HUMAN IMMUNODEFICIENCY VIRUS (HIV) – CLINICAL GUIDELINE FOR MIDWIVES

1. Aim/Purpose of this Guideline
1.1. To inform the Obstetric and Midwifery team about the screening and management of HIV in pregnancy and the post-partum period.
1.2. To inform the multi professional team involved in care of babies born to HIV positive mothers of the management and follow up required.

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
- 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.
- 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
- In women planning a pregnancy, who need HIV anti-retrovirals for their own health, commence a regime recommended for use in pregnancy
- 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
- The aim of the Department of Health (DoH) (1999) was to increase the voluntary uptake of the HIV test to 90% in an endeavour to reduce the vertical transmission rate of HIV through the use of antiviral treatments in pregnancy, prophylaxis for the new-born and avoidance of breast feeding. Standards for monitoring antenatal
screening were revised and updated in 2012.

- Offering the test to everyone normalises HIV testing and raises awareness amongst the general population about a major public health issue
- The British HIV Association (BHIVA) and The British Association for Sexual Health and HIV (BASHH) (2008) made recommendations to increase the offer of HIV
testing in high prevalence areas. Midwives are to target pregnant women who
delay testing at booking by re-offering a test in the second trimester.
- In addition to this women who test negative but are deemed to be ‘high risk’ are to
be offered another test in late pregnancy
- Consideration should be made to test babies of mothers who decline HIV testing
during pregnancy

2.4. Confidentiality and Disclosure of Information
- In addition to hospital medical records, information is also recorded in hand-held
notes. It is vital that nothing is recorded in hand-held notes without discussion and
the woman’s explicit permission given. The information recorded may be seen by
family or friends.
- A positive HIV result should not be recorded in the hand held notes unless agreed
by the women. The result should be filed in the hospital records and the reasons
for this fully explained to the woman.
- HIV status should be revealed only on a ‘need to know basis’ and verbal disclosure
should be discreet and sensitive
- An HIV test must be offered to all women during their antenatal care as an integral
part of routine antenatal screening. It is classed as an ‘opt out’ offer i.e. included
along with all the other tests offered at booking.
- The HIV test can be offered at any time during the pregnancy including during
labour and the post natal period. It is recommended to fast track results after 20
weeks gestation and to perform them urgently for women in or threatening labour or
in the immediate postnatal period.
- All women can be given the “HIV and Pregnancy” leaflet (available through the HIV
service at the Hub or on-line at http://i-base.info/guides/pregnancy/pdf) at their
booking appointment. This leaflet should also be available in clinic areas. Written
information given prior to the woman’s booking interview allows her time to give
more thought to HIV testing issues and to formulate any questions she may wish to
ask.
- All women are encouraged to disclose a HIV positive result to their General
Practitioner (GP). However unless there are child protection issues this remains the
woman’s choice.

2.5. Disclosure Protocol Including Contact Tracing Partners and Existing Children

2.5.1. Disclosure to other Health Care Professionals
- Disclosure of HIV status is on a need to know basis and should be
specifically agreed with the woman and never assumed
- Disclosure should be recommended to the patient’s GP and Community
Midwife (CMW) and in time, to their baby’s neonatologist/paediatrician and
Health Visitor
- The discussion with regard to disclosure should be recorded in the maternal
hospital notes (antenatal and medical) together with permission to disclose to
specific parties. Once permission to disclose to relevant parties is agreed
and documented, regular written correspondence should be maintained
between 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
(particularly where domestic abuse is disclosed or suspected) and disclosure should be seen as a process during which support should be given. The HIV team will arrange formal partner notification.

- Reference should be made to the British HIV Association (BHIVA) document: “HIV transmission, the Law and the Work of the Clinical Team” (www.bhiva.org) as well as the BHIVA Guidelines for the Management of HIV in Pregnancy.

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. Initial Assessment
- This is to be facilitated as soon as possible following HIV diagnosis in pregnancy or when pregnancy is confirmed in a known HIV positive woman. Management should be within a multi-disciplinary team where lines of communication and responsibility are clear and specific.

2.6.2. Follow-up Assessments
- These should be conducted regularly, the frequency depending on the individual patient

2.6.3. Antenatal Multidisciplinary Team
- Dr Kathryn Eccleston- Genitourinary Medicine, Miss Aylur Rajasri- Obstetrics & Gynaecology, Dr Paul Munyard- Neonatal Paediatrician and Midwives
- Antenatal surveillance to be managed by the HIV team. Blood monitoring and tests for sexual health screening will be organised by the HIV team and the results made available to the Obstetrician, with the patients consent.

2.6.4. Antiretroviral Therapy in Pregnancy
- This should be with reference to BHIVA guidelines

2.6.5. Women Diagnosed with HIV in Pregnancy
- Although there is most evidence and experience in pregnancy with Zidovudine plus Lamivudine (Combivir), Tenofovir plus Emtricitabine (Truvada) or Abacavir plus Lamivudine (Kivexa) are acceptable nucleoside backbones. In the absence of specific contraindications, it is recommended that the third agent in highly active antiretroviral therapy (HAART) should be Efavirenz or Nevirapine (if CD4 count is less than 250 cells/µL) or a boosted protease inhibitor (PI). Ritonavir boosted Lopinavir (Kaletra), Atazanavir and Darunavir have been shown to be effective and suitable third agents. HIV genotypic resistance testing, hepatitis co-infection, previous antiretroviral therapy (ART), adherence considerations and maternal choice should guide HAART choice. Pharmacokinetic data indicates that levels of Kaletra and Darunavir may drop, particularly in the third trimester, so increase the dose of Kaletra to 3 tablets bd if the viral load (VL) is not fully suppressed and/or if therapeutic drug level monitoring demonstrates levels are low, or consider twice daily dosing of Darunavir (assuming drug resistance and adherence
are not of concern). Consider use of Raltegravir if a rapid reduction in viral load is required, for example in a late booker.

- Unless indicated for maternal health reasons, aim to start HAART at around 20 week’s gestation and all women should have commenced by week 24 of pregnancy. Consider starting HAART earlier if baseline HIV viral load is > 100,000c/ml. If the pre-treatment CD4 count indicates maternal therapy is not needed for maternal health then HAART may be stopped following delivery. However NNRTIs cannot be stopped abruptly in this manner and it must be remembered that the CD4 count may drop by up to 25% in pregnancy and so may not be a reliable marker of whether HAART needs to be continued after pregnancy. A senior HIV physician must make this decision on an individual case basis with the patient.

- Zidovudine monotherapy can be considered in women planning a Caesarean section who have a baseline VL <10,000c/ml and a CD4 cell count >350cells/µL.

2.6.6. Women on HAART at the Time of Conception

- Where a woman is stable on a HAART regime either she or the HIV physician may decide not to change therapy unless there are reasons identified to do so

- Avoid Didanosine and Stavudine in pregnancy

2.6.7. Adherence Information

- 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.

2.6.8. Sexual Health

- Maintaining the sexual health of pregnant women with HIV infection is important for avoiding morbidity and helping to prevent onward transmission of Sexually Transmitted Infections (STIs) and HIV to both partners and babies

- Full sexual health screening including syphilis serology should be performed at initial assessment and repeated at 28 weeks

2.6.9. Women found to be Co-infected with Hepatitis B or Hepatitis C in Pregnancy

- These patients should be managed in line with current BHIVA guidelines for the management of HIV in pregnancy and reference can be made to the BHIVA co-infection guidelines

- In the case of Hepatitis B this includes performing a Hepatitis B DNA level on those who are Hepatitis B surface antigen positive and using a Highly Active Antiretroviral Therapy(HAART) regime including drugs with anti-Hepatitis B activity (in the absence of HIV resistance this generally means using Lamivudine and Tenofovir and a third agent in the HAART regime, Emtricitabine could also be used in the place of Lamivudine, together with Tenofovir as Truvada)

- If a mother is found to be Hepatitis C antibody positive, particularly if she is Hepatitis C RNA positive, a pre-labour Caesarean Section should be offered

2.7. Obstetric Management of HIV Positive Women
2.7.1. Antenatal Management
- HIV infected women requesting invasive prenatal diagnosis (maternal age, increased Down’s syndrome screening) should be counselled by a Fetal Medicine Specialist / Consultant Obstetrician
- Liaison with an HIV Consultant is important as administration of Antiretroviral Therapy (ART) to cover the procedure is recommended and deferred until the viral load is <50c/ml where possible
- If prenatal diagnostic tests are required, it may be best to wait for an amniocentesis (avoiding inserting the needle through the placenta) as this may further reduce vertical transmission and also the HIV viral load may be lower / undetectable with ART at that time
- Women admitted in labour to the maternity unit un-booked must be offered a HIV test which should be processed
- When HIV positive women on HAART present to Delivery Suite in pregnancy with signs and symptoms of Pre-eclampsia, Obstetric Cholestasis or other manifestations of liver dysfunction, it should be remembered that these may be due to the adverse effects of the ART. Any woman presenting with malaise, vomiting or oedema should be investigated for acidosis, hepatitis, pancreatitis and Disseminated Intravascular Coagulation (DIC). It is important to liaise with both the obstetric and HIV consultants.

2.7.2. Intrapartum Management
- The aim of administering ART in labour (whether by continuation of the mother’s oral ART or giving intravenous (IV) Zidovudine (AZT) is to ensure the baby has therapeutic levels at the time of first exposure, which is usually during delivery. The HIV virus can penetrate the baby’s mucous membranes (e.g. mouth/eyes) following exposure to infected cervico-vaginal secretions or maternal blood.

2.7.3. Delivery
- Except in rare circumstances, the mode of delivery will already have been discussed with a known HIV positive woman during the antenatal period
- A final delivery care plan will be filed in the mother’s hospital notes, Delivery Suite folder and the mother’s hand-held records
- The woman may have further questions at the time of labour and delivery and may wish to change her mind regarding any intervention. Any discussion should be documented carefully and the mother’s views respected.

2.8. HIV Positive Women with Undetectable HIV Ribonucleic Acid (RNA)
- Unless the mother is on AZT monotherapy during the antenatal period, IV AZT is not required for women with an undetectable viral load at 36 weeks’ gestation regardless of the mode of delivery
- A plan for delivery will have been made for each woman by her Obstetric team. Normal delivery is offered to all women unless this is contra-indicated by obstetric factors.

2.8.1. HIV Positive Women with Detectable HIV RNA
- If there have been compliance issues or a woman has not accessed services, commence IV AZT and order an urgent viral load on admission.
Give consideration to stat dose 200mg Nevirapine (discuss with HIV consultant on-call – accessed via Derriford switchboard out of hours).

- Women who have a detectable viral load will require IV AZT and should have a pre-prepared prescription in her central file ready for delivery

2.8.2. Induction of Labour

- Women with a detectable viral load and opting for a vaginal delivery who are admitted for induction of labour should commence the IV AZT infusion when labour becomes established or membranes rupture

2.8.3. Elective Caesarean Section

- Women with a detectable viral load who are admitted for an elective caesarean section should receive at least 4 hours of IV AZT prior to the caesarean section

2.9. Management of Labour and Delivery

- There is a risk of infection through contact with cervico-vaginal secretions and maternal blood, and any interventions that breach the baby’s skin will increase exposure and result in a higher risk of vertical transmission
- Spontaneous Rupture of Membranes (SROM): Labour should be managed actively, in order to keep the duration from membranes rupture to delivery to a minimum. In term pregnancies where labour is not established but there has been SROM, augment labour with IV Oxytocin as soon as reasonably possible with the aim of achieving delivery within 24 hours.
- Fetal Scalp Electrode (FSE) and Fetal Blood Sampling (FBS) are contraindicated. Discuss with an Obstetric Consultant.
- Avoid an Artificial Rupture of Membranes (ARM) unless absolutely necessary. Discuss with an Obstetric Consultant. An ARM should only be performed if it is going to alter the management of labour, i.e. suspicious Cardiotocograph (CTG), Oxytocin for dysfunctional labour, etc. Whenever possible, for a woman with a detectable viral load, start AZT infusion 1 hour before ARM.
- If an instrumental delivery is necessary, the instrument of choice should be that which will achieve a safe vaginal delivery with minimum maternal and fetal trauma. The decision for an instrumental delivery should be made by an Obstetric Consultant and preferably be conducted by the most senior obstetrician present.
- An episiotomy should be avoided unless clinically indicated
- Early recourse to Caesarean Section should be considered if labour is not progressing satisfactorily. Discuss with an Obstetric Consultant.
- Women admitted with SROM, but not in established labour, should be actively managed, for the same reason. Refer to section on SROM for further management. The duration of membrane rupture should be kept to a minimum and immediate augmentation by IV Oxytocin should be considered.

2.10 Threatened Preterm / Threatened Labour

- Women who have been commenced on IV AZT where indicated for threatened preterm or threatened labour should resume their pre-existing oral ART if they do not deliver
- There is no additional contraindication for the use of tocolytics and Betamethasone. These can be used in conjunction with IV AZT where indicated in the event of preterm labour.
• Women with preterm rupture of membranes (PROM) at less than 34 weeks gestation need to be discussed/reviewed by the Consultant Obstetrician on call with input from the HIV team. In the majority of cases, the risks of immediate delivery and prematurity outweigh the risks of prolonged ROM and potential vertical transmission, especially in those with an undetectable viral load, and, therefore, adopting a conservative approach is reasonable.

• Women with premature rupture of membranes (ROM) at more than 34 weeks gestation need to be discussed/reviewed by the Consultant Obstetrician on call with input from the HIV team. These women should have their deliveries expedited as soon as reasonably possible either by augmentation (if undetectable viral load (VL)) or by Caesarean Section (with at least 1 hour of IV AZT unless obstetric indication for immediate delivery).

2.11. Postnatal Care and Contraception Advice for Mother
• Babies should be bathed as soon as reasonably possible after delivery
• After delivery there is no indication for the women to be segregated. Discretion should be used by the midwife in the administration of ART to mother and her baby.
• On transfer to the ward please ensure that the mother has enough tablets to recommence her ART. It should be seen as a matter of urgency if the supplies are low.
• Also administer Cabergoline 1mg post-delivery for suppression of lactation as per care plan
• HIV women with CD4 count <200 must not be given the MMR vaccine if they are not immune to rubella as it is a live vaccine. As postnatal follow up will be arranged by the HIV team they will arrange administration of the vaccine when the CD4 count is >200. Please document this instruction in the maternal HIV care plan and hospital notes when the rubella status is known to be negative in HIV women.

2.12. Paired Blood Samples
• Blood samples are taken after delivery from the mother for HIV pro-viral DNA PCR (full EDTA/FBC 4mls purple bottle). From the baby for HIV pro-viral DNA and HIV RNA PCR the samples of blood should be 1-2 ml each in 2 x EDTA/FBC purple bottles. They should be on separate forms and sent to the laboratory labelled with both the mother’s and baby’s details on the forms and bottles. This should be within the first 48 hours.

2.13. Infant Feeding
• HIV is present in breast milk and can be transmitted to the neonate both through free virus and via HIV infected cells in the milk. Although the concentration of the virus is low, the quantities of milk consumed are high leading to a substantial viral exposure in the baby. Breastfeeding increases the vertical transmission rate.
• Recent observations from studies found that mixed feeding carried the greatest risks of vertical transmission. This is because the introduction of other foods including formula feed increases the permeability of the gut therefore resulting in increased rates of acquisition of the infection for the infant.
• In circumstances where safe, affordable alternatives exist, a HIV positive woman should be advised not to breastfeed her baby. There may be a range of cultural issues, which make this a difficult course of action for the woman. Questions from family and friends may prove difficult to answer when they are not aware of the woman’s HIV status and she will need additional support for her choice of feeding.
• The preparation for infant feeding must be discussed during the antenatal period and the woman advised to buy a steriliser, milk and bottles. Also discuss the benefits of Cabergoline for suppression of lactation.

2.14. After Discharge from Hospital
• Plans for future HIV follow-up need to be made. HIV follow up is carried out at 2 weeks in the HIV clinic when an HIV resistance test is carried out if treatment has been stopped.
• The woman’s HIV status is only to be disclosed to other health care professionals with the woman’s informed consent. It is seen as a matter of importance that the woman’s GP, Health Visitor, and Community Midwife are made aware of her status so that the baby can safely access the immunisation programmes.
• Community Midwives should exercise caution in the completing of Newborn Screening forms. It is not necessary to enter confidential information regarding the baby’s medication. In the extremely unlikely event of an abnormal result the information can then be provided with the second sample.

2.15. Contraception and Cytology
• Condoms can prevent STIs and HIV super infection and should be recommended to everyone at risk of these
• For women not taking ART all available methods are suitable subject to the usual risks/benefits for the individual methods
• HIV treatment reduces the efficacy of the combined oral contraceptive pill (OCP) and therefore the use of intra-uterine contraceptive devices (IUCDs) or Depo Provera is advocated
• If cytology is required this should be arranged for a 12 week postnatal visit

2.16. Postnatal care for Neonate
• A paediatrician need not attend the birth unless there is another indication
• Babies should be bathed as soon as reasonably possible after delivery
• The mother should be offered skin-to-skin contact with her baby as soon as possible after the birth

2.17. Infant therapy
• Consent for Vitamin K should be discussed on the woman’s admission to Delivery Suite and is to be given promptly after the birth
• All babies born to HIV positive mothers require 4 weeks of prophylactic antiretrovirals following birth, commenced within 4 hours. The antiretroviral regimes required are documented below. The neonatal prescription sheet will be written up by the neonatologist as per the neonatal HIV policy when the baby is born. The drugs should be available on Delivery Suite four weeks prior to the date of delivery.

2.18. Antiviral Therapy in Pre-term Babies < 35 weeks Gestation
• Many preterm babies are unable to tolerate oral feeds from birth. The immature gut is also at risk of developing Necrotising Enterocolitis (NEC).
• In addition, some studies have shown an association between NEC and the use of oral antivirals. Although a causal link has yet to be established, the use of oral ARTs in preterm babies (who have yet to be established on enteral feeds) needs to be done with this in mind.
• In addition, apart from AZT, the use of other antiretrovirals in the preterm infant is further complicated by the lack of clear dosing and safety data. Because of this, it is
very important that each case is discussed with the HIV specialist in conjunction with the neonatal lead to risk assess the most appropriate treatment.

2.19. Indication for Monotherapy
- Monotherapy may be considered if the mother’s viral load is undetectable (<50c/ml) from 4 weeks before delivery.

2.19.1. Monotherapy for Term Babies – 35/40 weeks
- AZT 4mg/kg, PO, 12 hourly to start within four hours of birth, to continue for four weeks
- If unable to tolerate oral or enteral feeds AZT infusion to be given within 4 hours of birth at a dose of 1.5mg/Kg IV 6 hourly over 30mins. Change to oral AZT at a dose of 4mg/kg, PO, 12 hourly as soon as enteral feeds are tolerated.

2.19.2. Monotherapy for Pre-term Babies <30 weeks
- Start AZT infusion within four hours of birth at a dose of 1.5mg/Kg IV 12 hourly over 30mins
- Change to oral AZT at 2mg/kg 12hourly as soon as enteral feeds are fully established and tolerated
- Ensure baby completes a 4 week course of AZT. For example if a baby only fully tolerates enteral feeding at 3 weeks of life baby will need to be on a week’s course of oral AZT in addition to the 3 week course of IV AZT to complete the 4 weeks AZT cover.

2.19.3. Monotherapy for Preterm Babies 30 to 34+6 weeks
- AZT to start within 4 hours of birth at 2mg/kg 12hourly PO for the first two weeks then 2mg/kg PO 8 hourly for the next two weeks
- If unable to tolerate oral or enteral feeds, AZT infusion should be given instead of the oral preparation within four hours of birth at a dose of 1.5mg/Kg IV 12 hourly over 30mins
- Change to oral AZT at above doses as soon as enteral feeds are tolerated to complete 4 weeks cover

2.20. Indications for Triple Therapy
- The decision to commence triple treatment will have been made antenatally by the HIV doctor and the indications include:
  - Mother presents late in pregnancy and has not received 4 weeks of therapy
  - Mother has a detectable viral load at 34 weeks or later or 4 weeks before delivery >50c/ml
  - Mother is found to be HIV positive after delivery
  - Baby is born premature and mother has a detectable viral load
  - Note: Alternative triple therapy may be required if maternal viral resistance is present. Please discuss as early as possible with an HIV specialist.

2.20.1 Triple Therapy for Term Babies - 35/40 weeks
- AZT 4mg/kg, PO, 12 hourly to start within four hours of birth for four weeks
- Lamivudine 2mg/kg PO twelve hourly starting within four hours of birth for four weeks
- When the mother has not received Nevirapine or has received 3 days or less days of Nevirapine 2mg/kg PO daily to start within four hours of birth for one
week, increasing to 4mg/kg for the second week, then stop. When the mother has received more than 3 days of Nevirapine, the baby is to start Nevirapine 4mg/kg PO daily within four hours of birth for two weeks, then stop.

2.20.2. Triple Therapy for Pre-term Babies - 34+6 weeks
- Apart from AZT, no effective intravenous preparations are available for other ARTs. The use of oral ARTs must therefore be balanced with the higher risk of these babies developing HIV and NEC.
- Emphasis therefore should be directed to the maternal use of antiretrovirals which loads the infants via transplacental transfer whenever possible. In this respect, Nevirapine given at least 2 hours prior to delivery have been shown to be very effective.
- As a general rule (as per the British HIV association recommendation), the treatment option in these babies includes maternal Nevirapine given at least 2 hours prior to delivery and IV AZT given postnatally to the baby. Oral treatment can then be considered once feeding is established.
- Nonetheless, always consult the HIV specialist in conjunction with the neonatal lead to consider the most appropriate treatment option and to joint risk assess treatment options.

N.B. There are no antiretroviral IV preparations for any drugs other than AZT.

2.21. Adherence to Treatment
- 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.
- 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.

2.22. Care on Postnatal Ward
- 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.
- 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.

2.23. Testing Schedule
- Babies should have HIV RNA and Proviral DNA samples taken within the 1st 48 hours. Further samples should be taken from baby at 6 and 12 weeks including
urea & Electrolytes (U&Es), Liver Function Tests (LFTs), Glucose and Full Blood Count (FBC).

- A final HIV antibody test should be carried out at 18 months
- Babies born to HIV positive mothers will require follow up. At Treliske this is usually by Dr Paul Munyard – Consultant in Neonatal Medicine, and his team

2.24. Immunisation
- All routine immunisation can be given to the baby at the usual times. NB. Neonatal BCG should be delayed until the result of the three-month HIV PROVIRAL DNA PCR test confirms that HIV proviral DNA is not detectable.

2.25. Safeguarding Children Concerns
- Where child protection concerns arise they should be dealt with in line with established Trust safeguarding children procedures

2.26. Maternal Drug Resistant HIV
- Resistance mutations detected in the mother’s HIV during or prior to pregnancy may necessitate the infant receiving non-standard prophylactic therapy following birth.
- This will need to be identified as soon as possible by the mother’s HIV physician and discussed antenatal with the named HIV paediatrician for the hospital and the departmental pharmacist.

2.27. HIV Exposure in Pregnancy
- The policy is to reduce the risk of mother to child transmission of HIV by identifying women who may be at risk from sero-converting during pregnancy or breastfeeding and babies who are born to un-booked women who are at high risk of HIV

2.28. The ‘Window Period’
- After primary infection with HIV, there is a period of up to three months before HIV antibodies may be detected. This is called the ‘window period’. During this time further tests (weekly HIV viral load) are necessary to make an early HIV diagnosis to allow prompt treatment of the mother. This is undertaken by the HIV team.
3. Monitoring compliance and effectiveness

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<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>
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<tr>
<td>Lead</td>
<td>Obstetric Lead for Maternal Medicine</td>
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<td>Tool</td>
<td>Health records to be reviewed against each aspect of the guideline</td>
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<td>Frequency</td>
<td>When a case occurs</td>
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<td>Reporting arrangements</td>
<td>Any deficiencies identified will be reported to the Maternity Risk Management Forum or Audit Compliance Forum.</td>
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<td>Acting on recommendations and Lead(s)</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Changes will be agreed as per the action plan Risk Management Newsletter</td>
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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>
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<tr>
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</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr A G Rajasri, Consultant Obstetrician Dr K Eccleston, Consultant in GU/HIV Medicine</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252729</td>
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<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 To inform the multi professional team involved in care of babies born to HIV positive mothers of the management and follow up</td>
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<td>Medical Director</td>
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<td>Maternity Guidelines Group Obs and Gynae Directorate Divisional Board for Noting</td>
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<td>Head of Midwifery</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy)</td>
<td>Internet &amp; Intranet</td>
</tr>
</tbody>
</table>
Related Documents:


Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<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 2015</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>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000
### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): HUMAN IMMUNODEFICIENCY VIRUS (HIV) CLINICAL GUIDELINE FOR MIDWIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong> Obs and Gynae Directorate</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong> Elizabeth Anderson</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
- To inform the multi professional team involved in care of babies born to HIV positive mothers of the management and follow up

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

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) **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**
- No

   b) **If yes, have these *groups been consulted?**
   - N/A

   c) **Please list any groups who have been consulted about this procedure.**
   - N/A

7. **The Impact**

   Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td>All pregnant women and their babies</td>
</tr>
<tr>
<td>Category</td>
<td>X</td>
<td>All pregnant women and their babies</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
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<td></td>
<td></td>
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<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Disability</strong> - learning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>disability, physical disability, sensory</td>
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</tr>
<tr>
<td>impairment and mental health problems</td>
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<td></td>
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</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
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<tr>
<td><strong>Marriage and civil partnership</strong></td>
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<tr>
<td><strong>Pregnancy and maternity</strong></td>
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<tr>
<td><strong>Sexual Orientation,</strong></td>
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<td></td>
</tr>
<tr>
<td>Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td></td>
<td></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 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.  
N/A

Signature of policy developer / lead manager / director  
Dr A G Rajasri  
Date of completion and submission  
20th October 2015

Names and signatures of members carrying out the Screening Assessment  
1. Elizabeth Anderson  
2.  

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

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

Signed: Elizabeth Anderson  
Date: 20th October 2015