HIVE WEBINAR

Strengthening Postnatal HIV Prevention: Country Experiences With Postnatal Prophylaxis for Infants With Perinatal HIV Exposure

Thursday, September 18, 2025

HIV Impact Network for Vertical Transmission Elimination

PATA

icap Global Health

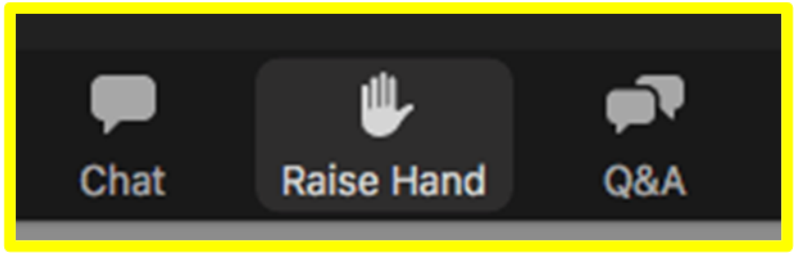
Welcome & Introductions

Maureen Syowai
Program Director (CQUIN/HIVE)
ICAP in Kenya

HIV Impact Network for Vertical Transmission Elimination

Housekeeping

- 90-minute webinar with framing presentations followed by a panel discussion and Q&A
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the “raise hand” function on the toolbar and we will unmute you so that you have control of your microphone
- Slides and recording will be available on the HIVE website (hiveimpactnetwork.com)



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Agenda

- **Welcome and Introductions** – Maureen Syowai, Program Director, ICAP in Kenya
- **Presentation** – WHO's updated recommendations for post-natal prophylaxis for HIV-perinatally exposed infants - Nandita Sugandhi, Medical Officer & Pediatrician, WHO, Geneva
- **Country Presentations**
  - Kenya: Christine Awuor, Program Officer VTP, NASCOP, Kenya
  - Nigeria: Mercy Morka, Head of SI, NASCP, Nigeria
- **Panel Discussion/Q&A –** Lulu Ndapatani, HIVE VTP Advisor ICAP in Kenya and Eleen Ekanem, HIVE Country Representative, PATA
- **Closing Remarks** – Franklin Emerenini, Deputy Director, HIVE, ICAP in Nigeria

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Presenters

Nandita Sugandhi
Medical Officer & Pediatrician
World Health Organization
Geneva

Christine Awuor
Program Officer – VTP
NASCOP, Kenya

Mercy Morka
Head of Strategic Information
NASCP, Nigeria

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WHO 2025 updated recommendations on the use of ARVs for the prevention and treatment of HIV in paediatric populations

Nandita Sugandhi

Medical Officer & Pediatrician

World Health Organization, Geneva

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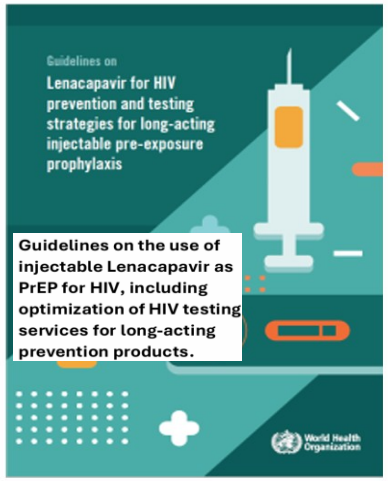
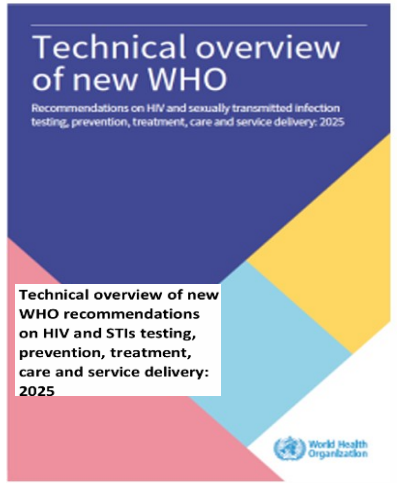
2025 updated recommendations on the use of ARVs for the prevention and treatment of HIV in paediatric populations

World Health Organization

New 2025 WHO recommendations





- New ARV dosing for neonates and infants
- Infant Postnatal Prophylaxis
- Breastfeeding in the context of maternal HIV infection
- LEN PrEP
- ARV Recommendations for treatment sequencing
- Dual treatment for HIV infection
- TB Preventative Therapy
- HIV Service Delivery
- Advanced HIV disease
- Mpox
- STI Screening

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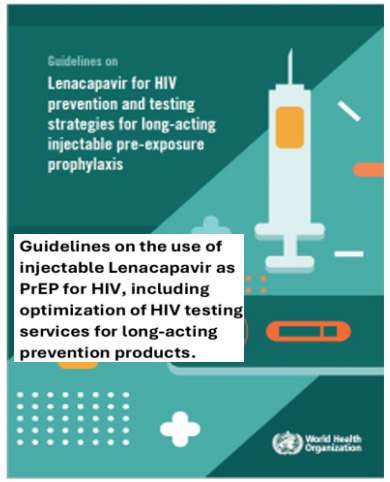
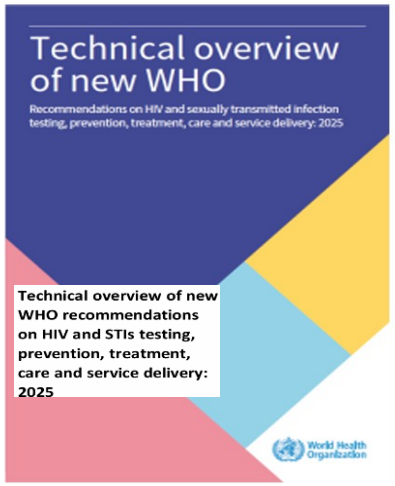
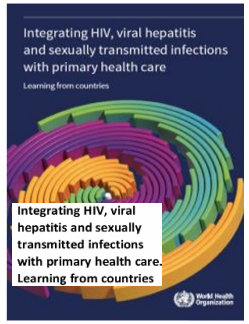
New 2025 WHO recommendations







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New evidence to inform dosing of ABC and DTG formulations

Term* Neonates (birth-4 weeks)

DTG 10 mg dispersible scored tablet

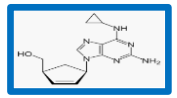
DTG dosing for neonates 0-4 weeks of age			
Neonatal Age	Dosage Form	# Tabs	Dosing Schedule
Birth to < 2 weeks	DTG 10 mg dispersible scored tablet	½ tablet	**Every 48 hours****
	DTG 5 mg dispersible tablet	1 tablet	**Every 48 hours****
2 weeks to <4 weeks	DTG 10 mg dispersible scored tablet	½ tablet	Once daily
	DTG 5 mg dispersible tablet	1 tablet	Once daily

* Born at ≥37 weeks gestational age

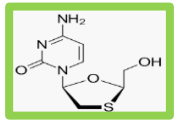
** Every other day at approximately the same time

World Health Organization

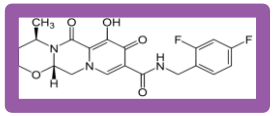
Infants ≥4 weeks weighing 3-<6 kg



ABC = abacavir



3TC = lamivudine



DTG = dolutegravir

pALD

ABC 60 mg + 3TC 30 mg + DTG 5 mg

New!

Weight	# tabs pALD per day
3 to < 6kg	1
6 to <10kg	3
10 to <14kg	4
14 to <20kg	5
20 to <25kg	6

Implications of new pharmacokinetic and safety data on neonatal dosing using available ARV drug formulations

- **DTG-based regimens can now be recommended for initial treatment of ART infection across almost all populations**
  - ➢ DTG 5 mg <u>every other day</u> may be given to term infants* from birth until 2 weeks of age with an ABC/3TC containing NRTI backbone
  - ➢ DTG 5 mg daily may be given to term infants from 2 weeks onwards until the infant reaches 6kg

  **Caveat- no safety data in neonates<37 weeks gestational age (premature)*

Neonatal Dosing of abacavir, lamivudine, and dolutegravir			
Age band	Drug and Dosing Schedule	Formulation	Dose (tab)
0 to < 2 weeks	**DTG** 5 mg *every 48 hours*	5 mg DTG dispersible tablet 10 mg DTG scored dispersible tablet	1 tab ½ tab
	ABC/3TC (30/15 mg) *every 48 hours*	120/60 mg ABC/3TC double-scored dispersible tablet	¼ tab
2 to < 4 weeks	**DTG** 5 mg *every 24 hours*	5 mg DTG dispersible tablet 10 mg DTG scored dispersible tablet	1 tab ½ tab
	ABC/3TC (30/15 mg) *every 24 hours*	120/60 mg ABC/3TC double-scored dispersible tablet	¼ tab

- **pALD can be used across infant and child weight bands to provide a complete 3 drug regimen**
  - ➢ Effective and safe for use in infants older than 4 weeks weighing at least 3kg

pALD for infants > 4 weeks	
Weight	# tabs pALD per day
3 to < 6kg	1
6 to <10kg	3
10 to <14kg	4
14 to <20kg	5
20 to <25kg	6

Evolution of the preferred WHO recommendations for initial HIV TREATMENT over the years

	2006	2010	2013	2016	2018	2019	2021	2025
NRTI backbone	d4T or AZT or ABC or TDF + 3TC or FTC		ABC or TDF + 3TC or FTC					
Anchor drug	NVP or EFV		EFV or LPV/r					

Progression towards simplified and less toxic regimens

DTG-based regimens preferred for all populations ≥4 weeks with a non-thymidine analog backbone (ABC or TDF)

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What to START: Recommendations for initial regimens unchanged- but DTG may be used in an initial regimen for term* neonates

Population	Preferred initial regimen	Alternative initial regimen
Adults and adolescents	TDF + 3TC (or FTC) + DTG	TDF + 3TC + EFV_{400}
Infants and children	ABC+ 3TC + DTG	ABC + 3TC +LPV/r or TAF[a] + 3TC (or FTC) + DTG
Neonates	ABC + 3TC + ***Updated!*** DTG	AZT + 3TC + NVP

*≥37 weeks gestational age

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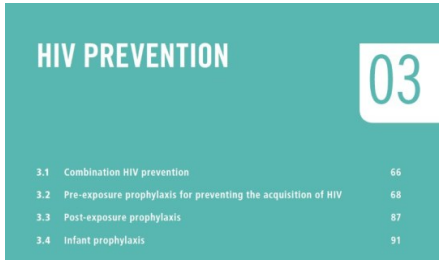
WHO Guidance – maintained in 2025



Good practice statement (2016)

ART should be initiated urgently among all pregnant and breastfeeding women living with HIV, even if they are identified late in pregnancy or postpartum, because the most effective way to prevent HIV vertical transmission is to reduce maternal viral load.[a]

[a] Whenever possible, all efforts should be made to identify Pregnant women living with HIV early enough to avoid the need for enhanced prophylaxis.

Source: *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach – second edition (13).*

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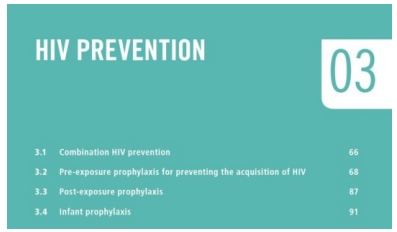
UNCHANGED: Risk Stratification (first introduced in 2016)



Maternal Viral Load the most important factor in determining risk of vertical HIV transmission

Infants at high risk of HIV infection are:

Born to women with HIV infection who have had <4 weeks of ART at the time of delivery

or

Born to women with HIV infection with VL>1000 copies/mL

or

Born to women with incident HIV infection during pregnancy or breastfeeding

or

Born to women identified for the first time during the postpartum period with or without a negative HIV test prenatally

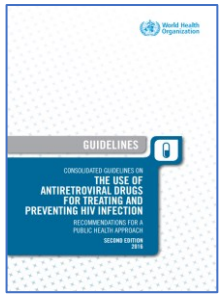
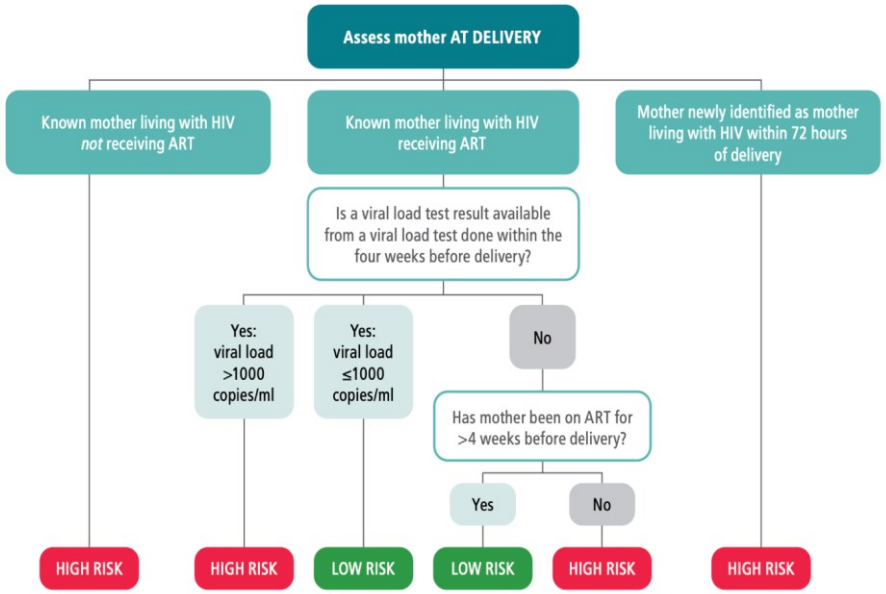


Fig. 3.1 Algorithm for risk assessment at the time of delivery to help identify infants at high and low risk of infection



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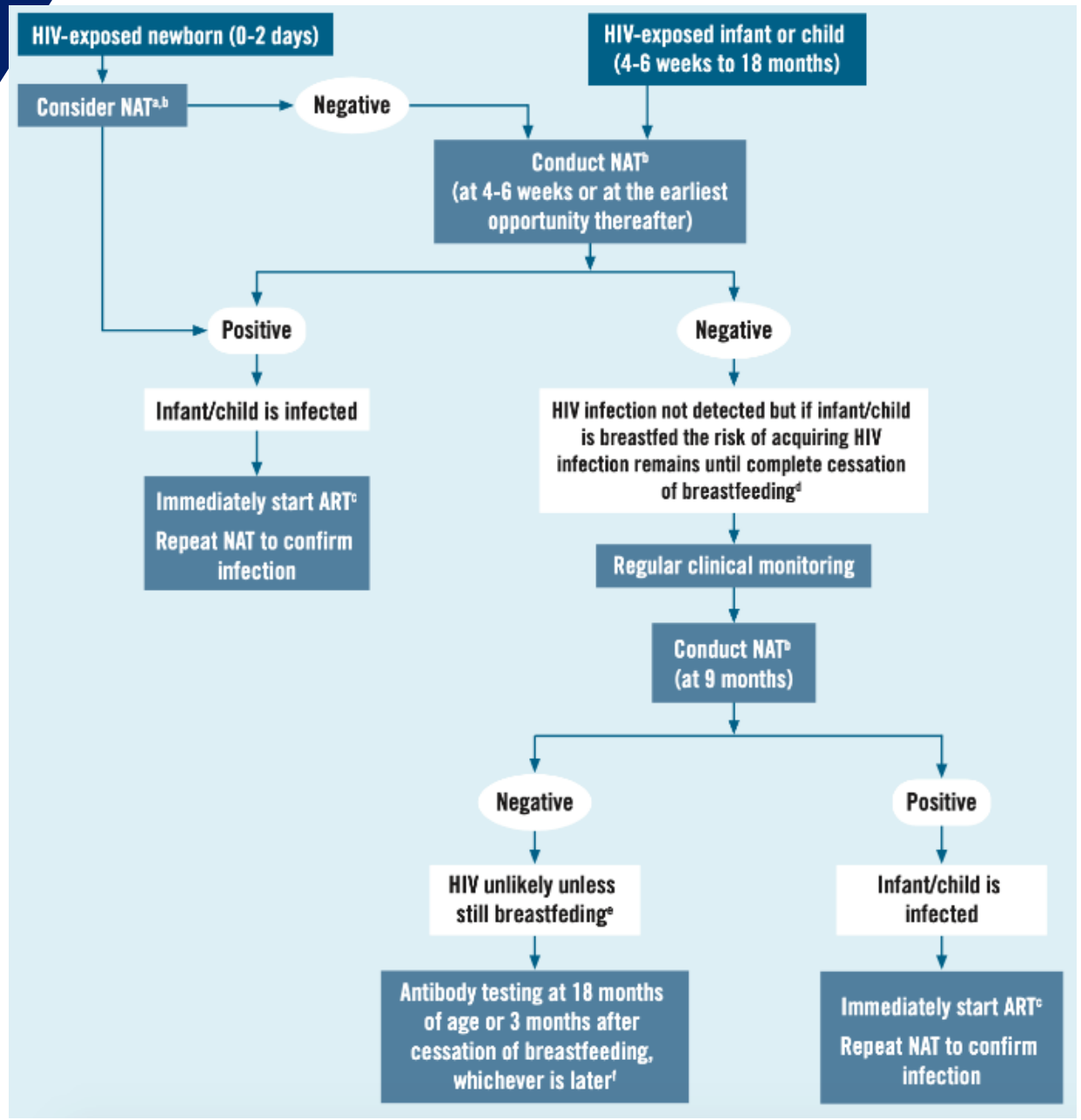
https://www.who.int/publications/i/item/9789240031593



Infant testing algorithm has also not changed

Moving to a multi-HIV NAT algorithm

- Birth (where of value)
- 6 weeks
- 9 months
- Any time HIV exposed infants present sick

Ensuring confirmatory testing of a positive NAT result is undertaken

Diagnosis is not complete without "final diagnosis" at the end of breastfeeding when risk period has ended

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Previous WHO postnatal prophylaxis recommendations

- Infants of mothers who are receiving ART and are breastfeeding should receive six weeks of infant prophylaxis with daily NVP. If infants are receiving replacement feeding, they should be given four to six weeks of infant prophylaxis with daily NVP (or twice-daily AZT) *(strong recommendation, moderate-certainty evidence for breastfeeding infants; strong recommendation, low-certainty evidence for infants receiving only replacement feeding).*

Routine

- Infants born to mothers with HIV who are at high risk of acquiring HIV[a] should receive dual prophylaxis with daily AZT and NVP for the first six weeks of life, whether they are breastfed or formula fed *(strong recommendation, moderate-certainty evidence).*
- Breastfed infants who are at high risk of acquiring HIV[a], including those first identified as exposed to HIV during the postpartum period, should continue infant prophylaxis for an additional six weeks (total of 12 weeks of infant prophylaxis) using either AZT and NVP or NVP alone *(conditional recommendation, low-certainty evidence).*

High Risk

High risk infants:

- Born to women with HIV infection who have had **<4 weeks of ART at the time of delivery**
- Born to women with HIV infection with **VL>1000 copies/mL**
- Born to women with **incident HIV infection** during pregnancy or breastfeeding
- Born to women **identified for the first time during the postpartum period** with or without a negative HIV test prenatally

https://www.who.int/publications/i/item/9789240031593

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In 2021 there were 16 different ePNP approaches in the AFRO region

Country	Target population	Regimen	Regimen duration				
			6 wks	8wks	12 wks	14 wks	End of breastfeeding
Mauritania	ALL INFANTS	NVP					
Gabon	HIGH RISK	AZT or NVP					
Namibia	HIGH RISK	AZT+NVP					
Malawi	HIGH RISK	AZT+3TC+NVP					
Gambia	ALL INFANTS	AZT or NVP					
DRC Cameroon Uganda	HIGH RISK	NVP				Extended if mother has UVL in DRC	
Togo	ALL INFANTS	AZT or NVP					
Ghana Niger South Sudan Zimbabwe	ALL INFANTS	AZT+NVP					
Nigeria Rwanda	HIGH RISK	AZT+NVP					
Ethiopia	ALL INFANTS	AZT+3TC		NVP			
Mozambique	ALL INFANTS	AZT+NVP		NVP			
Madagascar United Republic of Tanzania	HIGH RISK	AZT+NVP		NVP			
Eswatini	ALL INFANTS	AZT+NVP		NVP			Or until maternal VLS
Burundi	ALL INFANTS	AZT+NVP					
Sierra Leone	ALL INFANTS	NVP	Duration not specified				
Cote d'Ivoire Eritrea	ALL INFANTS	AZT+NVP	Duration not specified				
Central African Republic	HIGH RISK	AZT+NVP	Duration not specified				
Mali Seychelles	ALL INFANTS	AZT+3TC+NVP	Duration not specified				
Botswana	HIGH RISK	AZT+3TC+NVP	Until status is confirmed				
Mauritius	HIGH RISK	AZT+3TC+LPVr	Until status is confirmed				
Benin	ALL INFANTS	Regimen and duration not specified					

What is new since the current WHO postnatal prophylaxis recommendations were last reviewed in 2016?

Highly effective **DTG-based treatment** has been scaled up globally that is safe to use during pregnancy and breastfeeding with increased rates of viral suppression seen in adult populations

New infant safety and pharmacokinetic data on ARVs and formulations for available since last review in 2016

Additional RCT (PROMISE-EPI) of **alternative ARV options** in the postnatal period available and included in review and additional new analyses of data from previously published studies

Treatment optimization efforts have largely eliminated the use of NVP and AZT in WHO treatment guidelines except for neonatal populations as ARV prophylaxis or neonatal treatment for infants identified though birth testing

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Infant prophylaxis decisions

Infants of mothers who are receiving ART and are breastfeeding should receive six weeks of infant prophylaxis with daily NVP. If infants are receiving replacement feeding, they should be given four to six weeks of infant prophylaxis with daily NVP (or twice-daily AZT)

Infants born to mothers with HIV who are at high risk of acquiring HIV should receive dual prophylaxis with daily AZT and NVP for the first six weeks of life, whether they are breastfed or formula fed

Breastfed infants who are at high risk for acquiring HIV, including those first identified as exposed to HIV during the postpartum period should continue infant prophylaxis for an additional six weeks (total of 12 weeks of infant prophylaxis) using either AZT and NVP or NVP alone

Study, First Author	Countries	Period	Maternal Population	Infant Population	Intervention	Control	Number of Participants
PEP, Gray	South Africa	2000 - 2002	Inclusion: test HIV+ during delivery	Exclusion: HIV+ at birth, preterm, weight <1200g, on ventilation, unable to take oral medication, congenital abnormalities	6 weeks AZT	sdNVP	Intervention N=533 Control N=518
SWEN, Bedri	Ethiopia, India, Uganda	2001- 2007	Inclusion: >18 years, >32 weeks gestation, enrollment <24 hours of delivery (India only), intend BF Exclusion: ART other than NVP, obstetric complications, various blood lab values	Inclusion: HIV negative, weight >2000g, various blood lab values criteria for both mother and infant Exclusion: infant complications, various blood lab values	sdNVP + 6 weeks NVP	sdNVP	Intervention N=977 Control N=1047
PEPI-Malawi, Kumwenda	Malawi	2004 - 2009	HIV+ (<5% started ART by 14 weeks), intend to BF, given birth within 24 hours of enrollment	Exclusion: HIV+ at birth or with life-threatening condition	Arm 2: sdNVP + 1 week AZT + NVP from Day 8 until week 14 Arm 3: sdNVP + 1 week AZT + AZT/NVP from day 8 until week 14	sdNVP + 1 week AZT	Intervention Arm 2 N=1016 Arm 3 N=997 Control N=1003
BAN, Chasela	Malawi	2004 - 2010	Inclusion: >14 years, <30 weeks, CD4 >250, enrollment ≤36 hours of delivery Exclusion: serious maternal infection or complication, previous use of ART	Inclusion: birthweight >2000g, Exclusion: HIV+ within 2 weeks, infant complications	Arm 2: sdNVP + 1 week AZT+3TC + NVP for 28 weeks or until EOB Arm 3: sdNVP + 1 week AZT+3TC + maternal ART for 28 weeks or until EOB	sdNVP + 1 week AZT+3TC	Intervention Arm 2 N=852 Arm 3 N=849 Control N=668
HPTN-040, Nielsen	Brazil, South Africa, Argentina, and USA	2008-2010	Exclusion: Received ARV other than ZDV during labor	Inclusion: HIV negative, formula-fed infants, ≥32 weeks, weight >1.5kg, no life-threatening conditions, able to take oral meds Exclusion: Received ARV other than oral ZDV before enrollment	Arm 2: 6 weeks AZT + 3 doses NVP during first 8 DOL Arm 3: 2 weeks AZT+3TC+NFV, continue AZT for an additional 4 weeks	6 weeks AZT	Intervention Arm 2 N=562 Arm 3 N=556 Control N=566
PHPT-5, Lallemant	Thailand	2011- 2014	>18 years, antenatal ART <8 weeks before delivery (intervention) vs ≥8 weeks, not intend BF	Non-BF infants	maternal ART + AZT+3TC+NVP for 2 weeks, continue AZT+3TC for 2 more weeks	observational control maternal ART + 4 weeks AZT	Intervention N=89 Control N=236
ANRS 12174, Nagot	Burkina Faso, South Africa, Uganda, and Zambia	2016	≥18 years, with CD4 ≥350 not on ART, singleton delivery, BF	Inclusion: HIV negative at 7 DOL Exclusion: clinical or biological abnormalities (≥grade 2), birthweight <2kg	1 week NVP + LPV/r for 50 weeks or until EOB	1 week NVP + 3TC for 50 weeks or until EOB	Intervention N=621 Control N=615
IMPAACT-PROMISE, Flynn	India, Malawi, South Africa, Tanzania, Uganda, Zambia, Zimbabwe	2018	not eligible for ART (CD4 >350), HIV+ during pregnancy or labor/birth	Inclusion: birthweight >2kg, infant tested HIV negative 6 - 14 DOL Exclusion: HIV+ test or test results unavailable, life-threatening condition	18 months NVP or until EOB	6 weeks NVP + maternal ART	Intervention N=1211 Control N=1219
PROMISE-EPI, Kankasa	Zambia, Burkina Faso	2024	HIV+ on ART, ≥15 years, singleton delivery, BF	Exclusion: HIV+, on FTC, severe congenital malformations, grade 3/4 DAIDS clinical symptom	3TC for 12 months if mother has a VL ≥1000 at EPI-2 visit (6-8 weeks of age) or 6-month visit	Country-specific standard of care Zambia (pre-2020): AZT+3TC+NVP for 12 weeks (high-risk infants) (post-2020): AZT+3TC+NVP for 12 weeks (all) continued if VL ≥1000 Burkina Faso: NVP for 6 weeks	Intervention N=753 Control N=753
HPTN-046, Coovadia	South Africa, Tanzania, Uganda, and Zimbabwe	2012	Inclusion: ≥18 years, BF Exclusion: any serious medical disorder	Inclusion: HIV negative at 7 DOL, birthweight >2000g Exclusion: any serious medical	6 months NVP	6 weeks NVP	Intervention N=759 Control N=763

WHO 2025 recommendations for infant postnatal HIV prophylaxis

Routine or "low risk"

New!

Infants who are not at high risk of acquiring HIV should receive six weeks of infant prophylaxis with a single drug, with nevirapine as the preferred option *(strong recommendation, moderate-certainty evidence)*; **DTG or 3TC are alternative options** *(conditional recommendation, very-low-certainty evidence)*

High risk

New!

Infants at high risk of acquiring HIV should receive a three-drug regimen, with ABC, 3TC and DTG as the preferred option *(Strong recommendation, low-certainty evidence)*

Breastfeeding infants who complete six weeks of a three-drug regimen should follow with single-drug prophylaxis for the remainder of breastfeeding or until the mother achieves suppression of viral loads with Nevirapine as the preferred option for infant prophylaxis, and DTG or 3TC as alternative options.

For NVP *(strong recommendation, moderate-certainty evidence)*

for 3TC *(conditional recommendation, moderate-certainty evidence)*

for DTG *(conditional recommendation, very-low-certainty evidence)*

Conclusion

- New recommendations from WHO further **optimize use of ARVs for paediatric HIV treatment and prevention**
- In the context of modern maternal ART, the risk of vertical HIV transmission during breastfeeding is minimal, but **infant ARV prophylaxis offers another layer of protection**
- **Risk stratification** to differentiate infants at low risk vs. high risk of HIV infection is **the first clinical decision point** in the management of HIV exposed infants
- **Single drug ARV prophylaxis for six weeks** with NVP as a preferred drug is recommended for infants at **low risk** of transmission and DTG and 3TC may be used as alternatives
- **Triple drug regimen for six weeks is recommended for infants at high risk of HIV infection**, whenever they are identified and **may be followed by single drug prophylaxis** to provide an extra layer of protection during breastfeeding until maternal viral suppression is achieved
- The **routine infant diagnosis schedule** is also **unchanged** for all HIV exposed infants and needs to be considered alongside clinical decision points in the cascade of care for HIV exposed infants

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Thank you.

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Kenya Case Study

Christine Awuor

Program Officer in VTP Unit

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Country profile - HIV burden in Kenya

1,326,419

Kenyans living with HIV

62,881

Children (0-14 years) living with HIV in 2024

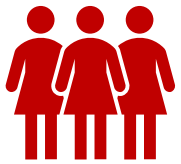
National HIV prevalence is 3.03%

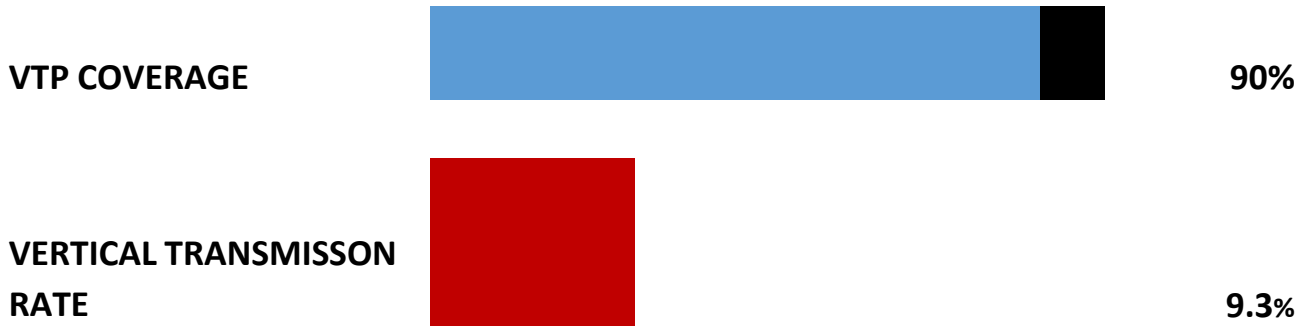
1.9 | **4.08**

21,009

AIDS-related deaths

Women with HIV 867,571





6039 VTP Sites

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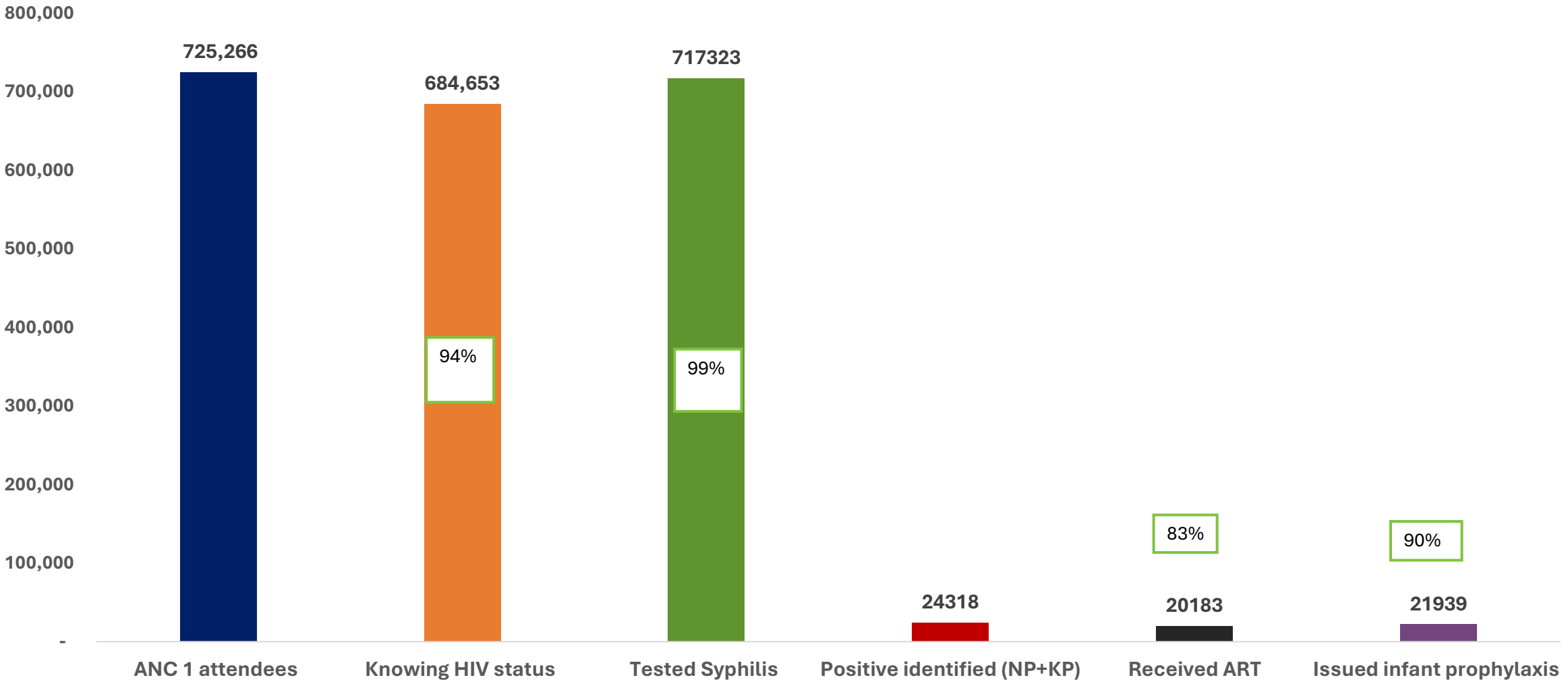
Source: NSDCC, Kenya HIV Estimates 2025.

VTP performance (January – June 2025)



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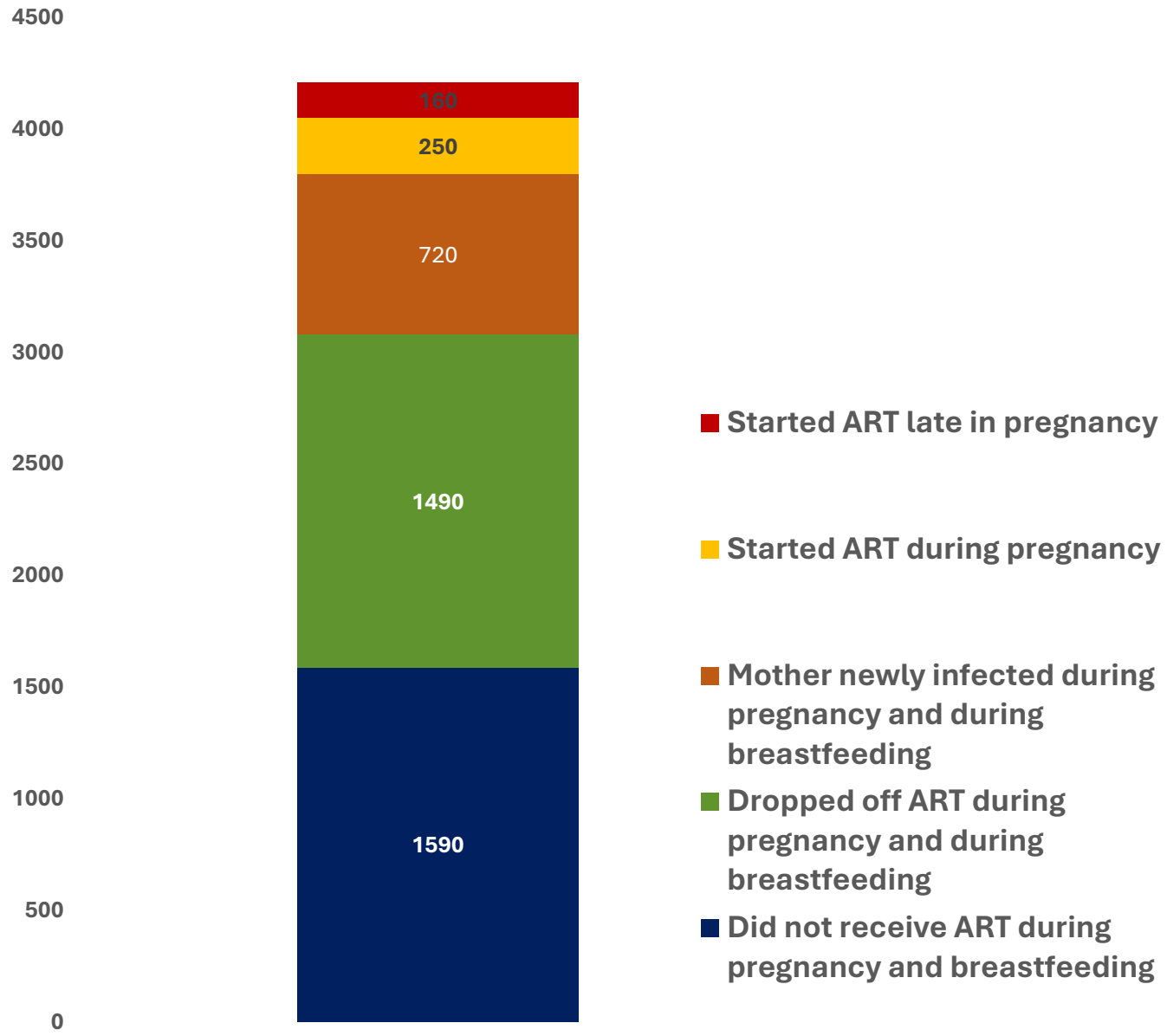
Sources of new child infections in Kenya



- **71% (3080**) of all new HIV infections in children aged 0-14 years were attributed to:
  - ❖ Pregnant and breastfeeding women not receiving ART (37%), or
  - ❖ Dropping off ART (34%)
- **17%** from new incident infections during pregnancy and breastfeeding
- **9.5%** of women on ART are not virally suppressed

Strengthening adherence and continuity of treatment will address 80% of vertical transmissions in Kenya

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Current infant prophylaxis guidance

- All infants are considered as high risk and receive prophylaxis until 6 weeks after complete cessation of breastfeeding
- Infant prophylaxis is issued at 1st ANC visit or at HIV diagnosis during pregnancy or breastfeeding period with instructions to the mother on use and storage.

ARV Prophylaxis regimen

- AZT+NVP for 6 weeks
  then
- NVP until 6 weeks after complete cessation of breastfeeding

Kenya HIV Prevention and Treatment Guidelines, 2022

Table 7.3: ARV Prophylaxis for HIV-Exposed Infants

Infant Scenario	Infant Prophylaxis	Maternal Scenarios
HIV Exposed Infant	• Infant prophylaxis ○ AZT+NVP for 6 weeks, NVP + cotrimoxazole should be continued until 6 weeks after complete cessation of breastfeeding ○ Infant prophylaxis can be discontinued after a minimum of 12 weeks on NVP if the child is not breastfeeding (death of mother or separation with mother) ○ The infant prophylaxis regimen applies to all infants irrespective of age when identifying HIV exposure (e.g., mother diagnosed HIV-positive in the postpartum period)	If mother not on ART, initiate ART as soon as possible (preferably same day) If mother is on ART for ≥ 3 months and the VL is ≥ 50 copies/ml, intensify adherence, repeat the VL If VL <50 copies/ml, continue current regimen

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Programmatic approach to monitoring PNP

Follow up of the perinatally exposed infant

- Infant follow-up is synchronized with immunization and growth monitoring
- Infant prophylaxis refilled at every immunization visit(6,10,14wks, 6,9,12,15,18months) and dose is adjusted as weight changes
- PCR done at 6 weeks, 6 months, 12 months and antibody test at 18 months
- Mother infant pairing and linkage with mentor mothers who act as case managers for longitudinal tracking

Maternal follow up

- All mothers issued with PNP for infant at 1° ANC or when diagnosed thereafter with clear instructions on use and storage.
- Client is enrolled into VTP clinic for regular followup
- Viral load assessment done according to national guidance (new on ART 3 months if virally suppressed, then every 6 months until cessation of breastfeeding & for KP at diagnosis of pregancy if virally suppressed every 6 months until ceessation of breastfeeding
- Peer education and psychosocial support through MMs

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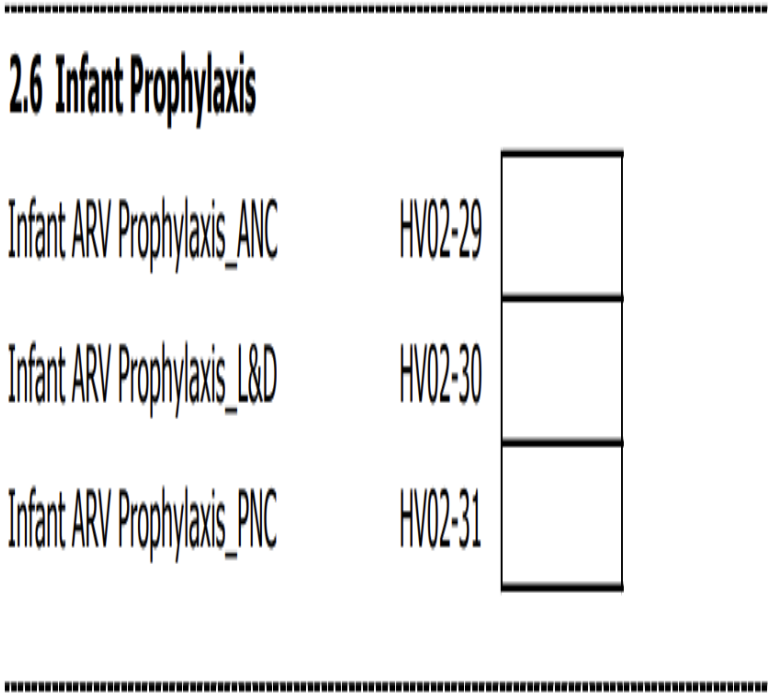
Monitoring infant prophylaxis

Standardized reporting in both paper and electronic tools

- MCH Handbook – client card captures HIV status and infant exposure status. Used to document PNP alongside child services offered at every clinic visit
- HIV exposure infant register- Tracks PNP provision for all clinic visits
- Kenya EMR- Tracks PNP provision for all clinic visit and flags out missed opportunities and appointments

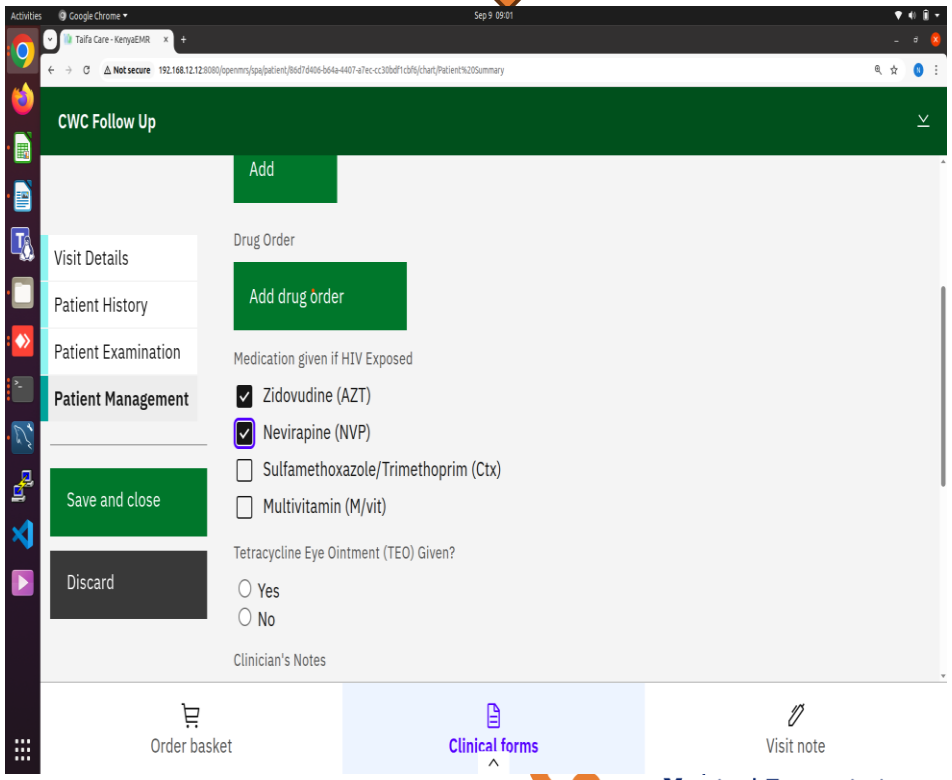
National Monthly Reporting Tool – MOH 731b



2.6 Infant Prophylaxis

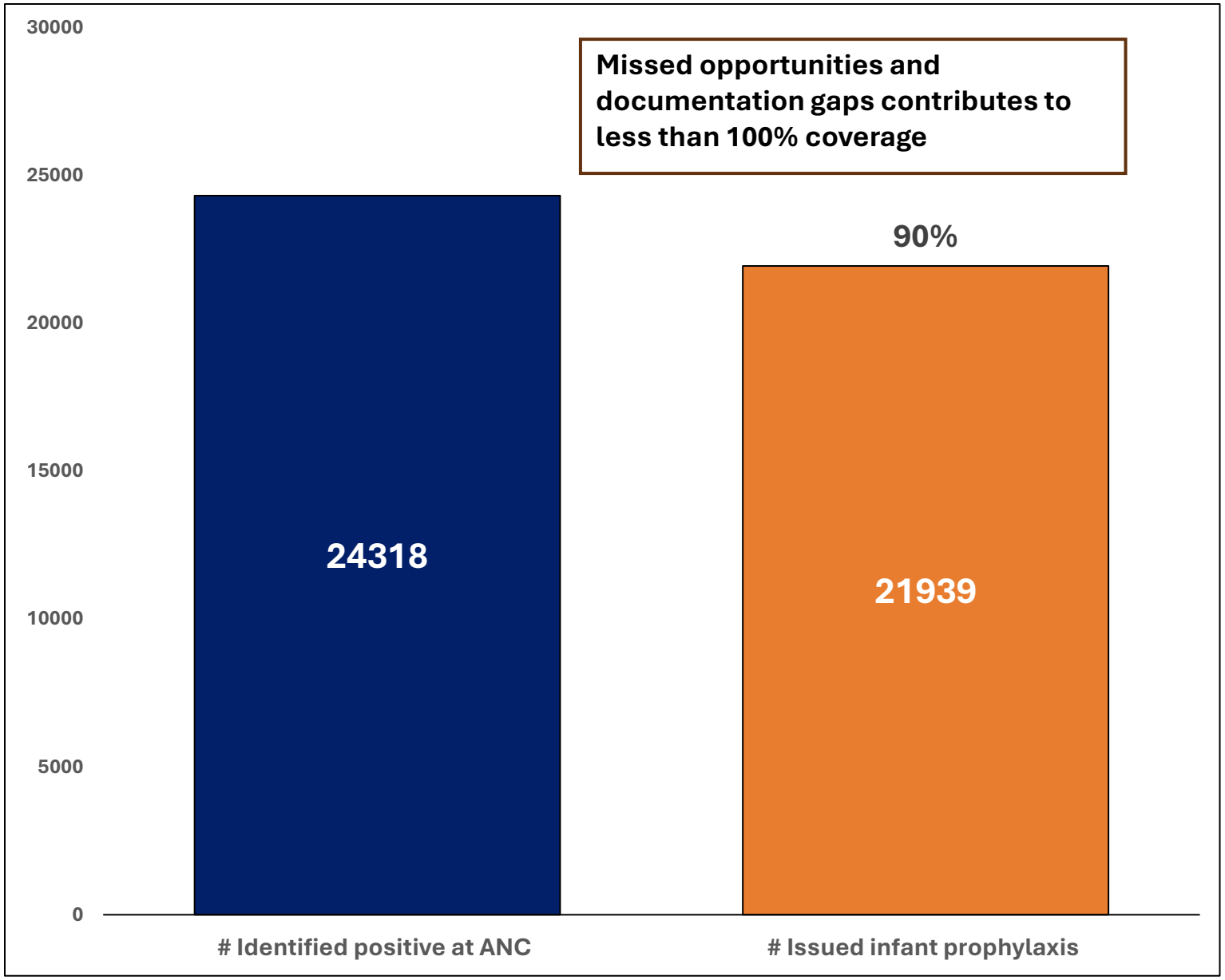
Infant ARV Prophylaxis_ANC	HV02-29	
Infant ARV Prophylaxis_L&D	HV02-30	
Infant ARV Prophylaxis_PNC	HV02-31	

Kenya EMR



Vertical Transmission Elimination

Infant ARV prophylaxis coverage (January –June 2025)

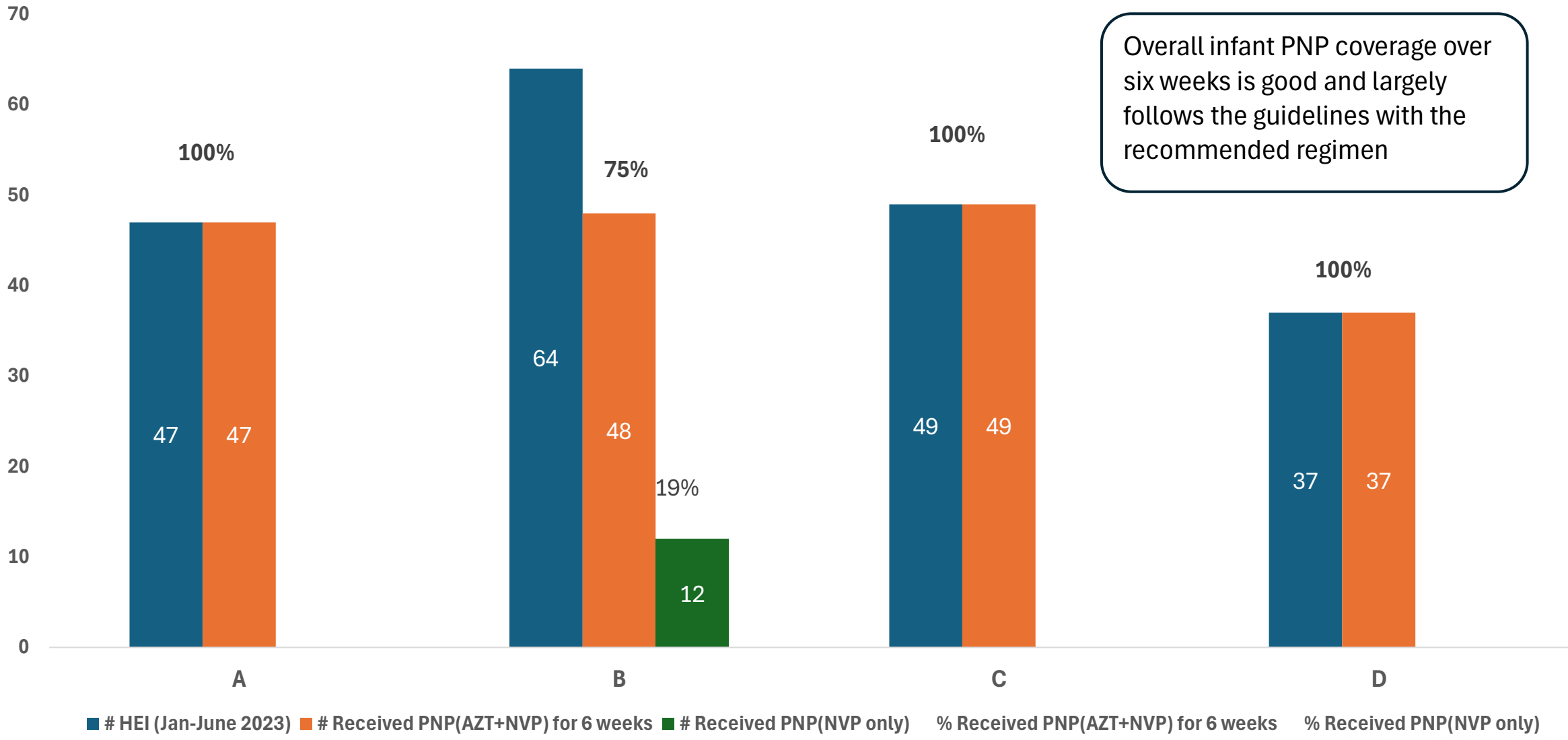


Strategies to improve PNP coverage

- Strengthen documentation and utilization of the ANC/maternity and postnatal registers to capture infant prophylaxis
- Strengthen service integration of VTP into MCH
- Data validation before and after reporting
- Improve tracking for all clients who were not issued with infant prophylaxis

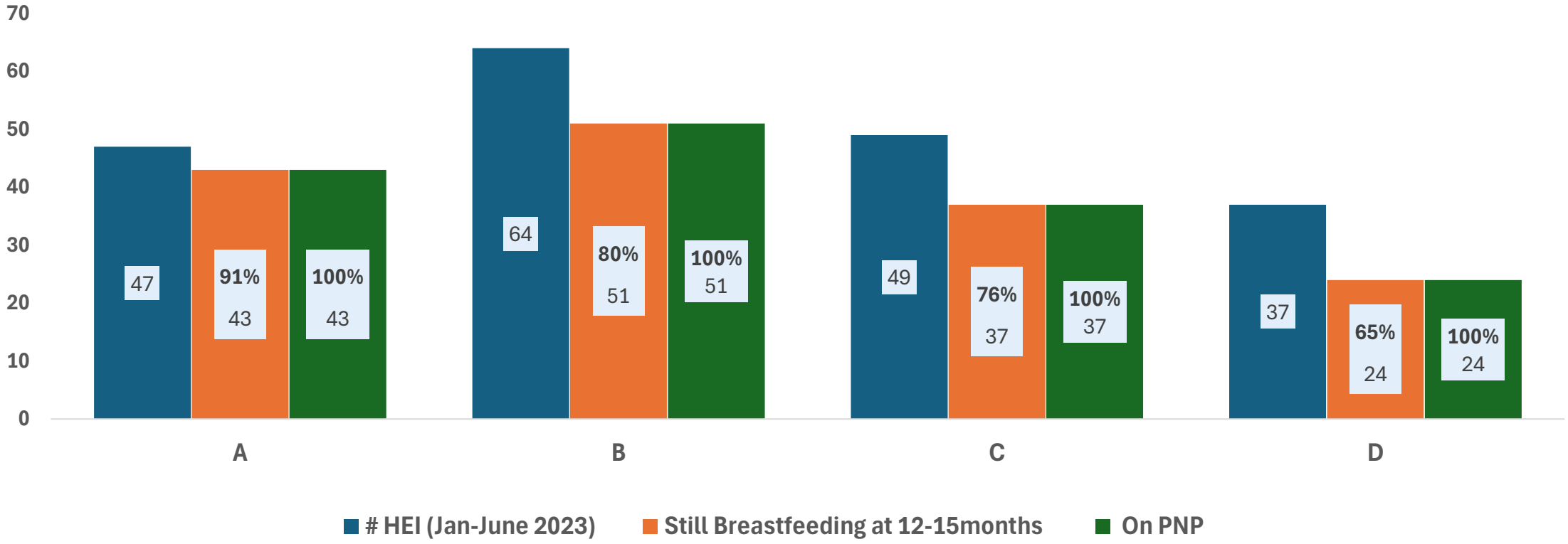
HIV Impact Network for Vertical Transmission Elimination

PNP coverage & regimen compliance in first 6 Weeks across 4 Facilities



Overall infant PNP coverage over six weeks is good and largely follows the guidelines with the recommended regimen

Postnatal prophylaxis coverage at 12-15 months in perinatally exposed infants still breastfeeding



Across all selected facilities, PNP coverage for HIV-exposed infants still breastfeeding at 12-15 months was 100%.

HIV Impact Network for Vertical Transmission Elimination

Policy update on postnatal prophylaxis

Kenya is transitioning to provision of infant prophylaxis through risk-based stratification

Category of risk	Infants at High risk of HIV Acquisition	Infants at Low risk of HIV Acquisition
Recommended Regimen	ABC+3TC+DTG for 6 weeks then extended prophylaxis using NVP until 6 weeks after complete cessation of breastfeeding	Initiate NVP prophylaxis and continue until 6 weeks after complete cessation of breastfeeding

HIV Impact Network for Vertical Transmission Elimination

Determining HIV risk for perinatally exposed infants

High Risk PBW

- All newly diagnosed clients in pregnancy and post partum
- AGYW <19 yrs (new or known positive)
- PBFW with high viral load >50copies/ml
- Recent STIs
- Poor treatment adherence
- Return after treatment interruption
- New or established Mental health conditions
- PBFW who are FSW, PWID, Alcohol and substance use

Consider infant at high risk for VT

High-risk Infant Package

- EID (refer to EID algorithm)
- Triple drug Infant prophylaxis using ABC+3TC+DTG for 6 weeks, the Extended Infant Prophylaxis using NVP 6 weeks until complete cessation of breastfeeding
- Cotrimoxazole Prophylaxis until complete cessation of breastfeeding
- TB screening at each clinic visit
- Routine growth monitoring and immunization

Low risk PBW

- Clients with HIV on treatment and virally suppressed at baseline (<50copies/ml)
- Good adherence to treatment and follow up.
- Has an established social support system
- Controlled comorbidities

Consider infant at low risk for VT

Low Risk Infant Package:

- EID (refer to EID algorithm)
- Extended Infant prophylaxis using NVP until 6 weeks after complete cessation of breastfeeding
- Cotrimoxazole Prophylaxis until complete cessation of breastfeeding
- TB screening at each clinic visit
- Routine growth monitoring and immunization

HIV Impact Network for Vertical Transmission Elimination

Next Steps

- Finalize and launch guidelines
- Dissemination to health care workers
- Integrate risk-based post natal prophylaxis into existing service delivery points
- Support supply chain for end-end visibility from forecasting, procurement and distribution
- Update electronic tools to capture infant prophylaxis regimens based on risk category

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Thank you.

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Nigeria Case Study

Mercy Morka
Head of Strategic Information
NASCP, Nigeria

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Nigeria's VTP program

HIV prevalence in Nigeria of 1.4% in adults (aged 15 – 49 years) and 0.2% among children (0 – 14 years) (NAIIS 2018) may suggest a low VTR.

Women have higher HIV prevalence than men of the same age group, highest among females of age 20-24 years. About 1,200,000 women (15+) are living with HIV in Nigeria

Nigeria along with the global community is working towards the elimination of vertical transmission of HIV, Hepatis B and Syphilis by 2030.

Vertical transmission rate at 6 weeks of birth is 8.5% and final transmission at 18 months is 22% (2025 spectrum estimates)

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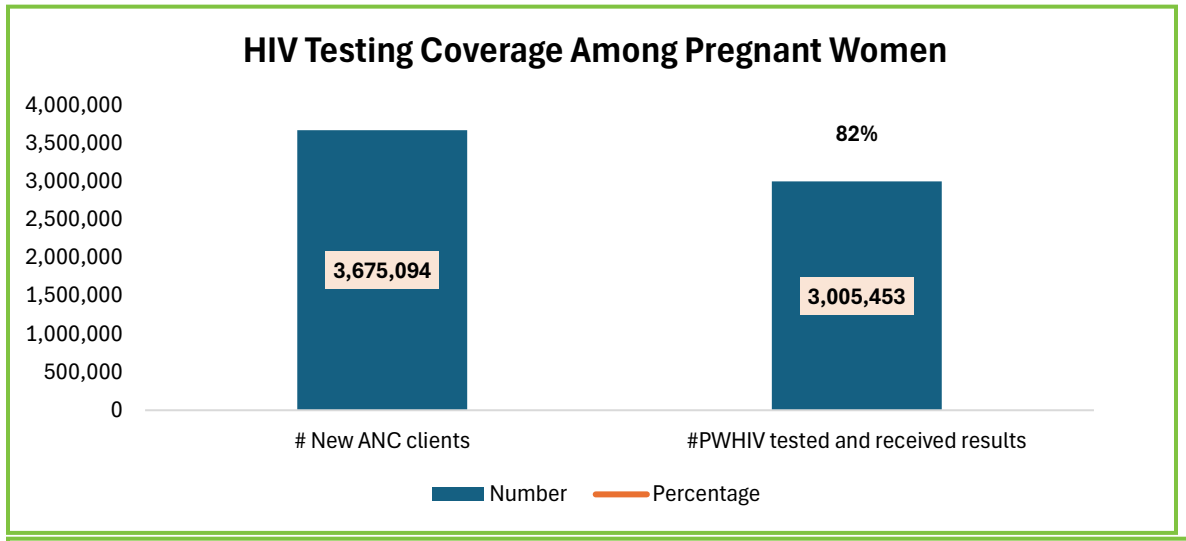
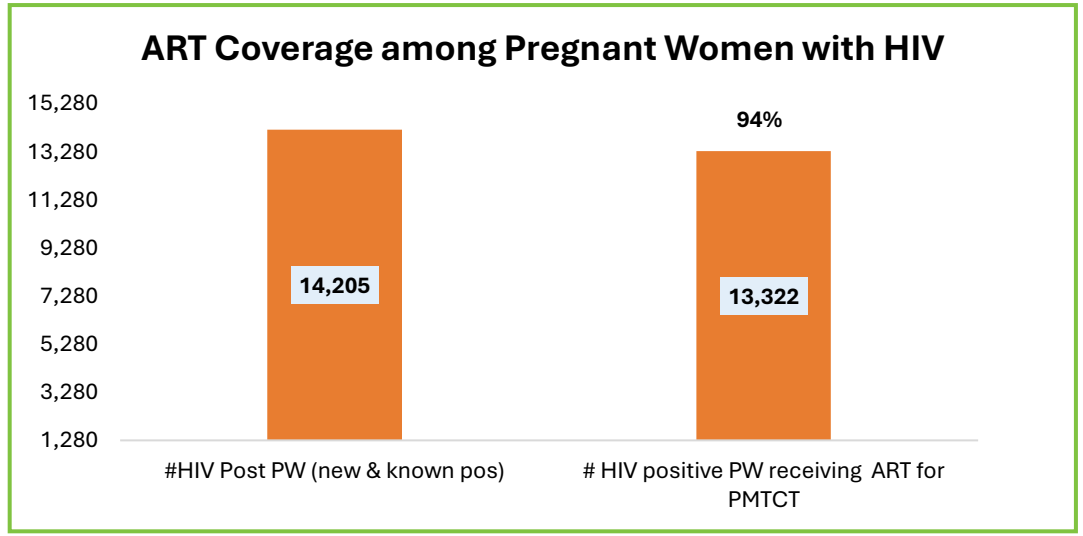
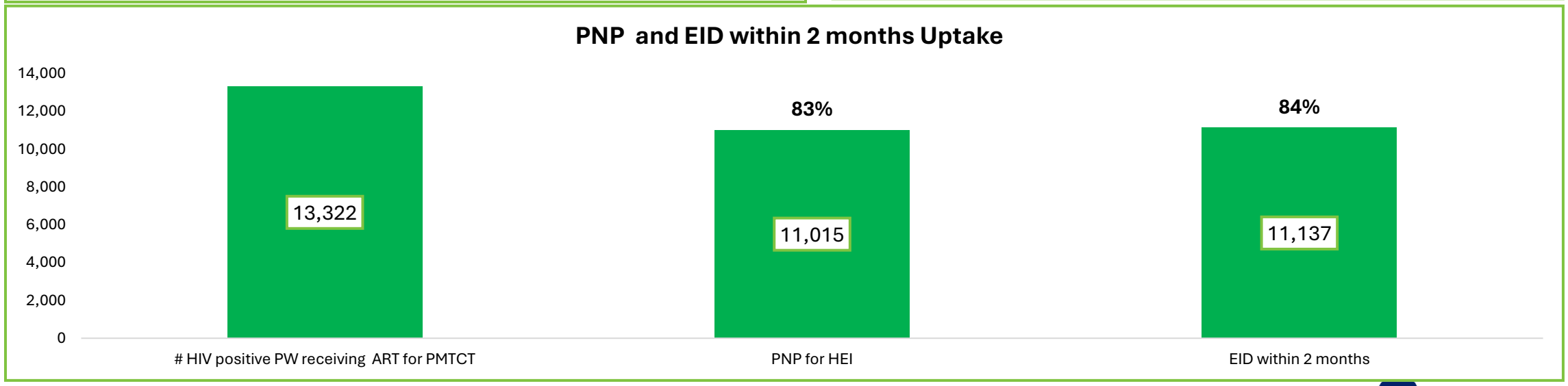
Country VTP performance (Jan-Jun 2025)







- **ANC Coverage at 73%**
- **# HIV-positive PW receiving ART for PMTCT was used as a proxy for the number of HIV-exposed infants born to HIV-infected women and served as the denominator.**

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Current infant prophylaxis guidance

- All infants perinatally exposed to HIV should receive ARV prophylaxis.
- Infant prophylaxis regime is based on risk classification either low risk or high risk.
- Antiretroviral prophylaxis should commence immediately but within 72 hours of birth.

Infants at low risk of HIV acquisition

- NVP only once daily for 6 weeks

Infants at high risk of HIV acquisition

- Dual prophylaxis with AZT (twice daily) and NVP (once daily) for the first 12 weeks of life, whether they are breastfed, or formula-fed.

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Perinatally exposed infant package of services

- Single or dual ARV prophylaxis to all infants based on risk classification.
- Routine immunization, growth monitoring and support
- Cotrimoxazole prophylaxis starting at 6 weeks.
- NAT at birth, DBS for DNA PCR at 6 to 8 weeks of age, 9 months (if symptomatic and negative on Antibody test), and 6 weeks after cessation of breastfeeding.
- HIV antibody testing for children older than 18 months. Conduct HIV antibody test at 9 months to determine HIV exposure where the maternal status is unknown.
- Ongoing infant feeding counselling and support.
- Screening and management of tuberculosis and other OIs
- Prevention and treatment of malaria
- Nutritional care and support
- Psychosocial care and support

HIV Impact Network for Vertical Transmission Elimination

Criteria for defining infants at high-risk of HIV acquisition in Nigeria

Born to women with established HIV infection who have **received less than four weeks of ART** at the time of delivery

Born to women with established HIV infection with **viral load >1000 copies/mL** in the four weeks before delivery;

Born to women with **incident HIV infection during pregnancy** (this includes women diagnosed in labour) or breastfeeding;

Identified for the first time during the postpartum period, with or without a negative HIV test prenatally.

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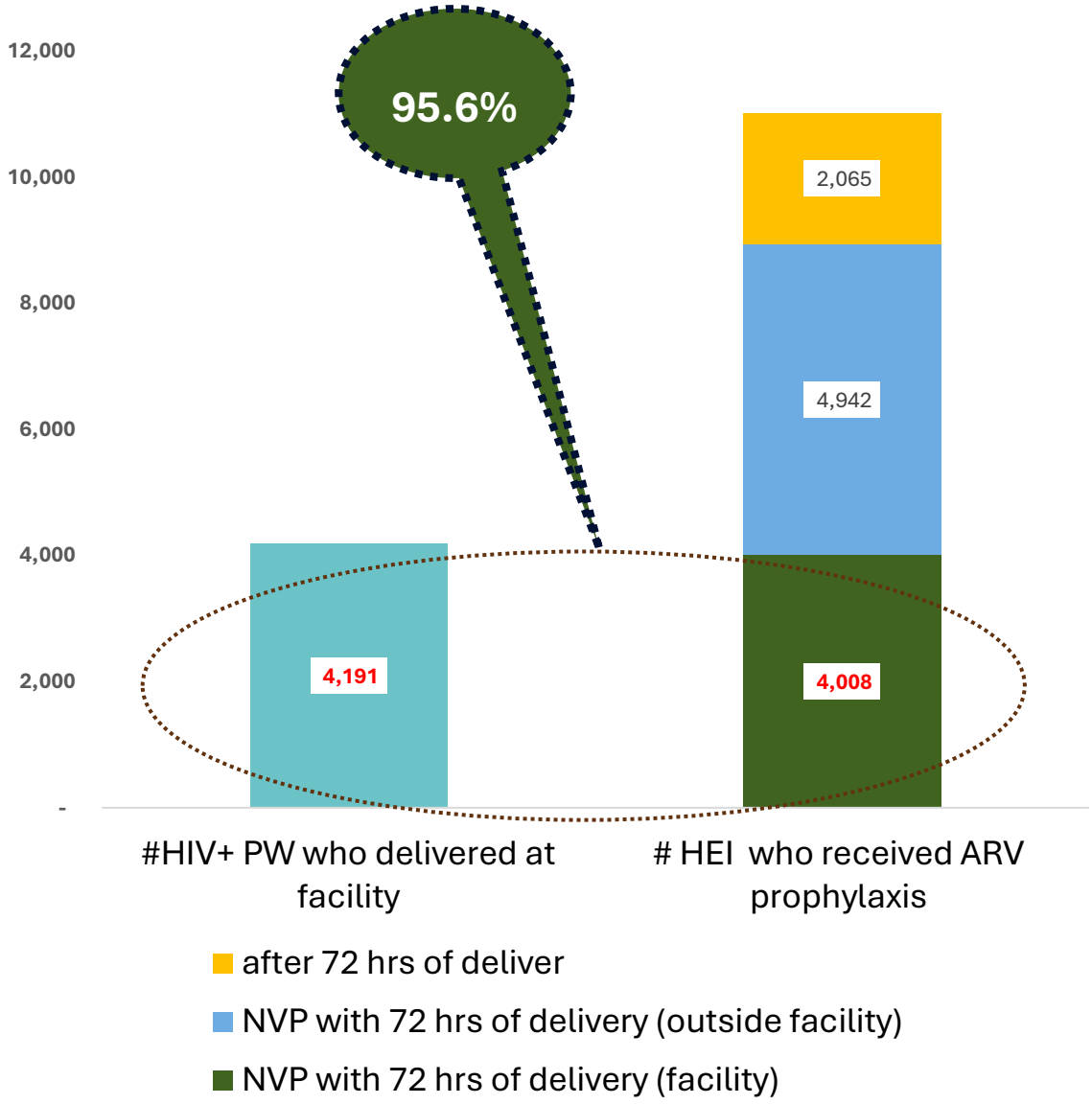
PNP performance overview Jan – June 2025



- Deliveries in VTP sites offering ARVs are the ones mainly captured
- For spoke sites not offering ARVs, infants are referred to comprehensive sites and are captured as "outside facility"
- Using # of deliveries by WHIV as a proxy for eligible, PNP coverage was 95.6% among infants delivered in the facility.
- 60% (**4,942) of infants who received** PNP were delivered outside PNP providing facilities.
- 25% (**2,065)** of infants received PNP after 72 hrs of delivery. Probably due to delivery outside VTP PNP facility

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PNP section in old VTP monthly summary form (MSF)

F	Labour and Delivery Summary (Source: Facility & PMTCT Delivery Registers)			
20	Total deliveries at facility (booked and unbooked pregnant women)			
21	Number of booked HIV positive pregnant women who delivered at facility			
22	Number of unbooked HIV positive pregnant women who delivered at the facility			
23	Number of live births by HIV positive women who delivered at the facility			
24	Number of infants delivered to Hepatitis B positive pregnant women at the facility			
25	Number of babies born to hepatitis B positive mothers who received immunoglobulin within 24 hrs of delivery			
26	Number of HIV exposed infants who received HBV monovalent vaccine within 24hrs of delivery at the facility			
G	Child Follow Up Summary (Source: Child Follow Up Register)			
		Site of Delivery		Total
		Facility	Outside Facility	
27	Number of HIV-exposed infants born to HIV positive women who received ARV prophylaxis within 72 hrs of delivery			
28	Number of HIV-exposed infants born to HIV positive women who received ARV prophylaxis after 72 hrs of delivery			
29	Number of infants born to HIV infected women started on CTX prophylaxis within two months of birth			
30	Number of Infants born to HIV positive women whose blood samples were taken for DNA PCR test within 72 hrs of birth			
31	Number of Infants born to HIV positive women whose blood samples were taken for DNA PCR test between >72 hrs - < 2 months of birth			
32	Number of Infants born to HIV positive women whose blood samples were taken for DNA PCR test between 2-12 months of birth			
		Positive	Negative	
33	Number of HIV PCR results received for babies whose samples were taken within 72 hrs of birth			
34	Number of HIV PCR results received for babies whose samples were taken between >72 hrs - < 2 months of birth			
35	Number of HIV PCR results received for babies whose samples were taken between 2-12 months of birth			
36	Number of HIV Exposed babies who tested for HIV within 18-24 months of birth by Rapid Test			

** Booked – These are women who registered for ANC in the PMTCT sites*

***Site of delivery: Outside facility – These are babies that were not delivered in facilities where PNP is given. They could have been delivered at spoke sites or community not offering PNP*

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PNP section in the newly revised VTP monthly summary form (MSF)

C	Labour and Delivery Summary (Source: NHMIS Delivery Register)				
			Booked	Unbooked	Total
10	Number of HIV positive pregnant women who delivered at facility	Livebirth			
		Stillbirth			

D	Child Follow Up Summary (Source: Child Follow Up Register)					
			<=72 Hrs	>72 Hrs		Total
11	Number of HIV-exposed infants (HEIs) who received ARV prophylaxis	Nevirapine				
		Nevirapine + Zidovudine				
		At birth <=72 hour	>72-<2 months	2-12months	>12 months	Total
12	Number of HIV-exposed infants (HEIs) whose blood samples were taken for first DNA PCR test					
13	Number of first HIV PCR test results received for HIV-exposed infants	Positive				
		Negative				
14	Number of children exposed to HIV aged 24 months within this reporting period who have documented final outcome status	Positive	Negative	Unknown		Total

This new reporting systems allows for reporting at both the facility and community. NDARS (National data reporting system) will be provide this disagregate. Previous reporting system collects data only from the health facility

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PNP Implementation Challenges

- PNP not provided across all the current sites providing HIV testing for pregnant women (34,000)
- Possible double counting of HEI who were provided PNP at both PMTCT comprehensive sites as well as in the spoke sites by referrals
- Tools not able to report risk stratification but partially resolved in the new tool

Mitigation Strategies

- Mother baby pair tracking system planned to be deployed will help to reduce double counting of PNP data
- Use of the new reporting tool which disaggregates PNP by risk stratification and ARV regimen
- Use of client unique identifiers to reduce double counting

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Thank you.

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Q&A/Discussion

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Moderators

HIV Impact Network for Vertical Transmission Elimination

Closing Remarks

Franklin Emerenini
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ICAP in Nigeria

HIV Impact Network for Vertical Transmission Elimination

Slides & recordings from this session will be available on the HIV Vertical Transmission Elimination Network (HIVE) website

hiveimpactnetwork.com

The next HIVE webinar will take place in October…Dates TBA!

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Thank you.

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