



NORTHREACH

November 2020 Aware Newsletter

This month's newsletter will focus on Pregnancy and HIV!

Many women living with HIV are concerned about how pregnancy could be affected and about passing their HIV infection on to their babies. Recent studies have shown that with good prenatal care, use of anti-HIV medications and health care support, women living with HIV can have much-improved chances of having a healthy pregnancy and giving birth to healthy, HIV negative babies.

How does pregnancy affect HIV?

Studies have shown that pregnancy, by itself, does not speed up or slow down the course of HIV progression.

How does HIV affect pregnancy?

HIV infection does not appear to change the way a pregnancy normally progresses if the mother remains healthy. The risk of complications increases for both the mother and baby if the mother develops an HIV-related opportunistic infection, such as Pneumocystis pneumonia (PCP), during pregnancy. HIV does not appear to affect the development of the unborn child. The main risk that HIV poses during pregnancy is the risk of infecting the baby. The average risk of mother-to-infant transmission in untreated women is about 20-25%. This risk can be greatly reduced (to 8-10%) by different ways, as discussed below.

Mother-to-baby HIV transmission

Mother-to-baby HIV transmission can occur at three stages:

- before birth
- during birth (labour and delivery)
- after birth through breast-feeding

Most researchers believe that transmission most commonly occurs during the last weeks of pregnancy or during delivery.

Factors that increase the risk of mother-to-baby transmission include:

- having a high viral load
- having a genital infection (like herpes) during pregnancy
- drinking alcohol, smoking cigarettes or using recreational/street drugs during pregnancy
- having the mother's water "break" more than four hours before delivery
- vaginal delivery
- difficult labour that requires cutting the vagina (episiotomy) and the use of forceps
- breast-feeding

Factors that decrease the risk of mother-to-baby transmission include:

- low/undetectable viral load





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- use of anti-HIV medications
- elective Caesarian section for delivery
- active prevention of opportunistic infections
- active treatment of co-existing genital infections
- access to good prenatal care and health care services
- avoiding invasive investigative procedures during pregnancy
- no breast-feeding (formula only)
- treatment of newborn with anti-HIV medications

Treatments to reduce and prevent mother-to-baby transmission through anti-HIV medications

- The anti-HIV medication AZT (zidovudine) has been shown to reduce the risk of transmission from mother to baby. AZT is recommended for women during the last six months of pregnancy, during labour, and during delivery (by intravenous route), and for the baby during the first six weeks after birth.
- Other studies have shown that even when AZT is started later in pregnancy, or just around the time of delivery, it can still reduce the risk of transmission by about half.
- Recent studies showed a single dose of nevirapine (Viramune) given to the mother during labour and a single dose given to the baby after birth can also dramatically reduce the chances of mother-to-baby transmission.

Caesarean delivery

- The risk of transmission is reduced if the baby is delivered by planned Caesarean section rather than by vaginal delivery. This is called an “elective” C-section and is scheduled for the 38th week of pregnancy.

Information on the guidelines for the management of pregnant HIV positive women is available at the Canadian Medical Association website at http://www.cmaj.ca/cqi/collection/iv_infection_aids. Information provided can be found at: <https://www.catie.ca/ga-pdf.php?file=pdf/ACASfs/HIVPreg.pdf>

