Perinatal HIV/AIDS Surveillance

Exposed Peds (once HIV exposed peds are reportable)

1. Surveillance staff should attempt to have established relationships with all known caregivers of HIV+ expecting mothers (OB, TOPWA, etc.)
    a. *Ideally*, once an HIV+ mother is identified (tested positive prior to or during pregnancy), the provider should notify local surveillance staff of an expected delivery (good practice but not required). Even though the mother may not be a newly reported HIV+ case, this practice is more of a "heads" up to surveillance staff to be aware of a possible HIV exposed case, should the pregnancy go to term. This is a key activity practiced by other states that have exposed reporting. This process, if followed by the provider, allows for more complete and timely reporting of the exposed case, once born.
    b. As it becomes available, the surveillance staff should document (and place in a tickler file) the following, in preparation of the completion of the case report after delivery:
        i. Mother's demographic and risk information
        ii. Place of prenatal care
        iii. The week of the pregnancy that prenatal care began
        iv. All meds the mother was prescribed
        v. The expected due date
        vi. The hospital where the delivery is expected to occur.
    c. The surveillance staff should file this information in a tickler file under the month of the expected delivery. This serves as a tool to use for validation of reporting by the OB/provider where the baby was born.
    d. If after one month from a scheduled birth, there is still a case pending in the tickler file, the surveillance staff should follow-up with the prenatal care provider to ascertain the status of the expecting mother.
        i. If the pregnancy was terminated for any reason, all information on the case should be shredded.
        ii. If the birth occurred and wasn't reported, the hospital of birth should be contacted to determine why the birth was not reported. Systems of reporting perinatal HIV exposed births by that facility should be re-examined.
        iii. Complete the case report on the birth.
2. By law, the OB/provider should contact the local surveillance office to report a neonate born to an HIV infected women by the next business day.
3. The surveillance staff should follow-up with the hospital/provider to complete the case report with the above information**,** and to document all other available information from the medical records and birth certificate at the hospital or medical facility.
4. The completed case report should be submitted to Tallahassee for reporting of the perinatally HIV exposed pediatric case (diagstat='3').
5. **An EPF will NOT need to be completed unless the child is identified as infected at a later date.**

Seroreverter Peds (babies < 18 months of age)
(Once HIV exposed peds are reportable)

According to CDC, as published in the MMWR, a child (under 18 months of age) is considered a "seroreverter" (not infected)**,** if the following criteria are met:

1. At least two negative ***antibody*** tests obtained from ***separate*** specimens at greater than **6 (six)** months of age. OR
2.
    a. Two negative ***HIV virologic tests*** (undetectable viral load tests) obtained from ***separate*** specimens where the first one was **at least 1 month of age** and the second was greater than or equal to **4 (four)** months of age. AND
    b. There are NO other laboratory or clinical evidence of HIV infection. **OR**

3. A child who does **NOT** meet the above criteria for definitive "not infected" status but who has:
    a. One negative EIA HIV antibody test performed at greater than or equal to **6 (six) months** of age and **NO** positive HIV virologic tests, if performed **OR**
    b. One negative HIV virologic test* performed at greater than or equal to **4 months** of age and **NO** positive HIV virologic tests, if performed **OR**
    c. One positive HIV virologic test with at least **two subsequent negative virologic tests,** at least one of which is at **greater than or equal to 4 months of age**; or negative HIV antibody test results, at least one of which is at **greater than or equal to 6 months of age** **AND**
    NO other laboratory or clinical evidence of HIV infection (i.e., has not had any positive virologic tests, if performed, and has not had an AIDS-defining condition). ***OR***

4. ***Clinical or Other Criteria (if the above definitive or presumptive laboratory criteria are NOT met)*** and the case has been determined by a physician to be "not infected", and a physician has noted the results of the preceding HIV diagnostic tests in the medical record **AND** **NO** other laboratory or clinical evidence of HIV infection (i.e., has not had any positive virologic tests, if performed, and has not had an AIDS-defining condition).

If any of the above criteria are met, a case report should be completed to report the seroreverter (diagstat= '6') case, regardless if the case had previously been reported.

An EPF will NOT need to be completed.

HIV Positive Peds (babies < 18 months of age)

In a child aged less than 18 months, a reportable case of HIV infection (positive HIV case) must meet at least one of the following criteria:

Laboratory Criteria: Definitive

Positive results on **two** *separate* specimens (excluding cord blood) using one or more of the following HIV virologic (non-antibody) tests:

- HIV nucleic acid (DNA or RNA) detection
- HIV p24 antigen test, including neutralization assay, in a child greater than or equal to 1 month of age
- HIV isolation (viral culture) **OR**

Laboratory Criteria: Presumptive

A child who does not meet the criteria for definitive HIV infection but who has:

Positive results on only one specimen (excluding cord blood) using the above HIV virologic tests and no subsequent negative HIV virologic or negative HIV antibody tests

OR Clinical or Other Criteria (if the above definitive or presumptive laboratory criteria are not met)

- Diagnosis of HIV infection, based on the laboratory criteria above, that is documented in a medical record by a physician, or
- Conditions that meet criteria included in the 1987 pediatric surveillance case definition for AIDS (17,19)

If any of the above criteria are met, a case report should be completed to report the HIV infected perinatal case (diagstat= '4'), regardless if the case had previously been reported, AND an EPF will also need to be completed and submitted to SHO.

Follow-up for all unresolved perinatally exposed peds greater than 5 months of age.

Follow-up is necessary on ***ALL*** reported exposed peds that are unresolved after five months of age. A program will be written and disseminated to all HARS users (or generated by SHO) for all non-HARS users. This program should be run monthly and any exposed pediatric case with an undetermined status should be follow-up as directed by SHO. (The TAG for this follow-up has yet to be developed.)

Keep in mind that negative viral loads under 18 years of age are reportable. -However, negative WB ARE **NOT REPORTABLE**. Therefore, it may be necessary to contact the provider to determine if there are any documented HIV negative Western Blot tests on file, especially if the child is greater than 6 months of age.

HIV Positive Peds (babies >=18 months of age)

In a child aged 18 months or older, a reportable case of HIV infection (positive HIV case) must meet the same criteria as for an adult HIV positive case.

If any of the above criteria ***are*** met, a pediatric case report should be completed to report the HIV infected perinatal case (diagstat= '4'), regardless if the case had previously been reported.

An EPF will also need to be completed and submitted to SHO, *if* the year of birth is since 2000.

HIV Positive Peds (Children greater than 12 years of age)

If a child is 13 years of age or more (technically an adult), and determined to have a pediatric risk, perinatal or not, then the case needs to be reported on a pediatric case report form. This form will allow the reporter to correctly document the pediatric risk, including birth information and mom's information, especially if this case has a perinatal risk.

It is crucial to assess the year of ***first*** diagnosis. If the exact year of diagnosis is not noted, but the age of diagnosis is noted, you need to back-calculate from the year of birth to calculate the year of diagnosis. *If a copy of the lab of first diagnosis is not available, the first year of diagnosis should be documented on the case report under physician's year of diagnosis. The month of diagnosis (if not known) should be indicated as '99'.*

If the case is known to be perinatal, any other adult risks that occurred later in life (sex with male or sex with female, etc.) should be documented ONLY in comments.

Sex with male or female should ***ONLY*** be documented if the risk is a "suspected" risk of HIV, and the case was known **NOT** to be perinatal. Any such case is considered to be a **HIGH PRIORITY** case requiring additional follow-up. The statewide NIR coordinator should be notified of the case by the surveillance staff at the time of report.

The case will remain a pediatric case in HARS, until there is a documented AIDS diagnosis.