centesis, fetal scalp blood sampling or rupturing the membranes. Doctors also can advise the woman not to breastfeed her baby, because breastfeeding also can transmit the virus to the baby.

What are the symptoms of HIV/AIDS in babies?

HIV-infected babies do not show signs of HIV infection at birth, but about 15 percent develop serious symptoms or die in the first year of life. Nearly half die by age 10. However, new HIV-fighting drugs are improving the outlook for infected children; many are free of serious symptoms much of the time.

Babies of HIV-positive women should be tested for the virus within 48 hours of birth. These early tests, which detect the virus itself, instead of antibodies, can detect about 40 percent of infected newborns. Testing is generally repeated, allowing identification of most infected babies by one month, and virtually all by six months. (The HIV screening test, which tests for antibodies to the virus, is not reliable for an infant born to an infected mother. This is because the mother's antibodies may be present in her baby's blood for up to 18 months, even if the baby has not been infected.) Therefore, it is imperative that every infected woman discuss with her doctor what would be the most appropriate test and how often it should be done.

The CDC recommends that all infants diagnosed with HIV be treated with a combination of HIV-fighting drugs. Studies show that combination therapy slows the progress of the disease and improves survival in infected babies and children, as it does in adults. A recent study found that combination treatment, including protease inhibitors, reduced the risk of death by 67 percent in infected children and adolescents.

Most adults with AIDS suffer from "opportunistic" infections, which rarely occur in people whose immune systems are not weakened. A child with HIV/AIDS, however, is at special risk of serious illness from common bacteria. Early diagnosis of HIV infection and frequent follow-up can help prevent or reduce the severity of some infections.

One opportunistic infection common in both babies and adults with AIDS is Pneumocystis carinii pneumonia. Often this is the first AIDS-related illness to appear in infected infants, and it is a major cause of death in the first year of life. The CDC recommends that a baby born to an HIV-positive mother — even if the baby has not yet been diagnosed with HIV or AIDS — be treated, beginning at four to six weeks of age, with drugs that help prevent pneumonia. (Medication is stopped if tests show the baby is not HIV-positive.)

Babies with HIV infection should receive all routine childhood immunizations, plus some additional ones. The chickenpox vaccine, however, is not recommended. Babies with HIV/AIDS should be vaccinated yearly against influenza, starting at seven months of age, and should receive the conjugated pneumococcal vaccine in the first year.

Where are HIV/AIDS counseling and testing available?

Your doctor may offer counseling and testing for HIV/AIDS or make a referral to a local testing site. The local AIDS Secretariat and public health nurses are a wealth of information. The AIDS Secretariat numbers are 462-5975 or 460-6209 and they are open from 8:00 am to 4:30 pm. They are located in the Ramco building on Independence Drive.

What steps can a pregnant woman take to remain uninfected?

Women should avoid all possible sources of infection before and throughout pregnancy, including sexual contact with someone who is infected, and contact with needles, razors or other items possibly contaminated with the blood of an infected person. If there is any question about a partner's HIV status, proper use of condoms helps protect against HIV and other sexually transmitted diseases.

HIV in Pregnancy

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HIV and AIDS in Pregnancy

AIDS stands for acquired immune deficiency syndrome. The cause of AIDS is the human immunodeficiency virus (HIV). HIV can be transmitted through sexual intercourse or exposure to infected blood or blood products. An infected woman can pass the virus to her baby during pregnancy, delivery or breastfeeding.

In 1994, it was shown that drug treatment during pregnancy greatly reduces the risk that an HIV-infected mother will pass the virus to her baby. Since then, the number of babies who contract the virus from their mothers has dropped dramatically. In the USA between 1992 and 1999, the number of children reported to the Centers for Disease Control and Prevention (CDC) with HIV infection contracted from their mothers declined 83 percent. In 2002, the CDC recommended that all pregnant women be offered voluntary testing for HIV as a routine part of prenatal care. This is the current standard of care which exists here in Antigua & Barbuda.

New treatments available in the United States and in other developed countries can now reduce to 2 percent or less the risk of a treated mother passing HIV to her baby. However, about 600,000 babies worldwide contract HIV each year, 90 percent of which occur in developing countries where new treatments are not generally available.

How are most women infected?

The most common way women become infected is through unprotected (without a condom) heterosexual intercourse with infected partners. Women are more than twice as likely as men to become infected via heterosexual sex. Approximately 33% of women who developed AIDS in 2000 were infected through heterosexual intercourse; another 25 percent by injection drug use (sharing drug needles); and 1 percent by receipt of blood transfusion, blood components or tissue. The fact that 36% reported no known risk factors emphasizes the importance of routine testing during pregnancy.

Who should be tested for HIV?

Ideally, all women should be aware of their HIV status before conception. Women not tested prior to pregnancy should be offered counseling and voluntary testing during pregnancy.

Routine voluntary testing of all pregnant women is important because more than half of all HIV-infected women would go undiagnosed if only those women acknowledging high-risk behaviors were screened. Women who have not been screened during pregnancy can be screened during labor and delivery with rapid tests that produce results in one hour or less, allowing treatment, when necessary, to protect the baby.

How should women with HIV/AIDS be treated during pregnancy?

People with HIV/AIDS are generally treated with combinations of HIV fighting drugs. These drug combinations often slow the spread of HIV in the body, keep blood levels of the virus low (or even undetectable) and help prevent AIDS-related infections. An HIV-infected pregnant woman should receive treatment with these drugs just as if she were not pregnant.

If a woman learns she has HIV in her first trimester and she has not yet been treated with any HIV-fighting drugs, she should be evaluated and treated. An HIV-infected woman who becomes pregnant and is already taking these drugs generally should continue to take them throughout pregnancy. It is not yet known whether some of these drugs may pose a risk to the unborn baby, but to date the risk appears very low.

What treatment helps prevent HIV/AIDS in babies of HIV-infected mothers?

It recommended that HIV-infected pregnant women be offered combination treatment with HIV-fighting drugs to help protect their health and to help prevent passing the infection to their babies. Infected pregnant women should take the drug zidovudine (ZDV) as part of their drug regimen as early as 14 weeks of pregnancy, and continuing throughout pregnancy and labor and delivery. ZDV is the only drug proven to help prevent infection in the baby. (The baby also should be treated with ZDV for the first six weeks of life.) Women who do not yet need combination treatment for their own health may choose to be treated with ZDV alone. However, studies suggest that newer HIV-fighting drugs (such as protease inhibitors) may reduce the risk to the baby more than ZDV alone because they greatly reduce the levels of the virus in the mother's blood. Zidovudine when given to an HIV-positive pregnant woman and to her baby at birth decreased by two thirds the risk of passing the infection on to her baby. Eight percent of babies of women treated with ZDV became infected, compared with 25 percent of babies of untreated women.

Women who have not received any drug treatment prior to labor should be treated during labor with one of several drug regimens. These may include a combination of ZDV and another drug called 3TC, or nevirapine. Studies suggest that even these short durations of treatment may help reduce the risk to the baby.

Studies also show that some HIV-infected women can cut in half the risk of transmitting the virus to their babies by having a cesarean delivery before labor begins and their membranes have ruptured. Please consult your doctor for more information. The American College of Obstetricians and Gynecologists recommends that HIV infected women be offered a cesarean delivery at 38 weeks to further reduce the risk to their babies, unless they have very low or undetectable amounts of the virus in their blood.

Doctors can recommend other precautions to help protect the baby. A doctor who knows that a woman is HIV positive can avoid using procedures that could increase the exposure of the baby to the mother's blood during pregnancy or labor, such as amnio-