Table 3: Prescription Drugs of Choice During Pregnancy and Lactation		
Drug/Drug Class or Condition	**Use in Pregnancy**	**Use in Lactation**
Antibiotics	Penicillins, Cefalosporins, Erythromycin non-Estolate, Clindamycin, Metronidazole, Vancomycin	Penicillins, Cefalosporins, Erythromycin non-Estolate, Clindamycin, Metronidazole, Vancomycin
Asthma	Salbutamol is the preferred reliever. Budesonide is the inhalation steroid of choice; beclomethasone, fluticasone Salmeterol is the preferred long-acting beta2 agonist	No human data. Dosing by inhalation likely safe due to low levels in maternal blood and breastmilk.
Bacterial vaginosis	Metronidazole, Clindamycin *Topical treatment does not protect against pre-term delivery, but as effective as oral for eradicating infection.*	Metronidazole, Clindamycin *May hold breastfeeding for 12-24 hours after treatment with Metronidazole*
Candidiasis, vulvovaginal	Topical Clotrimazole or Miconazole applied for 7 days preferred. Alternates: Topical Nystatin x 14 days OR Fluconazole 150 mg po as a single dose.	Topical Clotrimazole, Miconazole, Nystatin. Minimal systemic absorption and therefore, unlikely to appear in milk.
Candidiasis, nipple		*Apply to the nipple after breastfeeding*. Topical Clotrimazole or Miconazole ***Nipple fissures or cracks***: antibiotic ointment e.g., Mupirocin 2% ***Inflamed nipple***: Topical low-potency steroid e.g., Hydrocortisone ***Infant oral candidiasis***: Nystatin
Contraception	Progestin-only contraceptives preferred postpartum due to no effect on lactation; associated with less VTE risks compared to combined oral contraceptives. Women who become pregnant while using IUD should be assessed for ectopic pregnancy.	
Depression	Antidepressants may be used with caution during pregnancy. Risks of adverse effects should always be weighed against the risks associated with untreated depression during pregnancy. Studies support the fetal safety of commonly used antidepressants such as TCA (e.g., Amitriptyline), SSRI (e.g., Fluoxetine) – no congenital malformations reported. *Poor neonatal adaptation syndrome* has been reported in newborns exposed to such antidepressants during 3rd trimester. The adverse effects of untreated depression on both mother and babies appear to outweigh the risks of poor adaptation syndrome in few neonates. If decision is made to discontinue antidepressant therapy, tapering over several weeks is recommended. Infants exposed to	

Table 3: Prescription Drugs of Choice During Pregnancy and Lactation		
Drug/Drug Class or Condition	**Use in Pregnancy**	**Use in Lactation**
	antidepressants during late pregnancy should be closely monitored for 24-48 hours after birth. *Poor neonatal adaptation syndrome is described as self-limiting and characterised by jitteriness, grasping muscle weakness, and respiratory difficulties.*	
Diabetes	Insulin is the agent of choice *Untreated diabetes associated with increased risk of malformations.*	Does not cross into breastmilk
	Glibenclamide appears likely safe. 1st trimester exposure not associated with malformation risks. No neonatal hypoglycemia	Compatible with breastfeeding. Monitor infant for hypoglycemia
Hypertension	Labetalol, Methyldopa, Nifedipine XL are 1st line agents	WHO recommends most antihypertensives are safe in usual dosages. Monitor baby. *BP usually peaks 3-5 days postpartum and the recommendation is to continue antihypertensive therapy to cover this period, then reassess.* *May discontinue Methyldopa 2 days after delivery as it may increase risk of depression especially in high-risk individuals.*
Malaria	Quinine is the 1st line agent and can be used in all trimesters	Compatible with breastfeeding. . Monitor for haemolysis and jaundice, especially if the infant is premature or < 1 month old. Avoid in G-6-PD deficient infants
	ACT (Artemisinin-combination therapy) can be used in 2nd & 3rd trimesters. As an alternative in 1st trimester if Quinine not available.	According to WHO, both Artemether & Artesunate have been used in lactating mothers, no toxic effects have been found in their breastfed infants. WHO further recommends that antimalarials are safe in usual dosages except Mefloquine & Sulfadoxine/Pyrimethamine
Urinary Tract Infection (UTI)	Cefalexin or Amoxicillin (based on sensitivity)	Compatible with breastfeeding
	Nitrofurantoin (avoid ≥36 weeks)	Compatible with breastfeeding for healthy full- term infants. Avoid if possible if the infant is premature or < 1 month old. Monitor the infant for side-effects (haemolysis and jaundice). Avoid in infants with G-6-PD deficiency
Sources: See References below.		