

HIV and Pregnancy

With the advances in HIV care and treatment, many HIV+ women are living longer, healthier lives. As they think about the future, some of these women are deciding to have the babies they always wanted.

The good news is that the advances in HIV treatment have also brought down the rate of mother-to-child HIV transmission significantly. If the mother takes appropriate medical precautions, the rate of transmission can be reduced from 25 percent to below 2 percent. In addition, studies have shown that being pregnant will not make HIV progress faster in the mother.

However, deciding to become pregnant when HIV infected is a big decision. Here are some of the considerations?

1. Will my HIV affect my ability to become pregnant?

Women with HIV have decreased fertility rates compared to HIV negative women, however, to become pregnant, you must have unsafe sexual intercourse which puts your partner at risk for HIV.

2. Will a pregnancy accelerate the course of my HIV infection?

There is no evidence that pregnancy is associated with increased HIV progression (more rapid declines in CD4 count, or more rapid increase in viral load). There is no evidence that HIV causes birth defects.

3. Will HIV affect the course of pregnancy?

A number of studies have shown that HIV infected women may deliver prematurely and that their infants will have lower birth weights than uninfected women.

4. What are the chances that my baby will be HIV-infected?

Mother-to-child transmission (MTCT), also known as vertical transmission, may occur

- before birth
- during Birth
- after birth through breastfeeding.

The risk of transmission from an HIV positive woman to her baby is approximately 25%.

This risk is higher for women with lower CD4 counts and higher viral loads. Most transmission occurs during the birthing process, although it may occur during the pregnancy or by breast feeding. It is, therefore, recommended that women with HIV not breast feed their babies.

5. Can anything be done to decrease the risk?

The risk of HIV being passed to her child can be reduced by certain interventions. These include:

- taking antiretrovirals during pregnancy (excluding the first 3-4 months of pregnancy)
- taking antiretroviral drugs during labour
- choosing caesarean section as the method of delivery
- giving the baby a short course of antiretroviral therapy after birth
- abstaining from breast-feeding.

Study ACTG 076 demonstrated that the use of AZT can decrease the risk of perinatal transmission to approximately 8%. The woman is given oral AZT during pregnancy, intravenous AZT during labour and delivery and the baby is given oral AZT for the first few weeks of life.

6. What about the use of other antiretroviral drugs?

The safety of other antiretroviral drugs in pregnancy is currently unknown. Most experts feel that the woman should receive combination antiretroviral therapy in the same manner as if she was not pregnant.

It is necessary, however, to balance the optimal treatment of the mother and the potential to decrease perinatal transmission versus the unknown potential to cause birth defects. You should consult your doctor if you become pregnant to determine the best treatment for you and for your baby.

7. What about the role of Cesarean section?

There are two types of delivery: Cesarean section (C-section) and vaginal delivery. Elective or planned C-sections are done before labor begins and before the mother's "water" (the membranes that surround the baby) breaks. This reduces the baby's contact with the mother's blood.

Early studies showed that elective C-sections lowered transmission rates. (Emergency C-sections, those done after the membranes break, do not reduce HIV transmission.)

But today HIV+ women who are on effective HIV therapy and have undetectable viral loads have low transmission rates for vaginal births without C-sections. Since C-sections require surgery, they carry some risks. Women who have C-sections are more likely to get infections than those who give birth vaginally.

For a woman on HIV therapy with a low viral load (less than 1,000), a C-section is not likely to further reduce her already low risk of transmitting HIV. But for a woman with a viral load over 1,000 or one who is not already receiving treatment at the time of delivery, a C-section may reduce the chances of transmission. Speak to your doctor about the pros and cons of each method of delivery.

8. What else should I consider?

Even though your health may be improved by antiretroviral therapy, there are other factors that you should consider.

If you and/or your partner become ill or die from your HIV, who will care for your child?

If your child becomes infected, you may experience considerable guilt. Are you prepared to watch your child suffer and possibly die from HIV?

Deciding to become pregnant when HIV infected is a big decision. Make sure you discuss the implications with your partner and with your doctor. Although treatments can decrease the risk your baby will become infected, this cannot be guaranteed with certainty.

9. What should I do before I get pregnant?

- Find an obstetrician (OB) who is familiar with HIV care. He or she can explain your options for getting pregnant with as little risk to your partner as possible.
- Get screened and treated for sexually transmitted diseases
- Give up smoking, drinking and drugs. All of these can have a negative impact on your health and the health of your baby
- Start taking prescription pregnancy vitamins that contain folic acid and calcium while you are trying to become pregnant. This can reduce the rates of some birth defects.
- If friends and family are unsupportive or critical of your decision to have a child, put together a support network of people who are caring, non-judgmental and well educated about HIV and pregnancy. Your network can consist of medical providers, counselors and other HIV+ women who are considering pregnancy or have had children.

10. What antiretroviral drugs should be used in pregnancy?

All HIV+ pregnant women should consider the three-part AZT regimen that has been widely used to decrease mother-to-child transmission. Under this approach, AZT is usually started at week 14 of pregnancy (alone or in a combination regimen), intravenous AZT is given during labor and delivery, and the baby is given AZT for six weeks.

Women already taking HIV treatment who find out they are pregnant during the first trimester should talk to their doctor about the benefits and risks of continuing HIV drugs during this time. Women who are taking HIV therapy and find out they are pregnant after the first trimester should continue their HIV treatment.

In all cases, if the current HIV regimen does not include AZT, the guidelines recommending adding it. Certain drugs, such as Sustiva and the liquid formulation of Agenerase, and combinations of drugs, such as ddl and d4T, should be avoided because of possible side effects in the pregnant woman or developing baby.

A woman in labor who has not taken HIV drugs can still reduce the risk of infecting her baby by using medication during labor and delivery and to treat the baby for a short time after birth. Babies born to mothers who received no HIV treatment still have a lower risk of becoming infected if they are given AZT immediately after birth.

11. What prenatal tests should be avoided?

HIV+ women may want to avoid some of the more invasive prenatal tests, such as amniocentesis, chorionic villus sampling, and percutaneous umbilical blood sampling.

12. What should I do after the baby is born?

Since a baby can be infected with HIV through breast milk, it is important not to breast feed if you have other options. However, occasional breast feeding appears to increase risk over continuous breast feeding. You can still have a strong bond with your child even if you bottle feed.

Once the baby is born, he or she will receive three or four HIV tests before getting the final results after several months. During this time, the baby may need to take HIV medication and anti-pneumonia medication. This doesn't mean the baby is sick; it is just a precaution to decrease the chances of transmission and illness.

13. How do I know if my child is infected with HIV?

During pregnancy a mother transfers her immunities to the child. If she is infected, her antibodies to HIV are transferred. Therefore, after a child is born and for the first 12 to 18 months, the child will test positive with an antibody test. This may not mean that the child is infected. For this reason, the antibody test is not a reliable indicator of HIV status for children under 18 months. In cases such as these, the [viral load test](#) may be used to provide additional information about the child's infection status. After 12 to 18 months, the child will shed the mother's antibodies. If it is infected, the child will continue to test positive with an antibody test.