Aneurin Bevan University Health Board

Antenatal Screening for HIV and the Subsequent Care of Mother and Baby Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 2
Approved by: Maternity Clinical Effectiveness forum
Owner: maternity Services
Issue date: 08/12/2016
Expiry date: 08/12/2019
Policy Number: ABHB/0466

Contents:

Introduction

One of the major successes in the management of HIV-positive patients has been the prevention of Mother To Child Transmission of HIV-1. With the widespread implementation of routine antenatal screening for HIV-1, transmission of HIV-1 from mother-to-child is now a rare occurrence in the UK as a result of interventions relating to the management of HIV positive women and their baby during pregnancy , delivery and post-natally.

Policy Statement

The Maternity and Neonatal services of Aneurin Bevan Health Board are committed to offering all women who book for care in Gwent an HIV test, in line with the recommendations of the Welsh Assembly Government in the report "Antenatal Screening to Reduce Mother to Baby Transmission of HIV" (2000). Antenatal screening Wales Policy, Standards and Protocols (2010)

The Antenatal and Neonatal HIV Policy will ensure appropriate medical and obstetric management of women diagnosed HIV positive in pregnancy. The policy seeks to give direction to Obstetricians, Midwives, Physicians and Paediatricians with regard to provision of care to mother and/or baby in these circumstances.

This guidance does not cover co-infection with HIV and Hepatitis B or C: those cases should be discussed separately with the specialists involved in their care

Patients receiving their antenatal care in Cardiff should be managed according to the separate guidance and pathway relating to shared care with UHW

Aims

To provide information to the healthcare staff involved about the services available in the Health Board to women with HIV, how to access these , a guidance to the care in the antenatal, delivery and post natal period and what to do in an emergency, in order to improve the care these women receive in their pregnancy in order to prevent HIV transmission

Objectives

Clarity in decision making for women with HIV during pregnancy and prevention of HIV transmission

Scope

This document relates to all staff involved in the management of women with HIV during pregnancy especially those from obstetrics,

paediatrics and those working in sexual health and women with HIV who are pregnant or would like to become pregnant

Roles and Responsibilities

All staff involved in management of pregnant women and those women who are HIV positive are responsible for the implementation of this document

Main Body

HIV testing

Procedure to be followed for HIV testing for Pregnant Women

Rationale for Testing

The detection of infection in pregnancy means that women can take advantage of the therapies that can protect their child and improve their own health. (RCM/DOH 1999). All women are recommended to have a HIV test in pregnancy.

Advantages of HIV Testing in Pregnancy:
If a woman is found to be HIV positive, specific management can significantly reduce the chances of the unborn baby becoming HIV positive.
Provision of antiretroviral therapy for the woman during pregnancy and delivery, and for the baby for the first four weeks of life, has been shown to reduce vertical transmission by 67.5%.

A planned LSCS and/or specific management plan for pregnancy and delivery will reduce vertical transmission further.

Advice on avoidance of breastfeeding should be given, as breast milk can transmit the virus.

Unborn babies of HIV positive women cannot benefit from these precautions unless the woman's status is known.

There are also benefits to the mother's health

Disadvantages of HIV Testing in Pregnancy
A positive result can in some cases disrupt family relationships.
A positive result may affect mortgage or life insurance applications.
A negative result has no effect.
However these must be weighed against the advantage of prevention of transmission to the unborn child. This must be emphasised to mother

Resources

SST bottle, antenatal serology form, gloves, vacutainer, cotton wool, and plaster.

Information regarding the tests will be given to all women at booking by the community midwife. A copy of the ASW 'Information for women 'leaflets are provided by Antenatal Screening Wales This is in line with Antenatal Screening Wales and National Screening Committees Policy and standards (This explains why HIV testing is recommended and allows for further discussion as necessary. Offer the woman the opportunity to involve her partner if she wishes. (DOH 1998))

During the home booking the community midwife must ensure that pre-test discussion occurs to coincide with the written information received and document in appropriate area of antenatal screening record "(This provides the opportunity to ensure questions are answered and the woman is fully informed (DOH 1993). The midwife must sign the appropriate patient held notes after this discussion. Further discussion time will be available at first hospital visit).

Encourage partner involvement (If he wishes to be tested, he should be referred to the GUM Clinic, Cordell Centre (Danziger 1998))

If there are any particular counselling concerns refer either to GUM Clinic or Antenatal Screening Coordinator in Antenatal Clinic (This will ensure continuity of care and provide the expertise needed). If language is an issue an independent advocate/interpreter MUST be present. Family members, partners and friends must not be used

Blood will be taken at the Antenatal Clinic dating scan appointment. Universal precautions must be practised when taking any blood samples. Women will be advised they may be recalled if problems are identified with any of their booking bloods. (This is to allow a monitoring system to be put in place for bloods taken/results received).

Where no problem is found, women should be informed of the results of all the tests she has consented to by the maternity service at the 16 week antenatal visit. Where sampling has occurred later in pregnancy results should be given within 3 weeks of the sample being taken.
A dated and signed record that the result has been discussed with the woman must be made in the maternity notes. (Antenatal Screening Wales)

Procedure to be followed if negative HIV test
Negative results will be documented in the Maternity notes. The results may also be documented in the hand held notes. Standard C 26 (This will enable good communication between all health professionals whilst ensuring confidentiality. (DOH 1998 & 1999))

Ensure that the woman understands the implications of a negative result. If the woman has any concerns about recent infection risk and seroconversion – a retest is advisable later in pregnancy (12 weeks after any "risky behaviour"). Retest should be offered to all women with risk factors for HIV or if their partner has risk factors for HIV e.g. patient or partner have history of i.v. drug use or patient or partner are from high risk areas for HIV e.g. Sub-Sahara Africa, Thailand. If uncertain which countries have a higer prevalence of HIV please contact GUM/HIV service at Cordell Centre.Referral to GUM clinic (Cordell Centre) for further counselling should be offered to those who decline re- testing. The patient's reasons for declining the re-test should be sensitively explored. Should a patient refuse re-testing and referral to GUM for further counselling her case must be discussed with senior staff including consultants in obstetrics, HIV and paediatrics to decide if further action is required which may impact on mode of delivery or management of the baby after delivery.

Women should be reminded of how to protect themselves from infection in the future i.e. condoms. Partners should be offered GUM referral for testing particularly if they are high risk for HIV. (It can take up to 3 months for antibodies to appear in the blood system, a

test taken within this window period may give a false negative result). Even if a woman is HIV negative, her partner could be HIV positive.

Procedure to be followed if client declines HIV test

If the woman declines the test because she feels she is low risk, the midwife needs to ensure that she is aware of the risk categories and the benefits to the baby of testing (The midwife must explain the benefits of knowing the HIV status to the woman and her baby, when this is achieved, the discussion must be fully documented in the woman's notes).

Tests to be re-offered at each visit to those who have declined, including 28/40 – 32/40. (DOH 1998)

The patient's reasons for declining the test should be sensitively explored. Referral to GUM (Cordell Centre) clinic for further counselling should be offered to those who decline the test especially if they have risk factors associated with HIV i.e. patient or partner have history of iv drug use, come from a high risk area for HIV e.g. Sub-Sahara Africa, patient has male partner who has sex with men. Those at high risk with a negative test should be offered re-testing later in pregnancy in line with the end of window period. Should a patient refuse testing and referral to GUM for further counselling her case must be discussed with senior staff including consultants in obstetrics, HIV and paediatrics to decide if further action is required which may impact on mode of delivery or management of the baby after delivery.

Management for women diagnosed HIV Positive in Antenatal Clinic

Any HIV positive result is phoned through to the Lead Midwife for HIV in RGH (Kim Jenkins) by the health board laboratory. The antenatal screening coordinator also needs to be informed of the result.
In her absence a named deputy will take the result.

Lead HIV Midwife asks a clerk to phone up the patient and arrange for her to attend obstetric OPD asap where the patient is informed of the preliminary result and is told of the next steps which will be an appointment at Cordell centre for further confirmatory testing. The Lead Midwife for HIV will arrange appointment at Cordell and inform GUM.

On attending the obstetric OPD appointment the woman is seen alone by the Lead Midwife for HIV/ named deputy (with Health Board HIV Liaison Nurse GUM together if required)and told the result of the test. (NB: being seen alone can initially be awkward. However, it is important to maintain confidentiality and give her the opportunity to decide whether or not she wishes to tell her partner the HIV result.) Explain to anyone accompanying the woman that it is our routine policy and procedure to give results alone.
If language is an issue an independent advocate/interpreter MUST be present. Family members, partners and friends must not be used.

The Lead Midwife for HIV/Screening Co-ordinator/ named deputy gives information on services available and the importance of attending an HIV specialist clinic ASAP for further confirmatory testing, to assess her medical situation and options for management. She will also be given written information on what HIV means.

Information will be given regarding the GUM Clinic (Cordell Centre) at RGH and an appointment made for the HIV Clinic. In addition, the woman will be given information regarding specific HIV services for children. The woman's permission will be sought to allow the Lead HIV midwife / named deputy to inform the named paediatric consultant of her HIV status.

The named Obstetric Consultant (if applicable) is informed of the woman's HIV positive result and a referral made to the Consultant Obstetrician with a special interest in HIV. NHH women will have their care transferred to RGH. The Screening Coordinator/named deputy will directly refer women booked for MLC to the care of this Consultant, informing the Named Midwife with the woman's permission.

Antiretroviral treatment will usually be commenced by the HIV/GUM team by the second trimester in line with BHIVA guidelines, those patients with high CD4 counts requiring antiretroviral treatment for prevention of mother to child transmission (rather than for their own health) should be started on a regimen containing a protease inhibitor. Dose adjustments of HAART should be undertaken as required e.g. boosted Atazanavir increased to 400mg od, Daurunavir should be given twice a day rather than once a day, Nevirapine should be prolonged release and a TDM should be

considered. STI screen including slides/swabs for BV should be offered in line with BHIVA guidance.

All women under HIV care must be advised to make an appointment with the HIV team as soon as possible after they become pregnant or if they are planning a pregnancy to allow further management to be discussed. Patients under HIV care who are on 6 monthly follow up must be seen more frequently during their pregnancy.

A treatment plan will be placed in the main Obstetric notes/Hand held record regarding care regimes in labour/delivery and for care of the baby following the 32-34 week antenatal visit, following a multidisciplinary team discussion.

At 37-38 weeks a plan should be documented in notes and CS date booked if required. IV Zidovudine should be prescribed by the consultant obstetrician and kept on labour ward and the Neonatologists informed. The ABHB microbiology team should be informed of plans to send proviral DNA samples from mother and baby to the laboratory on delivery.

Care in Labour/Delivery of HIV Positive Women

Delivery by Elective Caesarean Section (El LSCS) before Rupture of Membranes decreases vertical transmission by 50%. Antenatal, Intrapartum maternal and neonatal antiretroviral therapy reduces transmission by 67.5%.

Women with undetectable HIV plasma loads on combination HAART (3 drugs being used to treat HIV) may be safely delivered at term by vaginal delivery without intrapartum i.v. antiretroviral therapy.

Intrapartum IV Zidovudine and caesarean section should be offered if viral load is not known, is detectable , SROM, or if patient not on 3 drug HAART

Wherever possible, the method of delivery and use of antiretroviral therapy will be planned between the patient and obstetrician in consultation with the HIV physician and designated specialist neonatal paediatrician. Viral load at 36 weeks will usually be used to determine mode of deliver in the absence of other contributing factors.

Scenarios involving HIV patients who are "elite controllers" or are on AZT monotherapy are not covered in this guideline and should be managed on an individual basis with reference to current BHIVA guidelines

Zidovudine Infusion (all ZDV infusion details in this category)

Procedure comprises:
• Loading dose 2mg/kg over 1 hour.
• Maintenance 1mg/kg/hr for this should be continued until baby is delivered and the umbilical cord is clamped.

Infusion should be commenced at least 4 hours pre-operatively for C-S (but in the event of labour pre-ELCS the LSCS should not be delayed to complete the infusion if progress is rapid or membranes have ruptured).

Zidovudine infusion: 1 x 20ml vial = 200mg.
May be diluted with 5% Dextrose or 0.9% Sodium Chloride.

Procedure
.. Remove 100ml from 500ml bag of above fluids
.. Add 1000mg (one thousand milligrams) AZT = 2mg/ml (5 vials)
.. Start Loading dose of 2mg/kg/hr (e.g. 70kg woman = 140mgs/hr = 70mls/hr)
.. Maintenance dose of 1mg/kg/hr (e.g. 70kg woman = 70mgs/hr = 35mls/hr)

Dilutions are stable for 48 hours at room temperature or in the fridge.

A specialised care plan/care protocol will be found attached to the inside cover of the woman's notes. There will also be a drug chart with the prescribed Zidovudine. These will be placed there following the 30-week Antenatal Clinic appointment.
Zidovudine will be ordered by the obstetric consultant following this appointment and stored in the Controlled Drug Cupboard on MDU.
All women should receive an IV Loading Dose, even if on oral therapy. IV drug infusion should be continued until the cord is clamped and cut.

Women already on treatments should continue their normal regimen after delivery, which will have been prescribed in GUMed/by HIV team.

Delivery
Universal precautions should be practised for any care involving exposure to body fluids. (See Aneurin Bevan Health Board Infection control for further information re: Blood Borne Viruses Policy)

Care prior to LSCS
.. Admit previous day
.. IV access to be established on evening of admission
.. Infusion of Zidovudine for at least 4 hours pre-operatively

Procedure for Elective Lower segment Caesarean Section
1 Staff to wear: plastic apron, waterproof gown, double gloves and eye protection
2 Normal abdominal drape; waterproof drape to operating table
3 Diathermy –secure all visible bleeding points on entry
4 Over sew any large uterine vessels around incision site with figure of eight suture
5 Attempt to open uterus without rupturing the membranes
6 If possible, deliver the baby in intact membranes
7 If ROM, suction baby's mouth and nose immediately, whilst still on operating table
8 Bathe baby as soon as practicable following delivery
9 Advise not to breastfeed

Spontaneous onset of labour prior to booked LSCS/iv Zidovudine
For women booked for EL LSCS but admitted in spontaneous labour:

.. . If HIV viral load detectable above 50 copies for immediate C-S, if <50 and on HAART (i.e. 3 drug anti-retroviral treatment) induce/augment labour. Add GBS prophylaxis as per protocol.
.. IV infusion of Zidovudine should commence immediately (The loading dose can be given over 30 minutes if necessary
.. LSCS expedited (The LSCS should not be delayed to complete the infusion if progress is rapid or membranes have ruptured).

IF SROM <34 weeks or Premature delivery <34 weeks: MDT discussion about appropriate management whilst receiving steroids, consider stat 200mg Nevirapine 2-4hours before delivery if possible+ optimising HAART including raltegravir+ IV Zidovudine (see section 8.3) + double dose tenofovir i.e. 2x300mg if mother not on Truvada/tenofovir
Add GBS prophylaxis as per protocol

Procedure for Vaginal Delivery

Vaginal delivery should be offered only if viral load at 36 weeks <50copies /ml and on HAART (i.e. 3 drug anti-retroviral treatment)

Intrapartum IV Zidovudine and caesarean section should be offered if viral load is not known, is detectable, SROM, woman not on 3 drug HAART

Please refer to Aneurin Bevan Health Board Infection Control Manual for guidance re: Maternity procedures.

For women opting for vaginal delivery:
Aim: to decrease contact time between the baby and potentially infected maternal blood and vaginal secretions.
1 Avoid invasive procedures where possible i.e. FSE/FIBS
2 Defer ARM and consider Syntocinon if SROM
3 Avoid episiotomy and difficult instrumental delivery (especially forceps). If instrumental delivery is indicated, low cavity forceps are preferable to ventouse
4 Zidovudine regimen should be managed as for LSCS
5 Active management of third stage as high risk of PPH
6 Bathe baby as soon as practicable following delivery
7 Advise not to breastfeed
Following delivery refer to Paediatric guidelines for care of baby.

Late-presenting woman not on treatment

A woman who presents after 28 weeks should commence HAART without delay.

Women presenting in labour/with rupture of membranes (ROM)/requiring delivery without a documented HIV result must be recommended to have an urgent HIV test. A reactive/positive result must be acted upon immediately with initiation of the interventions for prevention of mother to child transmission (PMTCT) without waiting for further/formal serological confirmation.

If the viral load is unknown or >100 000 HIV RNA copies/mL a three or four drug regimen that includes raltegravir is suggested.

An untreated woman presenting in labour at term should be given a stat dose of nevirapine (200mg) and commence fixed-dose zidovudine with lamivudine and raltegravir.

It is suggested that intravenous zidovudine be infused for the duration of labour and delivery which should be by emergency or pre-term cesarian section (as detailed previously).

In preterm labour, if the infant is unlikely to be able to absorb oral medications consider the addition of double-dose tenofovir (i.e. 2x 300mg) (to the treatment described in above) to further load the baby.

Postnatal Care of HIV Positive Women

There is no need for HIV positive women to be nursed in isolation. However, please remain aware of the need for privacy when discussing issues that they may not want others to overhear. There is no need to appoint designated toilet facilities, but advise on a high standard of hygiene whilst bleeding postpartum. Give alco-wipes to the woman to clean any "spotting" from the toilet seat and advise on careful disposal of soiled sanitary towels in yellow bags.

Use routine universal precautions when handling body fluids. Advice on avoidance of breastfeeding should be given to HIV positive women in order to reduce the risk of transmission to the baby who may not have been infected in utero or during delivery.

Refer to client's wishes regarding confidentiality.

Discuss contraception prior to discharge. Specialist advice can be sought from Cordell Centre. Patients should be made aware that conception can occur before next period. Some anti-retroviral therapies reduce the efficiency of the oral contraceptive pill. The Depot and IUS do not interact with anti-retrovirals (please discuss with GUM Drs if any queries). A barrier method should be advised as well as any other form of contraception to:
.. Protect the woman from a more virulent strain of HIV, or
.. Avoid transmission to a negative partner
Ensure condoms provided for client on discharge from hospital especially if no other method of contraception commenced prior to discharge (Contact Cordell Centre if required).

Ensure a cervical smear has been taken within the past year and stress the need to have them annually thereafter, as there is an

increased risk of cervical intraepithelial neoplasia in immunosuppressed women. A cervical smear should be performed at the postnatal appointment 12 weeks post delivery.

Anti-retroviral drugs that are to be continued will be prescribed on the drug chart for the mother and baby. Ensure mother and baby have sufficient medication until next appointment and that mother is administering the baby's medication correctly.

ART can be discontinued in women who were on it solely for the indication of reducing mother to child transmission (decision to be made by GUM team) however it is suggested that the Nevirapine long half- life should be covered with Combivir for 2 weeks if Nevirapine given stat perinataly (Discuss with GUM physician)

Ensure mother has a follow up appointment with her GU Consultant.

Care of babies born to HIV positive women

Prior to 1985, infected blood products caused early cases of HIV in children. The main cause is now vertical transmission. There are 830,000 children in the world with HIV/AIDS and vertical transmission accounts for 90% of these (WHO 1998). 15-25% of children born to HIV mothers will become HIV positive if no treatment is given and in some cases will develop AIDS within the 1st year of life. Treatment for HIV during pregnancy will reduce the rate of vertical transmission to the baby from 25% to less than 5% (DoH 1999)

Reducing the risk of the transmission of HIV from mother to baby

The implementation of an appropriate anti-retroviral therapy regimen for mother and baby, having a planned pre-labour LSCS and avoiding breast-feeding will reduce the risk of vertical transmission of HIV to <2% (BHIVA 2001)

General principles of treatment of the baby

A planning meeting will be held between 30/32 weeks gestation. An obstetric and neonatal plan will be agreed at this meeting and placed in the notes.

This will detail:
.. Maternal anti retroviral treatment
.. Specific factors to consider i.e. other maternal infections

.. Anti retroviral therapy will be required.

Neonatal treatment to be commenced as soon as possible (no later than 4 hours ideally) continue thereafter for the 1st 4 weeks of life. The choice of drug for the infant will depend on the clinical scenario

Paediatric management and drug regimens will not be covered in this guidance. Paediatric team should be contacted urgently to discuss neonatal treatment and drug and vaccination regimens.

Laboratory diagnosis of HIV infection
The gold standard for HIV infection in infancy is HIV proviral DNA PCR on peripheral blood lymphocytes.

Day of birth (within 24 hours)
Please ensure not cord blood
Laboratory should also get sample of mother's blood for HIV proviral DNA PCR (10 ml in 2 purple tops) for comparison with the babies sample in line with BHIVA guideline

Test	Where to send	How to collect
HIV proviral DNA PCR and HIV antibodies	Collindale by prior arrangement please discuss with ABHB microbiologist	2 mls of blood into an EDTA tube
FBC	RGH Haematology Lab	Routine sample
U & Es	RGH Biochemistry Lab	Routine sample
CMV Urine for PCR	RGH Microbiology Lab	1 specimen

Six weeks of Age (2 weeks after discontinuing AZT therapy)

Test	Where to send	How to collect
HIVproviral DNA PCR and HIV antibodies	Collingdale by prior arrangement please discuss with ABHB microbiologist	2 mls of blood into an EDTA tube
FBC	RGH Haematology	Not routinely

	Lab	repeated,delete
U & Es	RGH Biochemistry Lab	as above
CMV Urine	RGH Microbiology Lab	not repeated, can delete
LFT's	RGH Biochemistry	as above

AZT Needs to be stopped at 4 weeks

Three Months of Age

Test	Where to send	How to collect
HIV proviral DNA PCR and HIV antibodies	Collingdale by prior arrangement please discuss with ABHB microbiologist	2 mls of blood into an EDTA tube

If the HIV tests are negative at this stage and the baby is not breast fed then the child is not likely to be infected.

Confirm disappearance of maternal HIV antibodies in the baby at 18 – 24 months.

BCG vaccination is delayed until at least 2 negative tests off treatment.

Communication

Documented communication between all the professional agencies involved whilst maintaining patient confidentiality is of paramount importance.

a) The birth plan agreed no later than 34 weeks gestation will contain details of the ART regimen of the mother which will in turn determine the ART regimen given to the baby in the 1st 4 weeks of life.

b) The Consultant Paediatrician will ensure that Pharmacy is informed of the likely drug regimen for the baby when the birth plan is agreed.

c) Pharmacy will ensure that the appropriate ART for the baby is available on the Neonatal Unit from the time the birth plan is agreed

d) The Obstetrician will determine the exact timing of planned LSCS at about 38 weeks and communicate this to the Consultant Paediatrician who has agreed the birth plan. The HBV and HCV status of the mother will also be made known to the Consultant Paediatrician.

e) Following delivery the Consultant Paediatrician will ensure that the mother is aware of the recommendation to avoid breast feeding

f) Following delivery, the Consultant Paediatrician will ensure that ART commences within 12 hours and that the HIV screening protocols are followed.

g) Following discharge the Consultant Paediatrician will ensure that the GP/HV is informed that the baby should follow the routine immunisation programme except for BCG and confirm that breast feeding is contraindicated

h) When the baby is confirmed non-infected the Consultant Paediatrician will ensure the BCG (if indicated) is given.

i) The Consultant Paediatrician will be responsible for follow up until at least 2 years and the reporting protocols completed as described above.

Useful Contacts

Dr Papworth, Consultant Neonatologist,
RGH tel: (01633) 234599

Mrs Jyoti Singh, Consultant Obstetrician
RGH tel: (01633) 234234

Dr Humphrey Birley, Consultant GU Medicine

RGH tel: (01633) 234234 – The Cordell Centre
Dept. Sexual and Reproductive Health Office: (01633)623720

Dr Carys Knapper, Consultant Sexual and Reproductive Health
RGH tel: (01633) 234234 – The Cordell Centre
Dept. Sexual and Reproductive Health Office: (01633)623720
Mobile: 07964109094

Training

To support the Antenatal and Neonatal HIV Policy and to ensure all midwives are competent to discuss HIV screening in pregnancy all current staff have:
.. Attended an in-house training session regarding HIV Awareness and orientation to the policy facilitated by the Antenatal Screening Co-ordinator. This training will be offered on a bi-annual basis for new staff in post.
.. An annual update for all midwives involved in caring for women who are pregnant and HIV positive will be provided on an annual basis as part of the Antenatal Screening Update. Information on attendance at these updates is kept by the screening co-ordinator and will also be forwarded to the training and development department to be entered on to PRISM

Equality

An equality impact assessment has been performed

Audit

The Antenatal Screening Co-ordinator will undertake a Bi-annual audit as part of the performance management framework (Balance Score Card) of the offer and uptake of HIV screening. The findings will be reported to Antenatal Screening Wales and published by Antenatal screening Wales to the Health Board via the Balance score card report biannually.

The Paediatric team will undertake an annual audit of the vertical transmission rates from mother to baby.

Review

3 years

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Mode of delivery in HIV-infected pregnant women and prevention of mother-to-child transmission. European Collaborative study. HIV Medicine 2010; 11: 368-78

HIV in Pregnancy, Management (Green-top 39), Royal College of Obstetrics and Gynaecology http://www.rcog.org.uk/womens-health/clinical-guidance/management-hiv-pregnancy-green-top-39

WHO: Global Health Observatory Data Repository: HIV/AIDS: **http://apps.who.int/ghodata/?vid=22500#**

Appendix 1: Checklist to be used to aid management

Checklist Guide for the management of pregnancy and labour in women with HIV infection

This document is to be used as an aid only and must be used in conjunction with the main ABHB Policy for routine Antenatal

Screening for HIV and the subsequent Care of Mother and Baby which is available on the intranet on the following web link : http://howis.wales.nhs.uk/sitesplus/866/document/232589

Booking and first trimester management-

Ensure booked under JS for appointment at RGH
Ensure have met with GUM team. Lead midwife for RGH- Kim Jenkins,

Discuss basic management including ARVs for mother, baby , intrapartum, no breast feeding and potential options for mode of delivery

Routine booking bloods-FBC, G&S, rubella immunity check, Hep B, Syphilis + Hep C ,varicella zoster, measles and toxoplasma
Dating scan Initial viral load and CD4 count (GUM clinic). ART based on individual needs. Screening for other STDs- Clamydia, N Gonorrhea, Bacterial vaginosis, HSV

N.B. HIV Test to be re-offered at each visit to those who have declined and the pateint's reasons should be sensitively explored. Referral to GUM clinic for further counselling should be offered to those who decline the test especially if they have risk factors associated with HIV. Those at high risk with a negative test should be offered re-testing later in pregnancy in line with the end of window period.

Second trimester

15-17 weeks : Down's screening. If amniocentesis is required →liase with GU physician (for viral load/HAART (raltegravir and combivir and loading Nevirapine)
20/40 anomaly screening scan
16-20/40 – ART commenced to reduce MTCT (if not on it for maternal indications)
Obstetric management – shared care between CMW and hospital

Third Trimester

28/40 routine bloods – FBC, G&S , OGTT as well
34/40 discuss choices re: delivery and meet paediatricians (Dr Papworth @ RGH @NHH)
36/40 (GU clinic) viral load→ determines mode of delivery (if <50 copies of RNA/ml and on 3 drug HAART→ allow vaginal birth including VBAC , planned elective caesarean section if viral load >400, but viral load between 50-399 the mode of delivery to be a MDT decision based on response to ART, duration etc)
Elective caesarean section is recommended if not on 3 drug HAART(even if viral load is undetectable) For co-infection with hepatitis B or C discuss with colleague
37-38/40 → plan documented in notes and CS date booked. IV Zidovudine prescribed and kept on labour ward. Neonatologists informed. Address any obstetric problems as they arise.

Term pre-labour SROM- expedite delivery. If viral load detectable above 50 copies for immediate C-S, if <50 and on HAART (i.e. 3 drug anti-retroviral treatment) induce/augment labour. Add GBS prophylaxis as per protocol.

SROM <34 weeks: MDT discussion about appropriate management whilst receiving steroids, consider stat 200mg Nevirapine 2-4hours before delivery if possible+ optimising HAART including raltegravir+ IV Zidovudine + double dose tenofovir i.e. 2x300mg if pre-term labour. Add GBS prophylaxis as per protocol.

Intrapartum care

Follow standard infection control procedures
Vaginal delivery if viral load <50copies /ml and on HAART (i.e. 3 drug anti-retroviral treatment),

Intrapartum IV Zidovudine and caesarean section if viral load is not known, is detectable , SROM, woman not on 3 drug HAART

Avoid procedures such as ARM unless delivery imminent, FSE application, FBS if possible

If instrumental delivery is indicated, low cavity forceps are preferable to ventouse

Bathe infant as soon as born

If first presentation in labour (i.e positive rapid test→ liase with GU physicians) stat 200mg Nevirapine 2-4hours before delivery if possible+ HAART suggest combivir and raltegravir+ IV Zidovudine + double dose tenofovir i.e. 2x300mg if pre-term labour, Baby to receive HAART, emergency LCS)

At birth proviral DNA sample should be taken from mother and baby

Postpartum care

ART discontinued in women who were on it for the indication of reducing MTCT (suggest cover Nevirapine long half- life with Combivir for 2 weeks if Nevirapine given stat perinatally)

Exclusively bottle feed baby

Neonatal treatment to be commenced as soon as possible (no later than 4 hours),

If baby born within 2 hours of stat dose of nevirapine being given to

mother, baby should also be commenced on nevirapine in combination ARV

Information and supportive advice about minimising exposure of infant to bodily fluids

Neonatal viral PCR at birth, 6 weeks, 3months following post exposure prophylaxis, antibody testing for sero-conversion between 18-24 months

DRUG doses

IV Zidovudine: 400 ml of normal saline with 1000mg of Zidovudine. Loading dose of 2mg/kg/hour for one hour followed by 1mg/kg/h until continued until baby is delivered and the umbilical cord is clamped. Aim for at least 4 hours of infusion if delivery is by c/section and there is **no SROM**.

For women booked for EL LSCS but admitted in spontaneous labour: IV infusion of Zidovudine should commence immediately (The loading dose can be given over 30 minutes if necessary) LSCS expedited (The LSCS should not be delayed to complete the infusion if progress is rapid or membranes have ruptured).

Zidovudine: 1 x 20ml vial = 200mg. May be diluted with 5% Dextrose or 0.9% Sodium Chloride.

Procedure: Remove 100ml from 500ml bag of above fluids Add 1000mg (one thousand milligrams) AZT = 2mg/ml (5 vials) Start Loading dose of 2mg/kg/hr (e.g. 70kg woman = 140mgs/hr = 70mls/hr) Maintenance dose of 1mg/kg/hr (e.g. 70kg woman = 70mgs/hr = 35mls/hr) Dilutions are stable for 48 hours at room temperature or in the fridge.

APPENDIX 2

EQUALITY IMPACT ASSESSMENT GUIDANCE

Aneurin Bevan Health Board

Flowchart for the Completion of the EqIA Paperwork

1. Complete **FORM 1** 'Preparation and Assessment of Relevance & Priority'

↓

2. Complete **FORM 2** 'Evidence Gathering'

↓

3. Complete **FORM 3** 'Action Plan'

↓

4. Complete **FORM 4** 'Assessment of Relevance and Priority Scoring Chart' **To be scored following consideration of relevant action to be taken**

↓

5. Complete **FORM 5** 'Outcome Report'

FORM 1

Equality Impact Assessment (EqIA)

Form 1

Part A: Preparation and Assessment of Relevance and Priority

Step1: Preparation

1 What are you equality impact assessing?

Routine Antenatal Screening for HIV and the subsequent **Care of Mother and Baby guideline**

2. Policy Aims and Brief Description - What are its aims, give brief description.

To provide information to the healthcare staff involved about the services available in the Health Board to women with HIV, how to access these , a guidance to the care in the antenatal, delivery and post natal period and what to do in an emergency, in order to improve the care these women receive in their pregnancy in order to prevent HIV transmission

3. Who Owns the Policy? - Who is responsible for the policy/work?

Authors: J Singh

4. Who is involved in undertaking this EqIA? - Who are the key contributors to the EqIA and what are their roles in the process?

J Beasley Senior Midwifery Manager

5. Other Policies- Describe where this policy/work fits in a wider context.

Labour Ward guidelines , Sexual and Reproductive Health and Neonatal guidelines

6. Stakeholders – Who is involved with or affected by this policy?

All staff involved in the management of pregnant women, those who are diagnosed with HIV and their children. Women utilising maternity services in ABHB and those who are diagnosed with HIV and their children

7. What factors may contribute to the outcomes of the policy? What factors may detract from the outcomes? These could be internal or external factors.

The following will contribute to the successful outcome of this guideline:
Widespread dissemination of the guideline
Widespread availability of the guideline

Next Steps
For the next stage of the EqIA process please see form:
Part A, Step 2 - Evidence Gathering.

Aneurin Bevan Health Board

FORM 2 **Equality Impact Assessment: Part A, Step 2 Evidence Gathering**

Equality Strand	Evidence Gathered	Does the evidence apply to the following with regard to this policy/work? Tick as appropriate																			
		Eliminating Discrimination and Eliminating Harassment		Promoting Equality of Opportunity		Promoting Good Relations and Positive Attitudes		Encouraging Participation in Public Life		Taking account of difference even if it involves treating some individuals more favourably											
Race	There is no evidence identified to demonstrate that a person's race will affect operation of this guideline however clients from certain countries are deemed to be at higher risk of suffering from HIV		✓		✓		✓		✓												
Disability	There is no evidence identified to demonstrate that a person's disability will affect operation of this guideline		✓		✓		✓		✓												
Gender	There is no evidence identified to demonstrate that a person's gender will affect operation of this guideline		✓		✓		✓		✓												
Sexual Orientation	There is no evidence identified to demonstrate that a person's sexual orientation will affect operation of this guideline		✓		✓		✓		✓												
Age	There is no evidence identified to demonstrate that a person's age will affect operation of this guideline		✓		✓		✓		✓												
Religion/ Belief	There is no evidence identified to demonstrate that a person's religion/belief will affect operation of this guideline		✓		✓		✓		✓												
Welsh Language	There are facilities for translation if required as a consultant in sexual health is Welsh speaking		✓		✓		✓		✓												
Human Rights	There is no evidence that a person's human rights will be affected by operation of this guideline																				

*This column relates only to disability due to the DDA 2005 specific duty

FORM 3

Aneurin Bevan Health Board
Equality Impact Assessment Action Plan

Name of Policy:

Recommendation	Expected Outcome	Divisional/Department Response	Responsible person	Progress to date
All clients should be offered the test regardless of race				
WHO data used to inform if area/country of origin has higher prevalence of HIV				
Clients should be given the opportunity to have an interpreter if they desire				

FORM 4

Aneurin Bevan Health Board: Equality Impact Assessment
Assessment of Relevance and Priority – Scoring Chart

Name of Policy:

Equality Strand	Evidence: Existing evidence to suggest some groups affected gathered from Part A Step 2.	Potential Impact: Nature, profile, scale, cost, numbers affected, significance.	Decision: Multiply 'Evidence' score by 'Potential Impact' score. ** please see bottom of the page for maths rule*
Race	1	1	1
Disability	1	1	1
Gender	1	1	1
Sexual Orientation	1 1	1	1
Age	1	1	1
Religion/ Belief	1	1	1
Welsh Language	1	1	1
Human Rights	1	1	1

Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Impact Decision	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

* Rule: Multiplication of a negative number by a positive number yields a negative result.
Multiplication of two positive numbers yields a positive result.
Multiplication of two negative numbers yields a positive result.

FORM 5

Aneurin Bevan Health Board

Equality Impact Assessment (EqIA) Outcome Report

Policy Title:	Policy for Routine Antenatal Screening for HIV and the subsequent Care of Mother and Baby
Organisation:	Aneurin Bevan university Health Board
Name of policy Assessors:	Jayne Beasley
Division/ Department:	Family and Therapies Division Maternity Services
Proceed to Full EqIA:	The assessors are satisfied that as there are no negative impacts identified in this assessment a full EqIA is not required
Summary of the EqIA process and key points to be actioned:	This EqIA has been undertaken using the tool kit designed by the NHS Centre for Equality and Human Rights. The tool kit gives due consideration to each statutory limb of the Equality Act (2010) and in keeping with an inclusive equality agenda also includes consideration of the Welsh Language Act and the Human Rights Act. Tjis report is not intended to provide a definitive account of the content and outcome of the EqIA screening process but offers a summary of the findings. In this instance no negative differential is identified
Responsibility for validation of the EqIA:	Maternity Clinical Effectiveness Forum
Date:	**08/12/2016**
Monitoring Arrangements:	This Guideline will be monitored via the Maternity Services Clinical Effectiveness Forum

Policy expiry: date:	**08/12/2019**

This information is available on request in a range of accessible formats, Welsh and other community languages as required.

For more information please contact: Aneurin Bevan Health Board Policy Process Manager on 01495 765460

APPENDIX 5

CHECKLIST FOR THE APPROVAL AND RATIFICATION PROCESS OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

CHECKLIST FOR THE APPROVAL AND RATIFICATION OF POLICIES AND OTHER WRITTEN CONTROL DOCUMENTS

Please note that no policies or other written control documents should be taken to the [enter sub committee name] for ratification unless they have been seen and approved by the [enter the name of the sub group or forum].

Name of Policy or written control document:

…… Routine Antenatal Screening for HIV and the subsequent Care of Mother and Baby guideline

…….

…….

Owner(s): Maternity services

Review Date:
…….……08/07/2019……

1.	Please specify the date and name of person who carried out the policy or other written control document Equality Impact Assessment	Date: …08/12/2016 Name : …J Beasley
2.	Have you taken into consideration the relevant legislation that may be applicable to this policy or other written control document?	Yes ✓ No

Comments : .....

……..

……..

……..

.....

3. Has a patient information leaflet been developed to assist this policy or written control document?

Yes [ ] No [✓]

Not Applicable [ ]

If yes, is the information available in the variety of accessible formats and languages? *(including welsh and other community languages as appropriate)*

Comments : .....

.....

.....

.....

4. Where appropriate, have you consulted with the relevant services/personnel throughout the Aneurin Bevan Health Board when completing the policy or other written control document?

Yes [✓] No [ ]

(e.g. Voluntary, Legal, Pharmacy, IT, Finance, personnel, etc.)

Comments : .....

.....

.....

.....

5. If applicable, please state what training has been identified as a result of this policy or other written control document, and what has been taken:
(Has the training department been informed of any training needs?)

……Forms part of midwifery training programme……
……

……

6. Have the necessary users been consulted in the development of this policy or written control document?

   (e.g. Aneurin Bevan Health Board, Division/Locality wide, Third Sector, etc.)

   Yes [✓] No [ ] Not Applicable [ ]

   Please provide details: consulted with sexual health lead

7. Has the necessary Equality Impact Assessment documentation been completed?

   Yes [✓] No [ ]

8. Has the necessary Environment Impact Assessment been completed?

   Yes [ ] No [ ] Not Applicable [✓]

   If no, give reason(s): .....

   ……..

   ……..

   ……..

Ratification

The [enter name of committee, group or forum] has considered the information and agrees/ratifies on [08/12/2016].

Chair signature ……J
Singh……..……

Comments : ……..

……..

……..

……..

……..

……..