular injection, at a single dose

Dual elimination of MTCT of HIV and syphilis

- EMTCT impact targets are:
  - transmission rate of <5% in breastfeeding populations
  - < 50 new paediatric HIV infections /100 000 live births
  - < 50 cases of congenital syphilis/ 100 000 live births
- There are four process targets
  - > 95% antenatal care coverage (at least one visit)
  - > 95% coverage of HIV and/or syphilis testing of pregnant women
  - > 95%antiretroviral treatment coverage of HIV-positive pregnant women
  - > 95% treatment of syphilis-seropositive pregnant women

Towards Validation of Pre-elimination of Mother to Child transmission of HIV and Syphilis

Fewer than **50** New HIV infections among children per 100,000 live births

Fewer than **50** cases of congenital Syphilis per 100,000 live births

Less than **5%** HIV Mother to child transmission Rates

At least **95%** coverage of HIV and syphilis testing of pregnant women

At least **95%** treatment coverage of syphilis-seropositive pregnant women

At least **95%** anti-retroviral therapy coverage of pregnant women living with HIV

At least **95%** Antenatal care coverage (at least one visit)

Antiretroviral pre exposure prophylaxis

- PrEP is effective in preventing HIV acquisition
- Pregnancy and breastfeeding are NOT contraindications to use of PrEP
- PrEp in pregnancy is NOT associated with increased adverse pregnancy-related events
- ARV regimen
  - **Recommended**
    - Tenofovir 300 mg + Emtricitabine 200 mg once daily
  - **Alternative**
    - Tenofovir 300 mg once daily
    - Tenofovir 300 mg + Lamivudine 300 mg once daily

Post exposure prophylaxis (PEP)

- Short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure
  - occupational
  - sexual intercourse
- > 80% reduction in risk of HIV infection when started soon after exposure
- Adherence to a full 28-day course of ARVs is critical
- Pregnancy and breastfeeding are NOT contraindications to use of PEP
- Not the right HIV prevention option for people who may be exposed to HIV frequently

Use of post exposure prophylaxis

- Initiated within **72 hours** after high risk exposure
  - HIV uninfected
- Recommended antiretroviral regimens for PEP:

  Adults
  - TDF + 3TC + ATV/r for 28 days

  Children
  - ABC + 3TC + LPV/r for 28 days
- HIV uninfected women taking PEP should:
  - use condoms with sex partners
  - be offered infant NVP if breastfeeding

Contraception is the best kept secret for PMTCT

- Reduction in unintended pregnancies reduces the number of infants born to HIV-positive mothers
- Unmet need for family planning is high, particularly in sub-Saharan Africa, where HIV prevalence is also high
- Eliminating MTCT will not be possible without addressing unmet needs for family planning
- Women should be encouraged to use dual method
  - condom to prevent STIs
  - more effective method to prevent pregnancy

HIV infection does not preclude use of any contraceptive method

- Women living with HIV can **continue** to use all existing hormonal contraceptive methods without restriction
- Drug-drug interactions between hormonal contraceptives and ART should be taken into account
- **HIV infected women should NOT be forced to use any contraceptive method**

Contraceptive Methods for PLHIV (WHO 2015 Medical Eligibility Criteria)

Contraceptive Method	ARVs Being Used					
	NRTIs (any)	NNRTIs		PIs (any)	INSTIs	
		EFV or NVP	ETR		RAL	DTG*
IM medroxyprogesterone (DMPA; Depo Provera)	1	1	1	1	1	-
Norethisterone enanthate (NET-EN; norethindrone)	1	2#	1	2	1	-
Implants	1	2#	1	2	1	-
Combined oral contraceptive (pill)	1	2#	1	2#	1	-

Category 1: No restriction for the use of the contraceptive method
Category 2: Advantages of using the method generally outweigh the theoretical or proven risks
Category 3: The theoretical or proven risks usually outweigh the advantages of using the method

Preconceptions services

- High rates of unintended pregnancies have been reported among HIV-infected women
- Preconception care should be offered to all women of reproductive age
- HIV positive women may be reluctant to bring up issues about their reproductive desires
- HIV-infected women who
  - desire pregnancy should be virally suppressed prior to conception
  - do not desire pregnancy should be offered effective contraception

ART during pregnancy/breastfeeding

- Goal of antiretroviral therapy is to suppress viral replication
- Uninterrupted ART will help maintain undetectable viral load levels
  - preventing damage to the body's immune system
  - restoring and maintaining healthy living
- Lifelong ART should be started in all pregnant and breastfeeding women living with HIV
- Preferred regimen TDF + 3TC (or FTC) + EFV
- High levels of **adherence** to ART critical to achieve sustained viral suppression

Monitoring response to ART

- Viral load monitoring is an effective means of enhancing adherence
- Monitoring is important to
  - ensure successful treatment
  - identify adherence problems
  - determine treatment failure
- Viral load is the preferred method of monitoring of pregnant or breastfeeding women & children on ART

Recommendations for viral load testing

- Entry into ANC
- Diagnosis of pregnancy if woman on ART
- 6 months after ART initiation for those newly diagnosed
- Woman who is virally suppressed
  - repeat every 6 months until end of breastfeeding
- Women not virally suppressed
  - have adherence support
  - Viral load repeated after 3 months until viral load suppression is confirmed
- **Infant prophylaxis with syrup nevirapine should continue until maternal viral suppression is confirmed**

Failure to suppress

- If plasma viral load is >1000 copies/mL in pregnant or breastfeeding woman on ART for at least 6 months, the following interventions should be initiated:
  - intensified adherence support
  - repeat viral load after 3 month
- if still above 1,000 copies/ml
  - review adherence and concomitant medication
  - change to second-line ART
  - support from case manager/ peer mother/mentor mother

Labour and delivery

- Vaginal delivery is safe among women on ART who are virological suppressed
- Childbirth at health facilities is an important strategy to
  - reduce maternal morbidity and mortality
  - improve fetal outcomes
  - reduce mother-to-child transmission of HIV
- Women who do not deliver at health facilities
  - fail to receive obstetric interventions
  - are less likely to use ARVs during delivery
- Elective caesarean delivery where feasible if
  - with HIV RNA levels >1000 copies/ml near delivery
  - with unknown HIV RNA levels

Immediate postnatal maternal care

- Challenges to antiretroviral adherence
- Need to discuss social support before hospital discharge
- Health care providers should be vigilant in screening for signs of the following that may affect ART adherence:
  - depression
  - intimate partner violence
  - illicit drug or alcohol use

Late postnatal maternal Care

- All women should be asked about resumption of sexual intercourse and possible dyspareunia as part of an assessment of overall well-being 2–6 weeks after birth
- At the 6 week post-delivery visit, all HIV infected women should be offered
  - contraception
  - cervical cancer screening
  - assessment for postnatal depression
  - assessment and support to promote adherence to ART

Non communicable diseases

- Non-communicable diseases are now a leading cause of premature mortality
- HIV increases the risk of non-communicable diseases
  - cardiovascular
  - metabolic
  - liver
  - kidney disease
- Counselling on lifestyle changes to prevent hypertension, diabetes mellitus, and dyslipidaemia
- All women living with HIV should be screened & offered initial management for non-communicable diseases

Mental health screening and management

- Depression is one of commonest psychiatric illnesses
- Delivery and chronic illness (including HIV) is a strong risk factor for depression
- All PLHIV & postpartum women should receive a basic screening for depression using the following two questions:
  - during the past month have you often been bothered by feeling down, depressed, or hopeless?
  - during the past month have you often been bothered by little interest or pleasure in doing things?
- More thorough screening for depression using the PHQ-9 screening tool if the answer is yes to either question

Alcohol and drug abuse

- Alcohol and drug use can be a significant contributing factor to:
  - poor maternal and infant outcomes
  - poor adherence and HIV treatment failure
- Screening tools
  - CRAFFT for adolescents
  - CAGE for adults
- All individuals who screens positive referred to a health provider experienced with managing alcohol and drug use disorders

Intimate partner violence

- Major public health problems and constitute violation of human rights of the women
- ~ 1 in 3 women worldwide have experienced either physical and or sexual intimate partner violence or non-partner sexual violence in their lifetime
- Health care providers should screen for intimate partner violence during all postnatal care visits
- Women who report intimate partner violence should be referred to the social workers in the facility for support

Pregnancy in women with perinatal HIV infection

- Significant number of pregnancies are unintended
- Components of prenatal care and general principles of ART and HIV management similar
- Perinatally infected women have unique challenges in reproductive health and PMTCT
  - lower median CD4 counts
  - detectable viral loads
  - drug resistances
  - pregnancy complications such as preterm delivery, low birthweight, and preeclampsia
  - psychosocial challenges may be magnified due to the presence of a lifelong chronic illness, high rates of depression and frequent loss of one or both parents

Neonatal care in the immediate post delivery period

- Warmth and stimulation in the labour room
- No airway suction unless indicated
- 1% TEO for opthalmia neonatorum prophylaxis
- Breast feeding initiation within half hour of delivery
- Complete examination
  - congenital abnormalities
  - neonatal illnesses
- Information and demonstration of cord care

Neonatal care in the immediate post delivery period

- Support mother with information and skills on:
  - infant feeding
  - identification of danger signs
- Identify HIV exposed infants and infants of unknown exposure status

Comprehensive care for HIV exposed/infected children

- The following should be offered to all HIV Exposed Infants and infected children
  - immunization
  - malaria prevention in areas with malaria
  - growth monitoring
  - cotrimoxazole preventive therapy
  - nutritional counseling and support
  - tuberculosis screening, prevention and treatment
  - confirmatory HIV testing and treatment

Infant & child HIV testing

- All infants and children below 18 months should have their HIV exposure status determined
- All HIV-exposed infants should be offered HIV testing at 6 weeks or at 1st contact thereafter using DNA PCR
- **HIV-exposed infants who are unwell should be offered HIV testing at that visit irrespective of their age**

Infant & child HIV testing

- HIV exposed infants should have DNA PCR test for Dx at
  - 6-week immunization visit

  Those with negative PCR results should have a repeat PCR at
  - 6 months and 12 months – refer to EID algorithm
- Infants with a positive HIV DNA PCR result
  - should be presumed to be HIV-infected
  - started on ART in line with national guidelines
  - obtain a second sample for
    - confirmatory HIV DNA PCR
    - viral load test should be obtained
- PCR testing for infants below two weeks has potential to identify HIV infected HEI earlier but currently under pilot. If conducted should be followed by a repeat PCR at 6 weeks for all those who are PCR negative

Prophylaxis for HIV-exposed infant

- Dual ARV prophylaxis is recommended for HIV-exposed infants (HEI)
  - initiated at birth or as soon or as soon as identified as HEI
- **AZT and NVP will be given for first 6 weeks then syrup NVP is continued for a MINIMUM 6 weeks thereafter**
- **NVP syrup should be discontinued ONLY after:**
  - **maternal viral suppression is confirmed in postnatal period**
  - **favorable maternal clinical and psychosocial assessment**
- Antiretroviral prophylaxis should be stopped after 6 weeks for infants who were not breastfed at all
- Initiate Infant cotrimoxazole prophylaxis at 6/52 of age

ART for HIV infected infants

- Infants with an positive HIV DNA PCR result should
  - be presumed to be HIV infected
  - started on ART in line with national guidelines
- At the time of ART initiation
  - 2nd Dry Blood Spot (DBS) sample should be collected
  - sample for viral load test

This should not delay initiation of ART which should be based on first positive DNA PCR test

ART for HIV infected infants diagnosed through birth testing at age

- The recommended is AZT + 3TC + NVP
- At 3 weeks, the regimen is changed to the recommended first line regimen for children >3 weeks
- consideration should be made of maternal ART and whether the mother is on a failing regimen
  - < 2 weeks: AZT + 3TC + NVP
  - 2 weeks : < 4 weeks: AZT + 3TC + LPV/r
  - 4 weeks: < 3 years: ABC + 3TC + LPV/r

Preventing and treating opportunistic Infections in children

No change in guidance on

- Screening for TB
- Isoniazid preventive therapy
- Cotrimoxazole preventive therapy
- Follow up schedule

Vaccine	Age	Remarks
• BCG • Polio (OPV O)	At birth	• Or at first contact with child
• DPT1-HeB1-Hib1 • Polio (OPV 1) • Rotavirus • Pneumococcal	6 weeks	• Or at first contact with child after that age
• DPT2-HeB2-Hib2 • Polio (OPV 2) • Rotavirus • Pneumococcal	10 weeks	• 4 weeks after DPT 1 and OPV 1 can also be given any time after this period, when in contact with the child.
• DPT3-HeB3-Hib3 • Polio (OPV 3) Pneumococcal	14 weeks	• 4 weeks after DPT 2 and OPV 2 can also be given any time after this period, when in contact with the child
• **Measles**	**6 months**	• **HIV exposed infants and admitted to hospital for any other illness**
• Measles Rubella	9 months	• Repeat at 9 months as per KEPI schedule.
• Measles Rubella	18 months	• Can also be given any time after this period, when in contact with the child

Feeding infants and young children born to HIV infected mothers

- Maternal or infant ARVS significantly reduces the risk of HIV transmission to breastfeeding infants
- HIV positive mothers should be encouraged and supported to
  - exclusively breastfeed for the first 6 months
  - continue breastfeeding for **at least** 1 year with appropriate complementary feeds until a nutritionally adequate diet can be sustained without milk
- The mother should be on ART and infants provided with ARV prophylaxis for at least 12 weeks.

Community engagement

- Important to achieve the MTCT goal
- Successful elimination of MTCT will require community involvement and utilization of community-based support systems
- The devolution and the 'Nyumba Kumi' initiative being rolled out countrywide provide opportunities to engage with the communities to support e-MTCT
- Counties to map existing and potential community structures that can support e-MTCT
- Leverage on community structures including local administration

Strategies for community engagement

- Establish community level
  - coordination structures
  - communication structures
  - monitoring structures
  - support for pregnant & breastfeeding women irrespective of HIV status
- Use traditional administrative structures
- Involve PLWHIV such as mentor mothers
- Innovate and use non-HIV initiatives
  - as table banking
- Integrate PMTCT services with other community primary health care initiatives

Thanks