Management of Human Immunodeficiency Viruses (HIV) in Pregnancy

Document Control:

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V1.0	23/10/2020	Alison Evans. Jon Lartey	To originate document
V2.0	03/01/2024	Charlie Aldous	PPROM management, ICASH details, AN appointments Appendix

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document: Consultant Obstetrician, iCaSH Consultant, Lead Pharmacist iCaSH, Neonatologist and Antenatal Screening Midwives.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to the Norfolk and Norwich University Foundation Trust); please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Contents Page

1. Introduction

1.1. Rationale

This document has been developed to ensure service-users accessing maternity care at the NNUH have access to safe care that is in line with national recommendations and requirements.

1.2. Objective

The objective of this guideline is to ensure the best possible health outcome for women who are living with HIV and their babies.

1.3. Scope

The purpose of document is to provide direction on the management of women confirmed as HIV positive in pregnancy and the implementation of care across the multi-disciplinary team to achieve the best health outcome for the woman and her unborn baby. The scope of the document covers patients who are confirmed to be HIV positive and receiving maternity care at the Norfolk and Norwich Hospital or transfer their care to this trust during pregnancy. This guideline should be reviewed by all medical staff and implemented to prevent incidents occurring.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
ANNBS	Antenatal and Newborn Screening
ANS	Antenatal Screening
ANSM	Antenatal Screening Midwife
ART	Anti-retroviral Therapy
BHIVA	British Human Immunodeficiency Virus Association
HIV	Human Immunodeficiency Virus
iCaSH	Integrated Contraception and Sexual Health Service
ISOSS	Integrated Screening Outcomes Surveillance Service
NHSE	National Health Service England
NICU	Neonatal Intensive Care Unit
PID MDT	Perinatal Infectious Diseases Multidisciplinary Team
SHS	Sexual Health Service
UKNSC	UK National Screening Committee

2. Responsibilities

All healthcare professionals must fully comply with this guideline to ensure timely review and management of results.

3. Policy Principles

3.1. Antenatal Screening in Pregnancy

Screening for HIV is offered to all pregnant women at the booking appointment by the midwife in addition to screening for Syphilis and Hepatitis B. If a woman choses to decline infectious disease screening, she must be informed she will be contacted by the ANSM by 20 weeks gestation to explore her options. The formal re-offer is a

requirement of the NHSE Screening Programme and the aim of this is to ensure the service user has made an informed choice regarding her screening options in pregnancy and understands the benefits of screening. The outcome of this conversation is to be documented on the electronic maternity record and the GP is to be notified if the patient declines infectious disease screening. For those women who decline due to a needle phobia, the needle phobia pathway should be initiated (See Appendix 1).

Following the discussion, for those who decline infectious disease screening a NICU alert will be completed allowing the neonatology team to assess whether the baby requires infectious disease screening after birth. Babies at a higher risk of contracting a vertically acquired infectious disease are babies born to women who are:

- Current or past intravenous drug users (IVDU) including sharing drug taking equipment i.e., spoons/filters/pipes.
- Sex workers.
- Those positive for other infectious diseases – Hepatitis B/C/syphilis.
- Those who have undergone a blood transfusion before 1991.
- Individuals having unprotected sexual intercourse with someone known to have HIV, hepatitis B/C.
- Service users who have had medical or dental treatment in parts of the world where the infection is more common e.g. Africa, Eastern Europe, Central and East Asia.
- Those who have undergone treatment using needles that may have been re-used or equipment that has not been sterilised effectively, unsterile body piercings/tattoos/acupuncture.

During the antenatal screening journey, a small number of women will show a “non-specific reactivity” to the initial laboratory test for HIV, in which case further testing is required. Testing will be arranged by the ANSM to ensure appropriate samples are taken in a timely manner. The woman will be contacted by the ANSM and the reason for repeat will be explained. In addition, she will be informed how she will receive the result and be given contact numbers for the ANSM team. She can be reassured that the likelihood of such cases being genuinely HIV positive is very low.

A failsafe process is in place between the laboratory and ANS team to ensure all women who screen positive for HIV receive appropriate care. See Trust Guideline for the Management of antenatal and new-born screening blood results (853).

3.2. HIV in Pregnancy Background

HIV is a retrovirus which attacks and destroys immune cells causing gradual failure of a person’s immune system over time. The risk of vertical transmission when HIV is untreated in pregnancy is around 25% and before universal HIV screening in pregnancy, transmission rates were high. Since 1999, rates have declined significantly, and the rate of vertical transmission has remained under 0.3% since 2012 (ISOSS HIV Report, 2021). The reduction of vertical transmission is directly

related to the opportunity for antenatal screening, high uptake of early and effective ART and optimised clinical care before and during pregnancy, at birth and in the postnatal period (Infectious Disease Screening Handbook, October 2023). Suppression of HIV using ART is the main objective of HIV management. ART works by interrupting the life cycle of the HIV virus, disabling its ability to replicate in the human immune cells thereby allowing the immune system to recover. The fall in the level of virus in the blood stream and other parts of the body, including the genital tract, significantly reduces the risk of vertical transmission, across the placenta during pregnancy or during exposure to maternal body fluids at delivery.

The aim of treatment is to reach full virological suppression, where the virus becomes undetectable (<40 copies/mL) in the blood. Regular viral load testing during pregnancy is used to monitor progress. For those not already on treatment, appropriate ART should be commenced early in pregnancy. This should happen soon after diagnosis and women are recommended to stay on treatment for life, which reduces the long-term risk of HIV related health problems and HIV transmission to others.

Where full viral suppression is achieved, the risk of HIV transmission during delivery is the same regardless of whether a woman has a vaginal delivery or a caesarean section and so for most women, HIV should not impact decisions about the method of delivery.

3.3. Management of HIV in Pregnancy

See Appendix 1 for the quick reference guide.

Management of HIV infection in pregnancy should be in line with the British HIV Association (BHIVA) Guidelines.

When a woman is confirmed to be living with HIV, the laboratory will inform the ANSM directly via the shared ANNBS email account (antenatal.newbornscreening@nnuh.nhs.uk). The ANNBS inbox is manned Monday-Friday 08.30-16.30. The laboratory must ensure a response from the ANNBS team has been provided which will confirm the result has been received. In the event a reply is not provided by the ANNBS team, the laboratory must contact the ANNBS team via telephone to ensure the result has been received. As an additional failsafe, on a weekly basis, the laboratory will access the shared infectious diseases spreadsheet to ensure all positive results are accounted for.

Following notification of the HIV positive result, as per NHSE requirement, the service user should be offered a face-to-face appointment within 5 working days with the Lead Obstetric Consultant for infectious disease to discuss the result. If this is not possible due to clinic activity, the result must be communicated by a specialist ANNBS midwife within 5 working days and the service-user provided with a face-to-face appointment with the Lead Obstetric Consultant for infectious diseases at the soonest possible opportunity.

- The discussion between the ANSM and the woman will include:
  - Current information about HIV infection in pregnancy using appropriate supporting resources

- Signposting to relevant resources
- Discussion regarding referral to sexual health services (SHS) for assessment and treatment
- Asking for any relevant information to aid referral, for example medication the patient is taking, including over-the-counter and supplementary/complementary medicines
- Explanation that testing of partner(s)/sexual contact(s) may be required

The ANSM will refer the patient to iCaSH (CCS-TR.icashnorwich@nhs.net) to ensure the genitourinary team are able to provide expertise into the individualised care plan.

In addition, a neonatal alert should be completed by the ANSM and forwarded to the Lead Neonatology Consultant for Infectious Diseases and the electronic maternity record updated.

The screening team must complete notification(s) to the Integrated Screening Outcomes Surveillance Service (ISOSS).

As per BHIVA recommendations, HIV pregnancy care should be a multi-disciplinary approach. Therefore, the multi-disciplinary team will aim to meet monthly to discuss shared patients to ensure cohesive and collaborative team working achieve to ensure the best possible outcome achieved for the woman and her unborn baby.

3.4. Antenatal, Intrapartum and postnatal management of HIV positive women.

Care for women with HIV in labour should be provided in line with the BHIVA guideline. Please access the full BHIVA guideline with this link (See Appendix 2 for extract):
https://www.bhiva.org/file/5bfd30be95deb/BHIVA-guidelines-for-the-management-of-HIV-in-pregnancy.pdf

During pregnancy a clear plan of care will be created to ensure individualised care is provided and documented on the 'Patient Individualised Care Plan' as per Appendix 3. This document should be updated at each contact and saved to the maternity electronic record (save using date as the title to ensure most up-to date plan is accessed).

If a woman with HIV is an inpatient for acute reasons and requires iCaSH input, during clinical hours genitourinary consultants can be contacted at iCaSH. Out of hours, on call advice is provided by Addenbrookes Hospital Infectious Diseases service via the Switchboard.

If a woman presents in labour, either unbooked, or having previously declined testing or without verifiable results for infectious diseases, they should be encouraged to have screening for infectious diseases (Syphilis, HIV and Hep B/C) as these women are often vulnerable and with higher risk factors. Urgent testing can be performed - follow Clinical Guideline for the Management of Concealed or Undiagnosed Pregnancies for the management of concealed or undiagnosed pregnancies Trustdocs Id: 16848.

3.5. HIV and Breastfeeding

HIV is carried in breastmilk and can be transmitted through breastfeeding. HIV treatment can significantly reduce the risk of transmission, but this is yet to be quantified. For women on treatment with a consistently undetectable viral load, the risk is likely to be low, but it is not eliminated altogether. The British HIV Association (BHIVA) continue to advise that formula feeding is the safest feeding option as it eliminates the risk of HIV transmission following delivery. However, they highlight the importance of facilitating early discussion around infant feeding and advocate for women who are virologically suppressed to be supported if they wish to breastfeed. Support should include early planning and close monitoring by the perinatal infectious diseases multidisciplinary team (PID MDT) in line with BHIVA guidance on infant feeding.

3.6. Screening Safety Incidents

Due to the nature and characteristics of screening tests, safety incidents within screening programmes require special attention and management. Where an incident occurs along any of the UKNSC screening pathways the ANSM should be informed and the UKNSC document “Managing Safety Incidents in NHS Screening Programmes” referred to.

4. Related Documents

BHIVA Guidelines for the Management of HIV in Pregnancy
https://www.bhiva.org/pregnancy-guidelines

5. References

1. British HIV Association guidelines for the management of HIV in pregnancy and postpartum 2018- 2020 British HIV Association guidelines for the management of HIV in pregnancy and postpartum 2018 (2020 third interim update) (bhiva.org)
2. NHS Infectious Diseases in Pregnancy Screening Programme Handbook NHS Infectious diseases in pregnancy screening programme handbook - GOV.UK (www.gov.uk)
3. HIV: what does my positive screening result mean? NHS Infectious Diseases in Pregnancy Screening Programme Screening for hepatitis B, HIV and syphilis - NHS (www.nhs.uk)
4. Managing Safety Incidents in NHS Screening Programmes Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)

6. Monitoring Compliance

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Coverage of HIV screening	Quarterly review and submission to NHSE	Antenatal and Newborn Screening Team	Antenatal and Newborn Steering Group Meeting	Quarterly
Timely intervention - new and already known positive women seen by MDT ≤ 5 working days	Quarterly review and submission to NHSE	Antenatal and Newborn Screening Team	Antenatal and Newborn Steering Group Meeting	Quarterly

The audit results are to be discussed at a relevant governance meeting such as Clinical Governance, the Antenatal and Newborn Steering Group Meeting, and externally at the NHSE Antenatal and Newborn Screening Board Meetings. These groups will review the results and recommendations for further action. Results will be sent to the relevant committee or Sub-Board who will ensure that the actions and recommendations are suitable and sufficient.

7. Appendices

Appendix 1. HIV Referral Pathway

Appendix 2. Management of HIV positive women in pregnancy (extract)

Appendix 3. Patient Individualised Care Plan

Appendix 4. Antenatal Contact Pathway

Appendix 1 – HIV Referral Pathway

Appendix 2- BHIVA Management of HIV positive women in pregnancy and labour (extract)

- Antenatal HIV care should be delivered by a multidisciplinary team (MDT).
- Assessment of antenatal and postnatal depression should be undertaken at booking, and 4–6 weeks postpartum and 3–4 months postpartum in accordance with National Institute for Care and Health Excellence (NICE) guidelines.
- Sexual health screening is recommended for pregnant women newly diagnosed with HIV.

Laboratory monitoring for pregnant women living with HIV

- Pregnant women who are newly diagnosed with HIV do not require any additional baseline investigations compared with non-pregnant women living with HIV other than those routinely performed in the general antenatal clinic.
- HIV resistance testing should be completed and results available prior to initiation of treatment, except for late-presenting women (after 28 weeks). Women should be encouraged to continue combination ART (cART) post-delivery but, where they chose to stop cART, a further resistance test is recommended to ensure that mutations are not missed with reversion during the off- treatment period.
- In women conceiving on cART there should be a minimum of one CD4 cell count at baseline and one at delivery. The same testing regimen applies for women who commenced cART during pregnancy even if CD4 count is <350 cells/mm^3. It is recommended they also have a HIV viral load and liver function test (LFTs) 2-4 weeks after starting cART, at least once every trimester, at 36 weeks and delivery.

Current issues on the use of ART in pregnancy and pregnancy outcomes

- It is recommended that women conceiving on an effective cART regimen should continue this treatment.
- Women who conceive on non-standard regimens (e.g. protease inhibitor monotherapy) or regimens with potential for altered pharmacokinetic profiles in pregnancy, or for which evidence for use in pregnancy is limited, should have these regimens reviewed, and if needed, modified by specialist SHS/pharmacist depending on tolerability, resistance and prior antiretroviral history. Women conceiving on dolutegravir should have this reviewed due to an increase in the risk of neural tube defects.
- All pregnant women, including elite controllers, should start ART during pregnancy and be advised to continue lifelong treatment.
- Women are recommended to start tenofovir DF or abacavir with emtricitabine or lamivudine as a nucleoside backbone. It is recommended that the third agent in cART should be efavirenz or atazanavir, as these are agents with the most safety data in pregnancy.
- Zidovudine monotherapy is not recommended and should only be used in women declining cART with a viral load of <10,000 HIV RNA copies/mL and willing to have a caesarean section (CS)

Late-presenting women not on treatment

- A woman who presents after 28 weeks should commence cART without delay.
- If the viral load is unknown or >100,000 HIV RNA copies/mL, a three- or four-drug regimen that includes raltegravir 400 mg bd or dolutegravir 50 mg od is suggested.

Management of an untreated woman presenting in labour at term.

- All women should be given
  - a stat dose of nevirapine 200 mg; and
  - oral zidovudine 300 mg and lamivudine 150 mg bd; and
  - raltegravir 400 mg bd; and receive intravenous zidovudine for the duration of labour.

Hepatitis B and C co-infection

Please refer to BHIVA guidelines on the management of HIV in pregnancy.

Antenatal management

- Fetal ultrasound imaging should be performed as per national guidelines regardless of maternal HIV status.
- The combined screening test for fetal aneuploidies and non-invasive prenatal testing (NIPT) for those who screen as high risk is recommended as this has the best sensitivity and specificity and will minimise the number of women who may need invasive testing.
- Invasive prenatal diagnostic testing should not be performed until after the HIV status of the woman is known and should ideally be deferred until HIV viral load has been adequately suppressed to <50 HIV RNA copies/mL.
- If not on cART and the invasive diagnostic test procedure cannot be delayed until viral suppression is achieved, it is recommended that women should commence cART to include raltegravir and be given a single dose of nevirapine 2–4 hours prior to the procedure.
- External cephalic version (ECV) can be offered to women with plasma viral load <50 HIV RNA copies/mL.

Mode of delivery

- For women taking cART, a decision regarding recommended mode of delivery should be made after review of plasma HIV viral load results at 36 weeks.
- For women with a plasma viral load of <50 HIV RNA copies/mL at 36 weeks, and in the absence of obstetric contraindications, planned vaginal delivery should be supported.
- For women with a plasma viral load of 50–399 HIV RNA copies/mL at 36 weeks, pre-labour CS (PLCS) should be considered, taking into account the

actual viral load, the trajectory of the viral load, length of time on treatment, adherence issues, obstetric factors and the woman's views.

- Where the viral load is ≥400 HIV RNA copies/mL at 36 weeks, PLCS is recommended.
- In women for whom a vaginal delivery has been planned and labour has commenced, obstetric management should follow the same guidelines as for the HIV-negative population, apart from duration of ruptured membranes (see section 8.3).
- Vaginal birth after CS (VBAC) can be offered to women with a viral load <50 HIV RNA copies/mL
- Where the indication for CS is the prevention of vertical transmission, CS should be undertaken at between 38- and 39-weeks' gestation.
- Where PLCS is undertaken only for obstetric indications and plasma viral load is <50 HIV RNA copies/mL, the usual obstetric considerations apply and the CS will usually be performed after 39 weeks' gestation.

Preterm labour

- If the infant is unlikely to be able to absorb oral medications, consider addition of double-dose tenofovir DF to the maternal treatment above to further load the infant prior to delivery.

Pre-labour spontaneous rupture of membranes (SROM)

- In all cases of term pre-labour SROM, delivery within 24 hours should be the aim.
- If maternal HIV viral load is <50 HIV RNA copies/mL, immediate induction or augmentation of labour is recommended in women who have pre-labour SROM, aiming for delivery within 24 hours of SROM.
- For women with SROM and a last measured plasma viral load of 50–399 HIV RNA copies/mL, immediate CS is recommended
- For women with SROM and maternal HIV viral load ≥400 HIV RNA copies/mL, immediate CS is recommended
- Preterm SROM 34–37 weeks' gestation will require group B streptococcus prophylaxis in line with national guidelines. Otherwise no additional intervention required
- Preterm SROM <34 weeks gestation
    1. Intramuscular steroids should be administered in accordance with national guidelines:

        Please note that there are some clinically significant drug-drug interactions between protease inhibitor-based ART and steroid therapy; please seek specialist pharmacist advice should a woman on such an ART regimen be indicated for steroid therapy.

    2. Where HIV viral load is not controlled, this should be optimized.

3. There should be multidisciplinary discussion about the timing and mode of delivery.

Use of intrapartum intravenous infusion of zidovudine

Intrapartum intravenous zidovudine infusion is recommended for

(i) women with a viral load >1000 HIV RNA copies/mL plasma who present in labour or with SROM or who are admitted for PLCS.

(ii) untreated women presenting in labour or with SROM in whom the current viral load is not known

(iii) consider in women on cART with a plasma HIV viral load between 50 and 1000 HIV RNA copies/mL.

Loading dose: 2mg/kg for one hour

Maintenance dose: 1mg/kg/hr until cord is clamped

Method of reconstitution of Zidovudine infusion:

1) Zidovudine vials can be found on Blakeney ward, Delivery Suite and emergency drug cupboard
2) Remove 100ml from a 500ml bag of 5% glucose (leaving 400ml in the bag)
3) Add 5 vials (200mg in 20mls) of Zidovudine and add this to the 400mls of 5% glucose.

Reconstituted solution is stable for up to 48hrs at 25°C. If any visible turbidity occurs the preparation must be discarded.

Place of Birth

- All women living with HIV are recommended to give birth in either co-located birth center or obstetric unit that has direct access to paediatric care.

Water Birth

- Women who choose a water birth should be supported to achieve this ideally in a suitable birthing unit collocated with a paediatric unit

Neonatal management

For Guidelines on Post Natal Management of Neonate see: CA2018 Infants Born to HIV Positive Mothers Trustdocs Id: 1184. During pregnancy the neonatologist responsible for the care of babies born to women living with HIV will make an individualised care plan which will be accessible on the woman's electronic document template. The individualised care plan will detail any specific care required for the neonate in addition to the below. Care of babies born to women living with HIV is time critical, therefore any concerns should be discussed immediately with the on-call duty virologist.

The neonatologist should be aware of the delivery and should have been in contact with the mother antenatally for counseling and completion of care plan.

1. The infant should be washed with soap and water to remove blood if the viral load **is not** undetectable. If the viral load is undetectable, washing of the infant is not required.
2. Zidovudine syrup should be prescribed and administered as soon as possible and certainly no later than 4 hours of birth at doses below *unless the infant is a special case* (see neonatal guideline and individualised care plan). Can be found on Blakeney ward and Delivery Suite. Please refer to the dosing tables in Appendix 3 of the BHIVA guidelines (available at: https://www.bhiva.org/pregnancy-guidelines)
3. Blood tests for HIV status should be taken within 48hrs and sent with a paired maternal sample.
4. Avoidance of breastfeeding recommended, give Cabergoline 1mg STAT to suppress lactation.

    - There is on-going risk of HIV exposure after birth with breastfeeding, it is therefore recommended that women living with HIV feed their babies with formula milk. In the event that a woman chooses to breast feed, this should be discussed urgently with the neonatal and iCaSH teams – a plan should already be in place (see Individualised Care Plan).

Breast feeding

- In the UK and other high-income settings, the safest way to feed infants born to women with HIV is with formula milk, as there is no on-going risk of HIV exposure after birth. We therefore continue to recommend that women living with HIV feed their babies with formula milk. Women not breastfeeding their infant by choice, or because of viral load >50 HIV RNA copies/mL, should be offered cabergoline to suppress lactation.
- Abstaining from breastfeeding can have financial and psychological repercussions for women, requiring support from the HIV MDT.
- Women advised not to breastfeed for their baby's health should be provided with free formula feed to minimise vertical transmission of HIV.

Choosing to breastfeed in the UK

- Women who are virologically suppressed on cART with good adherence and who choose to breastfeed should be supported to do so but should be informed about the low risk of transmission of HIV through breastfeeding in this situation and the requirement for extra maternal and infant clinical monitoring.
- When a woman decides to breastfeed, she and her infant should be reviewed as per individualised neonatal birth plan in neonatal clinic for HIV RNA viral load testing during and for 2 months after stopping breastfeeding. The individualised neonatal birth plan can be viewed via the maternal records on the electronic document template and will determine the frequency of review. Any concerns should be raised with the on-call virologists immediately.

Appendix 3. Patient Individualised Care Plan

To be completed with each antenatal contact and attached to maternity IT record. In third trimester please print on yellow paper and file in buff notes and patient's yellow notes if she consents. Previous versions to be destroyed when new copy printed/saved.

Patient Initials: _____ **Date of Birth: _____**

Hospital No.: _____ **GU Clinic Code: _____**

i. **Patient history**

HIV status Known / Identified at antenatal screening

Partner status Positive / Negative / to be investigated

Hepatitis status B: Positive / Negative C: Positive / Negative

Previous pregnancies whilst living with HIV _____

Mode of delivery – Vaginal / C-section

ii. **Antiretroviral Therapy**

Date started __/__/____

Antiretroviral regimen:

1)
2)
3)
4)

- Importance of compliance and continuation of regime postnatally discussed
- Medication history checked and reviewed for potential drug-drug interactions with ART.

Viral Load and CD4 count

Date *dd/mm/yyyy*	**No. of weeks**	**Viral Load (copies/mL)**	**CD4 count (cells/µL)**
	Booking		
	36		

iii. **Antenatal management**

Antenatal discussion: (tick as completed)

- Hepatitis B/ C status checked/ discussed
- Review arranged at dating scan __/__/____
- Mode of delivery discussed and recorded
- OGTT discussed. *Required / Not required* (delete as appropriate)
- Serial growth scans discussed. *Required / Not required* (delete as appropriate)
- Serial bloods discussed and arranged
- NICU requirement discussed
- Breast feeding and cabergoline discussed
- Contraception discussed

iv. **Management of Delivery**

Estimated date of delivery: ____/____/____

Have delivery options been discussed with the patient and consent obtained? *Yes / No*

Vaginal Delivery / Pre-labour CS *(delete as appropriate)*

If CS, when? ____/____/____ Why?: High viral load / Other _____

Is intravenous zidovudine indicated? *Yes/No*

a) *Women with viral load >1000 cells/mL: Presenting in labour / SROM / elective C-section*

b) *Untreated women presenting in labour / with SROM and unknown viral load*

c) *Consider in women on cART with plasma HIV viral load 50-1000 cells/mL regardless of mode of delivery (continued oral dosing on their current regime is also reasonable)*

On the day of delivery, the midwife should take maternal blood samples (3 x 4.5ml EDTA purple bottles) and send to lab for maternal proviral DNA and viral load.

v. **Postpartum management**

- Antiretroviral plan:

  _____
  _____
  _____
  _____

- Breastfeeding been discussed

- Lactation suppression been discussed and cabergoline agreed?

Cabergoline 1mg *STAT* (2 x 0.5mg tablets) on the *first* day postpartum

Contraception to be commenced: _____

vi. **NSHPC form returned ð**

vii. **Healthcare team**

GUM Consultant: _____ Contact No.: _____

Obs Consultant: _____ Contact No.: _____

Neonatal Consultant: _____ Contact No.: _____

Version	Initials of HCP	Date updated
1		
2		
3		
4		
5		
6		

Record of care plan completion/amendment
(Complete every time proforma updated)

To be completed with each antenatal contact. In third trimester please print on yellow paper and file in buff notes and patient's yellow notes if she consents. Previous versions to be destroyed when new copy printed.

Appendix 4. Antenatal Contact Pathway

- At time of HIV positive result
  ANC review with JPL within 5 working days to discuss result with patient (as per appendix 1- HIV referral pathway)
- Booking ANC appointment
  Confirm appropriate referrals including iCASH, NICU and CMW referral.
  Commencement of Individualised Care Plan as per appendix 3
  Ensure organisation of HbA1c at booking and OGTT at 24-28 weeks gestation
  Assessment of antenatal and postnatal depression risk
  Ensure patient aware recommendation of sexual health screen for pregnant women newly diagnosed with HIV
- FAS ANC appointment
  Confirmation of continued appropriate management including as minimum viral load and CD4 count at booking, completed referral to NICU, iCASH and CMW informed
  Ensure completed HbA1c and scheduled OGTT
  Open discussion regarding breastfeeding and place of birth (as per Appendix 2 BHIVA Management of HIV positive women in pregnancy and labour)
- 28 Week Appointment
  Confirmation of continued appropriate management including up to date individualised care plan and completed OGTT
  USS not required unless other indication
- 32 Week Appointment
  Confirmation of continued appropriate management including up to date individualised care plan
  USS not required unless other indication
- 36 Week Appointment and USS Growth
  Confirmation of continued appropriate management including up to date individualised care plan including viral load and CD4 count at 36 weeks gestation as minimum

8. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	Women and Children	**Department**	Maternity and Gynaecology Care
Name of person completing form	Charlotte Aldous	**Date**	30/01/2024

Equality Area	**Potential Negative Impact**	**Impact Positive Impact**	**Which groups are affected**	**Full Impact Assessment Required YES/NO**
Race	None	None	N/A	No
Pregnancy & Maternity	None	Yes	N/A	No
Disability	None	None	N/A	No
Religion and beliefs	None	None	N/A	No
Sex	None	None	N/A	No
Gender reassignment	None	None	N/A	No
Sexual Orientation	None	None	N/A	No
Age	None	None	N/A	No
Marriage & Civil Partnership	None	None	N/A	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	N/A			

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.