Postpartum Follow-Up of Women Living with HIV  (Last updated November 14, 2017; last reviewed November 14, 2017)

The postpartum period provides an opportunity to review and optimize women’s health care. Comprehensive medical care and supportive services are particularly important for women living with HIV and their families, who often face multiple medical and social challenges. Components of comprehensive care include the following services as needed:

- Primary, gynecologic/obstetric, and HIV specialty care for the woman with HIV;
- Pediatric care for her infant;
- Family planning services;
- Mental health services;
- Substance abuse treatment;
- Support services;
- Coordination of care through case management for a woman, her child(ren), and other family members; and
- Prevention of secondary transmission for serodiscordant partners, including counseling on the use of condoms, antiretroviral therapy (ART) to maintain virologic suppression in the partner with HIV (i.e., Treatment as Prevention), and potential use of pre-exposure prophylaxis by the partner without HIV.

Support services should be tailored to the individual woman’s needs and can include case management; child care; respite care; assistance with basic life needs, such as housing, food, and transportation; peer counseling; and legal and advocacy services. Ideally, this care should begin before pregnancy and continue throughout pregnancy and the postpartum period.

Immediate linkage to care, comprehensive medical assessment, counseling, and follow-up are required for women who have a positive HIV test during labor or at delivery. Women who have an initially positive HIV

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Panel's Recommendations

- Antiretroviral therapy (ART) is currently recommended for all individuals living with HIV to reduce the risk of disease progression and to prevent the sexual transmission of HIV (AI).
- Plans for modifying ART after delivery should be made in consultation with the woman and her HIV care provider, ideally before delivery, taking into consideration the preferred regimens for non-pregnant adults (AIII).
- Because the immediate postpartum period poses unique challenges to antiretroviral (ARV) adherence, arrangements for new or continued supportive services should be made before hospital discharge (AII).
- Contraceptive counseling should start during the prenatal period; a contraceptive plan should be developed prior to hospital discharge (AII).
- Women with a positive rapid HIV antibody test during labor require immediate linkage to HIV care and comprehensive follow-up, including confirmation of HIV infection (AII).
- Prior to hospital discharge, the woman should be given ARV medications for herself and her newborn to take at home (AIII).
- Infant feeding counseling, including a discussion of potential barriers to formula feeding, should begin in the prenatal period and this information should be reviewed after delivery (AIII).
- Breastfeeding is not recommended for women in the United States with confirmed or presumed HIV infection, because safe alternatives are available (AII).

Rating of Recommendations: A = Strong; B = Moderate; C = Optional

Rating of Evidence: I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion
test should not breastfeed unless a confirmatory HIV test is negative (for detailed guidance on maternal HIV testing, please see the Identification of Perinatal HIV Exposure section). If HIV is confirmed, a full health assessment is warranted, including counseling related to newly diagnosed HIV infections, a discussion of the need for lifelong ART, an assessment of the need for opportunistic infection prophylaxis, and an evaluation for associated medical conditions. The newborn should receive appropriate testing and antiretroviral (ARV) drug management. Other children and partner(s) should be referred for HIV testing.

When care is not co-located or not within the same health care system, a case manager can facilitate care coordination. Women receiving case management are also more likely to be virologically suppressed and retained in care. It is especially critical to ensure continuity of ART between the antepartum and postpartum periods, so prior to discharge the mother should receive a follow-up appointment with her HIV care provider and HIV medications for herself and her newborn. Special hospital programs may need to be established to support dispensing of ART to mothers before discharge.

Decisions about any changes to an ART regimen after delivery should be made in consultation between the woman and her HIV care provider, ideally prior to delivery.

ART is currently recommended for all individuals living with HIV to reduce the risk of disease progression and to prevent HIV sexual transmission. The START and TEMPRANO trials were randomized clinical trials that demonstrated that early ART can reduce the risk of disease progression even in individuals with CD4 T lymphocyte cell count >500 cells/mm³, and the HPTN 052 randomized clinical trial demonstrated that early ART can reduce risk of sexual transmission to a discordant partner by 96%.

It is important to counsel a woman that no single method (including treatment) is 100% protective against HIV transmission; however, with full, sustained HIV suppression, the possibility of sexual transmission is extremely low.

Understanding the need for lifelong ART is a priority for postpartum care, but does present several specific challenges. Studies have demonstrated significant decreases in ART adherence postpartum. During the postpartum period, women may have difficulty with medical appointment follow-up, which can affect ART adherence. Systematic monitoring of retention in HIV care is recommended for all individuals living with HIV, but special attention is warranted during the postpartum period. A number of studies have suggested that postpartum depression is common among women with HIV. The U.S Preventive Services Task Force recommends screening all women for postpartum depression using a validated tool; this is especially important for women living with HIV who appear to be at increased risk for postpartum depression and for poorer ART adherence during the postpartum period. Women should be counseled that postpartum physical and psychological changes and the stresses and demands of caring for a new baby may make adherence more difficult and that additional support may be needed during this period.

Poor adherence has been shown to be associated with virologic failure, development of resistance, and decreased long-term effectiveness of ART. In women who achieve viral suppression by the time of delivery, postpartum simplification to once-daily coformulated regimens—which are often the preferred initial regimens for non-pregnant adults—could promote adherence during this challenging time. Efforts to maintain adequate adherence during the postpartum period may ensure effectiveness of therapy (see the section on Adherence in the Adult and Adolescent Antiretroviral Guidelines). For women continuing ART who had received increased protease inhibitor doses during pregnancy, available data suggest that reduction to standard doses can be initiated beginning immediately after delivery.

The postpartum period is a critical time for addressing safer sex practices in order to reduce sexual transmission of HIV to partners and should begin to be addressed during the prenatal period. Counseling on prevention of secondary transmission to the partner without HIV should include condoms, ART for the partner with HIV to maintain viral suppression below the limit of detection, and the potential use of pre-exposure prophylaxis (PrEP) by the partner without HIV. With full, sustained HIV suppression in the woman—with or without reliable PrEP use by her partner without HIV—the possibility of transmission is extremely low (for additional information, see Reproductive Options).
It is important that comprehensive family planning and preconception care be integrated into routine prenatal, postpartum and all health visits. Lack of breastfeeding is associated with earlier return of fertility; ovulation returns as early as 6 weeks postpartum, and earlier in some women—even before resumption of menses—putting them at risk of pregnancy shortly after delivery.29 Long-acting reversible contraceptives (LARC), such as injectables, implants, and intrauterine devices (IUDs), should be inserted prior to hospital discharge or during the health visit at 6 weeks postpartum. If LARC is postponed to the postpartum visit, Depo-Provera is an option to be given as a bridge to avoid unplanned pregnancy in the interim, particularly if the postpartum appointment is missed. Interpregnancy intervals of less than 18 months have been associated with increased risk of poor perinatal and maternal outcomes in women without HIV infection.30 Because of the stresses and demands of a new baby, women may be more receptive to use of effective contraception, yet simultaneously at higher risk of nonadherence to contraception and, thus, unintended pregnancy.31

The potential for drug-drug interactions between a number of antiretroviral (ARV) drugs and hormonal contraceptives is discussed in Preconception Counseling and Care for Women of Childbearing Age Living with HIV and Table 3. A systematic review conducted for the World Health Organization has summarized the research on hormonal contraception, IUD use, and risk of HIV infection and recommends the use of all contraceptive methods in women with HIV.32,33 Findings from a systematic review of hormonal contraceptive methods and risk of HIV transmission to partners without HIV concluded that oral contraceptives and medroxyprogesterone do not increase risk of HIV transmission in women who are on ART although data are limited and have methodological issues.34 Permanent sterilization is appropriate only for women who are certain they do not desire future childbearing.

Avoidance of breastfeeding has been and continues to be a standard, strong recommendation for women living with HIV in the United States, because maternal ART dramatically reduces but does not eliminate breastmilk transmission, and safe infant feeding alternatives are readily available in the United States. In addition, there are concerns about other potential risks, including toxicity for the neonate or increased risk of development of ARV drug resistance, should transmission occur, due to variable passage of drugs into breastmilk. However, clinicians should be aware that women may face social, familial, and personal pressures to consider breastfeeding despite this recommendation; this may be particularly problematic for women from cultures where breastfeeding is important, as they may fear that formula feeding would reveal their HIV status.35,36 It is therefore important to address these possible barriers to formula feeding during the antenatal period. Similarly, women with HIV infection should be made aware of the risks of HIV transmission via premastication (prechewing or prewarming) of infant food.37

References


