Universal Screening and Testing in Pregnancy

- When screening pregnant patients for HIV, clinicians should use a U.S. Food and Drug Administration–approved 4th-generation antigen/antibody combination immunoassay. (A2)
- Clinicians should refer patients who test positive for HIV to an experienced HIV care provider who can manage antiretroviral therapy (ART) initiation (ideally within 3 days). (A3)
- For patients who test negative for HIV early in pregnancy, clinicians should perform repeat testing in the third trimester. (A2)

PrEP to Prevent HIV

- If a patient requests pre-exposure prophylaxis (PrEP) or reports engaging in behaviors that confer risk of HIV acquisition, clinicians should assess PrEP candidacy or refer the patient for assessment. (A1) PrEP is not contraindicated during pregnancy or while breastfeeding an infant. (A2)

Testing for Acute HIV

- Clinicians should maintain a high level of suspicion for acute HIV in all pregnant patients who present with a compatible clinical syndrome. (A3)
- When a patient presents with symptoms suggestive of acute HIV infection, the clinician should perform an HIV test immediately, even if a previous HIV screening test result during the current pregnancy was nonreactive. (A2)
- When screening for acute HIV, clinicians should obtain plasma HIV RNA testing in conjunction with HIV serologic testing, preferably with a 4th-generation HIV antigen/antibody combination immunoassay, the plasma HIV RNA test should be performed even if the HIV serologic screening test result is nonreactive or indeterminate. (A2)
- If a patient’s plasma HIV RNA test result indicates a viral load >5,000 copies/mL, the clinician should make a presumptive diagnosis of acute HIV, even if the results of screening and antibody differentiation tests are nonreactive or indeterminate. (A2)
**NEW YORK STATE PUBLIC HEALTH LAW**

**Universal HIV Screening**
- Clinicians in prenatal care settings must provide HIV-related information and recommend HIV testing for all pregnant patients, including those who present in labor if their HIV status is not documented.
  - Immediately arrange an expedited HIV test, with consent, for patients in labor when no HIV test result is documented for the current pregnancy, with results available as soon as possible.

**HIV Testing**
- Any patient who does not have a documented HIV test result during the current pregnancy and who is not known to have HIV must, with their consent, receive expedited HIV testing during labor; results must be available within 12 hours of consent and preferably within 60 minutes. All birth facilities must have the capacity to provide and perform expedited HIV testing.
  - Facilities should use a U.S. Food and Drug Administration–approved HIV screening test, with results available preferably within 1 hour and no longer than 12 hours; the most sensitive screening test available should be used to allow for detection of early or acute HIV.
  - Ensure that expedited HIV test results are available prior to delivery to allow maximum benefits of intrapartum antiretroviral prophylaxis for the fetus.
  - Supplemental diagnostic testing must be obtained for all preliminary positive HIV test results in pregnant patients.
  - If a patient who presents in labor declines an HIV test, the infant is required to have an expedited HIV antibody screen at birth, with or without consent, with results available as soon as possible but no later than 12 hours after birth.
  - If the infant HIV test is reactive for HIV antibodies, a plasma sample should be collected from the infant for HIV-1 nucleic acid testing. (See New York Codes, Rules and Regulations [NYCRR] Title 10, Section 69–1.3.)
  - The DOH–4068 Maternal–Pediatric HIV Prevention and Care Program Test History and Assessment form must be completed for every pregnant individual presenting for delivery.

**Antiretroviral Prophylaxis**
- The hospital shall determine the need for, and ensure provision of, HIV prophylaxis and/or treatment per standard of care to prevent transmission to the infant, and shall record such in both the birth parent’s and newborn’s health records. (See New York Codes, Rules and Regulations [NYCRR] Title 10, Section 405–21.)

**Partner Notification**
- Clinicians must discuss partner notification with patients who have been recently diagnosed with HIV, and the discussion must be documented in the medical record and on the Medical Provider Reporting Form (DOH–4189), as required by Public Health Law, Article 21, Title III, Section 2730.

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**NEW YORK STATE LAW**

- Clinicians in prenatal care settings must provide HIV-related information and recommend HIV testing for all pregnant patients, including those who present in labor and do not have documented HIV status.
  - Immediately arrange an expedited HIV test, with consent, for patients in labor when no HIV test result is documented for the current pregnancy, with results available as soon as possible.
  - If a patient who presents in labor declines an HIV test, the infant is required to have an expedited HIV antibody screen at birth, with or without consent, with results available as soon as possible but no later than 12 hours after birth.
  - If the infant’s HIV test is reactive for HIV antibodies, a plasma sample should be collected from the infant for HIV-1 nucleic acid testing. (See New York Codes, Rules and Regulations [NYCRR] Title 10, Section 69–1.3.)
  - The hospital shall determine the need for, and ensure provision of, HIV prophylaxis and/or treatment per standard of care to prevent transmission to the infant, and shall record such in both the birth parent’s and newborn’s health records. (See New York Codes, Rules and Regulations [NYCRR] Title 10, Section 405–21.)

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**Checklist for HIV Testing and Management for Patients Who Present in Labor and Their Newborns**


- **Repeat HIV Testing**
  - Offer and recommend repeat HIV testing for patients in labor who do not have documented third-trimester HIV test results, who have engaged in or whose partners have engaged in behaviors that confer risk for HIV, or who have acquired a sexually transmitted infection during the current pregnancy.

- **Provide Counseling and Education About Antiretroviral (ARV) Prophylaxis**
  - Counsel regarding the use of ARV prophylaxis in the birth parent and the infant.
  - Provide education about the benefits of ARV prophylaxis for any patient with HIV who declines it for themselves or their newborn.

- **Manage a Reactive HIV Screening Test Result**
  - Obtain HIV diagnostic testing according to the CDC Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens.
  - Initiate maternal HIV prophylaxis; immediate initiation is recommended.
  - Administer newborn prophylaxis as soon as possible after birth. See DHHS Management of Infants Born to Women with HIV Infection.
  - Discuss the meaning of a preliminary positive HIV test result.
  - Do not delay prophylaxis while awaiting results of confirmatory serologic testing.
  - Inform the birth parent that HIV can be transmitted through breast milk and that breastfeeding is not recommended until they are confirmed to be HIV negative.

- **Manage a Confirmed HIV Diagnosis in the Parent**
  - If a supplemental HIV test confirms an HIV diagnosis in the parent, ensure an HIV diagnostic test of the infant is obtained within 48 hours of birth. Send the infant’s specimen to the Pediatric HIV Testing Service at the Wadsworth Center for nucleic acid testing to detect HIV-1 RNA or DNA.
  - Make arrangements for the parent with newly diagnosed HIV to see an experienced HIV care provider and, if indicated, provide referrals for case management and support services as well.
  - Ensure that the HIV-exposed infant is discharged from care with ARV medications, not just a prescription.
  - Make arrangements for the infant’s medical follow-up with an experienced pediatric HIV care provider.

- **Resources**
  - Wadsworth Center Order Desk to Obtain a Pediatric HIV Test Kit: 518–474–4175
  - Clinical Education Initiative (CEI) Line: 866–637–2342
  - NYSDOH AI Clinical Guidelines Program: www.hivguidelines.org