Adherence support

Peer mentoring, SMS medication reminders, motivational therapy and addressing tablet phobias through psychological techniques are all useful adjuncts to supporting adherence. On an individual basis, it may be appropriate to explore options for directly observed therapy, which may be virtual, through community nurses or support workers, or even as an inpatient, particularly with failure to achieve virological suppression approaching 36 weeks and where social circumstances are a significant barrier to adherence.

Preterm labour

If treatment failure occurs when the infant is likely to be delivered moderately or severely premature (<34 weeks) and may be unable to take medication enterally, intensification should consist of therapies that readily cross the placenta such as double-dose tenofovir DX, dolutegravir and single-dose nevirapine, as recommended in Section 8.7.2 (see Appendix 3 for table of antiretroviral agents that cross the placenta). See Section 10 for guidance on mode and timing of delivery and additional considerations.

If a woman/person is established on/optimised to a tenofovir AF-containing regimen and has a detectable viral load at delivery at term or preterm, we recommend a double dose of tenofovir DX (i.e. 2x 245 mg tenofovir DX) in addition to their regular tenofovir AF. The rationale for this recommendation is that placental transfer of tenofovir AF is low and 2x 245 mg tenofovir DX ensures transplacental transfer of ART to preload the unborn infant; the risk of maternal adverse effects of the immediate dose of tenofovir DX is low.

8.7.4 Managing ART in the context of nausea and vomiting of pregnancy and hyperemesis gravidarum

Nausea and vomiting of pregnancy is diagnosed when symptom onset is in the first trimester and other causes of nausea and vomiting have been excluded. Hyperemesis gravidarum may be diagnosed when there is protracted nausea and vomiting with the triad of more than 5% pre-pregnancy weight loss, dehydration and electrolyte imbalance. Nausea and vomiting of pregnancy may impact the ability of pregnant women/people to take and absorb antiretroviral agents, leading to variable antiretroviral drug exposure posing a risk of treatment failure and/or development of drug resistance. Clinical management of nausea and vomiting should therefore be proactive and guided by the relevant RCOG guidelines, and should include assessment of severity, prescription of anti-emetics, MDT discussion and inpatient care if required [103].

Consideration should be given to ensuring that women/people experiencing nausea and vomiting of pregnancy are on a regimen with a high-genetic barrier to resistance. If there are prolonged periods of no or very intermittent ART exposure and thus a risk of treatment failure and/or development of drug resistance, the writing group recommends that treatment is interrupted for the minimum time required to overcome the issue and that additional viral load and resistance testing is performed. However, there are no data that specifically address this in pregnancy. In cases of severe and prolonged nausea and vomiting of pregnancy, long-acting injectable therapy could be considered in consultation with an MDT with experience in managing perinatal HIV if the risks are thought to outweigh the benefits.