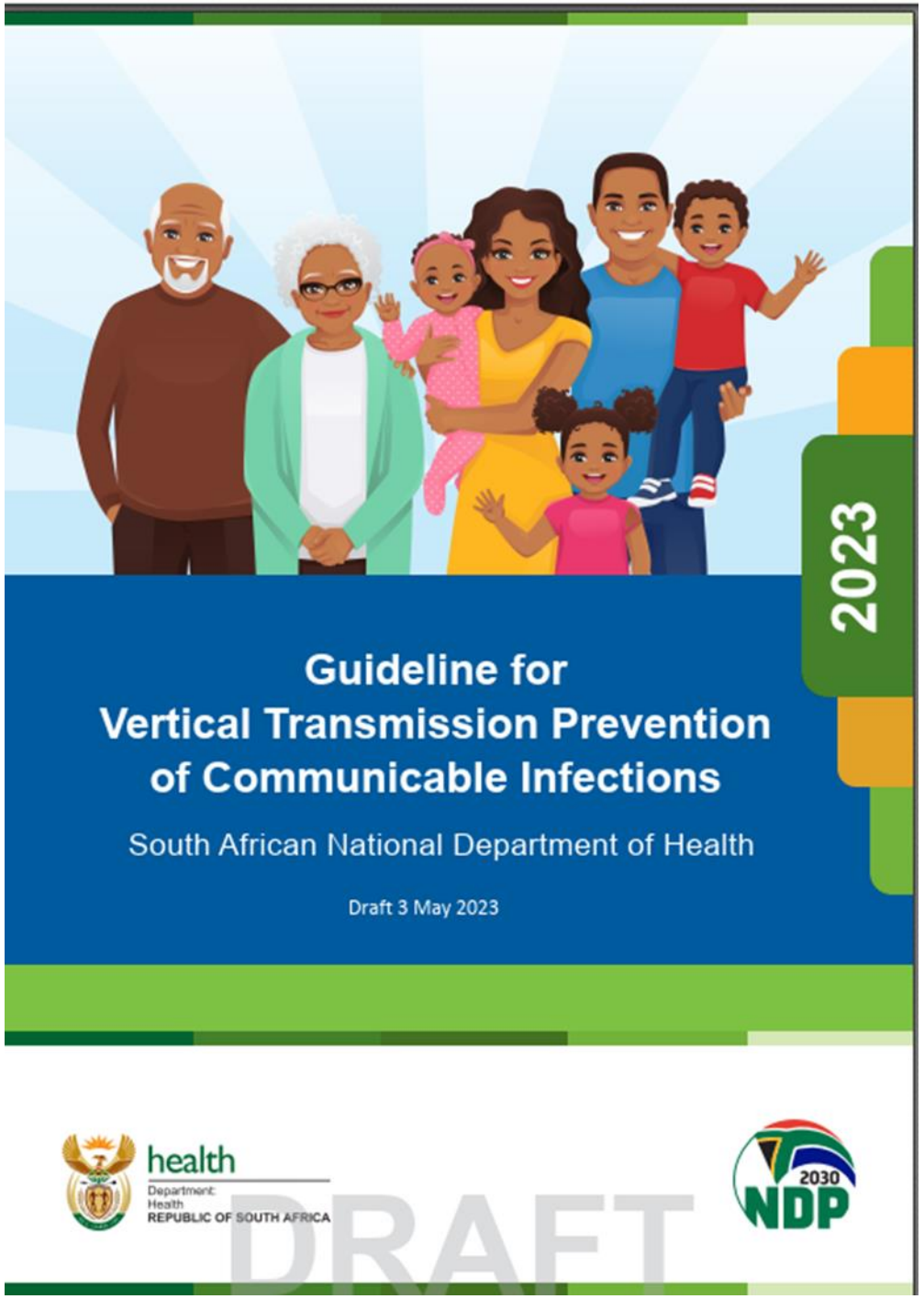
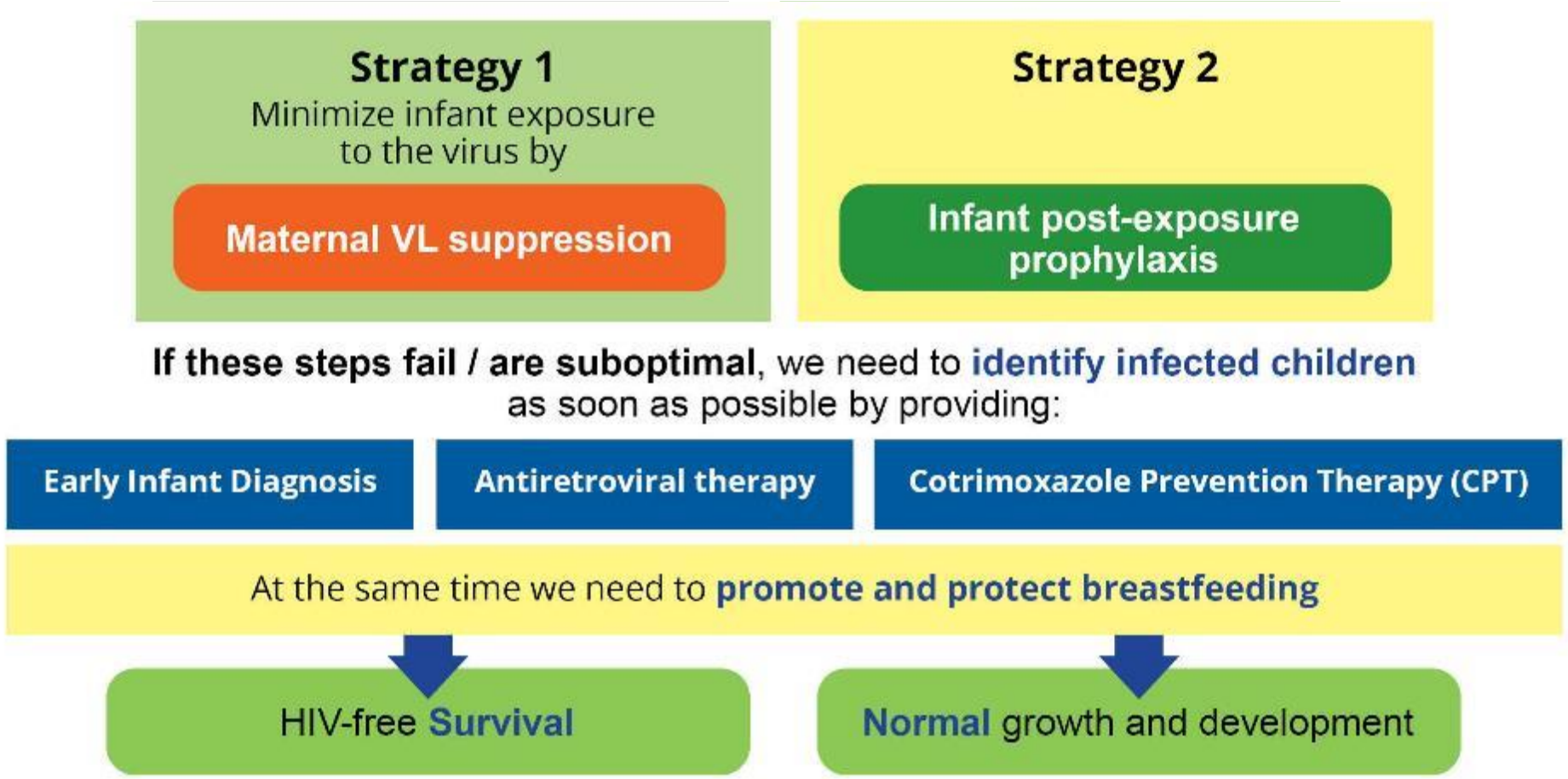
Vertical Transmission Prevention

Mother-to-child transmission will be known as vertical transmission



Overview of Recommended Interventions to for Vertical Transmission Prevention



Considerations for Vertical Prevention Transmission: overview

Still central theme of
maternal VL suppression, especially postnatally

Similarities with adult and adolescent section

- Focus on optimised regimens (DTG benefits also applicable to WOCP)
- Principles of switching and management of confirmed virological failure also apply

Differences

- Timing of the repeat VL in the VL management algorithm
- Specific changes to tighten the definition of higher risk for the HIV-exposed infant
- Specific changes related to cotrimoxazole prophylaxis

VTP: Optimising care for a mother living with HIV to minimise vertical transmission

Part 1: Implementing optimized regimens

Definition

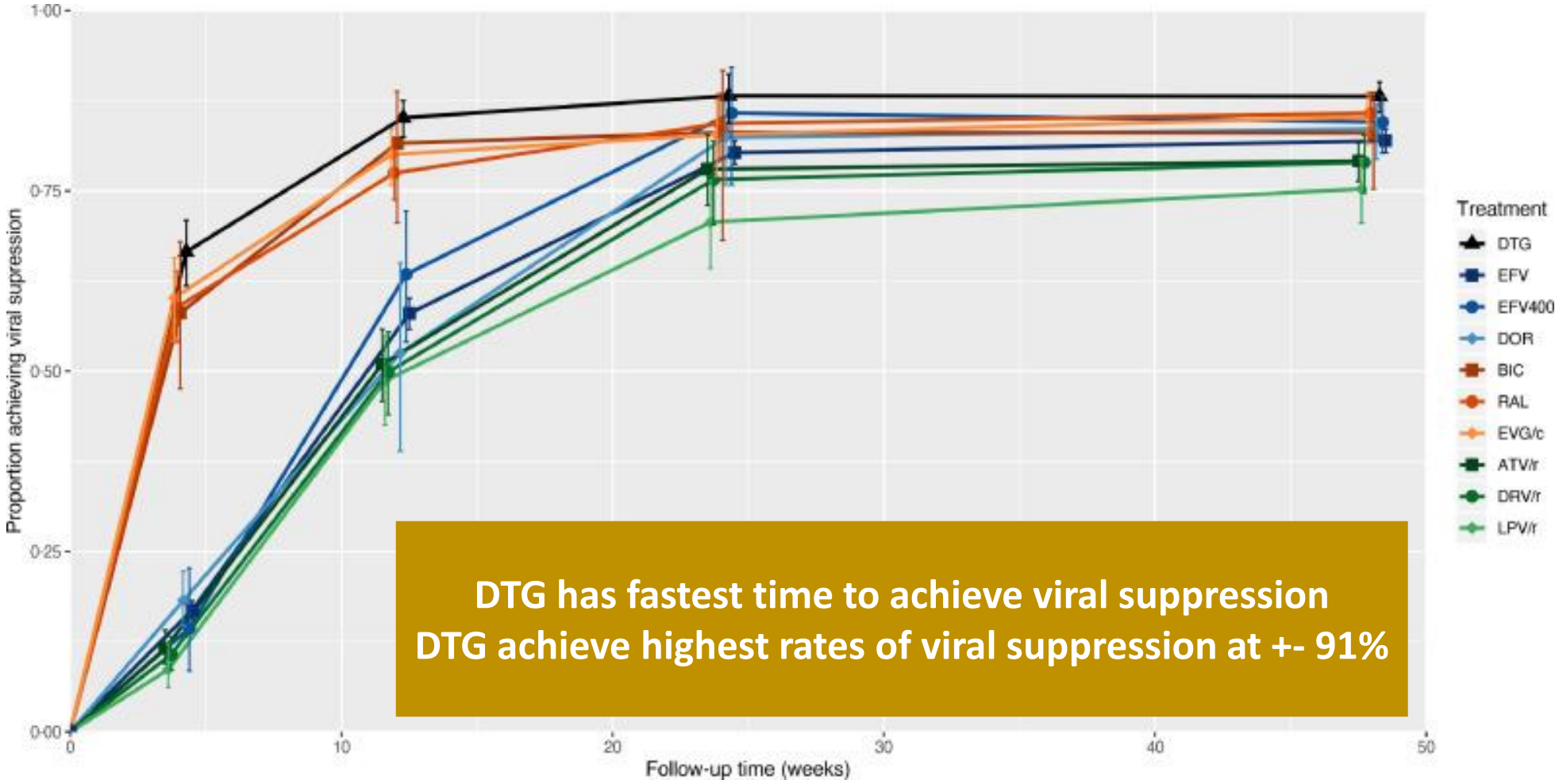
On an Optimised ART Regimen PLHIV can receive the best-available ART in the most efficient and cost-effective manner possible

An optimized regimen using DTG:

- simplifies regimens with reduced pill burden and dosing frequency
- enhances tolerability
- reduces toxicity
- reduces potential drug-drug interactions
- maintains viral suppression without jeopardizing future treatment options through the development of drug resistance

TLD is the regimen of choice in all pregnant and breastfeeding women, and also in those wanting to conceive

Optimised regimens: Benefits of Dolutegravir



DTG has fastest time to achieve viral suppression
DTG achieve highest rates of viral suppression at +- 91%

- DTG was **protective of drug-resistance**
- DTG led to **fewer discontinuations** due to better tolerance
- Can be used in TB-HIV co-infected persons and **pregnant women.**

No additional risk of NTDs!!

Optimised regimens: Recycling of TDF in second-line regimens

NADIA trial conclusions:

DTG in combination with NRTIs was as effective as DRV/r (a protease inhibitor)
including in those with extensive NRTI resistance in whom no NRTIs were predicted to have activity.
TDF was superior to AZT as second-line therapy.

- **TDF may safely be reused in 2nd-line therapy following 1st-line failure with TDF-containing regimens.**
- **TDF to replace AZT for patients on second-line ART. Benefits of TDF:**
  - Better viral suppression than AZT
  - Better tolerated than AZT
  - Less intense initial monitoring
  - Once daily (vs twice daily) and available as a fixed-dose combination (TLD)
  - Cheaper
  - Greater harmonisation with first-line TDF-based regimens would likely improve 2nd-line drug stock challenges.

A paradigm shift

In the new ART era of dolutegravir, TLD used as a

First-line regimen

Second-line regimen

Part of
Third-line regimens

→need to rethink our terminology related to "1st and 2nd-line"

TLD 1

Clients on a DTG-containing regimen, who **have never failed** a previous regimen
(old "1st line" terminology)

TLD 2

Clients on a DTG-containing regimen, who **have failed** a previous regimen
(old "2nd line" terminology)

Dolutegravir and neural tube defects

- In May 2018, a safety signal was raised.
  - –DTG (0.7%) vs EFV (0,1%)
- At the IAS conference in Mexico in July 2019, new data was released:
  - –DTG (0.3%), vs EFV ART (0.1%).
- Evidence from Tsepamo study released at AIDS 2020 virtual conference in July 2020:

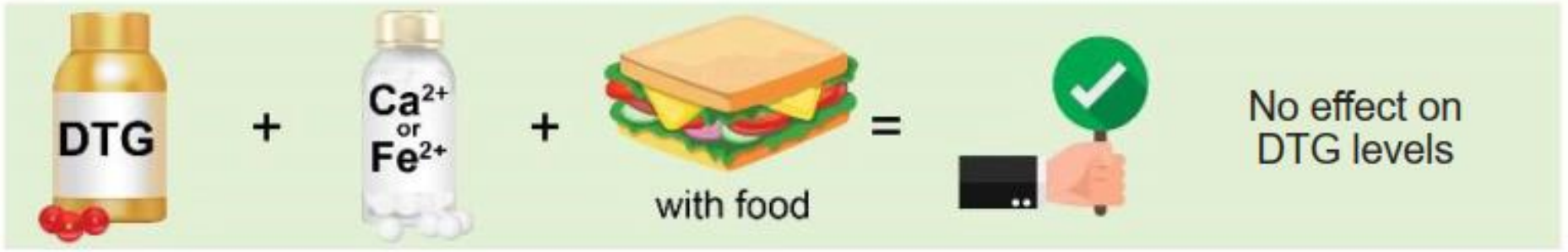
No statistically significant difference
in NTD prevalence between dolutegravir and any non-dolutegravir antiretrovirals from conception
(0.09% difference; 95%CI -0.03%, 0.30%).

Dolutegravir and the risk of NTDs

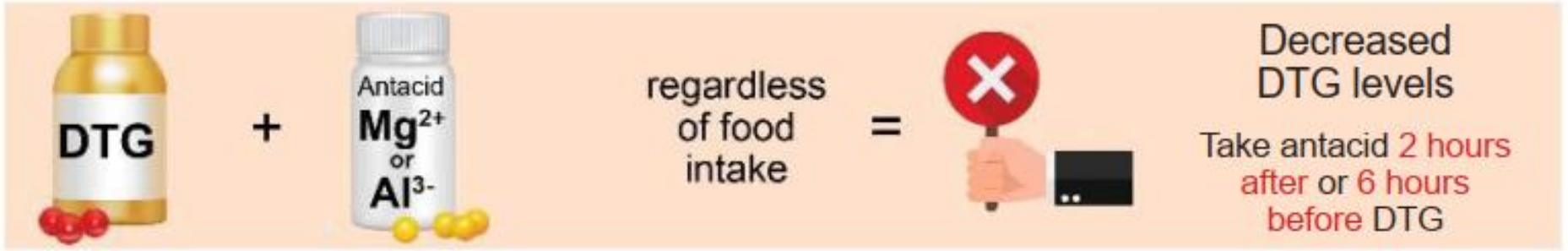
Many women and HCWs will still have concerns regarding dolutegravir and the risk of NTDs

- Provide reassurance
- There is no statistically significant difference in NTD prevalence between dolutegravir and any non-dolutegravir antiretrovirals from conception
- Inform them that the benefits of DTG far outweigh the risks, and DTG is now the recommended regimen in all men and WOCP
- If she is switching from TEE to TLD, inform her of the new side-effects that may be experienced when switching to a new drug
- Also explain about potential drug interactions with calcium iron, and antacids

Drug interactions between DTG and the polyvalent cations

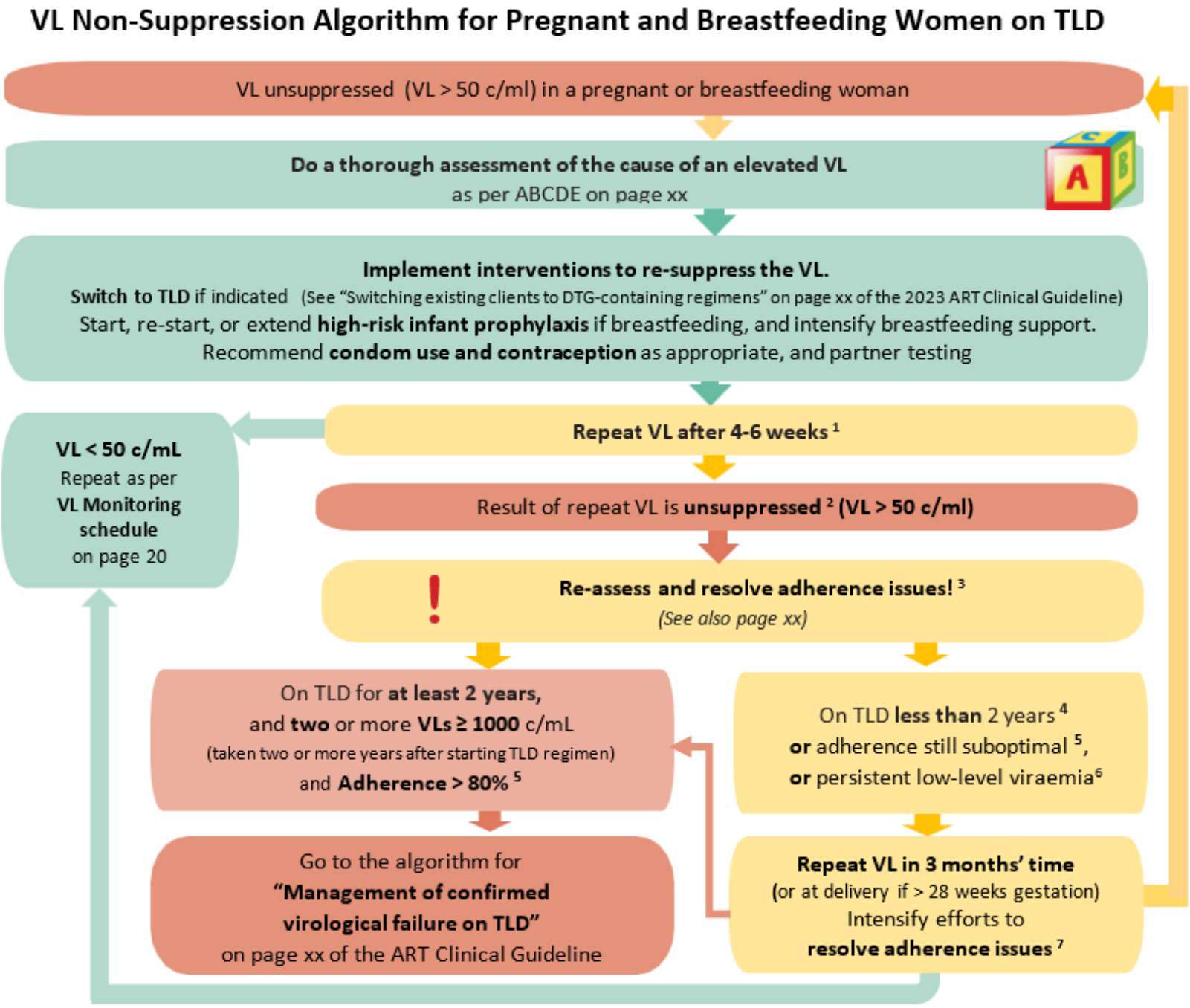


However, Calcium (Ca^{2+}) and Iron (Fe^{2+}) must be taken 4 hours apart



VL Monitoring and management

- Timing of the repeat VL in the VL management algorithm is different
- Principles of switching and management of confirmed virological failure also apply



Electronic Gate Keeping (EGK) Codes

EGK codes serve three functions:

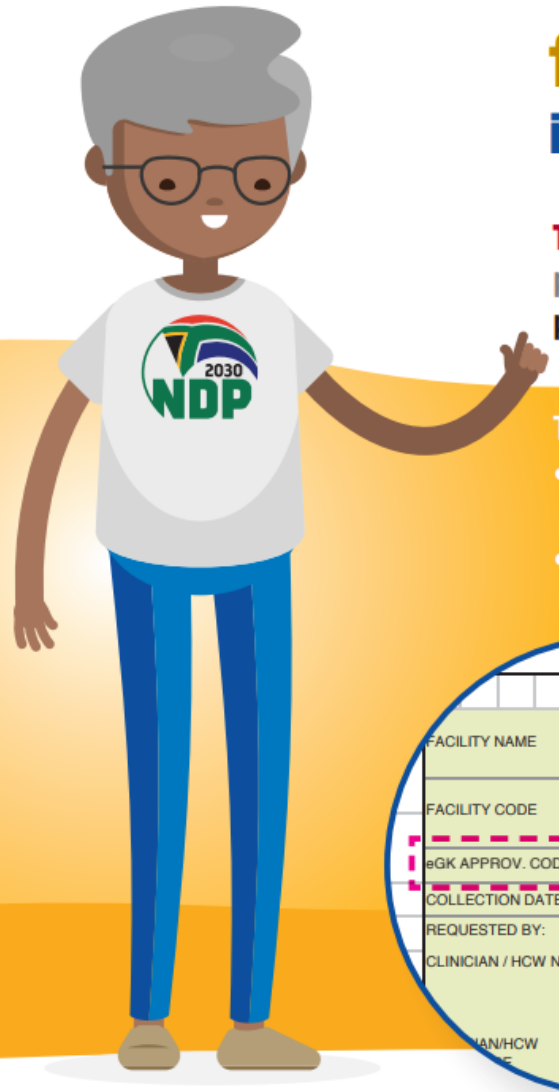
1. Prevent sample rejection
2. Allow individual patients to be traced using the NHLS RfA reports
3. Monitor VL suppression rates at a program level

EGK code Job Aid

Facility Guide

EGK authorisation codes for HIV Viral Load testing

in pregnant and breastfeeding women



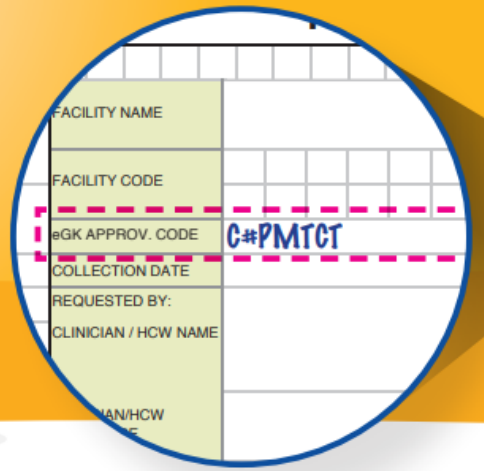
Two special EGK approval codes must be provided with **EVERY** HIV VL requested during **pregnancy** and **breastfeeding.**

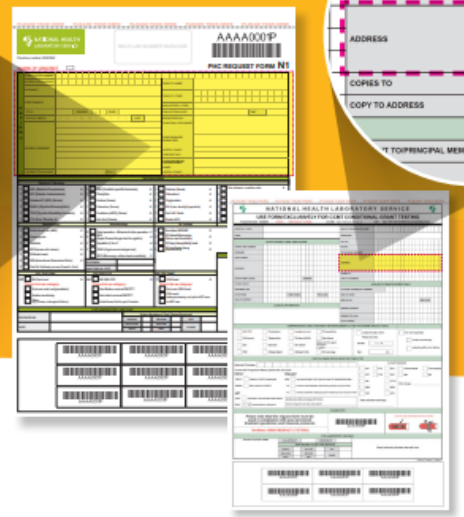
The electronic gatekeeping (eGK) codes will:

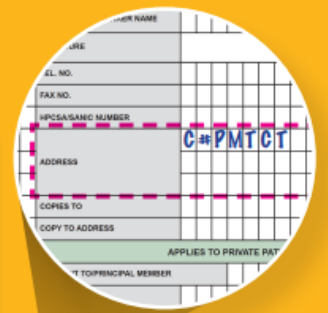
- prevent HIV VL tests from being cancelled by gatekeeping
- facilitate HIV VL monitoring of the pregnant and breastfeeding women

Pregnancy-related EGK approval codes	
C#PMTCT	To be used during pregnancy and breastfeeding
C#DELIVERY	To be used during labour

Please spell the eGK codes correctly







NHLS Requisition Form

Fill in the eGK code in 'eGK approval code' if present on the form **or,** on forms where this is not provided, clearly state in an available space such as below the 'HPCSA/SANC number' as indicated

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

NHLS Results for Action (RfA) Report

VL results >1000 cpml are highlighted in red.

VL results between 50-999 cpml are highlighted yellow.

The “Maternity EGK Group” column indicates the EGK code classification: antenatal, delivery, postnatal or other.

Province	District	Sub District	Facility	Ward	Folder No	Patient Surname	Patient Name	Patient DOB	Sex	Patient Address	Patient Tel No	Patient Age	Taken Date	Reviewed Date	Episode No	CDW Patient Identifier	HIV VL Result (Detected VL)	Maternity EGK Group	Total No. of Previous Consecutive VL >1000
KwaZulu-Natal	eThekwini Metro	eThekwini	Bluff Clinic	Not Applicable	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F	xxx xxxxxxxxxx	xxxxxxxxxx	32 years 11 months 5 days	DD-MMM-YY	07-FEB-2021	xxxxxxxxxx	xxxxxxxx	1010		1
KwaZulu-Natal	eThekwini Metro	eThekwini	Addington Hospital	Ikusasa Clinic	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	M	xxx xxxxxx xxxxxx xxxxxxxxxxxxx xxxxxxx	xxxxxxxxxx	70 years 9 months 23 days	DD-MMM-YY	07-FEB-2021	xxxxxxxxxx	-1	1006		
KwaZulu-Natal	eThekwini Metro	eThekwini	Ntuzuma Clinic	Anti-retroviral Clinic	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	M	xxxxxxxxxxxxxxxxx xx	xxxxxxxxxx	50 years 2 months	DD-MMM-YY	06-FEB-2021	xxxxxxxxxx	xxxxxxxx	1003		
KwaZulu-Natal	eThekwini Metro	eThekwini	Waterfall Clinic	Ward Not Stated	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F	xxx xxxxxx xxxxxx xxxxxxxxxxxxx xxxxxxx		32 years 8 days	DD-MMM-YY	02-FEB-2021	xxxxxxxxxx	xxxxxxx	950	Antenatal	
KwaZulu-Natal	eThekwini Metro	eThekwini	Overport Clinic	Not Applicable	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F			31 years 10 months 1 day	DD-MMM-YY	04-FEB-2021	xxxxxxxxxx	xxxxxxxx	947		
KwaZulu-Natal	eThekwini Metro	eThekwini	Mfume Clinic	Not Applicable	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	M	xxx xxxxxx xxxxxx xxxxxxxxxxxxx xxxxxxx		31 years 4 months 29 days	DD-MMM-YY	02-FEB-2021	xxxxxxxxxx	xxxxxxxx	943		
KwaZulu-Natal	eThekwini Metro	eThekwini	Glen Earle Clinic	Ward Not Stated	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F	xxx xxxxxx xxxxxx xxxxxxxxxxxxx xxxxxxx	xxxxxxxxxx	33 years 1 month 3 days	DD-MMM-YY	01-FEB-2021	xxxxxxxxxx	xxxxxxx	940	Delivery	
KwaZulu-Natal	eThekwini Metro	eThekwini	Goodwins Clinic	Anti-retroviral Clinic	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F	xxxxxxxxxxxxxxxxx xx		25 years 4 months	DD-MMM-YY	04-FEB-2021	xxxxxxxxxx	xxxxxxxx	940		
KwaZulu-Natal	eThekwini Metro	eThekwini	Halley Stott Clinic	Not Applicable	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F			37 years 2 months 14 days	DD-MMM-YY	02-FEB-2021	xxxxxxxxxx	xxxxxxxx	940		
KwaZulu-Natal	eThekwini Metro	eThekwini	Goodwins Clinic	Anti-retroviral Clinic	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F	xxxxxxxxxxxxxxxxx xx		35 years 10 months 16 days	DD-MMM-YY	04-FEB-2021	xxxxxxxxxx	xxxxxxxx	906		
KwaZulu-Natal	eThekwini Metro	eThekwini	Tongaat CHC	Unknown	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F			44 years 10 months 1 day	DD-MMM-YY	07-FEB-2021	xxxxxxxxxx	xxxxxxxx	898		
KwaZulu-Natal	eThekwini Metro	eThekwini	Lancers Road Clinic	Not Applicable	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	F			29 years 10 months 11 days	DD-MMM-YY	06-FEB-2021	xxxxxxxxxx	xxxxxxxx	897		
KwaZulu-Natal	eThekwini Metro	eThekwini	Prince Mshiyeni Hospital	Ward D3	xxxxxxx	xxxxxxx	xxxxxxx	DD-MMM-YY	M			64 years 4 months	DD-MMM-YY	05-FEB-2021	xxxxxxxxxx	xxxxxxxx	896		

Terms & Conditions | Cover Page | VL Results for Action | Previous VL>1000

Operation Phuthuma report – District level VLS rates

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

Request monthly Operation Phuthuma provincial reports via email (HIV@nicd.ac.za)

Province	District	Month	Jul 2022					Jun 2022				
		Maternity EGK Group	Total VL Tests	Number of Tests (<1000 cpml)	VL Suppression Rate (<1000 cpml)	Number of Tests (<50 cpml)	VL Suppression Rate (<50 cpml)	Total VL Tests	Number of Tests (<1000 cpml)	VL Suppression Rate (<1000 cpml)	Number of Tests (<50 cpml)	VL Suppression Rate (<50 cpml)
National (All)	National (All)	Antenatal	8 871	7 711	86,9%	6 107	68,8%	8 221	7 186	87,4%	5 828	70,9%
		Delivery	5 378	4 722	87,8%	3 939	73,2%	5 338	4 676	87,6%	3 904	73,1%
		Postnatal	14	14	100,0%	12	85,7%	35	30	85,7%	17	48,6%
		Other	14	13	92,9%	5	35,7%	12	12	100,0%	11	91,7%
		TOTAL	14 277	12 460	87,3%	10 063	70,5%	13 606	11 904	87,5%	9 760	71,7%
KwaZulu-Natal	All Districts	Antenatal	1 965	1 809	92,1%	1 518	77,3%	2 041	1 839	90,1%	1 516	74,3%
		Delivery	1 066	975	91,5%	844	79,2%	1 064	973	91,4%	803	75,5%
		Postnatal	6	6	100,0%	5	83,3%	35	30	85,7%	17	48,6%

Month	Jul 2022				
Maternity EGK Group	Total VL Tests	Number of Tests (<1000 cpml)	VL Suppression Rate (<1000 cpml)	Number of Tests (<50 cpml)	VL Suppression Rate (<50 cpml)
Antenatal	1 965	1 809	92,1%	1 518	77,3%
Delivery	1 066	975	91,5%	844	79,2%
Postnatal	6	6	100,0%	5	83,3%
TOTAL	3 037	2 790	91,9%	2 367	77,9%

Monthly Maternal eGK report (facility level)

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

Request monthly Maternal eGK report (up to facility level) via email (HIV@nicd.ac.za)

Province	District	Metrics	No Tests (eGK Materr	No Tests (eGK Materr	No Tests (eGK Materr	No Tests (eGK Materr	No Tests (eGK Materr	No Tests (eGK Materr	No Tests (eGK Materr	No Tests (eGK Materr
		Month	Jul 2022	Jul 2022	Jul 2022	Jul 2022	Jul 2022	Jul 2022	Jun 2022	Jun 20
		Facility	1	2	3	4	5	6	1	
			PMTCT	Delivery	PREGNANT	LABOUR	MATERNAL	OTHER	PMTCT	Delive
KwaZulu-Natal	Amajuba	Charlestown Clinic		3					2	
KwaZulu-Natal	Amajuba	Dannhauser Chc	3	8					2	
KwaZulu-Natal	Amajuba	Durnacol Clinic		1						
KwaZulu-Natal	Amajuba	Emfundweni Clinic	1							

District	Metrics	No Tests (eGK Materr	No Tests (eGK Materr	N
	Month	Jul 2022	Jul 2022	
	Facility	1	2	
		PMTCT	Delivery	
Amajuba	Charlestown Clinic		3	
Amajuba	Dannhauser Chc	3	8	
Amajuba	Durnacol Clinic		1	
Amajuba	Emfundweni Clinic	1		
Amajuba	Greenock Clinic	4		
Amajuba	Groenvlei Clinic	1		
Amajuba	Ingogo clinic			
Amajuba	Ladybank Clinic		2	

Maternal VL eG

Ready

Interpretation

- **Now that you know how many VLs had EGK codes per facility**
- **You need to determine**

How many VLs should have had EGK codes??

1. DHIS data provides the denominator for VL EGK codes in ANC

- Antenatal already on ART at 1st visit
- Antenatal start on ART

2. DHIS data provides the denominator for VL EGK codes at delivery

- Live births to HIV-positive women

VTP: Optimising Care for the HIV Exposed Infant to minimise vertical transmission

2019 GL definition of “high-risk” for an HEI

South African 2019 PMTCT GL

- Maternal delivery **VL > 1000** c/ml
- If no delivery VL result available at discharge
  - Review VL in the last **12 weeks** of antenatal care
  - High-risk if
    - VL **> 1000** c/ml, or
    - No VL in last 12 weeks

WHO Guidelines

- Review VL in the last **4 weeks** of antenatal care
- High-risk if
  - VL > 1000 c/ml, or
  - no VL in last 4 weeks
  - Mother on ART for < 4 weeks prior to delivery

Tightening the definition of higher-risk

Delivery VL will determine the final risk profile of the HIV exposed Infant

Higher-risk until proven low-risk

Need to consider

- VL threshold where the delivery VL is known
- When delivery VL is not known, at discharge from labour ward

Tightening the definition of higher-risk: Where the delivery VL result is known

Change 1: VL threshold for defining higher risk

VL > 1000 c/ml

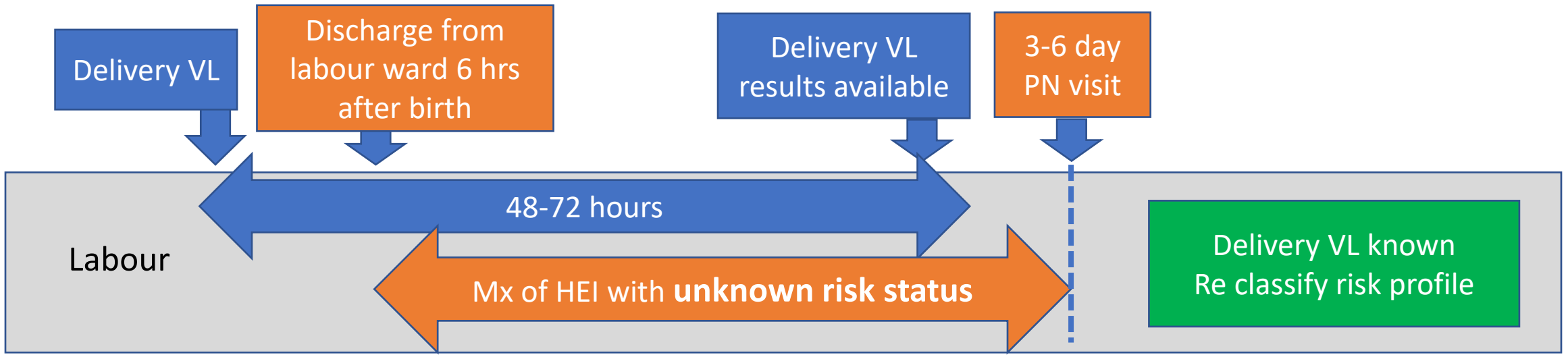
to

VL > 50 c/ml

Tightening the definition of high-risk:
When delivery VL is not known, at discharge from labour ward

Delivery VL will determine the final risk profile of the HIV exposed Infant

Higher-risk until proven low-risk



Considerations for defining “higher-risk”

- ANC 1st booking before 20 weeks gestation rate = 70%
- ANC on ART at 1st booking > 75%

For most women
NO VL done in last 4 wks

- Maternal Delivery VL > 1000 c/ml
- Review VL in the last **12 weeks** of antenatal care

84%
HEI will be high-risk

World Health Organization

- Maternal VL > 1000 c/ml
- Review VL in the last **4 weeks** of antenatal care

94%
HEI will be high-risk

Western Cape Government

- Maternal Delivery VL > 1000 c/ml
- Simplify decision

All HEI will be high-risk until proven low-risk by delivery VL results at 3-6 day visit

Tightening the definition of high-risk: Where the delivery VL result is not known

Change 2: Universal Dual Prophylaxis

2023 VTP Guideline

Dual prophylaxis will be given to all HEI at birth until proven low-risk by delivery VL results at 3-6 day visit

Pros and Cons of Universal Dual Prophylaxis

- **Simplicity in a blanket approach**
- **If mothers do not return at 3-6 day visit, at least babies are covered while VL remains unknown**
- **UDP may strengthen implementation of delivery VL and 3-6 day PN visit**

- There is AZT “wastage” for the 6 % additional HEIs who will get dual prophylaxis while their status is unknown, but this is a minimal cost when compared to potential gains from the changes

Changes for the VTP programme –HIV-exposed Infant

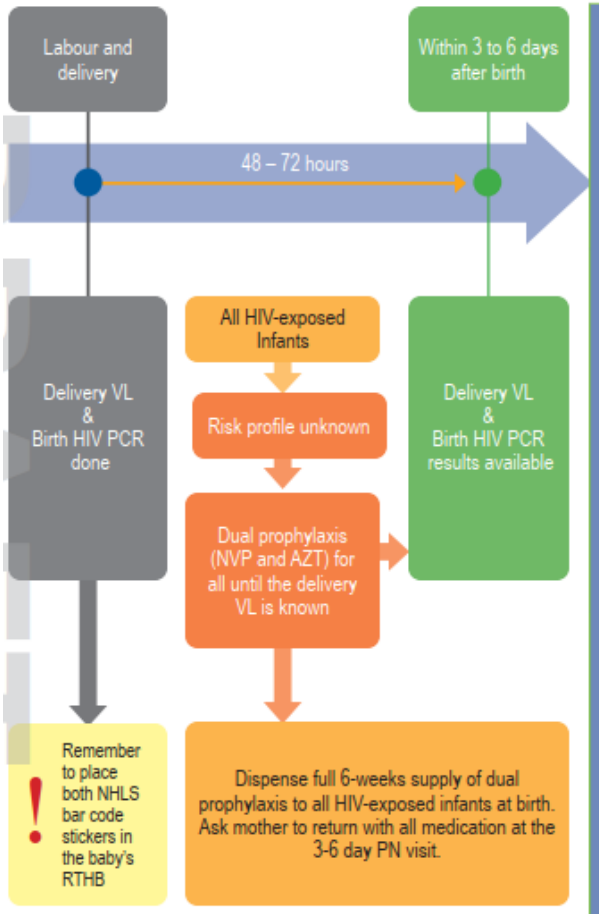
Summary: Tightening the definition of “high-risk” for transmission

- All babies will receive Dual prophylaxis at birth (NVP & AZT) until the results of the delivery VL are known
- Once delivery is VL known, the threshold for defining “higher-risk” has been moved from VL > 1000 c/ml to VL > 50 c/ml

566 HIV infections prevented ✓

Cost-saving of R11,3 million ✓

3 pages in the VTP Guideline



* All women known to be living with HIV should have a VL at delivery. This includes women who are newly diagnosed during labour, newly initiating ART, or re-initiating ART

** Breastfeeding includes exclusive breastfeeding or mixed feeding

Reclassify risk profile

Maternal Delivery VL *	Classification	Prophylaxis	Comment
Delivery VL< 50 copies/mL regardless of feeding choice	Low risk	Change to low-risk prophylaxis • Stop AZT • NVP daily for six weeks.	• Affirm and encourage good adherence. • Repeat maternal VL 6 monthly during breastfeeding. • Do all routine HIV tests for HIV-exposed infants as indicated on *"HIV Testing For The HIV-Exposed Infant" on page 27.*
Delivery VL ≥ 50 copies/mL in a breastfeeding mother**	Higher risk	Continue dual prophylaxis: • AZT twice daily for six weeks. • NVP daily for a minimum of 12 weeks.	• Do an ABCDE assessment and intervention as a matter of urgency to achieve a suppressed VL in the mother as soon as possible. Follow the *"VL Non-Suppression Algorithm" on page 22.* • Stop infant NVP only after confirmation of maternal VL being less than 50 c/mL, or until four weeks after cessation of all breastfeeding. • Do all routine HIV tests for HIV-exposed infants as indicated on *"HIV Testing For The HIV-Exposed Infant" on page 27.*
Delivery VL ≥ 50 copies/mL in a mother who is exclusively formula-feeding her infant from birth	Higher risk	Continue dual prophylaxis: • AZT twice daily for six weeks. • NVP daily for six weeks.	• Do an ABCDE assessment and intervention as a matter of urgency to achieve a suppressed VL in the mother as soon as possible. Follow the *"VL Non-Suppression Algorithm" on page 22.* • Do all routine HIV tests for HIV-exposed infants as indicated on *"HIV Testing For The HIV-Exposed Infant" on page 27.*
Birth PCR positive	HIV infected	Stop any NVP and AZT prophylaxis. Initiate ART. Confirm the positive result with a 2nd PCR on a new sample. Start cotrimoxazole prophylaxis therapy (CPT) at 6 weeks of age.	

PROPHYLAXIS FOR THE HIV-EXPOSED INFANT AT BIRTH

DOSING CHARTS FOR PROPHYLAXIS FOR THE HIV-EXPOSED INFANT

Summary of infant prophylaxis regimens

	Risk Profile	NVP	AZT
At birth (following maternal delivery VL review)	Low-risk, whether breastfed or formula-fed	6 weeks	Stop AZT
	Higher-risk and breastfed **	minimum of 12 weeks	6 weeks
	Higher-risk and exclusively formula fed	6 weeks	6 weeks
During breastfeeding	Higher-risk during breastfeeding	minimum of 12 weeks	6 weeks

Dosing charts for infant HIV prophylaxis in infants ≥ 2000 gm

NVP and AZT dosing table for prophylaxis at birth and during breastfeeding
(see also Management of an Unsuppressed VL during Breastfeeding on page xx)

	Birth–8 weeks		*6 weeks – 8 months*	*8 – 9 months*	*9 – 24 months*
	2.0 – 2.49 kg	≥2.5 kg			
NVP (Daily)	1 mL (10 mg) daily	1.5 mL (15 mg) daily	2 mL (20 mg) daily	3 mL (30 mg) daily	4 mL (40 mg) daily
AZT (Twice daily)	1 mL (10 mg) twice daily	1.5 mL (15 mg) twice daily	6 mL (60 mg) twice daily	Children >6 months of age requiring AZT prophylaxis should use treatment doses.	

Source: Paediatric Hospital Level EML 2022

Dosing charts for infant HIV prophylaxis in preterm infants < 2000 gm

Nevirapine, oral, daily

Weight	First 2 weeks after birth (mg of NVP)	After first 2 weeks after birth (mg of NVP)
500 to <625 g	1 mg	2 mg
625 to <850 g	1.5 mg	3 mg
850 to <1200 g	2 mg	4 mg
1.2 to <1.5 kg	3 mg	5 mg
1.5 to <1.9 kg	3.5 mg	6 mg

If the infant at the time of discharge is severely underweight-for-age (3 SD or 3 z-scores below the mean), give NVP according to weight (i.e. 4 mg/kg/dose daily) until in the normal weight-for-age range.

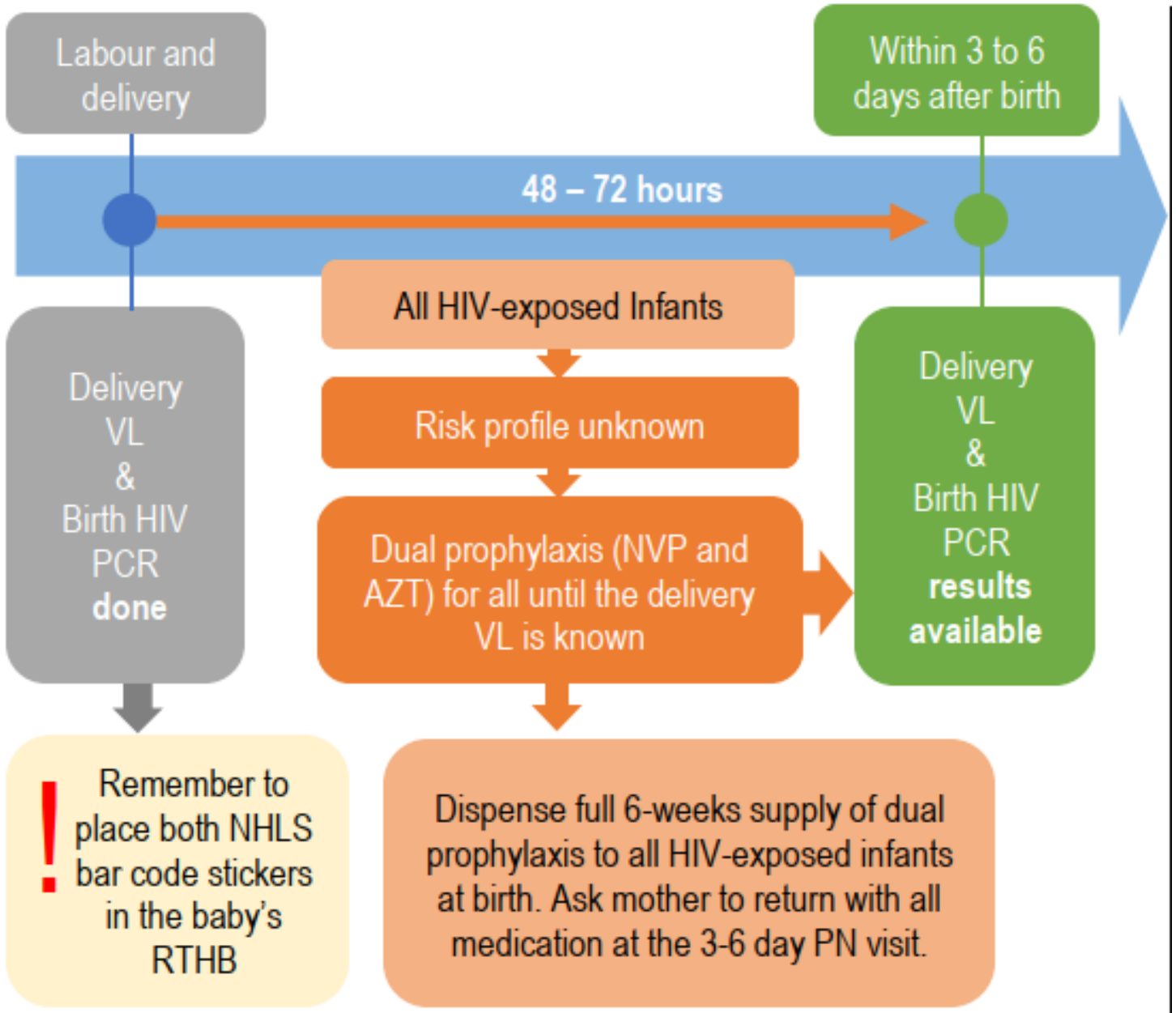
Zidovudine, oral, twice daily

Gestational age at birth	First 2 weeks after birth	2–4 weeks after birth	4–6 weeks after birth	>6 weeks after birth
30–35 weeks	2 mg/kg	3 mg/kg	4 mg/kg	
<30 weeks	2 mg/kg		3 mg/kg	4 mg/kg

Dosing chart for intravenous (IV) AZT prophylaxis

Gestational Age	Approximate birth weight	AZT IV dosing for the first 14 days (If unable to tolerate oral agents)
≥35 weeks	≥ 2.5 kg	3 mg/kg body weight IV every 12 hours
<35 weeks	< 2.5 kg	1.5 mg/kg body weight IV every12 hours

Prophylaxis for the HIV-exposed infant at birth (1)



Prophylaxis for the HIV-exposed infant at birth (2)

Reclassify risk profile

Maternal Delivery VL *	Classification	Prophylaxis	Comment
Delivery VL< 50 copies/mL regardless of feeding choice	Low risk	Change to low-risk prophylaxis • Stop AZT • NVP daily for six weeks.	• Affirm and encourage good adherence. • Repeat maternal VL 6 monthly during breastfeeding. • Do all routine HIV tests for HIV-exposed infants as indicated on *"HIV Testing For The HIV-Exposed Infant" on page 27.*
Delivery VL ≥ 50 copies/mL in a breastfeeding mother**	Higher risk	Continue dual prophylaxis: • AZT twice daily for six weeks. • NVP daily for a minimum of 12 weeks.	• Do an ABCDE assessment and intervention as a matter of urgency to achieve a suppressed VL in the mother as soon as possible. Follow the *"VL Non-Suppression Algorithm" on page 22.* • Stop infant NVP only after confirmation of maternal VL being less than 50 c/mL, or until four weeks after cessation of all breastfeeding. • Do all routine HIV tests for HIV-exposed infants as indicated on *"HIV Testing For The HIV-Exposed Infant" on page 27.*
Delivery VL ≥ 50 copies/mL in a mother who is exclusively formula-feeding her infant from birth	Higher risk	Continue dual prophylaxis: • AZT twice daily for six weeks. • NVP daily for six weeks.	• Do an ABCDE assessment and intervention as a matter of urgency to achieve a suppressed VL in the mother as soon as possible. Follow the *"VL Non-Suppression Algorithm" on page 22.* • Do all routine HIV tests for HIV-exposed infants as indicated on *"HIV Testing For The HIV-Exposed Infant" on page 27.*
Birth PCR positive	HIV infected	Stop any NVP and AZT prophylaxis. Initiate ART. Confirm the positive result with a 2nd PCR on a new sample. Start cotrimoxazole prophylaxis therapy (CPT) at 6 weeks of age.	

Cotrimoxazole Prophylaxis

Change 3: CPT will no longer be given to for HEI infants

- CPT for confirmed HIV-infected infants and children (unchanged)
- No CPT for HIV-exposed infants who are uninfected, regardless of the mother's VL or breastfeeding status

Clinical Evidence Informing CPT Guidelines

Current guidelines based on the 2004 CHAP study, in the context of

- no maternal ART,
- no infant prophylaxis (HIV),
- no paediatric ART,
- CPT showed benefit in those HIV-positive children with very low CD4 counts

Recent evidence for Botswana and South African studies

- **No benefit for mortality or morbidity for HEIs**
- **Potential harm**
  - SA study - CTX associated with microbiome dysbiosis and increase in resistance genes
  - Botswana study showed CTX prophylaxis increased resistance to CTX AND Amoxicillin (1st line pneumonia treatment)

Lockman et al. 2017; Daniels et al. 2019

Cotrimoxazole Prophylaxis Therapy for HEIs

In context of tighter definition and management of high-risk HEIs

No CPT for HIV-exposed infants
who are uninfected, regardless of the mother's VL or breastfeeding status

Focus should be on preventing HIV infection

- Achieving and maintaining **maternal VL suppression**
- **keeping HIV-exposed infants in care** with
- **PCR testing** as per guidelines, and
- **ART initiation** in the small proportion of children who do become HIV infected, with

- **CPT for confirmed HIV-infected infants and children (unchanged)**

Integration of clinical and service delivery components

Toolkit

Who decides which tool is used where??

→ The clinician

1. Tools for Clinical Management

Optimised regimens using TLD
Monitoring on ART
Preventing and managing STIs, NCDs and OIs with TPT and CPT

2. Tools for Differentiated Care (DMOC SOPs)

New patient	Stable patient	Non-stable patient
SOP 1 FTIC	SOP 5 RPCs SOP 6 Switch in RPCs	SOP 2 EAC SOP 7 Trace SOP 8 Re-engagement

SOP 3 Disclosure
SOP 4 MMD

3. Tools for the Provision of Integrated Care

Visit schedules to align EPI visits with paeds ART, maternal ART, maternal contraception, maternal PrEP, TB treatment and ART

Specific table aligning to infant EPI schedule:
HIV exposed infant and mother ART visits and mother's FP visits

Age group	Age of child	Routine visits as per RTHB	ART Dispensing cycle (DC)	Follow-up for the HIV-exposed baby	ART Follow-up for mother	Immunisations	Feeding advice	Growth monitoring	Development	Head circumference	Vit A	Deworming	Oral Health	TB Screen	Mother's Family planing (FP)
Neonate	1st week of life	3-6 days postnatal (PN) visit for mother and baby	1	• Follow-up results of birth PCR# and mother's delivery VL If birth PCR negative, re-classify the risk profile of the HEI: • Delivery VL < 50 c/mL (low-risk) • Stop AZT and continue NVP daily for six weeks • Delivery VL ≥ 50 c/mL (higher-risk) • Continue AZT twice daily for six weeks • Continue NVP daily for minimum of 12 weeks • Check adherence to NVP and AZT dispensed at delivery	• Follow-up results of mother's delivery VL • Delivery VL ≥ 50 c/mL: manage as per *"Viral Load Monitoring Schedule" on page 20*. • Check ART supply: The mother should have been provided with 2 months ART at discharge from labour ward which will last her until 6 week PN visit • Adherence check-in for mother • Provide breastfeeding support and routine PN care		x	x	EPI					x	x**
2-6 months (monthly follow-up)	6 weeks	6 weeks	2*	• Ensure that birth PCR and mother's VL results were checked, recorded and acted upon correctly • If low-risk, stop NVP • If higher-risk, stop AZT and dispense NVP for additional 6 weeks	• Postnatal cli… review and adherence check-in. If delivery … c/mL, repeat VL at this visit • Provide… • Prov…	x									
	10 weeks	10 weeks	3	• **Do 10 week HIV-PCR #** • If higher-risk, check result of repeat maternal VL done at 6 weeks visit. • If VL < 50 c/mL, advise to stop NVP after 12 weeks • If VL still ≥ 50 c/mL, dispense and continue NVP until the breastfeeding mother's VL is confirmed to be < 50 c/mL	• I… as p… *22* • If mother … either DMPA (Depo Provera®) or NET-EN (… terate®) after delivery, give repeat injectio… t this visit***	x									
	14 weeks	14 weeks	4	• Check that 10 week HIV-PCR results were checked, recorded and acted upon correctly	• Adherence check-in for mother • Provide breastfeeding support. • Provide ART for 3 DCs (3MMD) for mother	x									
	18 weeks	4 months	5												
	22 weeks	5 months	6												
	26 weeks	6 months	7	• **Do 6-month HIV-PCR test #** • Review results of PCR and VL in 1 week using NHLS RfA reports. If mother's VL ≥ 50c/mL, restart/extend infant prophylaxis if still breastfeeding. Go to *"Management of a High Maternal Viral Load after Delivery" on page 24*.	• **Clinical review and '6-month' VL.** • Provide breastfeeding support and discuss the introduction of complementary feeding at age 6 months • Script for and provide ART for 3DCs at a time (3MMD) • Review results of VL and PCR in 1 week using NHLS RfA reports. If VL ≥ 50c/mL, manage mother as per the *"VL Non-Suppression Algorithm" on page 22*	x									

Same as EPI schedule

Key points to note (pg 40-41):

- Align HIV exposed infant clinical follow-up and HIV testing schedule with EPI schedule
- Aim to provide all care at same service OR AT LEAST SAME return date schedule and same facility

Specific table aligning to infant EPI schedule:
HIV exposed infant and mother ART visits and mother's FP visits

Age group	Age of child	Routine visits as per RTHB	ART Dispensing cycle (DC)	Follow-up for the HIV-exposed baby	ART Follow-up for mother	Immunisations	Feeding advice	Growth monitoring	Development	Head circumference	Vit A	Deworming	Oral Health	TB Screen	Mother's Family planing (FP)
Neonate	1st week of life	3-6 days postnatal (PN) visit for mother and baby	1	• Follow-up results of birth PCR# and mother's delivery VL If birth PCR negative, re-classify the risk profile of the HEI: • Delivery VL < 50 c/mL (low-risk) • Stop AZT and continue NVP daily for six weeks • Delivery VL ≥ 50 c/mL (higher-risk) • Continue AZT twice daily for six weeks • Continue NVP daily for minimum of 12 weeks • Check adherence to NVP and AZT dispensed at delivery	• Follow-up results of mother's delivery VL • Delivery VL ≥ 50 c/mL: manage as per *"Viral Load Monitoring Schedule" on page 20*. • Check ART supply: The mother should have been provided with 2 months ART at discharge from labour ward which will last her until 6 week PN visit • Adherence check-in for mother • Provide breastfeeding support and routine PN care		x							x	x**
2-6 months (monthly follow-up)	6 weeks	6 weeks	2*	• Ensure that birth PCR and mother's VL results were checked, recorded and acted upon correctly • If low-risk, stop NVP • If higher-risk, stop AZT and dispense NVP for additional 6 weeks	• Postnatal clinical review and adherence check-in. If delivery VL ≥ 50 c/mL, repeat VL at this visit • Provide breastfeeding support. • Provide ART for 2 DCs (2MMD) for mother*	x								x	
	10 weeks	10 weeks	3	• **Do 10 week HIV-PCR #** • If higher-risk, check result of repeat maternal VL done at 6 weeks visit. • If VL < 50 c/mL, advise to stop NVP after 12 weeks • If VL still ≥ 50 c/mL, dispense and continue NVP until the breastfeeding mother's VL is confirmed to be < 50 c/mL	• If VL repeated at 6 weeks, review results. Manage as per *"VL Non-Suppression Algorithm" on page 22* • If mother received either DMPA (Depo Provera®) or NET-EN (Nur Isterate®) after delivery, give repeat injection at this visit***	x	x	x						x	x
	14 weeks	14 weeks	4	• Check that 10 week HIV-PCR results were checked, recorded and acted upon correctly	• Adherence check-in for mother • Provide breastfeeding support. • Provide ART for 3 DCs (3MMD) for mother									x	
	18 weeks	4 months	5											x	
	22 weeks	5 months	6				x	x						x	
	26 weeks	6 months	7	• **Do 6-month HIV-PCR test #** • Review results of PCR and VL in 1 week using NHLS RfA reports. If mother's VL ≥ 50c/mL, restart/extend infant prophylaxis if still breastfeeding. Go to *"Management of a High Maternal Viral Load after Delivery" on page 24*.	• **Clinical review and '6-month' VL.** • Provide breastfeeding support and discuss the introduction of complementary feeding at age 6 months • Script for and provide ART for 3DCs at a time (3MMD) • Review results of VL and PCR in 1 week using NHLS RfA reports. If VL ≥ 50c/mL, manage mother as per the *"VL Non-Suppression Algorithm" on page 22*	x	x	x	x		x			x	x

EPI

Same as EPI schedule

Same as EPI schedule (unless NET-EN)

Mother ART clinical follow-up AND contraception aligned with EPI schedule

- 2-month supply at birth

NEW:

- **2-month supply again at 6 wks***
- **3-month supply at 14 wks, 6 months and 3-monthly to align with VL**

Specific table aligning to EPI schedule
Mother's PrEP and FP visits

Age group	Age of child	Routine visits as per RTHB	PrEP Dispensing cycle (DC)	PrEP Follow-up for mother	Immunisations	Feeding advice	Growth monitoring	Development	Head circumference	Vit A	Deworming	Oral Health	TB Screen	Mother's Family planing (FP)
Delivery			1	• Provide 3 months* of PrEP (3MMD) which will last until 10 week PN visit		x								
Neonate	1st week of life	3-6 days postnatal (PN) visit for mother and baby		• Provide HIV test to mother (if not tested in labour) • Check PrEP supply: The mother should have been provided with 3 months* of PrEP at delivery which will last her until 10 week PN visit • PrEP adherence check-in for mother • Provide breastfeeding support and routine post natal care		x	x			EPI			x	x***
2-6 months	6 weeks	6 weeks	2*	• Postnatal clinical review • Provide breastfeeding support • PrEP adherence check-in										
	10 weeks	10 weeks	3	• Postnatal and PrEP clinical review and PrEP adherence check-in • Provide breastfeeding support. • Provide HIV test and STI screen to mother • Provide PrEP for 3 PrEP DCs (3MMD) for mother** • If mother received either DMPA (Depo Provera®) or NET-EN (Nur Isterate®) after delivery, give repeat injection at this visit****										
	14 weeks	14 weeks	4	• Postnatal clinical review • Provide breastfeeding support • PrEP adherence check-in										
	18 weeks	4 months	5											
	22 weeks	5 months	6											
	26 weeks	6 months	7	• PrEP clinical review • Provide breastfeeding support. • HIV test and STI screen for mother • Script for and provide PrEP for 3DCs at a time (3MMD)										

Same as EPI schedule

NEW: Annexure 4 (pg 49-50)

Align to infant EPI schedule:

- **Mother's PrEP visits including PrEP related HIV and STI monitoring**
- **Contraception visits**

Specific table aligning to EPI schedule
Mother's PrEP and FP visits

Age group	Age of child	Routine visits as per RTHB	PrEP Dispensing cycle (DC)	PrEP Follow-up for mother	Immunisations	Feeding advice	Growth monitoring	Development	Head circumference	Vit A	Deworming	Oral Health	TB Screen	Mother's Family planing (FP)
Delivery			1	• Provide 3 months* of PrEP (3MMD) which will last until 10 week PN visit		x								
Neonate	1st week of life	3-6 days postnatal (PN) visit for mother and baby		• Provide HIV test to mother (if not tested in labour) • Check PrEP supply: The mother should have been provided with 3 months* of PrEP at delivery which will last her until 10 week PN visit • PrEP adherence check-in for mother • Provide breastfeeding support and routine post natal care		x	x						x	x***
2-6 months	6 weeks	6 weeks	2*	• Postnatal clinical review • Provide breastfeeding support • PrEP adherence check-in	x	x	x						x	
	10 weeks	10 weeks	3	• Postnatal and PrEP clinical review and PrEP adherence check-in • Provide breastfeeding support. • Provide HIV test and STI screen to mother • Provide PrEP for 3 PrEP DCs (3MMD) for mother** • If mother received either DMPA (Depo Provera®) or NET-EN (Nur Isterate®) after delivery, give repeat injection at this visit****	x	x	x						x	x
	14 weeks	14 weeks	4	• Postnatal clinical review	x	x	x	x	x				x	
	18 weeks	4 months	5			x	x						x	
	22 weeks	5 months	6			x	x						x	
	26 weeks	6 months	7		x	x	x	x		x			x	x

EPI

Utilizes 3-monthly combined PrEP clinical reviews and drug refills from birth

- Where mother on PrEP at delivery, mother must leave maternity unit with 3-months of PrEP supply on hand

VTP: Optimising care for a mother living with syphilis to minimise vertical transmission

Resurgence of Congenital Syphilis case in SA

- Syphilis remains a significant cause of preventable perinatal death in SA.
- 2019 prevalence of syphilis is estimated at 2.6% (95% CI: 2.4%–2.9%)
- 30% increase in prevalence between 2015 and 2019
- Maternal syphilis screening coverage at first antenatal visit was 96.4% at national level.
- However, despite good antenatal attendance and early maternal syphilis testing, there has been a resurgence of congenital syphilis cases in many provinces in South Africa
- Adverse pregnancy outcomes occur in up to 80% of syphilis seropositive, untreated pregnant women
- South Africa has committed to dual elimination of both HIV and syphilis

Modifiable factors for congenital syphilis

- **Testing and f/up** **n=20 (38%)**
  - Booking test not traced *n*=12
  - Booking test not treated *n*=3
  - No booking test done *n*=5
- **Related to the timing of testing n=37%**
  - Seroconvert during pregnancy: *n*=16
  - Maternal treatment inadequate *n*=3
- **Drug stock-outs** ***n*=2**
- **Maternal factors:** **N = 16 (30%)**
  - Unbooked: n=10
  - Defaulted follow-up n=4
  - Late booker n=2

Quality of care related to testing and f/up of test result is improved

38% of CS cases could be prevented

If testing was more frequent

37% of cases could be prevented

Syphilis

PPIP Analysis of the modifiable factors in 52 cases of congenital syphilis in KZN revealed:

If quality of care related to testing and f/up of test results is improved

38% of CS cases could be prevented

If testing was more frequent

37% of cases could be prevented

Total preventable

38% + 37% =

75%

Rapid testing

To facilitate immediate results and treatment

More frequent testing

To identify seroconversion later in pregnancy

Change 1: Use of single and dual syphilis rapid tests

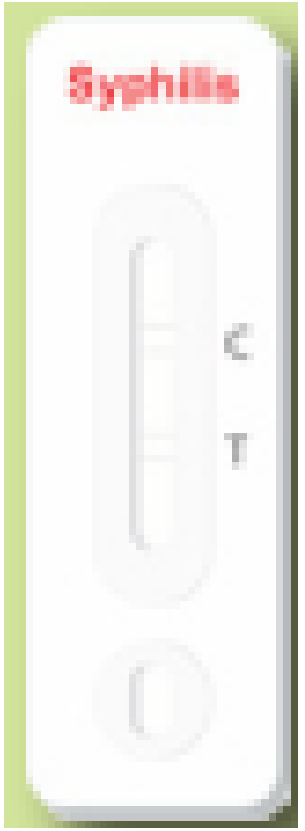
Change 2: Alignment of HIV and syphilis testing schedule

Frequency of syphilis testing

- **A pregnant woman should be screened and tested for syphilis at her 1st/booking visit in antenatal care. If she tests negative, syphilis testing should be repeated:**
  - Scheduled antenatal visits, at approximately 4-weekly intervals, e.g., for BANC+ clients, this could be at 20, 26, 30, 34, and 38 weeks gestation
  - During her labour/delivery admission
  - At the time of diagnosis of an intrauterine death
  - At any time, if the mother has clinical symptoms or signs suggestive of syphilis
- **Syphilis testing should be aligned with the HIV testing schedule:**
  - If a woman tests positive for HIV, but tests negative for syphilis, repeat syphilis testing should continue at the intervals described above.
  - If a woman tests positive for syphilis but tests negative for HIV, repeat HIV testing should continue at recommended intervals

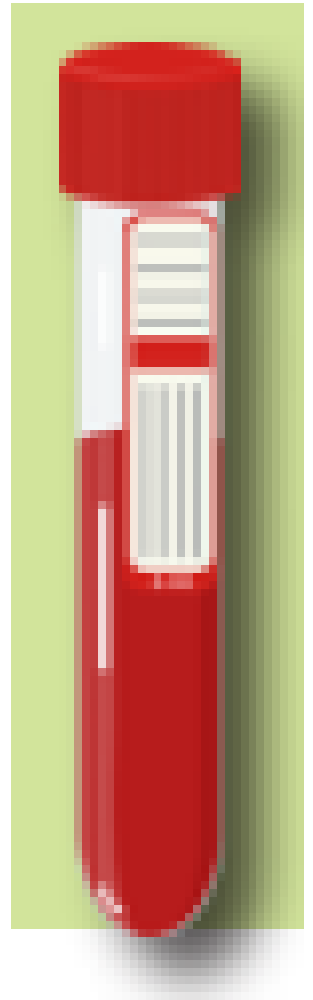
Types of syphilis tests and their uses: Rapid tests

- **Specific (or treponemal) test for syphilis**
- **Remain positive for life, even if the infection has been treated.**
- **Positive rapid tests should be confirmed using an RPR test.**
  - The RPR will determine if the positive rapid result indicates a current active infection or an earlier infection, and
  - the baseline titre allows the response to treatment to be monitored
- **Once a woman has tested positive using a rapid test, a rapid test should no longer be used for routine screening to identify new infections at subsequent visits.**
  - A rapid test cannot differentiate between a new and previous infection.
  - An RPR should then be used as the screening test to identify new infections



Types of syphilis tests and their uses: RPR

- **Non-specific (or non-treponemal) tests**
- **Done in a laboratory.**
- **RPR titres change in response to treatment or disease progression.**
- **Used to confirm a positive rapid tests**
  - The RPR will determine if the positive rapid result indicates a current active infection or an earlier infection, and
  - the baseline titre allows the response to treatment to be monitored



Rapid Syphilis Tests

When available and appropriate, rapid testing is the preferred first-line test in pregnancy, as it allows for immediate treatment.

- **Rapid syphilis tests are available as a single rapid diagnostic test (RDT) that tests only for syphilis, and a dual RDT which tests for both syphilis and HIV using the same drop of blood.**
- **Dual syphilis and HIV rapid tests should only be used in clients**
  - Whose HIV status is negative or unknown AND
  - Who have not had a previous syphilis infection

! Clients who are already known to be living with HIV should NOT be re-tested for HIV and should therefore not use a dual syphilis and HIV rapid test!

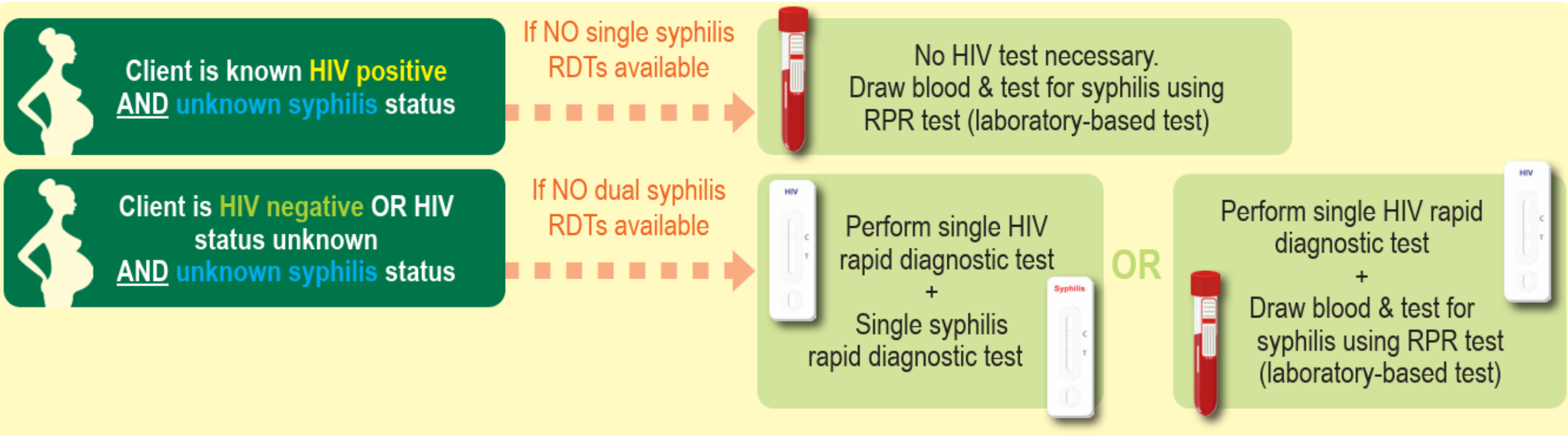
Which test should be used when?

Client is known HIV positive AND unknown syphilis status	No HIV test necessary. Perform single syphilis rapid test
Client is HIV negative OR HIV status unknown AND unknown syphilis status	Perform dual HIV/syphilis rapid test
Client is HIV negative OR HIV status unknown AND previous syphilis infection*	Perform single HIV rapid test
Client is known HIV positive AND previous syphilis infection*	No HIV test necessary. Draw blood & test for syphilis using RPR test (laboratory-based test)

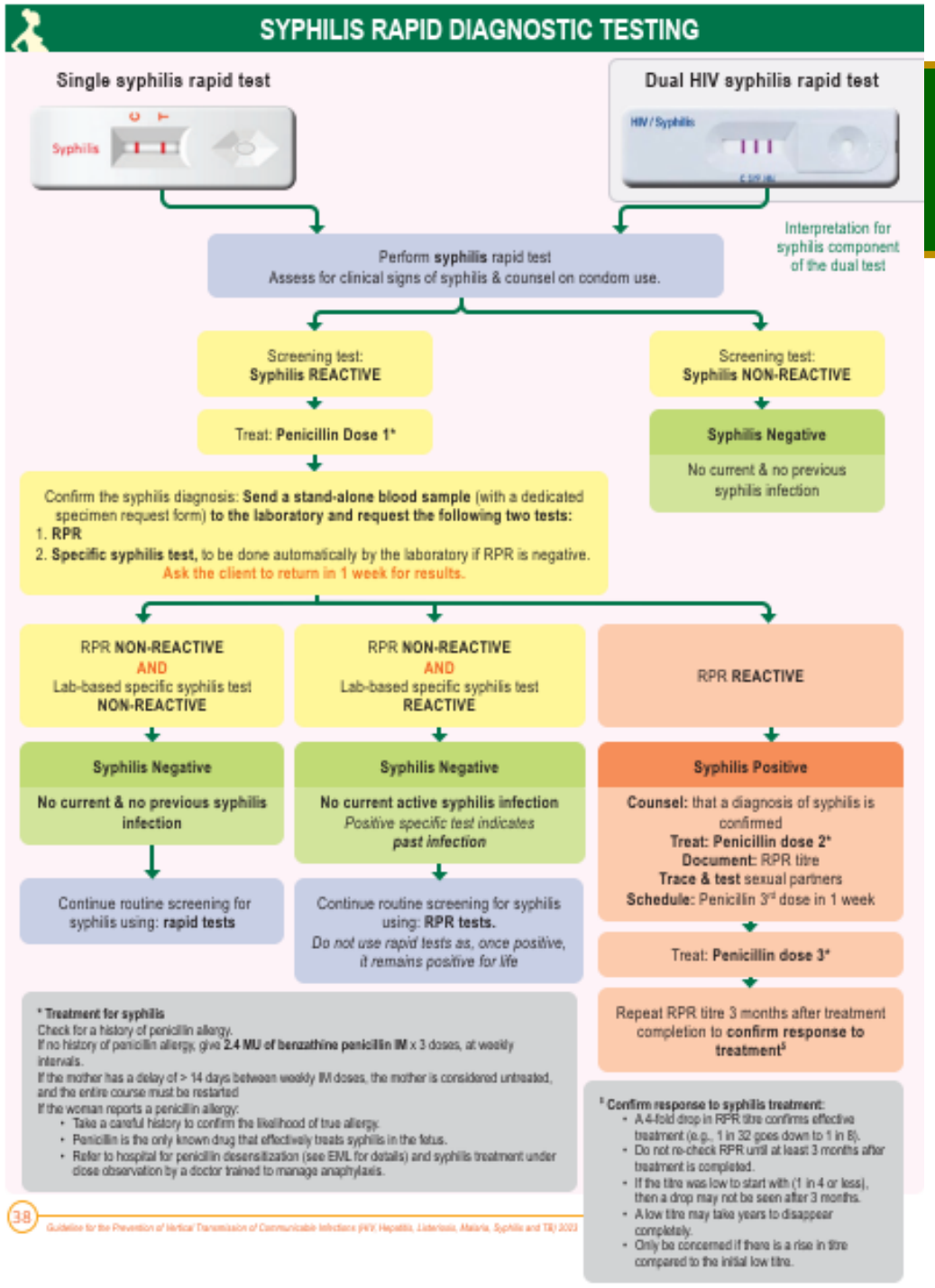
***Previous syphilis infection:** a client is said to have a previous syphilis infection if, during a previous screening the person screened positive for syphilis and through the confirmatory laboratory-based testing it indicated a past syphilis infection OR if syphilis has been diagnosed during their current pregnancy and syphilis treatment has concluded more than 3 months ago.

Draw blood & test for syphilis using RPR test (laboratory-based test)

What to do when a facility does not have syphilis rapid tests in stock



Syphilis


SYPHILIS RAPID DIAGNOSTIC TESTING
Single syphilis rapid test
Syphilis
Dual HIV syphilis rapid test
HIV / Syphilis
Interpretation for syphilis component of the dual test
Perform syphilis rapid test
Assess for clinical signs of syphilis & counsel on condom use.
Screening test: Syphilis REACTIVE
Treat: Penicillin Dose 1*
Screening test: Syphilis NON-REACTIVE
Syphilis Negative
No current & no previous syphilis infection
Confirm the syphilis diagnosis: Send a stand-alone blood sample (with a dedicated specimen request form) to the laboratory and request the following two tests:
1. RPR
2. Specific syphilis test, to be done automatically by the laboratory if RPR is negative.
Ask the client to return in 1 week for results.
RPR NON-REACTIVE AND Lab-based specific syphilis test NON-REACTIVE
Syphilis Negative
No current & no previous syphilis infection
Continue routine screening for syphilis using: rapid tests
RPR NON-REACTIVE AND Lab-based specific syphilis test REACTIVE
Syphilis Negative
No current active syphilis infection
Positive specific test indicates past infection
Continue routine screening for syphilis using: RPR tests.
Do not use rapid tests as, once positive, it remains positive for life
RPR REACTIVE
Syphilis Positive
Counsel: that a diagnosis of syphilis is confirmed
Treat: Penicillin dose 2*
Document: RPR titre
Trace & test sexual partners
Schedule: Penicillin 3rd dose in 1 week
Treat: Penicillin dose 3*
Repeat RPR titre 3 months after treatment completion to confirm response to treatment§
* Treatment for syphilis
Check for a history of penicillin allergy.
If no history of penicillin allergy, give 2.4 MU of benzathine penicillin IM x 3 doses, at weekly intervals.
If the mother has a delay of > 14 days between weekly IM doses, the mother is considered untreated, and the entire course must be restarted
If the woman reports a penicillin allergy:
• Take a careful history to confirm the likelihood of true allergy.
• Penicillin is the only known drug that effectively treats syphilis in the fetus.
• Refer to hospital for penicillin desensitization (see EML for details) and syphilis treatment under close observation by a doctor trained to manage anaphylaxis.
§ Confirm response to syphilis treatment:
• A 4-fold drop in RPR titre confirms effective treatment (e.g., 1 in 32 goes down to 1 in 8).
• Do not re-check RPR until at least 3 months after treatment is completed.
• If the titre was low to start with (1 in 4 or less), then a drop may not be seen after 3 months.
• A low titre may take years to disappear completely.
• Only be concerned if there is a rise in titre compared to the initial low titre.
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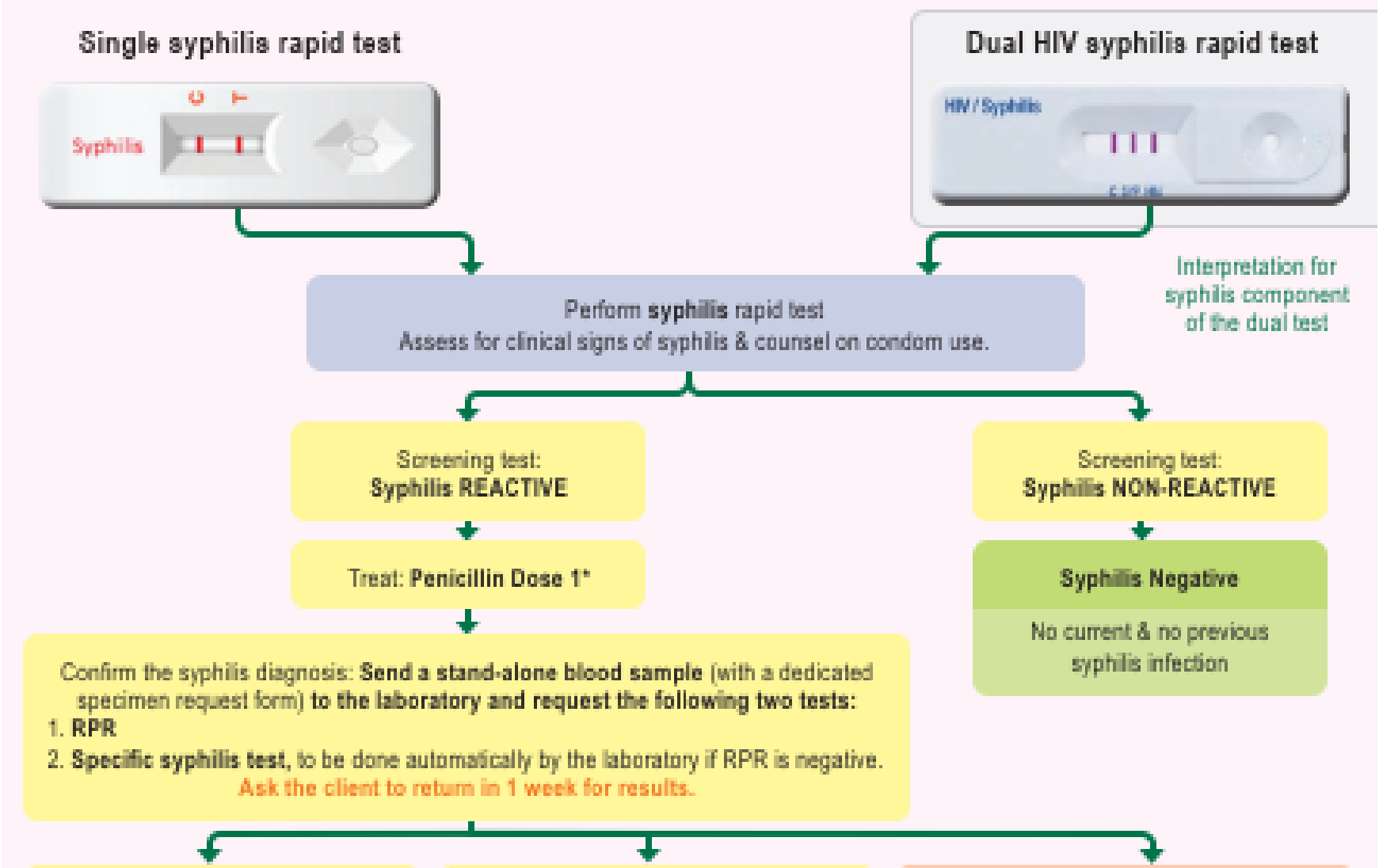
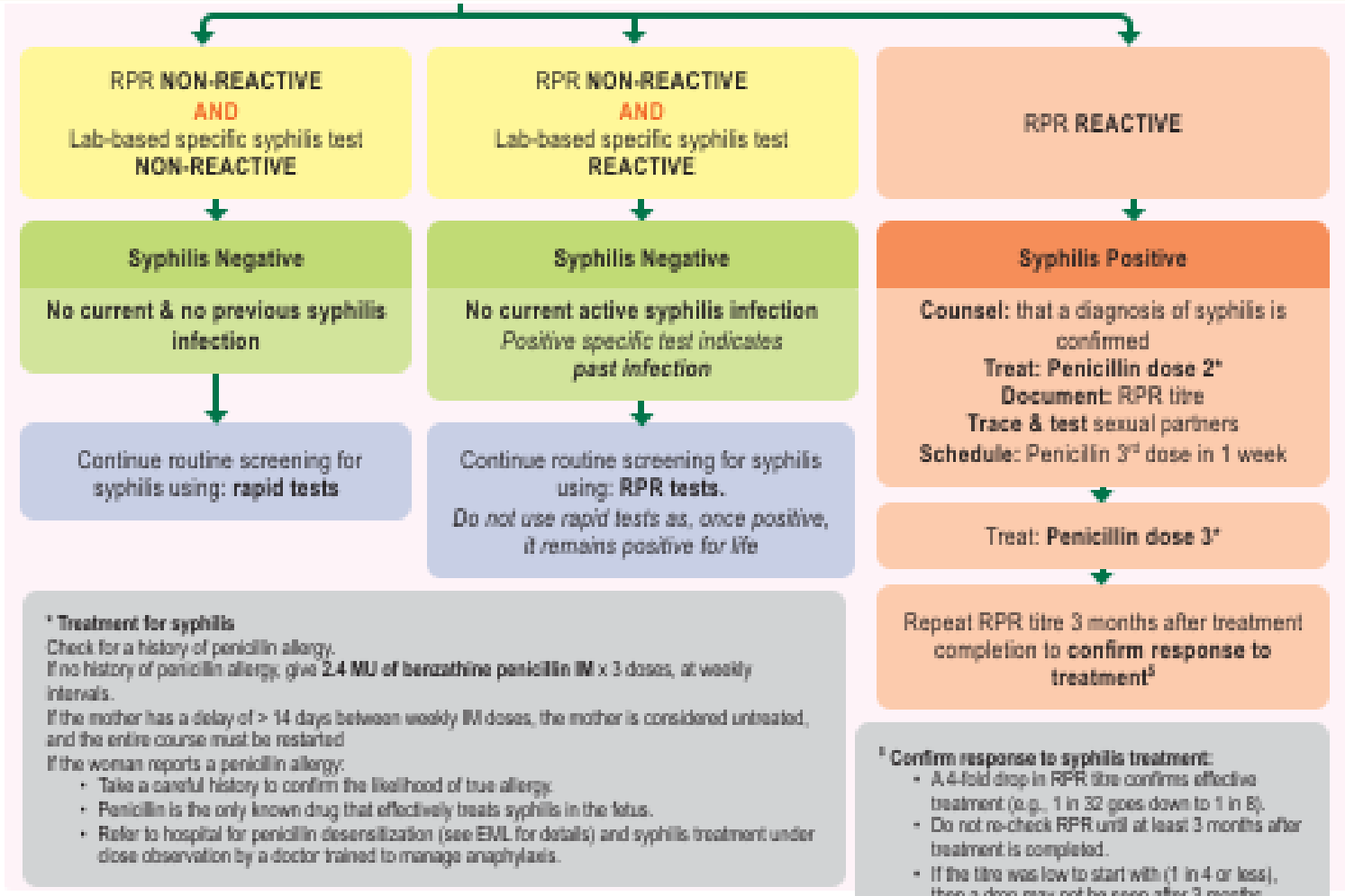
Guideline for the Prevention of Vertical Transmission of Communicable Infections (HIV, Hepatitis, Listeriosis, Malaria, Syphilis and TB) 2023

Syphilis Rapid Testing Algorithm (top half)



Syphilis Rapid Testing Algorithm (bottom half)



Confirm response to syphilis treatment:

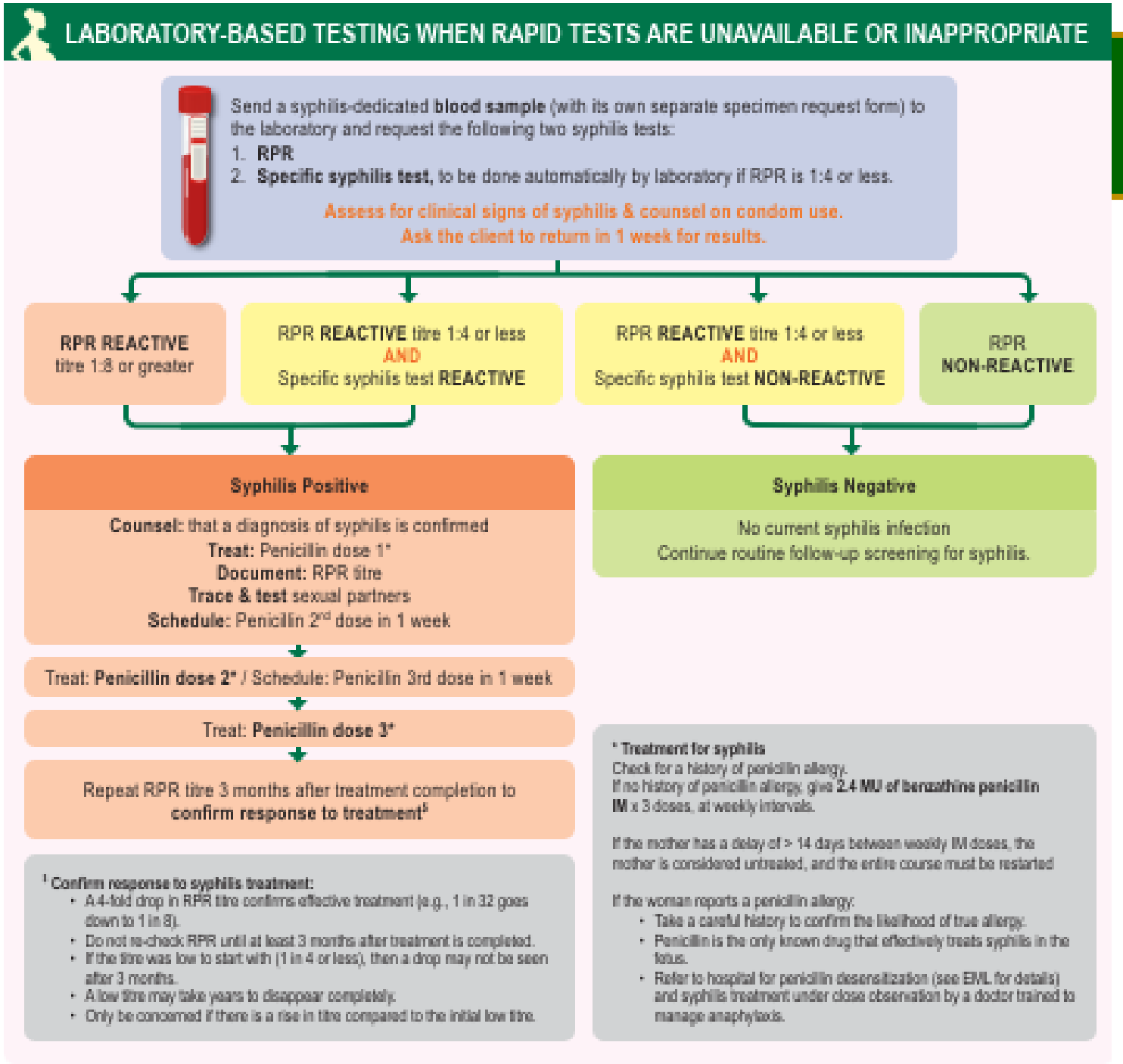
- A 4-fold drop in RPR titre confirms effective treatment (e.g., 1 in 32 goes down to 1 in 8).
- Do not re-check RPR until at least 3 months after treatment is completed.
- If the titre was low to start with (1 in 4 or less), then a drop may not be seen after 3 months.
- A low titre may take years to disappear completely.
- Only be concerned if there is a rise in titre compared to the initial low titre.

Treatment for syphilis

- **Check for a history of penicillin allergy**
  - All-over body rash, bronchospasm, hypotension/collapse, or neck/throat swelling after previously taking penicillin
- **If no history of penicillin allergy, give**
  - 2.4 MU of benzathine penicillin IM x 3 doses, at weekly intervals
- **If the mother has a delay of > 14 days between weekly IM doses, the mother is considered untreated, and the entire course must be restarted**

- **If the woman reports a penicillin allergy:**
  - Take a careful history to confirm the likelihood of true allergy.
  - Penicillin is the only known drug that effectively treats syphilis in the fetus.
  - Refer to hospital for penicillin desensitization (see EML for details) and syphilis treatment under close observation by a doctor trained to manage anaphylaxis.

RPR Algorithm



Congenital syphilis

- **30-40% of babies who acquire syphilis in-utero, die shortly before or after birth**
- **2 considerations:**
  - Babies' clinical symptoms
  - Mother's treatment status

Syphilis symptoms in the newborn


Seizures


Jaundice Hepatomegaly

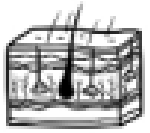

Splenomegaly


Long bone changes


Pallor Petechiae


Large, pale, greasy placenta


Growth restriction


Peeling Rash, Oedema
Nonimmune fetal hydrops


Loss of eyebrows, chorioretinitis, uveitis, cataract, glaucoma


Nasal discharge (“snuffles”)


Pneumonia


Myocarditis

Definition - Inadequately or untreated mother:

Inadequately treated mother

- Mother did not complete three doses in full, or
- Mother received three doses but there was a delay of > 14 days between weekly IM doses, or
- Last dose was not more than 30 days before delivery, or
- Dose that the mother received was incorrect was incorrect

Untreated mother:

- Mother did not receive any treatment for syphilis, or
- Mother was treated for syphilis with an antibiotic that was not penicillin

Management of the Syphilis-Exposed Baby

MANAGEMENT OF SYPHILIS EXPOSED BABIES

ASYMPTOMATIC BABIES BORN TO MOTHERS WITH FULLY TREATED SYPHILIS

Mother treated with benzathine penicillin G
2.4 million IU IM weekly for 3 consecutive weeks with last dose > 30 days before delivery.

↓

No treatment indicated.
Ensure partner traced and tested.

ASYMPTOMATIC BABIES BORN TO MOTHERS WITH INADEQUATELY TREATED* OR UNTREATED SYPHILIS**

↓

Single dose Benzathine Penicillin G
50 000 units/kg IM.
Never give IV.
Ensure partner is traced, tested and treated (as indicated).

SYMPTOMATIC BABIES BORN TO MOTHERS WITH SYPHILIS REGARDLESS OF TREATMENT STATUS

↓

Aqueous crystalline Penicillin G

- 50 000 units/kg 12 hourly IV or IM for the first 7 days of life, then 8 hourly from day 8 of life onwards to complete 10 days of treatment
- **Parenteral penicillin is drug of choice for treatment of congenital syphilis.** Data are insufficient regarding use of other antimicrobial agents (e.g., ampicillin).

Note: If mother was fully treated & baby symptomatic – re-test mother & follow-up on reason for treatment failure; ensure partner tracing done.

! If baby misses more than one day of treatment, the entire ten-day course must be restarted.

Babies with symptomatic syphilis

- All babies require admission for parenteral penicillin
- If unable to admit at current level of care, refer all babies with suspected congenital syphilis infection to appropriate level of care for inpatient admission & work-up.
- Refer all symptomatic babies with complications, e.g., thrombocytopaenia, anaemia, respiratory distress, signs of liver dysfunction, & suspected meningitis to a centre with high care or intensive care unit facilities.

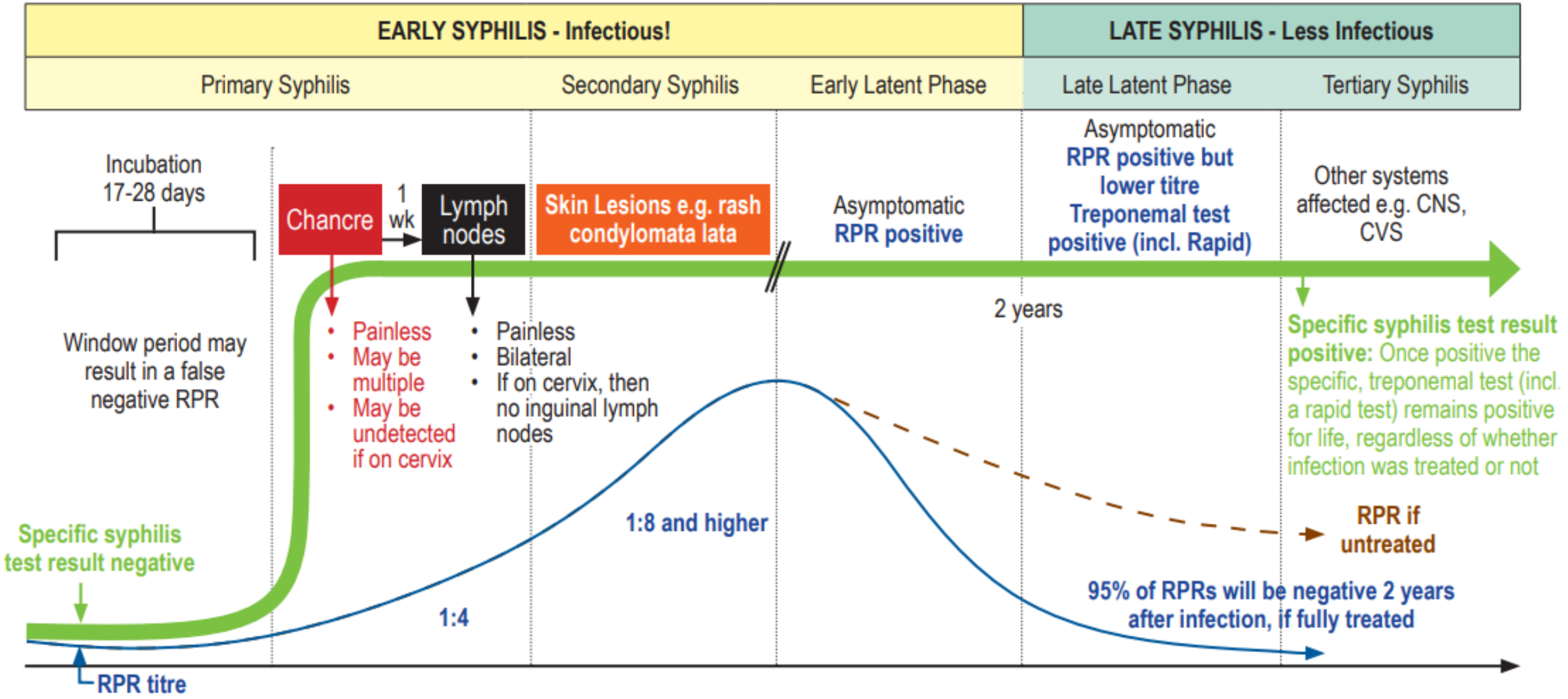
Mandatory notification for congenital syphilis

- Category 2 Notifiable Medical Condition (NMC):
- Health care workers must notify all cases of congenital syphilis within 7 days of diagnosis.
- Test or re-test all negative mothers with stillbirths or miscarriages for syphilis at time of presentation

Treating partners with symptoms

- **Trace and test partners of women with confirmed syphilis**
- **Test the partner using a rapid syphilis test if available and assess for symptoms and signs of a genital ulcer or secondary syphilis.**
- **If the rapid test is positive, and symptoms or signs of syphilis are present, treat the partner for early syphilis using one of the following options:**
  - A single immediate dose of benzathine penicillin 2.4 MU IM, if stock levels are sufficient
  - If penicillin stock levels are insufficient, give Doxycycline 100mg 12-hourly orally for 14 days

Syphilis Timeline

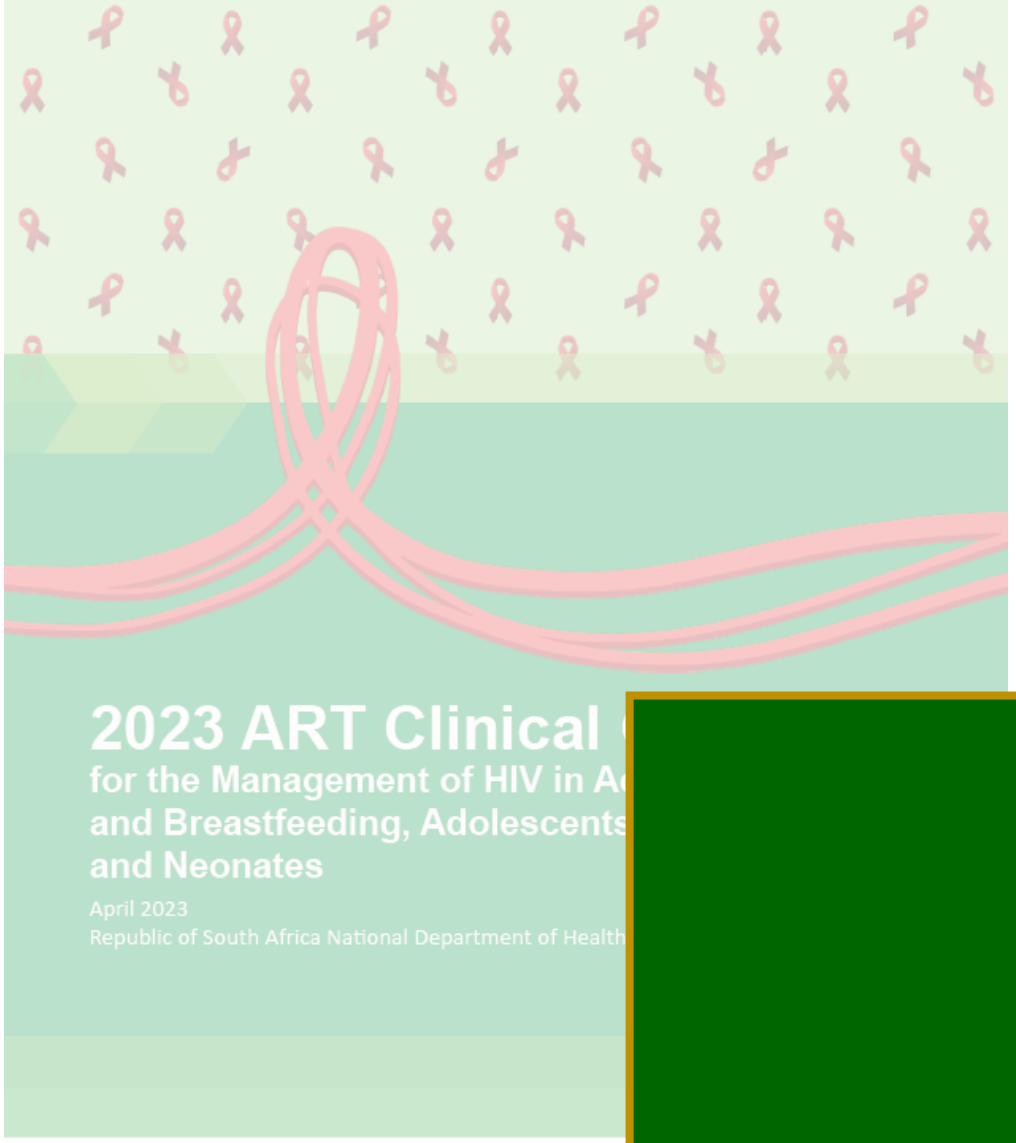


Treating partners without symptoms

- **If the rapid test is positive and there are NO symptoms or signs of syphilis, send a confirmatory blood sample to the laboratory for an RPR. Do not wait for the results before treating the partner, but be sure to check the results 1 week later.**
- **Treat the partner for latent syphilis using one of the following options:**
  - Benzathine penicillin 2.4 MU IM, once weekly for 3 weeks, if stock levels are sufficient
  - If penicillin stock levels are insufficient, give Doxycycline 100mg 12-hourly orally for 30 days

Summary of changes in clinical management

- **Increase access to optimised regimens (TLD) for pregnant and breastfeeding women**
  - No longer any concern re NTDs
  - TLD as both first (TLD 1) and second (TLD 2) line regimens (NADIA and ARTIST trials)
  - Simplified switching from TEE to TLD not dependent on VL
- **Tighten the definition of "high-risk" for HEIs**
  - VL threshold for high-risk moves from 1000 to 50 c/mL
  - Dual prophylaxis for all HIV-exposed infants at birth until delivery VL is known
  - Cotrimoxazole only for confirmed HIV-infected children
- **Syphilis**
  - Introduction of PoC single and dual rapid tests
  - Frequency of testing aligned with HIV testing schedule
  - Notification of syphilis-related stillbirths



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Thank you!

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