Michigan Department of Health and Human Services (MDHHS)
Perinatal Human Immunodeficiency Virus (HIV), Hepatitis B and Syphilis Testing and Reporting Guidelines
For Prenatal Care (PNC), Labor and Delivery (L&D), and Emergency Department (ED) Medical Providers

Physicians and other health care professionals providing medical treatment to pregnant women are required, at the time of initial prenatal screening and examination, and during the third trimester and at delivery in absence of previous testing results to test for HIV, Hepatitis B and Syphilis, unless the woman refuses to be tested or the provider deems the tests are medically inadvisable. (Per section 333.5123 of Michigan’s Public Health Code, Act No. 368 of the Public Acts of 1978. Amended 12/2018).

Health care facilities should have written policies and procedures, as well as standing orders in place to ensure that HIV, Hepatitis B and Syphilis testing are components of a health care facility’s clinical pathways.

A separate consent form for an HIV test is not required. A test subject or his or her authorized representative who provides general informed consent for medical care is considered to have consented to an HIV test. Medical providers must document any declination of testing in the patient’s medical record (per section 333.5133 of Michigan’s Public Health Code, Act No. 368 of the Public Acts of 1978. Amended 2018).

A physician who orders a test or a health facility that performs a test shall provide accurate testing information to the test subject both before and after the test is administered.

### PRENATAL, L&D, ED TESTING

<table>
<thead>
<tr>
<th>PREGNANCY STAGE</th>
<th>HIV</th>
<th>HEPATITIS B</th>
<th>SYPHILIS</th>
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</thead>
<tbody>
<tr>
<td><strong>All women in first trimester of pregnancy</strong></td>
<td>Women should be tested for Hepatitis B surface antigen (HBsAg), HIV (4th generation Ag/Ab assay) and Syphilis (treponemal and nontreponemal tests), as soon as possible in the first trimester of pregnancy, as part of routine prenatal care. (e.g., upon diagnosis of pregnancy at any healthcare facility; at the initial prenatal visit).</td>
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<td>All positive screening tests must be confirmed.</td>
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<td>Consult an infectious disease specialist, or experienced perinatal provider, promptly upon confirmation of a positive test result.</td>
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<td><strong>All women in third trimester of pregnancy</strong></td>
<td>Test in the third trimester, and per MDHHS recommendations between 28-32 weeks, regardless of perceived risk and/or previous negative test result. MDHHS recommends that testing is performed as early in the third trimester (28 weeks) as possible to allow for adequate treatment and best outcomes for the infant.</td>
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<td>Consult a pediatric infectious disease specialist upon confirmation of HIV infection in a pregnant woman so that a care plan for the infant can be developed prior to the onset of labor.</td>
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### Women who are at risk for high infection

For example, women who:
- have a sexually transmitted disease (STD) during pregnancy
- inject drugs
- have a sex partner who injects drugs
- have a partner who has sexual contact with a man
- exchange sex for money or drugs
- have an HIV-infected partner
- have an HBsAg-positive household member or sex partner
- have a new partner, or more than one sex partner, during the pregnancy

|  | Test at any time and as often as necessary regardless of previous negative test results. Test upon admission for delivery regardless of previous negative test results. |  |  |
|  | Test women who have signs or symptoms consistent with acute HIV infection using a plasma RNA test in conjunction with an HIV antibody test. |  |  |
|  | Consult an infectious disease specialist, or experienced perinatal provider, promptly upon confirmation of a positive test result. |  |  |
|  | Consult a pediatric infectious disease specialist upon confirmation of HIV infection in a pregnant woman so that a care plan for the infant can be developed prior to the onset of labor. |  |  |

### Women who present to L&D or ED with no available, documented test results or prenatal care

For example, women who:
- have no record of HBsAg testing
- have no record of 3rd trimester HIV or Syphilis test result
- have no prenatal care
- present in the immediate postpartum period (24 hours)

|  | Test STAT with rapid or expedited point of care testing. |  |  |
|  | Every woman’s medical record should include documentation of testing or declination of testing and reason for refusal. |  |  |
|  | All positive screening tests should be reviewed and confirmed promptly with an infectious disease specialist or HIV experienced perinatal provider. |  |  |
|  | A pediatric infectious disease specialist should be notified about the pregnant woman’s treatment history and viral load so that a care plan can be initiated prior to delivery. |  |  |
|  | All positive screening tests must be confirmed. |  |  |
|  | Hospitals must have procedures in place to report the confirmatory test results and HIV infection status to all women they test. |  |  |
A pediatric infectious disease specialist and the MDHHS Congenital Syphilis/Perinatal HIV Coordinator should be notified about any suspected HIV, Syphilis, or HBV infection in a pregnant woman so that a care plan for the infant can be developed prior to delivery. No mother should leave the hospital unless the maternal serologic status has been documented.

**Maternal Treatment**

Prenatal Care Providers: An appropriate antiretroviral treatment plan should be initiated promptly upon consultation with an infectious disease specialist or HIV experienced perinatal provider.

L&D and ED: Hospitals must have mechanisms in place to provide immediate initiation of appropriate antiretroviral prophylaxis - antepartum, intrapartum and/or at the onset of delivery - on the basis of any reactive rapid or expedited HIV test result, without awaiting results of a confirmatory test. Additionally, women who test positive for HIV should receive education on HIV transmission and be advised not to breastfeed.

Women who are HBsAg-negative but are at high risk of acquiring HBV should be offered the Hepatitis B (hepB) vaccine series.

Women who are HBsAg positive, need to be referred to an infectious disease specialist for follow-up and care.

Women who test positive for Syphilis should receive penicillin G in accordance with current CDC STD Treatment Guidelines.

**Infant Treatment**

Rapid HIV testing is recommended for all infants whose biological mothers have not been tested. Inform the person legally authorized to provide consent for the infant, that rapid HIV testing is recommended for infants whose HIV exposure is unknown.

HIV exposed infants should be started on single or multidrug antiretroviral prophylaxis as soon as possible after birth. Preferably within 6-12 hours of delivery.

Postnatal infant prophylaxis is recommended, with 6 weeks of antiretroviral medication(s).

Hospitals must have mechanisms in place to: (1) provide ZDV/AZT, as well as nevirapine if indicated, in syrup form to HIV-exposed infants in-house (2) ensure that antiretroviral medications in syrup form are available to the infant after discharge.

All infants should receive hepB vaccine within 24 hours of birth.

Infants born to HBsAg-positive women should receive hepB vaccine and Hepatitis B immune globulin (HBIG) within 12 hours of birth, followed by 2-3 more doses of hepB vaccine and post-vaccination serology 3-6 months after series completion.

No infant should leave the hospital unless the maternal serologic status has been documented.

Infants exposed to Syphilis should be evaluated (including a nontreponemal test), as they may need treatment with penicillin G, according to current CDC STD Treatment Guidelines, immediately after birth.

**Documentation**

Refusal to test, refusal to accept treatment, and a description of any required perinatal tests that were not performed for any reason, must be documented in the woman’s medical record.

All test results and treatment should be recorded in both the mother’s and the baby’s medical records, along with the date of testing, result, or refusal.

**Reporting**

Women who test positive for HIV, Hepatitis B and/or Syphilis must be reported within 24 hours, of diagnosis or discovery, to the local health department in the county of which the patient resides. (Per section 333.5111 of Michigan’s Public Health Code, Act No. 368 of the Public Acts of 1978, as amended)

Consultation concerning implementation of these guidelines can be obtained from:

- Michigan HIV Consultation Program at Henry Ford Health System – Urgent questions call: 313-575-0332
  Non-urgent questions visit: [https://www.henryford.com/hcp/academic/medicine/divisions/id/hiv-consult](https://www.henryford.com/hcp/academic/medicine/divisions/id/hiv-consult)
- Midwest AIDS Training and Education Center-Michigan
  Provider Education 313-962-2000 www.matecmichigan.org
- National Perinatal HIV Consultation and Referral Service 1-888-448-8765
- Michigan Department of Health and Human Services
  Perinatal HIV or Congenital Syphilis Questions 313-456-1330
  Perinatal Hepatitis B Questions 517-241-0870
- Michigan Law on HIV Testing Consent
- Michigan Law on Perinatal Testing
- CDC Perinatal Testing Recommendations
- Minerva Galang, MD Mercy Health Infectious Disease: 616-397-6586
- Rosemary Olivera, MD Helen DeVos Children’s Hospital, Grand Rapids: 616-479-0883
- Elizabeth Secord, MD Wayne State University Department of Pediatrics HIV Services: 313-461-5245
- Theodore Jones, MD, FACOG Beaumont Health Maternal/Fetal Medicine: 313-503-1873
- Mary Rose Forsyth, MA, MS MATEC Michigan: 313-408-3483

All previous versions are obsolete March 2020