



ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

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HIV Testing and Counseling in Labor and Delivery

Implementer's Guide Prevention of Mother-to-Child Transmission

Background Services to prevent mother-to-child transmission (PMTCT) of HIV were originally designed to provide testing and counseling primarily within antenatal clinics (ANC) with the actual delivery of antiretroviral (ARV) prophylaxis to HIV-positive women during labor. The antiretroviral prophylaxis was given to infants in the facility after birth. PMTCT services are now available in a number of countries, primarily through integration into routine antenatal care. However, availability of PMTCT services in ANC varies. The observation has been made that a significant number of pregnant women in labor are entering maternity wards with unknown HIV status. Therefore, labor and delivery (maternity) provides another opportunity to provide PMTCT services to women. For this reason, the Elizabeth Glaser Pediatric AIDS Foundation (the Foundation) has supported implementing HIV counseling and education, testing, and distribution of ARV prophylaxis through labor and delivery (L&D) services.

Description HIV testing and counseling in L&D wards is critical to providing services to pregnant women with unknown serostatus who enter L&D wards in the first stage of labor. Offering these services in L&D is feasible and increases access to PMTCT services and uptake of ARV prophylaxis for both mothers and infants. Knowledge of women's serostatus facilitates use of obstetric procedures appropriate for HIV-positive women during delivery. Furthermore, counseling provides information on infant feeding, and follow-up and use of postnatal care, family planning, and child health services for all women. In addition, information about *Pneumocystis jiroveci* pneumonia (PCP) is provided to HIV-positive women. Successful testing and counseling in L&D requires dedicated staff who have been trained to provide HIV education and pre- and post-test counseling during the intrapartum and postpartum periods.

The table on page two contains summary data on the number of women tested for HIV and the subset of women tested in L&D for five of the Foundation's country programs. The data highlight the substantial number of women with unknown serostatus who continue to enter facilities for delivery. Reasons for this include previous refusal of HIV testing, failure to attend ANC, or attendance at an ANC facility that does not provide PMTCT services. Until PMTCT services expand to reach all ANC services, this gap will persist. Knowledge of HIV status results in access to ARV prophylaxis for PMTCT, linkages to care and treatment for those who are HIV-positive, and linkages to prevention counseling for those who are HIV-negative.

This program brief is part of an Implementer's Guide which has been developed by the Elizabeth Glaser Pediatric AIDS Foundation to highlight successful approaches in implementing PMTCT and care and treatment programs. The audience for the guide includes program implementers, managers, clinicians and anyone involved in creating, managing, or providing PMTCT and care and treatment services.

The Foundation's PMTCT Program Data (2006): Selected Indicators and Countries*

Indicator	India	Kenya	Russia***	Swaziland	Tanzania
Total number of deliveries	62,100	42,000	13,200	16,000	65,000
Percent with unknown HIV status**	9%	13%	33%	33%	26%
Total number of women tested for HIV	80,600	60,900	12,700	18,800	124,000
Percent of women tested in L&D	7%	9%	31%	18%	7%

* Data have been rounded down to the nearest hundred.

**Minimum percentages including all women identified as having unknown HIV status at arrival of L&D ward; additional women with unknown status may not have been identified during L&D.

***The Foundation's program in Russia is targeted towards provision of services to women with unknown HIV status arriving for delivery. Within one year of introducing counseling and rapid testing in L&D, the percentage of HIV-positive women without prior ANC receiving ARV prophylaxis increased from 41% to 76%. Some women presented to the L&D hospitals in late stages of active labor or delivered at home, leaving insufficient time to provide rapid testing and effectively administer intra-partum maternal prophylaxis; however, 98% of the HIV-exposed infants received ARV prophylaxis.

Implementation

The following steps are recommended before introducing counseling and testing services in L&D:

- Conduct a baseline assessment to help establish counseling and testing services in L&D. Key issues that should be addressed include providing sufficient space for confidential counseling and testing, availability of testing supplies and equipment, appropriate training of staff, and commitment by management.
- Determine how to integrate PMTCT services into L&D. Depending on the number of staff available and the number on duty during each shift, advocate for routine counseling and opt-out testing of all pregnant women of unknown HIV status in the first stage of labor. Likewise, routine counseling and opt-out testing should be offered to postpartum mothers of unknown status before they are discharged from the hospital, health center, or clinic.
- Train all Maternal Child Health (MCH) healthcare providers in PMTCT to ensure availability of counseling and testing at all times. In some cases, a shortage of staff might require that additional trained counselors work in L&D or the flexible assignment of staff from elsewhere in the facility.

- Ensure a reliable supply of test kits and ARV prophylaxis within L&D. Integrate these and other supplies supporting PMTCT services into the supply chain management plan for stock outs.

The following steps are recommended before introducing counseling and testing services in L&D:

- Ensure the confidentiality of counseling in both labor and postnatal wards. This may require either the reorganization of available space or renovation to create space for confidential discussions.
- Develop standardized pre- and post-test counseling guidelines for L&D staff that conform to national guidelines, recognizing that additional counseling may be needed after delivery.
- Upon admission, check all mothers' ANC cards (if available) for HIV status and/or ask them if they have been tested for HIV.
- If a mother is HIV-positive, the healthcare provider should sensitively ask her if she received ARV prophylaxis at any time during ANC, whether she has

taken the ARV provided as instructed and if she requires additional supply. We recommend healthcare providers emphasize the importance of taking ARV prophylaxis rather than focusing on whether a woman lost it or did not take it before arrival.

Where women report no prior HIV test:

- Determine the stage of labor through history taking and examination pursuant to national guidelines.
- Provide HIV counseling to the woman in the first stage of labor; test her for HIV if she does not opt out.
- In accordance with national guidelines, use a rapid test to determine serostatus and provide the results as soon as possible. Depending on national policy, L&D or laboratory staff can perform testing procedures. Ideally, trained staff should always be available to test mothers who arrive for delivery, regardless of the time.
- Provide prevention counseling to HIV-negative and HIV-positive mothers. Emphasize to HIV-negative mothers the importance of staying negative and adopting protective behaviors. Discuss with all women infant feeding, family planning, follow-up, and care for the infant and mother. Schedule appointments for all women for postnatal care and other reproductive health services per national guidelines.
- Post-test counseling for HIV-positive women should emphasize the importance of ARV prophylaxis in decreasing the risk of HIV transmission to the infant; disclosure of HIV-positive status to solicit support from partners, family members, and confidants; and the need for spouses/partners to be tested for HIV so they can benefit from available care and treatment services. Follow-up care for HIV-positive women should include opportunistic infection prophylaxis, regular CD4 cell counts (where available) and clinical staging using WHO criteria to determine eligibility for care and treatment services.
- Because delivery may be imminent, the post-test counseling that precedes it may be limited. Immediate postpartum follow-up counseling will then be required to

address issues not covered adequately during pre-delivery counseling, allow time for additional questions, and reinforce key messages.

- Administer ARV prophylaxis to HIV-positive mothers according to national guidelines.
- If testing is not possible because of the rapid progression of labor, defer HIV counseling and testing to the immediate postpartum period. If the woman agrees to be tested and proves to be HIV-positive, administer ARV prophylaxis to her infant. It is critical this occur as soon after delivery as possible in instances where HIV-positive mothers do not receive antepartum ARV prophylaxis.
- Use recommended obstetric and infection control practices to deliver all women.
- Pursuant to national guidelines, record data on HIV counseling and testing, HIV status, and ARV provision in the mother's and infant's health records and the facility's records.
- Compile and analyze data regularly for program monitoring and observation of trends such as HIV prevalence and service utilization at each facility.

Additional considerations:

- Follow the national monitoring and evaluation system (e.g., Health Management Information System) when collecting and reporting routine data to track progress and improve quality of care. Tools used may include adapted L&D registers, and monthly and quarterly data collection forms. If these do not exist or do not function optimally, collaborate with the Ministry of Health to help strengthen the national monitoring and evaluation system.
- When feasible, MCH and L&D staff should receive PMTCT training simultaneously to promote teamwork and strengthen linkages between the two areas. Emphasize the importance of implementing PMTCT services in both L&D wards and ANC clinics to increase access and coverage of services.

Key Points

- The importance of delivering at a facility and early presentation to L&D should be emphasized to all women during ANC and through community education to create awareness of PMTCT services in L&D.
- HIV-positive women who learn their status during L&D are likely to be in considerable emotional discomfort. Therefore, it is important to establish strong linkages with psychosocial support programs during the postpartum period and to provide referrals.
- Expanding PMTCT services to L&D can reduce the number of women delivering with unknown HIV status and ensure increased access to a full range of PMTCT interventions for HIV-positive mothers and their exposed infants. Therefore, national AIDS programs and their partners should make the expansion of counseling and testing services in L&D to all facilities a priority.
- Counseling and testing in L&D is feasible and effective, especially when PMTCT services are provided in the ANC clinic.
- Minimal renovation or reconfiguring of space may be required to ensure privacy and confidentiality during pre- and post-test counseling in L&D.
- If there is insufficient time for counseling and testing before delivery, a woman should receive postpartum counseling and testing. If she is HIV-positive, her infant should receive ARV prophylaxis.
- Existing resources should be used effectively so that PMTCT services can be implemented at minimal additional cost.

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See Also

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