Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

<table>
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<tr>
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<th>Clinical Guideline for the Management of Herpes in Pregnancy V1.0</th>
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<td>Caroline Amukusana</td>
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<td>{Original Copy Signed}</td>
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Summary.
Algorithm for management of herpes in pregnancy and care of neonate

- **Recurrent genital herpes**
  - Treat with standard dose of aciclovir if needed
- **Primary acquisition of herpes in first or second trimester (refer to GUM)**
  - Treat primary episode with standard dose aciclovir
- **Primary acquisition of herpes in third trimester (refer to GUM)**
  - Treat primary episode with standard dose aciclovir
  - Consider prophylactic Aciclovir 400mg tds from 36/40 gestation
  - Consider Aciclovir 400 mg tds until delivery
  - Recommend planned CS for delivery if within 6 weeks of primary infection

- **Offer vaginal delivery unless within 6 weeks of primary acquisition**
- **If vaginal delivery ensues inform neonatal team**
- **Baby well**
  - Baby well
  - Normal postnatal care
  - Perform lumbar puncture for HSV PCR
- **Baby unwell**
  - Inform neonatal team
  - Normal postnatal care
  - Discharge home if baby well at 24 hours.
  - Advise parents regarding later management if any concerns
  - Normal postnatal care
  - Genital HVS lesions at delivery
  - Start Aciclovir 20 mg/kg tds for 10 days while awaiting results
  - Normal postnatal care
  - Discharge home if baby well at 24 hours.
  - Advise parents regarding later management if any concerns
Aim/Purpose of this Guideline

The aim of the guideline is to reduce maternal morbidity and to prevent neonatal herpes, which is a rare but serious viral infection. The average reported incidence is 1 in 15,000 live births but there is considerable variation between populations with rates of up to 1 in 7,500 in certain deprived inner-city populations. Incidence appears to be increasing, possibly due to increase in prevalence of sexually transmitted infections, demographic and social change and improvements in diagnostic tests.

Transmission
Factors associated with increased transmission risk include primary herpes in the mother, lack of transplacental maternal neutralising antibodies, prolonged rupture of membranes and immunosuppression in the mother.

Disseminated herpes is more common in preterm infants and occurs almost exclusively as a result of primary infection in the mother. Although recurrent genital herpes is associated with a very low risk of neonatal herpes, recurrent herpes at the time of delivery, which is commonly asymptomatic or unrecognised, may cause the localised forms of neonatal herpes: both local CNS disease and skin, eye and mouth infection.

It may be difficult to distinguish clinically between recurrent and primary genital HSV infections, as many first episode HSV infections are not true primary infections. Careful history and use of type specific serology can help.

Disseminated herpes infection in the mother
Disseminated herpes, which may present with encephalitis, hepatitis, disseminated skin lesions or a combination of these conditions, is rare in adults. However, it has been more commonly reported in pregnancy, particularly in the immunocompromised. The maternal mortality associated with this condition is high.

All immunocompromised women, such as those infected with the HIV virus, are at increased risk of more severe and frequent symptomatic recurrent episodes of genital herpes during pregnancy and of asymptomatic shedding of HSV at term.

For more detailed information on the diagnosis and management of HSV infection in the mother, please refer to the most up to date version of the BASHH guideline on the management of genital herpes.

For more information on presentation of neonatal herpes, on epidemiology and virology and for references please refer to the original document.

The Guidance

1.1. First or second trimester acquisition (until 27+6 weeks of gestation)

1.1.1 If not presenting to sexual health, women with suspected genital herpes should be referred to the Sexual Health Clinic by telephone to the secretarial team on extension 8477. The woman will be seen by a genitourinary medicine physician who will confirm or refute the diagnosis by viral polymerase chain reaction (PCR), advise on management of genital herpes and arrange a screen for other sexually transmitted infections.

1.1.2 Treatment should not be delayed. Management of the woman should be in line with her clinical condition and will usually involve the use of oral (or intravenous for disseminated HSV) aciclovir in standard doses (400 mg three times daily, usually for 5 days). The use of aciclovir is associated with a reduction in the duration and severity of symptoms and a decrease in the duration of viral shedding.

1.1.3 Aciclovir is not licensed for use in pregnancy but is considered safe and has not been associated with an increased incidence of birth defects. Transient neonatal neutropenia has been reported but no clinically significant adverse maternal or neonatal effects have been reported. Aciclovir is well tolerated in pregnancy.

1.1.4 If not the referrer, the obstetrician should be informed and should be involved in discussions around treatment, mode of delivery and risk to baby.

1.1.5 Paracetamol and topical lidocaine 2% gel can be offered as symptomatic relief. There is no evidence that either is harmful in pregnancy in standard doses.

1.1.6 Providing that delivery does not ensue within the next 6 weeks, the pregnancy should be managed expectantly and vaginal delivery anticipated. There is no evidence that HSV acquired in pregnancy is associated with an increased incidence of congenital abnormalities.

1.1.7 Following first or second trimester acquisition, daily suppressive aciclovir 400 mg three times daily from 36 weeks of gestation reduces HSV lesions at term and hence the need for delivery by caesarean section. It has also been shown to reduce asymptomatic viral shedding.

1.2 Third trimester acquisition (from 28 weeks of gestation)

1.2.1 There is some evidence of increased perinatal morbidity (preterm labour and low birthweight), together with stillbirth, however the data are conflicting, so no additional monitoring of such pregnancies is recommended.

1.2.2 Treatment should not be delayed. Management of the woman should be in line with her clinical condition and will usually involve the use of oral (or intravenous for disseminated HSV) aciclovir in standard doses (400 mg three times daily, usually for 5 days). In the third trimester, treatment will usually continue with daily suppressive aciclovir 400 mg three times daily until delivery.
1.2.3 **Caesarean section should be the recommended mode of delivery for all women developing first episode genital herpes in the third trimester**, particularly those developing symptoms within 6 weeks of expected delivery, as the risk of neonatal transmission of HSV is very high at 41%.

1.2.4 It can be difficult to distinguish clinically between primary and recurrent genital HSV infections. In up to 15% of cases where a woman presents with a first episode of clinical HSV infection, it will actually be a recurrent infection. **For women presenting with first episode genital herpes in the third trimester, particularly within 6 weeks of expected delivery, type-specific HSV antibody testing (immunoglobulin G [IgG] antibodies to HSV-1 and HSV-2) is advisable**. For these women, characterising the infection will influence the advice given regarding mode of delivery and risk of neonatal herpes infection. The presence of antibodies of the same type as the HSV isolated from genital swabs would confirm this episode to be a recurrence rather than a primary infection and elective caesarean section would not be indicated to prevent neonatal transmission.

However, it should be noted that it may take 2–3 weeks for the results of this test to become available. It is therefore recommended that an initial plan of delivery should be based on the assumption that all first episode lesions are primary genital herpes. This plan can then be modified if HSV antibody test results subsequently confirm a recurrent, rather than primary, infection. As interpretation of serology can be complicated, results should be discussed with a virologist and/or genitourinary medicine consultant.

### 2 Management of Pregnant Women with Recurrent Genital Herpes.

2.1 Women with recurrent genital herpes should be informed that the risk of neonatal herpes is low, even if lesions are present at the time of delivery. (0–3% for vaginal delivery).

2.2 Although there is no evidence that aciclovir is unsafe in early pregnancy, the majority of recurrent episodes of genital herpes are short-lasting and resolve within 7–10 days without antiviral treatment. Supportive treatment measures using saline bathing, vaseline and analgesia with standard doses of paracetamol alone will usually suffice.

2.3 Vaginal delivery should be anticipated in the absence of other obstetric indications for caesarean section.

2.4 **Daily suppressive aciclovir 400 mg three times a day should be considered from 36 weeks gestation.** There is insufficient evidence to determine whether this reduces the incidence of neonatal herpes; however, it reduces viral shedding and recurrences at delivery so may reduce the need for caesarean section. Limited information exists regarding the neonatal safety of prophylaxis. The risks, benefits and alternatives to daily suppressive therapy should be discussed and prophylaxis initiated for women who desire intervention.

2.5 This increase from the standard suppressive dose of 400 mg twice daily is recommended in view of the greater volume of distribution of the drug during pregnancy.

2.6 Sequential PCR culture during late gestation to predict viral shedding at term, or at delivery to identify women who are asymptomatically shedding HSV, is not indicated. There is no increased risk of preterm labour, preterm prelabour rupture of membranes or fetal growth restriction...
associated with women seropositive for HSV. The incidence of congenital abnormalities is not increased in the presence of recurrent genital herpes infection.

3. Management of women with genital lesions at the onset of labour

3.1 Management of a woman with genital herpes at the onset of labour will be based on clinical assessment as there will not be time for confirmatory laboratory testing. The clinician must take a history in order to ascertain whether this is a primary or recurrent episode. A viral swab from the lesion(s) should nonetheless be taken, since the result may influence management of the neonate.

3.2 The neonatologist should be informed.

3.3 Management of women with primary genital lesions at the onset of labour

3.3.1 Caesarean section should be recommended to all women presenting with primary episode genital herpes lesions at the time of delivery, or within 6 weeks of the expected date of delivery, in order to reduce exposure of the fetus to HSV which may be present in maternal genital secretions.

3.3.2 There is some evidence to suggest that the benefit of caesarean section reduces if the membranes have been ruptured for greater than 4 hours. However, there may be some benefit in performing a caesarean section even after this time interval.

3.3.3 Intravenous aciclovir given intrapartum to the mother (5 mg/kg every 8 hours) and subsequently to the neonate (intravenous aciclovir 20 mg/kg every 8 hours) may be considered for those mothers opting for vaginal delivery. It is unknown whether intrapartum aciclovir reduces the risk of neonatal HSV infection.

3.3.4 Where primary episode genital herpes lesions are present at the time of delivery and the baby is delivered vaginally, the risk of neonatal herpes is estimated to be 41%.

3.3.5 The risk of perinatal transmission depends on the timing of maternal acquisition of HSV, with the highest risk in infants born to women who have not completed HSV seroconversion during pregnancy (most commonly in the third trimester, within 6 weeks of delivery).

3.3.6 Although vaginal delivery should be avoided if possible, in women who deliver vaginally in the presence of primary genital herpes lesions, invasive procedures (application of foetal scalp electrodes, foetal blood sampling, artificial rupture of membranes and/or instrumental deliveries) should be avoided.

3.4 Management of women with recurrent lesions at the onset of labour

3.4.1 Women presenting with recurrent genital herpes lesions at the onset of labour should be advised that the risk to the baby of neonatal herpes is low (0–3% for vaginal delivery).
3.4.2 Evidence from the Netherlands shows that a conservative approach, allowing vaginal delivery in the presence of an anogenital lesion, has not been associated with a rise in the number of neonatal HSV cases.

3.4.3 **Vaginal delivery should be offered to women with recurrent genital herpes lesions at the onset of labour.** A caesarean section delivery can be considered but the risk to the mother and future pregnancies should be set against the small risk of neonatal transmission of HSV with recurrent disease (0–3% for vaginal delivery). The final choice of vaginal delivery versus caesarean section should be made by the mother, who should base her decision on the very low risk of transmission set against any other obstetric risk factors and the risks associated with caesarean section.

3.4.4 It has been reported that invasive procedures (foetal blood sampling, application of foetal scalp electrodes, artificial rupture of membranes and/or instrumental deliveries) increase the risk of neonatal HSV infection. However, given the small background risk (0–3%) of transmission in this group, the increased risk associated with invasive procedures is unlikely to be clinically significant so they may be used if required.

3.4.5 Women should be managed in accordance with standard National Institute for Health and Care Excellence (NICE) intrapartum guidelines. There is no evidence to guide the management of women with spontaneous rupture of membranes at term, but many clinicians will advise expediting delivery in an attempt to minimise the duration of potential exposure of the fetus to HSV.
4. Genital herpes in preterm pre-labour rupture of membranes (PPROM): before 37+0 weeks of gestation

4.1 PPROM with primary herpes

4.1.1 There is limited evidence to inform best obstetric practice when PPROM is complicated by primary HSV infection. Management should be guided by multidisciplinary team discussion involving the obstetricians, neonatologists and genitourinary medicine physicians and will depend on the gestation that PPROM occurred. If the decision is made for immediate delivery then the anticipated benefits of caesarean section will remain. If there is initial conservative management, the mother should be recommended to receive intravenous aciclovir 5 mg/kg every 8 hours. Prophylactic corticosteroids should be considered to reduce the implications of preterm delivery upon the infant. If delivery is indicated within 6 weeks of the primary infection, delivery by caesarean section may still offer some benefit despite the prolonged rupture of membranes.

4.2 PPROM with recurrent herpes

4.2.1 When PPROM is encountered in the presence of recurrent genital herpes lesions, the risk of neonatal transmission is very small and may be outweighed by the morbidity and mortality associated with premature delivery.

4.2.2 In the case of PPROM before 34 weeks there is evidence to suggest that expectant management is appropriate, including oral aciclovir 400 mg three times daily for the mother. After this gestation, it is recommended that management is undertaken in accordance with relevant RCOG guidelines on PPROM and antenatal corticosteroid administration to reduce neonatal morbidity and mortality and is not materially influenced by the presence of recurrent genital herpes lesions.
5. Management of HIV positive women with HSV infection in pregnancy

5.1 HIV-positive women with primary genital HSV infection in the last trimester of pregnancy should be managed according to the recommendations for all women with primary genital HSV infection.

5.2 Women who are HIV antibody positive and have a history of genital herpes should be offered daily suppressive aciclovir 400 mg three times daily from \textit{32 weeks of gestation} to reduce the risk of transmission of HIV infection, especially in women where a vaginal delivery is planned. Starting therapy at this earlier gestation than usual should be considered in view of the increased possibility of preterm labour in HIV-positive women.

5.3 The mode of delivery should be in line with the BHIVA HIV in pregnancy guideline recommendations according to obstetric factors and HIV parameters such as HIV viral load.

5.4 There is currently no evidence to recommend daily suppressive treatment of HSV for HIV antibody positive women who are HSV-1 or -2 seropositive but have no history of genital herpes.
6. Management of the neonate

In all cases the neonatal team should be informed

6.1 Management of babies born by caesarean section to mothers with primary HSV infection in the third trimester

6.1.1. These babies are at low risk of vertically transmitted HSV infection so conservative management is recommended. Liaise with the neonatal team. Swabs from the neonate are not indicated and no active treatment is required for the baby. Normal postnatal care of the baby is advised with a neonatal examination at 24 hours of age, after which the baby can be discharged from the hospital if well and feeding is established.

6.1.2. Parents should be educated regarding good hand hygiene and due care to reduce risk of postnatal infection. Parents should be advised to seek medical help if they have concerns regarding their baby. In particular, they should be advised to look for: skin, eye and mucous membrane lesions, lethargy/irritability, poor feeding.

6.2 Management of babies born by spontaneous vaginal delivery in mothers with a primary HSV infection within the previous 6 weeks

6.2.1. These babies are at high risk of vertically transmitted HSV infection. Liaise with the neonatal team.

6.2.2. If the baby is well:
   Swabs of the skin, conjunctiva, oropharynx and rectum should be sent for herpes simplex PCR.
   A lumbar puncture is not necessary.
   Empirical treatment with intravenous aciclovir (20 mg/kg every 8 hours) should be initiated until evidence of active infection is ruled out.
   Strict infection control procedures should be put in place for both mother and baby.
   Breastfeeding is recommended unless the mother has herpetic lesions around the nipples.
   Parents should be warned to report any early signs of infection such as poor feeding, lethargy, fever or any suspicious lesions.

6.2.3. If the baby is unwell or presents with skin lesions:
   Swabs of the skin, lesions, conjunctiva, oropharynx and rectum should be sent for herpes simplex PCR.
   A lumbar puncture should be performed even if CNS features are no present.
   Intravenous aciclovir (20 mg/kg every 8 hours) should be initiated until evidence of active infection is ruled out.
6.3 Management of babies born to mothers with recurrent HSV infection in pregnancy with or without active lesions at delivery

6.3.1 In the case of recurrent genital herpes infections in the mother, maternal IgG will be protective in the baby and hence the infection risk is low. Conservative management of the neonate is advised.

- Liaise with the neonatal team.
- Surface swabs from the neonate are not indicated.
- No active treatment is advised for the baby.
- Normal postnatal care of the baby is advised with a neonatal examination at 24 hours of age, after which the baby can be discharged from the hospital if well and feeding is established.

6.3.2. Parents should be educated regarding good hand hygiene and due care to reduce risk of postnatal infection. Parents should be advised to seek medical help if they have concerns regarding their baby. In particular, they should be advised to look for: – skin, eye and mucous membrane lesions, lethargy/irritability, poor feeding.
6.4 In cases where there are concerns regarding the neonate (clinical evidence of sepsis, poor feeding)

Liaise with the neonatal team. In addition to considering bacterial sepsis, HSV infection should be considered.
- Surface swabs and blood for HSV culture and PCR.
- Intravenous aciclovir (20 mg/kg every 8 hours) should be given while awaiting cultures.
- Further management by the neonatal team according to condition of the baby and test results.

2.7 Prevention of postnatal transmission

In 25% of cases a possible source of postnatal infection is responsible, usually a close relative. Efforts to prevent postnatal transmission of HSV are therefore important. The mother and all those with herpetic lesions who may be in contact with the neonate, including staff, should practice careful hand hygiene. Those with oral herpetic lesions (cold sores) should not kiss the neonate.
5. Compliance and effectiveness

| Element to be monitored                                                                 | Numbers of pregnant women with diagnosed HSV infection who are known to both Obstetric and Sexual Health services. Management to be audited annually. Numbers of pregnant women treated with antiviral medication in pregnancy. When a herpes antiviral drug is used against a previously undiagnosed genital herpes episode, a swab for herpes PCR should be sent – target 100%. Documentation in the clinic notes regarding discussion with patient of mode of delivery - target 100% Where a first episode diagnosis of genital herpes is made in the third trimester, the woman’s case should be discussed between the obstetrician and neonatologist with documentation of the agreed management – target 100%. Pregnant women with genital herpes should be provided with written information on genital herpes in pregnancy (e.g. the RCOG patient information leaflet) – target 90%. Cases of proven or suspected neonatal herpes – these should all be subject to an investigation to ensure management of the mother was in keeping with the guideline. Investigation to be led by Obstetric lead with input from both neonatal and sexual health teams. Any learning to be disseminated. |
| Lead                                                                                     | Obstetric lead consultant. |
| Tool                                                                                     | Annual audit of case notes. Immediate audit of notes of any child with proven or suspected neonatal herpes. |
| Frequency                                                                                | Annual audit of all cases with input from both Obstetric and Sexual Health teams. Annual report Immediate data and investigation of any cases of neonatal herpes with sharing of any learning between the three disciplines. |
| Reporting arrangements                                                                   | Report to be discussed at relevant specialty governance meetings and the learning to be taken to the specialty board meetings and then disseminated to staff. Outcomes to be documented in the meeting minutes |
| Acting on recommendations and Lead(s) | Departmental audit and governance leads will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes. The Sexual Health governance lead will organise and oversee this. Required actions will be identified and completed in a specified timeframe. |
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned within three months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders. |
5. Equality and Diversity

a. 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.

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

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Guideline for the Management of Herpes in Pregnancy

Version Control Table

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<td>1.0</td>
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<td>Dr. Lisa Haddon. Consultant in Sexual Health</td>
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## Appendix 2. Initial Equality Impact Assessment Form

Clinical guideline for the management of herpes in pregnancy.

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<tr>
<td>Name of individual completing assessment: Lisa Haddon</td>
<td>Telephone: 01872 258477</td>
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1. Policy Aim*  
Who is the strategy / policy / proposal / service function aimed at?  
To minimise the risk of neonatal herpes in infants born to women presenting in pregnancy with proven or suspected genital herpes

2. Policy Objectives*

3. Policy – intended Outcomes*

4. *How will you measure the outcome?

5. Who is intended to benefit from the policy?

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
b) If yes, have these *groups been consulted?

C). Please list any groups who have been consulted about this procedure.

7. The Impact  
Please complete the following table.

<table>
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<th>Rationale for Assessment / Existing Evidence</th>
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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. | No |

9. If you are not recommending a Full Impact assessment please explain why.

No requirement

Signature of policy developer / lead manager / director | Date of completion and submission

Names and signatures of members carrying out the Screening Assessment

1. Dr Lisa Haddon
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, SJ Pedler

Date 7th July 2016