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MANAGEMENT STRATEGY TO PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV/AIDS: RHC OF DALOA

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ABSTRACT

Aims: Mother-to-child transmission of HIV is the number one cause of infection in children under the age of 15. This study focused on the follow-up of HIV-positive pregnant women with a view to reducing the rate of this transmission. This study took place from December 02, 2019 to February 27, 2020 in the Gyneco-obstetrical service of the Regional Hospital Center of Daloa. **Methodology:** Thus, a medical survey was carried out among 200 pregnant women whose ages varied from 18 to 37 years. The procedure adopted in this study was a semi-structured interview based on a pre-developed questionnaire sheet. The survey sheet was made up of two main parts. The first was related to socio-demographic information (nationality, age, profession, marital status) on the respondent. The second part concerns the personal approach to HIV (the contamination mode, the prevention mode, advantage of screening pregnant women). **Results:** At the end of this study, 200 pregnant women received in prenatal consultation were screened, including 21 pregnant women who were HIV positive and 179 who were negative, representing a prevalence rate of 10.5 % among the study population. It also allowed us to note that pregnant women with HIV had an average age of 27 years. These women mainly belong to the 20-35 age group (61.9 %), that they were mostly married (57.14 %), multigest (76.19 %) and unemployed (38.1 %). The 2017 mother-to-child HIV transmission rate was identical to that of 2018 (0 %). However, for the year 2019 this rate was 2.83 %. Finally, the overall situation for the period from 2017 to 2019 shows us a rate of 0.6 %. **Conclusion:** This study has shown that knowledge of HIV status and good monitoring of pregnant women with HIV can significantly reduce the rate of mother-to-child transmission of HIV.

KEYWORDS: HIV, Mother-to-child transmission, Daloa, Côte d'Ivoire.

1. INTRODUCTION

HIV / AIDS is one of the main public health problems in the world, especially in low- and middle-income countries. Since the start of the epidemic, almost 78 million people have been infected with HIV and 39 million people have died.[1, 2] At the end of 2014, there were approximately 36.9 million people living with HIV. Almost half of these people were women, a large proportion of whom were of childbearing age, and almost 7 % were children, more than 90% of whom were infected by vertical transmission.[3, 4]

In Africa, the situation is particularly worrying because AIDS remains the leading cause of death for adults.[5] Côte d'Ivoire is one of the countries most affected by HIV in the West and Central Africa region (WCA), after Nigeria, Cameroon and the Democratic Republic of Congo (DRC) a high number of people living with HIV (PLHIV) estimated at 460,000 (420,000-510,000) according to 2014 estimates from UNAIDS. The fight against HIV is not confined to within the Ivorian borders, it also has a sub-regional scope in view of the significant migratory flows with the five (5) neighboring countries. Many modes of transmission expose people from all over the world every day, every minute and even every second. Blood transmission is one as well as two others closely linked to life, sexual transmission and mother-to-child transmission. It is difficult to conceive of giving life while transmitting the virus to the child. He is burdened with a heavy burden of HIV infection from birth.[6-8]

Education, prevention, treatment, research and international involvement do a lot every day to limit or

even reduce this rate of contamination and significant progress is made every day. But how to act in accordance with the different lifestyles, beliefs, culture, education, access to care, access to information as well as with the different economic means.[9-11] All social strata in each country are affected by this infection, which already makes a panel of people to target within the same population. Control of mother-to-child transmission of HIV is an important target to target, it is not the only one but it has a big role to play. Scaling up primary prevention of HIV infection in expectant parents as well as prevention of unwanted pregnancies is now an international priority. Today, great resources are available to control the pediatric epidemic via new strategies to prevent mother-to-child transmission, among others, through adequate prophylactic antiretroviral treatment and protected breastfeeding.[12-14] This situation justifies our choice to develop mother-child transmission in more detail in Daloa, to know the situation of the epidemic in the city and more particularly within the population of pregnant women, to provide information on the battles waged to avoid transmission. child of HIV and understand its impact on the management of this HIV infection which is too quickly called AIDS.

Thus, the present study which is part of the general framework of HIV / AIDS infection has set out to study the prevention of mother-to-child transmission of HIV / AIDS. To achieve this general objective, three specific objectives have been defined, namely: Describe the evolution over time of the mother-to-child transmission rate of HIV; Determine the HIV prevalence rate among pregnant women; Highlight drug management in order to prevent this transmission.

2. MATERIEL ET METHODES

2.1. Presentation of the study framework

The Regional Hospital Center (RHC) is a referral hospital for the Daloa Health District and the Haut Sassandra Administrative Region, also from several regions (Baffing, Gôh, Guemon, Marahoué, Nawa, Sans Pédro, Tonkpi and Worodougou). It is located in the Kirmann district and covers an area of 27 hectares including 15 buildings.

It also has 03 wastewater treatment tanks from services, a theoretical capacity of 183 beds and real capacity of 150 beds (Medicine 45, Surgery 36, Pediatrics 33, Gyneco-obstetrics 32, Ophthalmology 04). It has 225 human resources (administrative and social staff: 14, medical staff: 26, contractual staff: 60, paramedical staff: 125).

• Administrative Services of CHR: Direction, General surveillance, Economat, Office of the entries, Unit of seizures and data processing, Social service and that of the archives.

• Medical services: Medicine, Pediatrics, Surgery, Gyneco-obstetrics, Ophthalmology, Psychiatry and Micro-clinic of diabetes.

• Medico-technical services: A surgical unit, An obstetric unit, A dental office, a Kinesitherapy unit, a mini block of Ophthalmology, an electrocardiogram service (ECG), a medical analysis laboratory, an anti-venereal dispensary, a pharmacy and a medical imaging service (two radio rooms and an ultrasound unit).

2.2. Target service and activities

This study was carried out specifically in prenatal consultation (PNC) where four midwives are responsible for the care of women infected with HIV.

Screening of pregnant women in consultation is done in two stages. A first HIV test (screening test) is carried out on site with the consent of women, it is a rapid test "Abbott Determine". People who are negative on this rapid test are declared negative for HIV testing. People found positive for this rapid test undergo a second test (the SD Bioline test) which allows you to specify whether the person is infected with HIV-1, HIV-2 or HIV-1 and 2.

2.2.1. Rapid HIV test: Abine Determine HIV-1 / HIV-2 test

The Abott Determine rapid test is an immunochromatic test used for the qualitative detection of anti-HIV-1 antibodies in human serum, plasma or whole blood. Abott Determine HIV-1 / HIV-2 is made up of a sample depot area, a "patient window" containing immobilized recombinant antigens and synthetic peptides, and finally a "control window". The "control window" allows you to check the validity of the test by always displaying the control bar (a red line). It is based on the migration capacity of the sample deposited on the deposit line and that of the colloid selenium-antigen conjugate mixture.

2.2.2. Discrimination test: Standard Diagnostics (SD Bioline HIV-1/2 3.0)

The BIOLINE HIV-1/2 3.0 test is a rapid immuno-chromatographic test for the qualitative detection of antibodies of all isotypes (IgG, IgM, IgA) specific to HIV-1 and HIV-2 at the same time as in serum, human plasma or whole blood.

2.3. Study population

The study involved all pregnant women infected with HIV coming for prenatal consultation, pregnant women infected with HIV and who are already supported by the PMTCT program and medical staff.

2.4. Study strategy and ethical considerations

During this study, which took place from December 2, 2019 to February 27, 2020, a period of three months, an individual interview in face to face mode was carried out. The data were collected using a questionnaire sent to interested persons and to the files of women already

taken care of. The questionnaires for this study were intended for two groups of people: patients with positive HIV status and the medical staff responsible for monitoring them.

The questionnaire for patients includes two aspects including socio-demographic parameters (nationality, age, profession, marital status) and personal approach to HIV (contamination mode, prevention mode, advantage of screening pregnant women). The questionnaire intended for medical personnel also consists of two parts with socio-demographic parameters (nationality, age, gender, professional experience) and management strategy (tests performed on patients, methodology of tests different tests, frequencies of women recorded by day, type of treatment initiated).
Respect for ethics and professional conduct being an integral part of our study, we therefore have.
- Informed the participants of the purpose of our study and the procedures of our investigation.
- Explained the voluntary nature of their participation as well as the principle of confidentiality included in our research.
- Answered all the questions that were addressed to us in order to make them understand our objectives of the study and its interest.

2.5. Methodology
The sample (if it is plasma or serum) is placed in the deposition area and then (4) drops of diluents are added to it. We immediately see a purple color moving along the window in the middle of the plate. Five (5) to 20 minutes later if a colored band appears at the level of the control line (C), the test is valid and we can then even see if a colored band appears at the level of line 1 (we consider HIV-1 positive patient), at line 2 (HIV-2 positive patient) or overall (both HIV-1 and HIV-2 positive patients).

2.5.1. Biological analyzes
After confirming the test, a pre-therapeutic assessment is carried out, which consists of making the following examinations: Blood Formula Count (BFC), Viral Load (CD4), Transaminase (ALT and AST), Creatininemia, Fasting Glycemia.

2.5.1.1. Blood Formula Count (BFC)
The NFS is an exam that gives information about things in the blood such as red blood cells, white blood cells and platelets. It also reveals a large number of pathologies: anemia, coagulation problem, viral infection, consumption of platelets, etc. The assay is done through a blood sample, usually from the elbow.

2.5.1.2. Viral load (CD4)
The CD4 test is used to assess the patient's immune system.

2.5.1.3. Transaminases (ALT and AST)
Transaminases also called aminotransferases are enzymes that take part in the chemical reactions of the organism and lead to the creation of new amino acids necessary for the proper functioning of the organism. The dosage of transaminases consists of a venous blood sample, usually at the elbow. The collection tube may optionally contain an anticoagulant. The tubes are then examined and give a rate which you must transfer to the prescribing doctor so that he can refer you to additional examinations or prescribe a possible treatment.

2.5.1.4. Creatininemia
Creatininemia, or the measurement of creatinine levels, makes it possible to exploit renal function. Creatininemia is the breakdown product of creatine, an essential protein for energy production by muscles. The creatine dosage is not a collection of urine produced by the patient over a period of 24 hours. The urine is collected in a container kept at low temperature in accordance with the indications noted on the analysis sheet, the results should normally be between 8 and 16 mmol / 24 hours in women or 9 and 18 mmol / 24 hours in women. man. This difference is linked to the fact that a woman's muscle mass is lower than that of a man.

2.5.1.5. Blood sugar
Blood sugar measures the level of sugar in the blood. The examination consists of a blood test, in the presence of symptoms, a urine test can be performed. This is usually done at the bend of the elbow after putting a tourniquet. If the doctor chooses a urine sample, a test strip is dipped in the urine to detect the presence of glucose.

2.5.2. Initiation of treatment
2.5.2.1. Management of pregnant women with HIV before and after childbirth.

Before delivery if the patient is exposed to HIV-1, the preferential recommended treatment is: Tenofovir (TDF 300 mg + Lamivudine (3TC 300 mg) + Efavirenz (EFV 400 mg) one tablet / day. In the case of HIV-2 the recommended treatment is as follows: Lopinavir / Ritonavir (LPV 200 mg / r 50 mg) + TDF + Lamivudine (3TC 300 mg) one tablet / day In the case of co-infection (HIV-1 + 2) the treatment recommended is identical to that used in the context of an HIV-2 infection, a summary of its information is given in table 1.

Table 1: Treatment of pregnant women infected with HIV.

Pre-therapeutic examination	Treatment	Antiretroviral prophylaxis from the 14th week of pregnancy
-BFC -CD4 count -Transaminase (ALT and AST) -Viral load -Fast blood sugar -HIV typing -Creatininaemia	AZT+3TC+NVP Or AZT+3TC+EFV Or TDF+3TC (or FTC) +NVP TDF+3TC (or FTC) +NVP	AZT every day during the prenatal period. Nevirapine (NVP) as a single dose at the start of labor. AZT + 3TC during labor and delivery AZT + 3TC for 7 days after delivery not necessary if the mother received more than 4 weeks of AZT during pregnancy.

2.5.2.2. Antiretroviral prophylaxis and infant feeding

After delivery the mother is still on ARV treatment, the child immediately receives Nevirapine syrup (NVP) + Zidovudine (AZT) over six weeks, then the child is recovered for his first DBS test (PCR). If the result is negative, the child continues his treatment with NVP syrup + Cotrimoxazole. The mother and the child are received each month to continue the treatment until 1 year 6 months then the last PCR is called rapid test on the child, if the result is negative the child is declared HIV negative and exits the program of mother-to-child transmission (PMTCT) of HIV. On the other hand, if the PCR proves positive, this child is treated in pediatrics to initiate the treatment of HIV (it remains until the adolescent age) the treatment is for life. The data are presented in Tables 2 and 3 as appropriate.

Table 2: Prophylaxis of children at high risk.

Type of HIV	Molecule	Weight	Dosage	Duration
HIV 1 and HIV 1+2	Nevirapine	< 2 kg	0.5 ml/day	6 weeks
		[2-2.5 kg]	1 ml/day	
		≥ 2.5 kg	1.5 ml/day	
	Zidovudine	< 2 kg	0.5 ml 2x/day	
		[2-2.5 kg]	1 ml 2x/day	
		≥ 2.5 kg	1.5 ml 2x/day	
HIV 2	Zidovudine	< 2 kg	0.5 ml 2x/day	6 weeks
		[2-2.5 kg]	1 ml 2x/day	
		≥ 2.5 kg	1.5 ml 2x/day	

Table 3: Prophylaxis of children at low risk.

Type de HIV	Molecule	Weight	Dosage	Duration
HIV 1	Nevirapine	< 2 kg	0.5 ml/day	6 weeks
		[2-2.5 kg]	1 ml/day	
		≥ 2.5 kg	1.5 ml/day	
HIV 2 or HIV 1 + 2	Zidovudine	< 2 kg	0.5 ml 2x/day	6 weeks
		[2-2.5 kg]	1 ml 2x/day	
		≥ 2.5 kg	1.5 ml 2x/day	

2.6. Data processing and analysis

For this study, Microsoft office 2016 (Word, Excel), basic software for calculations and data entry was used.

3. RESULTS

3.1. Sociodemographic characteristics

3.1.1. Distribution of HIV-positive pregnant women by age group

Seroprevalence is mainly in the 20-35 years age group with 61.9 %. This age group is followed by that of 35 years and over with a 33.33 % seroprevalence. Finally, we have the age group less than or equal to 19 years who have a 4.77 % seroprevalence (Table 4).

Table 4: Distribution of pregnant women with HIV by age group.

Age group	Effective	Percentage
< 19 ans	01	4.77 %
20-35 years	13	61.9 %
> 35 years	07	33.33 %
Total	21	100 %

3.1.2. Distribution of HIV-positive pregnant women by profession

HIV positive women come from all socio-professional backgrounds. However, household HIV positive patients were more frequent with 38.10 %. This group of people is followed by officials and shopkeepers, who represent a percentage of 19.05 respectively. We then observe the body of the students with 14.29 %. Finally, comes the

hairdressers and the seamstresses with respectively 4.76 % (Table 5).

Table 5: Distribution of pregnant women with HIV by profession.

Profession	Effective	Percentage
Employee	04	19.05 %
Dressing table	01	4.76 %
Student	03	14.29 %
Shopkeeper	04	19.05 %
Dressmaker	01	4.76 %
Unemployed	08	38.1 %
Total	21	100 %

3.1.3. Distribution of HIV-positive pregnant women by marital status

According to table 6, HIV-positive pregnant women are found in all marital statuses, with a predominance among brides (57.14 %). They are followed by singles, who show a percentage of 33.33. As for concubines, they give a percentage of 9.52.

Table 6: Distribution of pregnant women with HIV by marital status.

Marital status	Effective	Percentage
Married	12	57.14 %
Cohabitation	02	9.52 %
Single	07	33.33 %
Total	21	100 %

3.1.4. Distribution of pregnant women with HIV by gestation

The results of this study show that there are many HIV positive people with a frequency of 76.19 % compared to HIV positive patients who give a frequency of 23.81 % according to table 7.

Table 7: Distribution of pregnant women by gestation.

Gestation	Effective	Percentage
Primigest	05	23.81 %
Multigest	16	76.19 %
Total	21	100 %

3.2. Data related to screening and monitoring of women

3.2.1. Description over time of the mother-to-child transmission rate of HIV

The study carried out on pregnant women with HIV who were treated by PMTCT from 2017 to 2019. In 2017, 230 pregnant women benefited from a screening test, including 178 pregnant women who were negative and 52 who were HIV positive corresponding 22.60 % frequency of HIV among the study population. The transmission rate was 0 % which implies that no woman has transmitted the virus to her child as shown in table 8.

Table 8: Rate of mother-to-child transmission of HIV in 2017.

Year	Number of HIV-positive pregnant women	Number of children declared HIV-positive	Transmission rate
2017	52	0	0 %

During 2018, 1042 pregnant women were screened with 66 pregnant women who were HIV-positive and 976 who were HIV-negative, representing a frequency of 6.33 % of the study population. We also note in 2018 that the transmission rate was 0 % so no child has contracted HIV (Table 9).

Table 9: Rate of mother-to-child transmission of HIV in 2018.

Year	Number of HIV-positive pregnant women	Number of children declared HIV-positive	Transmission rate
2018	66	0	0 %

In 2019, 225 pregnant women were the subject of the study among these 48 women were screened HIV-positive and 164 HIV-negative, representing a frequency of 21.33 % of the study population. Out of the 48 infected pregnant women, only one transmitted the virus to her child, therefore only one infected child, or 2.83 % of the transmission rate. This is explained by the fact that she did not benefit from PMTCT in time, since she was not taken care of until 9 months after delivery (Table 10).

Table 10: Rate of mother-to-child transmission of HIV in 2019.

Year	Number of HIV-positive pregnant women	Number of children declared HIV-positive	Transmission rate
2019	48	1	2.83 %

3.2.2. Prevalence during the study period

At the end of our study, which took place from December 2, 2019 to February 27, 2020, 200 pregnant women were screened, including 21 HIV positive and 179 HIV negative, i.e. a frequency of 10.5 % among the study population in accordance with the table 11.

Table 11: HIV prevalence rate during the study period.

Period	Number of pregnant women screened	Number of HIV-positive children	Prevalence rate
3 months	179	21	10.5 %

3.2.3. Monitoring of women

All HIV-positive women in our study received triple therapy with Tenofovir (TDF) + Lamivudine (3TC) + Efavirenz (EFV). This management strategy made it possible from 2017 to 2019 to have a mother-to-child HIV transmission rate of 0.6 %, as shown in the table below.

Table 12: Mother-to-child transmission rate of HIV from 2017-2019.

Period	Number of pregnant women screened	Number of children declared HIV-positive	Transmission rate
2017-2019	166	1	0.6 %

4. DISCUSSION

Our study concerned pregnant women already infected and treated by PMTCT from 2017 to 2019 and pregnant women coming for prenatal consultation in the gynecology and obstetrics service of the RHC of Daloa. At the end of this study, which took place from December 2, 2019 to February 27, 2020, 200 pregnant women were screened, including 21 with HIV, i.e. a prevalence of 10.5 %. From 2017 to 2018, over the entire period, the mother-to-child transmission rate of HIV was stable with 0 % transmission. In 2019 there is a slight increase in the transmission rate with 2.08 %.

Pregnant women with HIV are found in all age groups with dominance of the 20-35 age group with 61.90 %. Women in this category are followed by those belonging to the 35 and over age group with 33.33 %. Finally, pregnant women whose age is less than or equal to 19 years displays a frequency of 4.77 %. The results of this study are in agreement with those of several authors who have led to the same observations.[2, 6, 11, 13] The distribution of HIV-positive pregnant women is made across all socio-professional strata. However, housewives occupy a prominent place in our study with a frequency of 38.10 %. This situation is explained by the fact that the vast majority of women in the country are represented by housewives (unemployed) due to the low literacy rate of girls, which is a factor favoring HIV infection.[6, 8] According to the results of Bakayoko[15], 65.3 % of pregnant women with HIV are unemployed. Pregnant women with HIV are present in all marital statuses. However, the results of this study show that married women were the most represented with a frequency of 57.14 %. The results of our study join those of Keita[16] carried out in Mali. This is explained by the fact that most women of reproductive age, in the African context in general and particularly in Mali, are in a household. This result is also observed in[17] study on STDs. According to, Maïga[18] HIV-positive brides were the most represented with 67.4 %. The results of the distribution of pregnant women with HIV by gestation highlight the fact that HIV-positive multigests are the most represented in our study with a frequency of 76.19 %. This rate is comparable to that obtained in the work of Keita[16] at Ségou hospital, showing a higher frequency in multigests. Likewise, these results are in agreement with those of Sagna[19] who showed that multigest seropositive women were the most numerous with 87.31 %. This situation justifies this study, which highlights the fact that many women prefer to become pregnant despite knowing their HIV status.[20] In addition, because of the fundamental role that motherhood plays and because of certain cultural or social reasons, women whose partner is HIV-positive may go as far as risking infection to try to conceive a child in order to fully realize themselves as a mother.[20, 21]

According to the joint United Nations AIDS program (UNAIDS), 1,800 children are infected with HIV every day,[22] mostly during pregnancy, childbirth or breastfeeding. For the past decade, prevention of mother-to-child transmission of HIV (PMTCT) has been viewed as the most cost-effective access to antiretroviral (ARV) program and one of the most relevant prevention approaches. HIV infection.[23-27] Our results confirm this position in the measure where the mother-to-child transmission rates of HIV for the years 2017 and 2018 are respectively 0 %. For the year 2019, this mother-to-child transmission rate of HIV is 2.83 %. The overall situation for 2017-2019 gives a mother-to-child HIV transmission rate of 0.6 %. The importance of this rate is certainly due to the number of pregnant women with HIV who is 166. Despite this promoter rate, you should know that knowing your HIV status is an important step in accessing HIV care, treatment and prevention. Late diagnosis of HIV and therefore late access to HIV treatment are associated with an increase in the rate of transmission.[11, 13, 28] Several studies,[29-31] highlight risk factors for residual transmission, namely late treatment in the third trimester of pregnancy, or even at the time of delivery because it has been shown that the average duration of treatment during pregnancy was shorter in mothers who transmitted the virus to their children than in those who did not. According to a 2012 demographic and health survey, only 14 % of women and 10 % of men have had an HIV test in the past year. An estimated 62 % of adult women and 75 % of adult men have never been tested for HIV in Côte d'Ivoire, despite results showing that 62 % of adults say they know where to get tested.

Stigma, discrimination, fear of being tested, long distances to travel to health facilities, and long wait times in health facilities are the main deterrents for HIV testing.[8]

Over 90 % of all HIV infections in children are caused by mother-to-child transmission of the virus (MTCT). Yet 90 % of these infections can be prevented by effective services to prevent mother-to-child transmission of HIV (PMTCT). Elimination of mother-to-child transmission of HIV (MTCT) is defined as the national achievement of an MTCT rate of less than 5 % at 18 months among populations of lactating women and equal or less than 2 % among populations of non-breastfeeding women.[32] Achieving this target requires almost universal coverage of pregnant and lactating women in screening, treatment and viral suppression. Other relevant targets and indicators related to elimination are associated with the four pillars of PMTCT that were strengthened in the 2016 United Nations Political Declaration on HIV / AIDS. To receive a certificate from the World Health Organization (WHO) validating the national elimination of vertical transmission of HIV (and syphilis), countries must meet several process and process criteria. impact.[33] Mother-to-child transmission of HIV occurs when an HIV-positive woman transmits the virus to her child during pregnancy, childbirth, or breastfeeding. PMTCT includes a series of interventions to prevent new HIV infections in children: prevention for adolescents and young women, screening and treatment of pregnant and lactating women, identification of HIV-positive children and their delivery in connection with treatment services. PMTCT has four pillars that work together to provide a full range of services to women and families: Preventing HIV infection in women of childbearing age and their partners. Reproductive health services and prevention of unwanted pregnancies in HIV-positive women. Access to antiretroviral therapy (ART) to prevent new infections in infants of HIV-positive mothers. Treatment, care and support services for HIV-positive women, their infants and their families.[21, 28, 34] In July 2015, Cuba was the first country to receive validation from WHO for the elimination of mother-to-child transmission of HIV-1. This is defined by less than 50 cases per 100,000 new births, a transmission rate of less than 5 % if mothers breastfeed and less than 2 % if mothers do not breastfeed for at least 1 year, by knowledge of the HIV status of more than 95 % of pregnant women and the receipt of antiretroviral therapy for more than 95 % of pregnant women with HIV.[35-38] This accomplishment makes us believe more in the possibility of eliminating mother-to-child transmission of HIV, both nationally and globally.

5. CONCLUSION

HIV infection is one of the most common causes of death in developing countries, it is an infection that exposes children more by vertical transmission which is a transmission that occurs either during pregnancy or during childbirth and breastfeeding and young girls sexually. Our study, which took place from December 02, 2019 to February 27, 2020, allowed us to highlight the strategy of medication management in order to prevent mother-to-child transmission of HIV. It also allowed us to note that the pregnant women had an average age of 27 years, that they were mostly married women (57.14 %), multigest (76.19 %) and unemployed (38.10 %). The objective of this study was to describe the evolution over time of the mother-to-child transmission rate of HIV, it is 0.6 % from 2017 to 2019. The prevalence rate of pregnant women with HIV during prenatal consultation is 10.5 %. This study has shown that knowledge of HIV status and good monitoring of pregnant women with HIV can significantly reduce the rate of mother-to-child transmission of HIV.

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