Postpartum Follow-Up of People With HIV

(Last updated December 30, 2021; last reviewed December 30, 2021)

Panel’s Recommendations

- Antiretroviral therapy (ART) is currently recommended for all individuals with HIV to reduce the risk of disease progression and to prevent the sexual transmission of HIV (AI).

- ART should be continued after delivery (AI). Any plans for modifying ART after delivery should be made in consultation with the individual and their HIV care provider, ideally before delivery, taking into consideration the recommended regimens for nonpregnant adults (AIII) and plans for future pregnancies.

- Because the immediate postpartum period poses unique challenges to ART adherence, arrangements for new or continued supportive services should be made before hospital discharge (AII).

- People with a positive expedited HIV antibody test during labor should receive confirmatory testing. If testing confirms HIV infection, ART should be offered, and they should be given a supply of ART before hospital discharge to prevent treatment interruption (AII). Immediate linkage to HIV care and comprehensive follow-up also is needed (AII).

- Infants of people who have HIV newly diagnosed in the intrapartum period should begin presumptive HIV therapy and a supply of ART for their infants should be provided before hospital discharge (AII) (see Antiretroviral Management of Newborns with Perinatal HIV Exposure or HIV Infection).

- Breastfeeding is not recommended for people in the United States who have confirmed HIV or are presumed to have HIV as long as safer infant feeding alternatives are available (AI). People who desire to breastfeed should receive evidence-based counseling on infant feeding options (AIII) (see Counseling and Managing Individuals with HIV in the United States Who Desire to Breastfeed).

- Infant feeding counseling—including a discussion of potential barriers to formula feeding—should begin during the prenatal period; this information should be reviewed after delivery (AIII).

- Clinicians should discuss future reproductive plans and timing, as well as the risks and benefits of conceiving while on specific antiretroviral (ARV) medications and the use of appropriate contraceptive options to prevent unintended pregnancy (AII).

- Contraceptive counseling should involve shared decision-making and should start during the prenatal period; a contraceptive plan should be developed before hospital discharge, as desired by the patient (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

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

- Primary care, gynecologic/obstetric care, and HIV specialty care;
- Pediatric and pediatric HIV specialty care for the infant;
- Family planning services;

Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States
• Mental health services;
• Substance abuse treatment;
• Supportive services;
• Coordination of care through case management for the patient, their child (or children), and other family members; and
• Prevention of secondary transmission for partners with differing HIV status, including counseling on the use of condoms, antiretroviral therapy (ART) to maintain virologic suppression in the partner who has HIV (i.e., treatment as prevention), and the potential use of pre-exposure prophylaxis (PrEP) by the partner who does not have HIV (see Pre-exposure Prophylaxis (PrEP) to Prevent HIV During Periconception, Antepartum, and Postpartum Periods).

Supportive services should be tailored to the individual’s needs and can include screening for intimate partner violence; case management; child care; respite care; assistance with basic needs, such as housing, food, and transportation; peer counseling; and legal and advocacy services. Ideally, these services should begin before pregnancy and continue throughout pregnancy and the postpartum period.

During the postpartum period, immediate linkage to care, comprehensive medical assessment, counseling, and follow-up are required for all people with HIV and particularly for those who have a positive HIV test during labor or at delivery. The American College of Obstetricians and Gynecologists recommends that all people have contact with their obstetrician-gynecologists within 3 weeks postpartum and that postpartum care be provided as an ongoing process based on a woman’s individual needs, rather than as a single postpartum visit. People with HIV, particularly those who struggle with ART adherence, should have a follow-up appointment with the health care provider who manages their HIV care—whether that is an obstetrician or an HIV health care provider—within 2 to 4 weeks after hospital discharge. People who have difficulty attending in-person appointments should consider telemedicine visits.

When care is not co-located or not within the same health care system, a case manager can facilitate care coordination. People who are receiving case management are more likely to have viral suppression and be retained in care. Alternative models of HIV care delivery—such as HIV-adapted group prenatal care—have been associated with higher retention in HIV care for women in the postpartum period. It is especially critical to ensure continuity of ART between the antepartum and postpartum periods. People with HIV newly diagnosed in the intrapartum period should receive ART, and presumptive HIV therapy should be initiated immediately for the newborn before hospital discharge. Special hospital programs may need to be established to support dispensing ART to mothers before discharge.

Transgender and gender diverse people who were female sex assigned at birth may have additional needs for support and linkage to care during the postpartum period (see Perinatal HIV Prevention for Transgender and Gender Diverse People Assigned Female Sex at Birth).

**Postpartum Maternal Antiretroviral Therapy**

ART should be continued postpartum. Decisions about any changes to an ART regimen after delivery should be made after discussion between the individual and their HIV care provider, ideally before delivery. When providing counseling about postpartum ART, health care providers should...
consider the person’s desire for future planned or potential for unplanned pregnancies in the context of the person’s anticipated ART regimen, choice of contraceptive, and the potential for any drug–drug interactions during the postpartum period that were not an issue during pregnancy (see Prepregnancy Counseling and Care for Persons of Childbearing Age with HIV and Appendix C: Antiretroviral Counseling Guide for Health Care Providers). Some ART regimens that are recommended for nonpregnant adults may not be recommended for use during pregnancy or for people who are trying to conceive (see the Adult and Adolescent Guidelines). See Recommendations for Use of Antiretroviral Drugs During Pregnancy, Table 4, Table 5, Teratogenicity, and Combination Antiretroviral Drug Regimens and Maternal and Neonatal Outcomes for additional information and specific recommendations regarding regimens for use during pregnancy and when trying to conceive.

ART is currently recommended for all individuals with HIV to reduce the risk of disease progression and to prevent secondary transmission of HIV. The Strategic Timing of AntiRetroviral Treatment (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 counts >500 cells/mm³, and the HIV Prevention Trials Network (HPTN) 052 randomized clinical trial demonstrated that early ART can reduce the risk of sexual transmission of HIV to a discordant partner by 93%. According to the Centers for Disease Control and Prevention (CDC), people with HIV who take ART as prescribed and achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV through sex (i.e., Undetectable = Untransmittable).

Helping people with HIV understand the need for lifelong ART is a priority during postpartum care. Several studies have demonstrated significant decreases in ART adherence postpartum. During the postpartum period, people may have difficulty with medical appointment follow-up—including appointment adherence—which can affect ART adherence. Systematic monitoring of retention in HIV care is recommended for all individuals with HIV, but special attention is warranted during the postpartum period.

Maternal Adherence to ART and Postpartum Depression

Symptoms of depression have been associated with lower ART adherence and viral suppression during pregnancy and the postpartum period. Furthermore, postpartum depression is common among people with HIV. The U.S. Preventive Services Task Force recommends screening all postpartum people for postpartum depression using a validated tool (e.g., the Edinburgh Postnatal Depression Scale); such screening is especially important for people with HIV who appear to be at increased risk for postpartum depression and poor ART adherence during the postpartum period. People 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 ARV drug resistance, and decreased long-term effectiveness of ART. In people who achieve viral suppression by the time of delivery, postpartum ART simplification to once-daily, coformulated regimens—which are often the preferred initial regimens for nonpregnant adults—could promote adherence during this challenging time. Efforts to maintain adequate adherence during the postpartum period may ensure effectiveness of therapy (see Adherence to the Continuum of Care in the Adult and Adolescent Antiretroviral Guidelines). For people who are continuing ART and who
received increased protease inhibitor (PI) doses during pregnancy, available data suggest that doses can be reduced to standard doses immediately after delivery.

**Secondary Sexual Transmission and Contraception**

The postpartum period is a critical time for addressing safer sex practices to reduce secondary transmission of HIV to partners, and clinicians should begin discussing these practices with the patient during the prenatal period. Topics for discussion during counseling on prevention of secondary transmission to the partner without HIV should include condom use, ART for the partner with HIV to maintain viral suppression below the limit of detection, and the potential use of PrEP by the partner who does not have HIV. With full, sustained viral suppression in the person with HIV—with or without reliable PrEP use by the partner—HIV is sexually untransmittable (see Reproductive Options for Couples When One or Both Partners Have HIV).

It is important to integrate comprehensive family planning and preconception care into all health care visits, with special attention given to these topics during the routine prenatal and postpartum visits. Lack of breastfeeding is associated with earlier return of fertility. Ovulation returns as early as 6 weeks postpartum, and it can occur earlier in some people, even before resumption of menses, putting them at risk of pregnancy soon after delivery. If a long-acting reversible contraceptive (LARC)—such as an injectable, implant, or intrauterine device (IUD)—is desired by the patient, it should be inserted before hospital discharge or during the routine postpartum visit. If the insertion of a LARC is postponed until the postpartum visit, intramuscular depot medroxyprogesterone acetate (DMPA-IM) is a contraceptive option that can be given to avoid unplanned pregnancy in the interim, particularly if the postpartum appointment is missed or delayed. Interpregnancy intervals of <18 months have been associated with an increased risk of poor perinatal and maternal outcomes in women without HIV. Given the stresses and demands of caring for a new baby, people may be more receptive to the use of effective contraception, yet they are simultaneously at higher risk of nonadherence to contraception and, thus, unintended pregnancy.

The potential for drug–drug interactions between several ARV drugs and hormonal contraceptives is discussed in Prepregnancy Counseling and Care for Persons of Childbearing Age with HIV and Table 3. A systematic review conducted for the World Health Organization summarized the research on hormonal contraception, IUD use, and risk of HIV infection and concluded that women with HIV can use all forms of contraception. This is consistent with the CDC recommendations advocating access to a broad range of effective contraceptive methods, including combined hormonal contraceptives, progestin-only pills, depot medroxyprogesterone acetate (DMPA), and implants.

**Infant Feeding**

Avoidance of breastfeeding has been and continues to be a standard recommendation for people with HIV in the United States. Maternal ART dramatically reduces but does not eliminate the risk of HIV transmission via breast milk, and safe infant feeding alternatives are readily available. Other concerns include the potential for drug toxicity in the neonate or, should HIV transmission occur, the risk that the infant will develop ARV drug resistance due to subtherapeutic drug levels in breast milk. However, clinicians should be aware that people may face social, familial, and personal pressures to consider breastfeeding despite this recommendation; such pressures may be particularly problematic for people from cultures where breastfeeding is important because they may fear that formula feeding would reveal their HIV status. It is therefore important to address these possible barriers to
formula feeding during the antenatal period (see Counseling and Managing Individuals with HIV in the United States Who Desire to Breastfeed).

People who have an initial rapid positive HIV test during labor or after delivery should not breastfeed unless a confirmatory HIV test is negative. For detailed guidance on maternal HIV testing, see Maternal HIV Testing and Identification of Perinatal HIV Exposure. If HIV infection 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 ARV drug management. Other children and partner(s) should be referred for HIV testing. Similarly, people with HIV should be made aware of the risks of HIV transmission via premastication of infant food (i.e., by a mother prechewing or prewarming the food in her mouth). It is not yet known whether there is a risk of HIV transmission with premastication of food when the mother’s viral load is below the limit of detection.

**Lactation Inhibition**

For people who do not breastfeed (as recommended for people with HIV), symptoms related to breast engorgement can be very unpleasant in the days following labor and delivery. Supportive measures—such as using acetaminophen or ibuprofen for pain control, alternating hot and cold compresses on the breasts, or wearing a tight-fitting bra—can help relieve symptoms related to breast engorgement. Although pharmacologic options for lactation inhibition generally are not used in the United States, recent data suggest cabergoline may be appropriate for some people. Cabergoline is a dopamine agonist/ergot derivative that reduces the production of prolactin; however, it is not approved by the U.S. Food and Drug Administration for lactation inhibition. Cabergoline is contraindicated for women with hypertension—including pregnancy-induced hypertension, preeclampsia, or eclampsia—or liver disease and for women being treated with antipsychotics or those who have a history of puerperal psychosis. Bromocriptine, another dopamine agonist, is no longer used for lactation inhibition because of serious cardiovascular and neurologic complications associated with its use.
References


48. Bromocriptine mesylate (Parlodel) for the prevention of physiological lactation; opportunity for a hearing on a proposal to withdraw approval of the indication [Type]. 1994.