Human Immunodeficiency Virus (HIV) Maternity
Clinical guideline

V 3.0

December 2018
1. **Aim**

   To inform the Obstetric and Midwifery team about the screening and management of HIV in pregnancy and the post-partum period.

2. **The Guidance**

   2.1 **Pre-conceptual advice**

   2.1.1. **General Advice for all Situations**
   All couples where one or more partner is HIV positive should be referred to the HIV team for advice.

   2.1.2. **Pre-conceptual Advice**
   2.1.2.1 Folic acid supplementation (400mcg daily) should be commenced ideally prior to conception or as soon as the pregnancy is known within the first trimester. If the mother is on folate antagonists such as Co-trimoxazole Folic Acid should be given at an increased dose of 5mg and continued throughout pregnancy.
   2.1.2.2 Lifestyle advice regarding alcohol consumption, smoking and use of recreational drugs should be given prior to conception to both prospective parents or as soon as the pregnancy is known.

   2.2 **HIV Positive Women Planning a Pregnancy**

   2.2.1 In women planning a pregnancy, who need HIV anti-retrovirals for their own health, commence a regime recommended for use in pregnancy.
   2.2.2 In women with very low CD4 counts (<200 cells/mm3), it is preferable to defer pregnancy until sustained virological suppression has been achieved and if possible, immune reconstitution with a CD4 count above 200 cells/mm3 attained. This will minimise fetal exposure to potentially teratogenic antibiotics and antifungals used for the prophylaxis of opportunistic infections and also reduce the risk of the mother developing opportunistic infections during pregnancy.

   2.3 **HIV Antenatal Testing Guidelines**

   2.3.1 All pregnant women are routinely offered and recommended testing for HIV at their booking interview.
   2.3.2 Testing for HIV infection is integrated within the established antenatal screening for hepatitis B and syphilis with the woman's prior knowledge and consent.
   2.3.3 Women who choose not to be tested at this stage in their pregnancy should be given further opportunities to do so. They should be referred to the Screening Coordinator and re-offered screening before 20 weeks. If they decline the woman should be reoffered again at 28 weeks when bloods are taken for other tests.
   2.3.4 A leaflet ‘Screening tests for you and your baby’ which explains all blood tests, including HIV is sent to the woman with her antenatal booking letter.
   2.3.5 There should be no barrier to a woman having repeat tests for HIV at any stage of her pregnancy if either she or her clinician feels it necessary.
2.3.6 The decision whether or not to be tested should be recorded in the woman’s hand held notes.
2.3.7 Repeat tests should be offered to any woman who is thought to be at continuing risk of HIV infection.
2.3.8 **Late bookers or women opting for a test after 28 weeks** should have the test highlighted as urgent. Call the virologist and ask to have the test fast tracked within 24 hours.

2.4. **Confidentiality and Disclosure of Information**
In addition to hospital medical records, information is also recorded in hand-held notes. HIV positive results should be written in the hand held notes as “retroviral disease” so it is immediately obvious to clinical staff on admission reviewing the notes.

2.5. **Disclosure Protocol Including Contact Tracing Partners and Existing Children**

2.5.1. **Disclosure to other Health Care Professionals**
2.5.1.1 Disclosure of HIV should be discreet and sensitive specifically agreed with the woman and never assumed
2.5.1.2 Disclosure should be recommended to the patient’s GP and Community Midwife (CMW) to their baby’s neonatologist/ paediatrician and Health Visitor
2.5.1.3 The disclosure discussion should be recorded in the maternal hospital notes together with permission to disclose to specific parties.

2.5.2. **Disclosure to Sexual Partners**
This should be discussed and encouraged from the time the initial diagnosis is given, however it must be recognised that barriers to disclosure do exist. The HIV team will arrange formal partner notification.

2.5.3. **Testing Existing Children**
This should be discussed, encouraged and facilitated from the time the initial diagnosis is given and may be performed as soon as possible or deferred until testing the child of the current pregnancy. The HIV team will arrange follow up of other children if necessary.

2.6. **Medical Management of HIV in Pregnancy**

2.6.1 **Antenatal care**
2.6.1.1 All HIV positive women are cared for by a multidisciplinary team, which is comprised of: HIV Specialist Consultant (Kathryn Eccleston), Obstetrician (Sophie Haynes), Neonatologist (Paul Munyard), HIV Specialist Pharmacist (Ronan Sheehan)
2.6.1.2 Newly diagnosed HIV patients are referred to the Hub where the following investigations are performed:- confirmatory HIV test, FBC, HIV viral load, CD4, Hepatitis A, B &C serology, LFT, U&E, CMV, IgG, Toxoplasmosis IgG, HIV resistance test, HLAB5701,Glucose. STS plus CT/GC as required.
2.7 Antiretroviral Therapy in Pregnancy

Discussion should be documented that anti-retroviral treatment is recommended in pregnancy but is not licensed.

Drug Therapy Table

<table>
<thead>
<tr>
<th>1. Woman conceives on Combination Anti-retroviral Therapy (cART)</th>
<th>Woman conceiving on effective cART should continue this unless it contains contraindicated drugs. Women conceiving on PI monotherapy (increase risk pre-term labour and decrease pharmokinetics in pregnancy) should be modified to include one or more antiretroviral drugs that cross the placenta.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. All Pregnant women including Elite controllers should be on ART in pregnancy and continue life long</td>
<td>Start when feasible after 14/40 weeks of pregnancy or in 1st trimester if VL &gt;100,000 HIV RNA copies/ml or CD4 count less than 200cells/mm3. All women should have commences ART by 24 weeks.</td>
</tr>
<tr>
<td>3. Treatment guidance for commencing ART in pregnancy</td>
<td>Start tenofovir disoproxil fumarate or abacavir with emtricitabine or lamivudine as per British HIV Association (BHIVA) adult treatment guidelines. A third agent is recommended in absence of contraindications. Consider integrase inhibitor as third agent if viral load &gt; 100,000, if cART starting late in pregnancy or failing to suppress viral load. No need to alter dose in pregnancy if adult dose being used but consider TDM if combing tenovir and atazanvir or dosing off license. Darunavir should be BD if known resistance and should consider increasing if initiated in pregnancy. <strong>Lifelong cART is recommended. If woman declines zidovudine monotherapy is a non-preferred option in women with base line VL &lt;10,000 HIV RNA copies/ml and CD4 count &gt;350 AND who consent to Caesarean section.</strong></td>
</tr>
<tr>
<td>4. Women presenting ≥28/40</td>
<td>Should start cART as soon as possible. If HIV RNA &gt;100,000 cps/mL they should have a combination of 3 or 4 drugs to include raltegravir</td>
</tr>
</tbody>
</table>

Intravenous zidovudine (AZT)

If viral load >1000 RNA copies/ml who present in labour or with ruptures membranes or admitted for a planned c-section. For untreated women presenting in labour with unknown viral load. **Women on cART with viral load<1,000 HIV RNA copies/ml do not require IV zidovudine**

Dosage schedule for mother:

<table>
<thead>
<tr>
<th>Intravenous zidovudine (AZT) Infusion – dosage schedule as used in the American AIDS Clinical Trials Group Protocol 076 (ACTG 076)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (AZT) Loading dose infusion</td>
</tr>
<tr>
<td>Zidovudine (AZT) Maintenance infusion</td>
</tr>
</tbody>
</table>

2.7.1 Adherence Information and monitoring

HIV medicine is an evolving field with many uncertainties regarding the use of anti-retrovirals. The treatment is often individualised to account for the women’s disease progression. Unlike many treatments, HIV medication relies on 100% compliance from the patient to prevent long term morbidity.
2.7.2 Antiretroviral monitoring

<table>
<thead>
<tr>
<th>Resistance test</th>
<th>Done at baseline as non-pregnant females and ideally prior to starting cART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women stable on cART</td>
<td>Check CD4 count and HIV RNA as per non-pregnant patients, ensuring an HIV RNA is performed near delivery between 32-36 weeks</td>
</tr>
<tr>
<td>Women starting cART</td>
<td>Check viral load at 2-4 weeks after starting, 6 weeks, each trimester at least and then at 36 weeks and delivery</td>
</tr>
<tr>
<td>Therapeutic Drug Monitoring</td>
<td>If viral load not suppressed&lt;50 HIV RNA copies/ml at 36 weeks and compliance is not an issue – consider resistance test, TDM and intensification</td>
</tr>
</tbody>
</table>

2.8 Sexual Health

<table>
<thead>
<tr>
<th>STI screen</th>
<th>Done at or soon after baseline. Consider a repeat screen if patient is symptomatic or at risk of an STI. Treat infections as per CSHC / BB guidelines treat as per BASHH guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical smear</td>
<td>Perform if no smear for 3 or more years. Routine smears can wait until after pregnancy</td>
</tr>
</tbody>
</table>
| Hep B co infection                         | On diagnosis – obtain quantitative HBV DNA and ‘e’ Ag/Ab Screen for HEP A C and D and fibrosis Check LFTS 2-4 weeks after starting cART and regularly in pregnancy and postpartum
Add in Tenofovir – DF-lamivudine/emtricitabine should not be the only anti HBV drug used due to resistance (Emtricitabine and TDF – best combination)
HAV vaccine in 2nd trimester
Hepatitis flares post-delivery should be managed conservatively
Neonatal immunisation within 24 hours of Birth |
| Hep C co infection                         | On diagnosis obtain quantitative RNA and geno type and screen for inflammation/fibrosis
LFTs as above in HEP B
Should not be treated with ribavirin DDA therapies in pregnancy and should stop immediately
HBV vaccine in 2nd trimester |

2.9 Obstetric Management of HIV Positive Women

2.9.1 General Points

2.9.1.1 The aim of antenatal care is to achieve an undetectable viral load and for the pregnant woman to have the option of a planned vaginal delivery.
2.9.1.2 Communication between team members is essential and each delivery, regardless of mode should be planned.
2.9.1.3 Fetal ultrasound should be performed as per national guidelines.
2.9.1.4 If at any stage in labour maternal and fetal wellbeing are severely compromised immediate delivery is advised.
2.9.1.5 Psychological aspect is important and screening for depression should occur in pregnancy and postnatal at 6 weeks and 4 months
2.9.1.6 Women should be advised to bring in their antiretroviral drugs when admitted

2.10 Screening for chromosomal abnormality

<table>
<thead>
<tr>
<th>First trimester screening</th>
<th>All pregnant women with HIV infection should be offered first trimester screening for chromosomal abnormality in accordance with National Screening Committee guidelines. The probability of a false positive screening result is increased in women with HIV infection.</th>
</tr>
</thead>
</table>

| Invasive testing | If a prenatal invasive diagnostic test is being considered both maternal and fetal medicine teams need to be informed. The procedure should be deferred if possible until the HIV RNA is < 50cps/ml. If the woman is not on antiretroviral treatment and invasive tests cannot be postponed, start treatment with a regime including raltegravir 400mg bd and give single dose, 200mg of nevirapine 2-4 hours prior to the procedure. |

2.11 External cephalic version (ECV) can be performed in women with HIV

2.12 Birth Plan

2.12.1 Patient is given a typed maternal medicine care plan outlining their management in labour with contact emergency details. This is kept in her hand held notes and main notes or documented on Euroking.

2.12.2 The care plan should be finalized by 34wks due to the increase risk of preterm labour.

2.13 Intrapartum Management

2.13.1 Decision regarding mode of delivery
2.13.2 Maternal wishes should be considered when deciding between elective caesarean section and planned vaginal delivery.
2.13.3 The decision regarding mode of delivery should be made by the multi-disciplinary team at 34-36 weeks for women taking cART when viral load results are reviewed.
2.13.4 Elective caesarean section to prevent Mother to Child Transmission (MTCT) should be planned for 38 weeks to avoid the risk of rupture of membranes. The administration of steroids should be considered in these cases to reduce the risk of transient tachypnoea of the newborn (TTN).
2.13.5 Elective caesarean section for an obstetric indication in women with an undetectable viral load should be planned for 39 weeks.
2.13.6 Appropriate peri-operative antibiotics should be used to reduce the risk of maternal infection.
2.13.7 Vaginal birth after caesarean section (VBAC) may be considered in women with a HIV RNA viral load of less than 50 cps/mL. The decision will be made by the multidisciplinary team with consideration of current and previous obstetric factors.
2.14 Unbooked women presenting in Labour

2.14.1 All unbooked women should be offered a rapid HIV test. In addition an urgent virology screen is done (Hep B, syphilis and HIV). All women should be discussed with the Obstetric consultant and on call HIV Consultant (through Derriford switch board).

2.14.2 If HIV positive, give a stat dose of nevirapine 200mg , start on fixed dose zidovudine with lamivudine and add in raltegravir.

2.14.3 If baby is pre term and will not absorb oral medication consider double dose of tenofovir as an addition to above.

2.14.4 Women should receive intravenous zidovudine (as per protocol below). Baby should be discussed with the Paediatrician on call, and receive triple therapy.

2.14.5 HIV advice available via Derriford switchboard and HIV consultant on-call for the region if necessary. Call 01752 202082 and ask for the on-call doctor.

**ART should not be stopped post delivery**

2.15 Delivery

<table>
<thead>
<tr>
<th>Mode of delivery</th>
<th>Planned LSCS should be considered but can take into account trajectory of viral load, adherence issues, length of treatment time and obstetric and woman's views</th>
<th>Caesarean section is recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV RNA &lt;50 cps/mL at 36/40</td>
<td>Unless there are no obstetric contra-indications, women can aim for a vaginal delivery</td>
<td></td>
</tr>
<tr>
<td>HIV RNA 50 – 399 cps/mL at 36/40</td>
<td>Planned LSCS should be considered but can take into account trajectory of viral load, adherence issues, length of treatment time and obstetric and woman's views</td>
<td></td>
</tr>
</tbody>
</table>

2.16 Management of a planned vaginal delivery

2.16.1 **Induction of Labour** - Induction of labour can be considered for women on cART or whom a vaginal delivery has been recommended.

2.16.2 **Electronic fetal monitoring** - HIV alone is not an indication for continuous electronic fetal monitoring. Management of labour should follow the same principles as for the uninfected population if planned vaginal delivery has been recommended including being offered a community birth or birth on birth centre.

2.16.3 **Invasive intrapartum interventions** - Traditionally interventions such as amniotomy, fetal scalp electrode (FSE) and fetal blood sampling (FBS) have been avoided due to concerns that they increase the risk of MTCT of HIV. There are no studies to determine the risk of MTCT of these interventions in women with a fully suppressed viral count and on effective cART. The decision of whether to apply a FSE or perform a FBS due to fetal concerns in a woman with an undetectable viral load must be discussed with the obstetric consultant on call.
2.17 Instrumental Delivery
Instrumental delivery can be performed for women on cART with an HIV RNA <50 HIV RNA cps/mL. Choice of instrument will depend on what the operator feels is most appropriate. Low cavity forceps have traditionally been preferred due to their lower risk of fetal trauma compared to ventouse delivery.

2.18 Chorioamnionitis
There should be a low threshold to treat possible Chorioamnionitis, as infection increases the risk of MTCT of HIV.

2.19 Spontaneous Rupture of Membranes at Term
There is evidence from the pre-cART era that rupture of membranes (ROM) beyond 4 hours increases the risk of MTCT. This risk increases by a further 2% with every hour of pre labour rupture of membranes.

- **2.19.1 Timing of Induction of Labour** - Delivery must be expedited in all cases of term pre labour rupture of membranes.
- **2.19.2 Maternal HIV RNA < 50 cps/mL** - Induction of labour should be performed immediately in case of rupture of membranes at term.
- **2.19.3 Maternal HIV RNA is between 50-999 cps/mL** - Immediate caesarean should be considered. The case should be discussed with a member of the HIV multidisciplinary team as the trajectory of viral load, duration of treatment and compliance will need to be reviewed when considering mode and timing of delivery.
- **2.19.4 Maternal HIV RNA ≥ 1000 cps/mL** - Perform category two caesarean section.

2.20 Premature Delivery and Prolonged Premature Rupture of Membranes (PPROM)
One must weigh up the risks of transmission of HIV and preterm delivery to the baby. Decisions need to be made on a case-by-case basis involving the HIV, Obstetric and Neonatal specialists.

- **2.20.1 Gestation ≥ 34 weeks** - Management of PPROM will be the same as for term rupture of membranes when the gestation is 34 weeks or greater. In addition group B streptococcus prophylaxis must be undertaken as per local guidelines.

- **2.20.2 Gestation < 34 weeks** - When PPROM occurs at less than 34 weeks gestation intramuscular steroids for fetal lung maturation should be given. For women with an HIV RNA < 50 cps/mL, management should be conservative with induction of labour considered at 34 weeks in accordance with RCOG guidelines on the management of premature pre term rupture of membranes. Follow up until that point will include twice weekly review in Day Assessment Unit (DAU) with FBC, CRP and CTG assessment. For patients with an HIV RNA ≥50 cps/mL before 34 weeks there should be a multidisciplinary discussion, involving the neonatology team regarding timing, mode of delivery and optimisation of viral load.
2.21 Infant feeding

2.21.1 To prevent the transmission of HIV infection during the postpartum period, BHIVA / CHIVA (Children's HIV Association) continue to recommend the complete avoidance of breastfeeding, regardless of maternal disease status, viral load or treatment. Cabergoline 1mg should be given as a single dose in the first 24 hours post-partum.

2.21.2 All HIV positive mothers should be supported to formula feed their infants and advised on access to infant formula milk – they may need extra psychological and financial help.

2.22 Breastfeeding

In the rare instance where a mother, who is on effective cART and with a repeatedly undetectable viral load, chooses to breast feed this does not constitute grounds for safeguarding as in the past.

The woman should be supported and assisted to breast feed exclusively taking into account that she is well informed about the risk of transmission and the possible outcome. In this scenario certain measures need to be implemented:

2.22.1 Women must be referred to the multidisciplinary team (including HIV specialist midwife, HIV consultant, obstetric consultant and Paediatric team) for specialist counselling.

2.22.2 Exclusive breast feeding recommended for the shortest time possible, a period of six months maximum (World Health Organisation 2012).

2.22.3 Mixed feeding should be avoided.

2.22.4 Monthly testing of maternal viral load to ensure continued antiretroviral efficacy.

2.22.5 Monthly testing of baby (HIV proviral DNA) by the Paediatric team and 4-8 weeks after cessation of breast feeding.

2.23 After Discharge from Hospital

Follow up at 2 weeks in the HIV clinic.

2.24 Contraception and Cytology

2.24.1 Condoms can prevent STIs and HIV super infection and should be recommended to everyone at risk of these.

2.24.2 HIV treatment reduces the efficacy of the combined oral contraceptive pill (OCP) and in some cases the implant, therefore the use of other long acting reversible contraception should be advocated. Check interactions on the HIV drug interactions website.

2.24.3 If cytology is required this should be arranged for a 3 months postnatal visit.
2.25. Adherence to Treatment
2.25.1 It is important that the medication is given exactly at the times prescribed and that no dose is missed. There may be a risk that the HIV may become resistant and therefore more difficult to treat.
2.25.2 Where a dose has been forgotten, it should be given as soon as possible when remembered. The timing of the following dose may have to be changed when the last dose was taken with 6 hours or more delay. Women should be instructed how to administer the medication to their babies as soon as possible.

2.26. Care on Postnatal Ward
2.26.1 After transfer of the mother and baby to the postnatal ward the neonatologist will perform the usual baby check and prescribe medications to take home
2.26.2 Before discharging mother and baby ensure that the mother or relevant carer:
   - Understands the importance of adherence
   - Is competent in administering medication
   - Has treatment supply for 4 weeks
   - The timings of the drug administration are acceptable to the family. If the timing needs changing this can be done to a maximum of hourly increments, i.e. if the treatment is prescribed at 4am and 4pm, then each dose can be changed only by 1 hour from 4am to 5am etc.
   - A Follow Up appointment when the baby is 6 weeks old has been made.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>This guideline covers an uncommon condition in pregnancy and therefore each case will be reviewed against the full guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Obstetric Lead for Maternal Medicine</td>
</tr>
<tr>
<td>Tool</td>
<td>Health records to be reviewed against each aspect of the guideline</td>
</tr>
<tr>
<td>Frequency</td>
<td>When a case occurs</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Any deficiencies identified will be reported to the Maternity Patient Safety Forum or Audit Compliance Forum.</td>
</tr>
<tr>
<td>Acting on recommendaions and Lead(s)</td>
<td>The Maternity Patient Safety Forum will develop an action plan, assign an action plan lead and monitor progress</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Changes will be agreed as per the action plan Patient Safety Newsletter</td>
</tr>
</tbody>
</table>

4. **Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the [Equality and Diversity website](#).

4.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Human Immunodeficiency Virus (HIV) Maternity Clinical guideline V 3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>20&lt;sup&gt;th&lt;/sup&gt; December 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>20&lt;sup&gt;th&lt;/sup&gt; December 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>20&lt;sup&gt;th&lt;/sup&gt; December 2021</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Sophie Haynes, Consultant Obstetrician</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252937</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>To inform Obstetricians and Midwives about the screening and management of HIV in pregnancy and post-partum period</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>HIV, pregnancy, delivery, post, partum, Human immunodeficiency, virus, viral, anti, antiretroviral, HAART, AZT</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>October 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>HUMAN IMMUNODEFICIENCY VIRUS (HIV) CLINICAL GUIDELINE FOR MID-WIVES v2.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Divisional Board for Noting</td>
</tr>
<tr>
<td><strong>Divisional Manager confirming approval processes</strong></td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Not Required</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td><strong>Document Library Folder/Sub Folder</strong></td>
<td>Clinical/Midwifery and Obstetrics</td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
<td>None</td>
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**Related Documents:**


| **Training Need Identified?** | No |
Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Ver-</th>
<th>Summary of Changes</th>
<th>Changes Made by</th>
</tr>
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<tbody>
<tr>
<td>May 2012</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Dr A G Rajasri Consultant</td>
</tr>
<tr>
<td>20th October</td>
<td>V2.0</td>
<td>Major changes and detailed advice in light of new national guidance</td>
<td>Dr A G Rajasri Consultant Obstetrician Dr K Eccleston Consultant in GU/HIV Medicine</td>
</tr>
<tr>
<td>October 2018</td>
<td>V3.0</td>
<td>Total review of the guideline.</td>
<td>Sophie Haynes, Consultant Obstetrician</td>
</tr>
</tbody>
</table>

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This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

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Appendix 2. Initial Equality Impact Assessment Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Human Immunodeficiency Virus (HIV) Maternity Clinical Guideline v3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td><strong>Is this a new or existing Policy?</strong></td>
</tr>
<tr>
<td>Obs and Gynae</td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td><strong>Telephone:</strong></td>
</tr>
<tr>
<td>Dr Sophie Haynes</td>
<td>01872 252937</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - **Who is the strategy / policy / proposal / service function aimed at?**
   - To inform the Obstetric and Midwifery team about the screening and management of HIV in pregnancy and the post-partum period

2. **Policy Objectives***
   - To ensure all pregnant women are appropriately screened and mothers found to be HIV positive.

3. **Policy – intended Outcomes***
   - Reduction in vertical transmission of HIV, improved maternal and fetal outcomes with improved patient experience

4. **How will you measure the outcome?**
   - Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?**
   - All pregnant women and their babies

6a **Who did you consult with**

   b). Please identify the groups who have been consulted about this procedure.

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td></td>
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</tr>
</tbody>
</table>

**Please record specific names of groups**
- Maternity Guidelines Group
- Obs and Gynae Directorate

**What was the outcome of the consultation?**
- Guideline agreed and ratified
7. The Impact

Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>x</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>x</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>x</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td></td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
</tbody>
</table>

**You will need to continue to a full Equality Impact Assessment if the following have been highlighted:**

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this **excludes** any **policies** which have been identified as not requiring consultation. **or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | x |
9. If you are **not** recommending a Full Impact assessment please explain why.

Not required
<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sophie Haynes</td>
<td>December 2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
<th></th>
</tr>
</thead>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed ___ ___Sarah-Jane Pedler ___________

Date _December 2018_______________