

Pregnant people

Overview

- Sexually transmitted infections ([STIs](#)) and blood borne viruses (BBVs) in pregnancy are associated with significant morbidity and mortality, including spontaneous abortion, fetal demise, premature labour, low birth weight and neonatal infection.
- Many [STIs](#) and BBVs are asymptomatic and people may be unaware of their risk of infection or may be unwilling to disclose risk.
- Antenatal [STI](#) and BBV testing offers the opportunity for early detection; prompt and appropriate management; prevention or reduction of adverse outcomes for the fetus or neonate; prevention of long-term sequelae in the parent; informed antenatal care; patient education and contact tracing.
- RANZCOG recommends a risk-based assessment for some [STIs](#) but it is important to be aware of local epidemiology and guidelines.
- Pelvic inflammatory disease ([PID](#)) can occur in pregnancy and may be misdiagnosed. Do STI tests in a pregnant person with new or abnormal genital discharge, bleeding, or pelvic pain.

Testing advice

Infection	Consideration
Hepatitis B	Routinely offer and recommend hepatitis B virus testing at the first antenatal visit. If not high-risk, the testing guidelines recommend Hepatitis B surface antigen (HBsAg) testing only, with further testing with Hepatitis B e antigen (HBeAg) and Hepatitis B DNA if HBsAg positive. Consider vaccination post partum if not immune. Any person diagnosed with hepatitis B infection in pregnancy should be assessed by an experienced clinician who will determine the phase and stage of their hepatitis B, including consideration of treatment in the third trimester. Discuss need for the infant to receive hepatitis B immunoglobulin (HBIG) and vaccination at birth to prevent transmission, and need for follow-up testing for the infant.

Infection	Consideration
HIV	Routinely offer and recommend human immunodeficiency virus (HIV) testing at the first antenatal visit. Repeat test if patient exposed within previous 45 days (window period) or have ongoing risk of HIV acquisition. Pregnant people who test positive for HIV should be referred to a clinician experienced in treating HIV and HIV community organisations for peer support.
HCV	Pregnant people should be made aware of the benefits of routine screening for hepatitis C virus (HCV) infection. HCV Antibody test should be offered at first antenatal visit and people who are HCV antibody positive need to be tested for HCV RNA because the small risk of perinatal transmission is conditional on the presence of parental HCV RNA. Pregnant people who test positive for HCV RNA should be referred to a clinician experienced in treating HCV.

Infection	Consideration
Syphilis	Routinely offer and recommend syphilis testing at the first antenatal visit, at 26-28 weeks, and at 36 weeks or birth (whichever is earlier) according to CDNA National Guidelines. For a person at high risk of syphilis a further test at 6 weeks postpartum is recommended. Untreated syphilis in pregnancy is associated with significant complications including preterm birth, neonatal death and congenital syphilis. Early treatment in pregnancy improves neonatal outcomes. See local guidelines for further information, particularly in an outbreak declared area, as recommendations for repeat testing vary. If there is a clinical suspicion of syphilis or exposure to syphilis, refer to syphilis guideline and seek urgent specialist advice.

Infection	Consideration
Chlamydia	Routinely offer chlamydia testing at first antenatal visit to all pregnant people under the age of 30. Testing for chlamydia and other STIs regardless of age should be considered for people who live in areas where STI prevalence is high. Consider testing for people presenting with adverse outcomes such as preterm rupture of membranes and miscarriage. Consider the use of self-collected vaginal or urine samples for testing in asymptomatic people. Treatment during pregnancy is recommended.

Infection	Consideration
Gonorrhoea	Routinely offer gonorrhoea testing at first antenatal visit to all pregnant people under the age of 30. Testing for gonorrhoea and other STIs regardless of age should be considered for people who live in areas where STI prevalence is high. Consider testing for people presenting with adverse pregnancy outcomes such as preterm rupture of membranes and miscarriage. Consider the use of self-collected vaginal or urine samples for testing asymptomatic people. Treatment during pregnancy is recommended.
HSV	Screening for herpes simplex virus (HSV) is not recommended in pregnancy with either serology or swabs. For advice on pregnant people with past or current HSV infection, see the Herpes guideline.

HBsAg – Hepatitis B surface antigen

HBeAg – Hepatitis B e antigen

NAAT – Nucleic acid amplification test

FPU – First pass urine

Specimen collection guidance

Clinical indicators for testing

- Many tests are conducted as routine antenatal screening, and [HIV](#), [syphilis](#), [hepatitis B](#) and [chlamydia](#) testing should be seen as part of the routine antenatal screen.
- Bearing in mind sensitive risk indicators may not be disclosed in an antenatal setting, testing should be guided by risk assessment where possible; consider also particular at risk groups such as [people < 30 years](#), [people who use drugs](#), [Aboriginal and Torres Strait Islander people](#), past history of an [STI](#), contact of someone with an [STI](#) or BBV, late, limited or no antenatal care, homeless people, those with a recent partner change, and local epidemiology.
- Pregnant people undergoing pre-abortion assessment should be tested for [HIV](#), [hepatitis B](#), [syphilis](#), [chlamydia](#) and [gonorrhoea](#) on an opt-out basis. People undergoing surgical abortion should be offered antibiotic prophylaxis. Antibiotic prophylaxis is not recommended for medical abortion.
- Routine screening is not recommended for [herpes](#), human papillomavirus (HPV), [bacterial vaginosis](#) or [trichomoniasis](#), however management should be considered if clinical suspicion exists, as recommended.

Follow-up

If test results are positive, refer to [STI](#) management section for advice on:

- [Chlamydia](#)
- [Hepatitis B](#)
- [HIV](#)
- [Syphilis](#)
- [Hepatitis C](#)
- [Gonorrhoea](#)

For pregnant people who test positive for [hepatitis B](#), [HIV](#), [hepatitis C](#) or [syphilis](#) seek urgent specialist advice.

Test of cure

In the event of a positive test result for [syphilis](#), [chlamydia](#) or [gonorrhoea](#), test of cure should be considered following treatment. [Contact tracing](#) for all sexual partners is essential to prevent re-infection of the pregnant person.

Retesting

Retesting for [syphilis](#) in second and third trimester is recommended in some jurisdictions. See local guidelines for further information, particularly in an outbreak declared area.

Where continued risk (see clinical indicators for testing) is identified during pregnancy, consider retesting before delivery (about 36 weeks) and post partum.

Even if all test results are negative, use the opportunity to:

- Educate about condom use, contraception, HIV PrEP/PEP, safe injecting practices, consent, CST and vaccinations for HAV, HBV and HPV as indicated.
- Vaccinate for [hepatitis B](#) postnatally.
- Discuss and activate reminders for regular testing according to risk, especially if their behaviours indicate the need for more frequent testing.

Auditable Outcomes

- 100% of pregnant people are tested for [HIV](#), [syphilis](#) and [hepatitis B](#).