Guidelines for the Management of Women living with HIV (Antenatal, Intrapartum, Postnatal and Neonatal Care) in Swansea Bay Health Board

Approved by: Antenatal Forum

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Contents

1.Purpose of Guideline

This guidance aims to support health care staff to provide the optimum care for women living with HIV during pregnancy and delivery within Swansea Bay. The guidelines are in keeping with:

- Antenatal Screening Wales (2019) *Revised Policy, Standards and Protocols to Support the Provision of Antenatal Screening In Wales.* Available at: http://www.antenatalscreening.wales.nhs.uk/professional/opendoc/356699 Public Health Wales: Cardiff.
- Children's HIV Association (CHIVA) Guidelines (2011), available at: http://www.chiva.org.uk/guidelines
- British HIV Association (BHIVA) Guidelines (BHIVA) (2018), available at: http://www.bhiva.org/Guidelines.aspx

2. Background

All pregnant women in Wales should be offered and recommended a screening test for HIV at their booking visit or at the earliest available opportunity if presenting later in pregnancy. Antenatal screening for HIV plays a very important role in identifying HIV positive pregnant women. Early identification of HIV allows for appropriate management and treatment of the mother which can significantly reduce the risk of mother to child transmission (MTCT) of HIV.

Untreated HIV infection in pregnant women results in HIV transmission to approximately 15-26% of infants. Vertical transmission of HIV can be easily reduced to <1% by a combination of interventions:

- Antenatal diagnosis of HIV
- Effective maternal combined antiretroviral therapy (cART) to suppress HIV Viral Load (VL)
- Pre-Labour Caesarean Section (PLCS) at 38-39 weeks gestation or safe vaginal delivery
- Intravenous (IV) antiretroviral therapy to mother during delivery (only if HIV VL not optimally suppressed)
- Oral or IV antiretroviral prophylaxis to the baby for 2-4 weeks depending on level of risk of HIV transmission
- Complete avoidance of breastfeeding
- Formula feeding should be advised but if the woman wishes to breastfeed then please refer to - and follow – BHIVA guidelines available at: British HIV Association guidelines for the management of HIV in pregnancy and postpartum 2018 (2020 third interim update) (bhiva.org)

3. Antenatal Care

Good communication and liaison between members of the multidisciplinary team, the mother and local maternity services is key in ensuring the best possible outcome for the mother and her baby.

3.1 Newly diagnosed HIV in Pregnant Women

All women diagnosed with HIV for the first time during pregnancy should be informed their results have returned as “reactive” and need repeating. A positive diagnosis should only be given to the patient if the clinician is confident at doing so. Please then repeat the HIV blood test including Hepatitis A IgG, Hepatitis B surface antigen, Hepatitis B core antibody, Hepatitis C antibody and Syphilis screen. Please then contact Carly Porter Clinical Nurse Specialist on 07875 230224 or leave a message with the medical secretary Sian Griffiths on 01792 285017 and the patient will then be followed up within 24 hours

3.2 Referrals

The named midwife will contact the Sexual Health Clinic in Singleton on the above numbers. In the Sexual Health clinic, bloods are taken to confirm HIV antibody status, HIV RNA viral load and CD4 count (VL, CD4). All newly diagnosed women should have HIV genotype test prior to starting antiretroviral drugs. This will be organised by HIV team. Checklist completed by named midwife (Appendix 4).

Antenatal Screening Coordinator / Midwife with special interest in HIV will inform Mr Llewelyn Consultant Obstetrician who provides care for women living with HIV during pregnancy and a letter indicating early management plan for the baby will be sent to paediatric team.

Midwife with Special Interest in HIV should be informed of the woman’s HIV diagnosis as soon as possible to liaise with other teams. (See Appendix 5 for contact details).

Antenatal Screening Coordinator should also be informed of the woman’s diagnosis, if not already aware.

3.3 Care Plan

A care plan will be completed by HIV physician by 32 weeks, with copies placed in obstetric and HIV notes. Copies will be sent to Consultant Paediatrician and Consultant Neonatologist for later filing in infant notes.

Care plan contains details of intrapartum and post partum management, medications (including antiretroviral) prescribed, relevant investigations, as well as details of disclosure of HIV status to the patient’s family and GP.

The planned mode of delivery with the date for CS if required will also be documented. (For care plan model see Appendix 1)

A 35 week summary will be sent to labour ward, Consultant Paediatrician and Consultant Neonatologist. (For 35 week summary model see Appendix 2)

The paediatricians **must be informed well in advance** of the date of planned caesarean section by the Obstetric Consultant responsible for the care of the woman.

Antiretroviral therapy will be required for the baby. There may have been some exposure in utero and during delivery, however treatment will need **to commence within four hours of birth and continue** thereafter for 2-4 weeks of life depending on risk of HIV transmission.

4. Labour/Delivery

All known women living with HIV should have an individualised, regularly updated plan of care summarising the agreed obstetric/HIV management for each woman, including the antiretroviral regimen and recommended mode of delivery.

A copy of this plan of care should be held by the pregnant woman. It should also be included in her maternity and HIV notes. Women are encouraged to carry their maternity hand held records to improve communication and continuity of care.

5. Obstetric Management

Invasive prenatal diagnostic testing should ideally be deferred until HIV VL has been adequately suppressed to <50 IU/ml. If not on cART and the invasive diagnostic test procedure cannot be delayed until viral suppression is achieved, it is recommended that the woman should commence cART to include raltegravir and be given a single dose of nevirapine 2-4 hours prior to the procedure.

For women taking cART, a decision regarding recommended mode of delivery should be made after review of plasma HIV VL results at 36 weeks. Maternal cART should be continued postpartum unless indicated in the care plan.

5.1 Women on cART and VL undetectable (<50 IU/ml) within 4 weeks of labour

Women on cART and presented with term labour

Manage delivery as per non-infected woman

Women on cART and presented with term pre-labour spontaneous rupture of the membranes (ROM) and VL undetectable (<50 IU/ml) within 4 weeks of labour

Labour should be induced on admission

5.2 Women on cART and VL detectable (>50 IU/ml) within 4 weeks of labour

Women on ARVs and VL detectable (>50 IU/ml) within 4 weeks of labour

- Elective CS is recommended at 38 completed weeks gestation
- If HIV VL >1000 give IV zidovudine (Retrovir) throughout labour and delivery (see Appendix 3 for administration and dosing)

Women on cART and presented with term pre-labour spontaneous rupture of the membranes (ROM) and VL detectable (>50 IU/ml) within 4 weeks of labour

- LSCS is recommended in line with Category 2 time-scale.
- If HIV VL >1000 give IV zidovudine (Retrovir) throughout labour and delivery (see Appendix 3 for administration and dosing).

5.3 Preterm Premature Rupture Of Membranes (PPROM) occurs at <36 weeks

- Intramuscular steroids should be administered as per national guidelines.
- There should be multidisciplinary discussion about the timing and mode of delivery as soon as possible and optimisation of virological control.

5.4 Women on monotherapy

Zidovudine monotherapy is a non-preferred option to reduce perinatal HIV transmission in women with a baseline HIV VL < 10.000 copies/ml and CD4 >350 who refuse cART and consent to a CS. The following should be considered:

- IV zidovudine (Retrovir) throughout labour and delivery (see Appendix 3 for administration and dosing)
- PLCS is recommended between 38 and 39 weeks gestation.
- Manage as per viral detectable (See section B, page 6)

5.5 Women not on ARV

Women not on ARV treatment, labour at term*

Obstetric management: If delivery is not imminent (< 2hrs) deliver by CS
HIV management*:* Prescribe and give first dose of antiretroviral therapy ASAP and DO NOT STOP POST PARTUM:
Combivir (*zidovudine 300mg/lamivudine 150mg)* one tablet BD P.O
Raltegravir 400mg BD P.O

Also give:
A stat dose of nevirapine* 200 mg P.O as soon as possible.
IV zidovudine throughout labour and delivery (see Appendix 3 for administration and dosing)

***** *If delivery occurs <2 hrs post-maternal nevirapine, the neonate should also be dosed with nevirapine immediately.*

Women not on ARV treatment and pre-term labour

Obstetric management:

- Intramuscular steroids should be administered as per national guidelines
- Consider tocolysis
- There should be an immediate multidisciplinary discussion

HIV management: Prescribe and give first dose of antiretroviral therapy ASAP and DO NOT STOP POST PARTUM:
Combivir (*zidovudine 300mg/lamivudine 150mg)* one tablet BD P.O
Raltegravir 400mg BD P.O

Also give:
IV zidovudine (Retrovir) throughout labour and delivery (see Appendix 3 for administration and dosing) A stat dose of nevirapine 200 mg P.O
A stat dose of tenofovir 600 mg P.O

5.6 Unknown HIV status due to lack of testing

Women presenting in labour/ROM/requiring delivery without a documented HIV result or patient is from a high risk group and/or presents with HIV clinical conditions should be recommended to have an urgent HIV test.

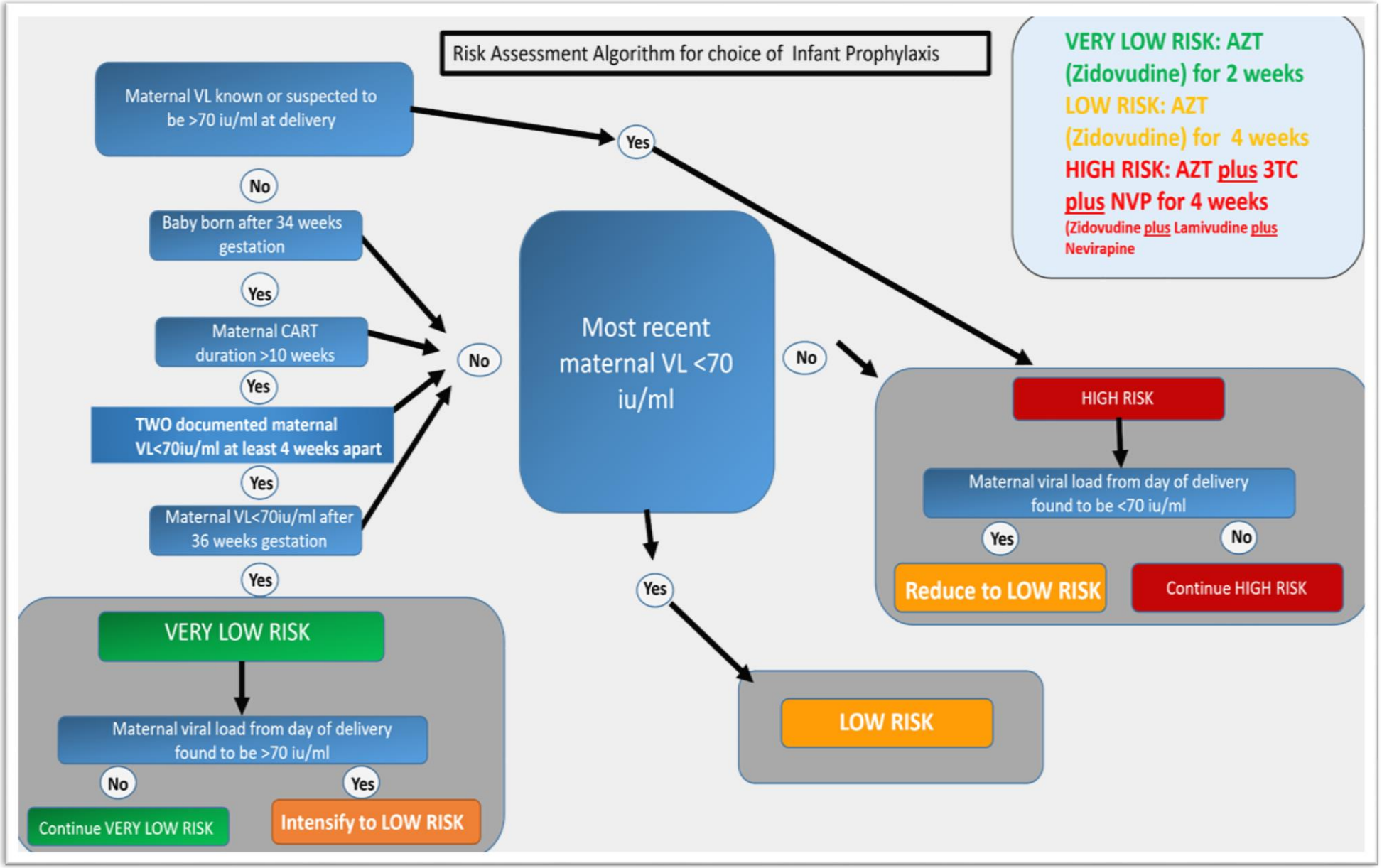
A reactive/positive result must be acted upon immediately, with interventions to prevent vertical transmission of HIV without waiting for further/formal serological confirmation.

see SBUHB "Protocol for the care of women in labour who have not accessed antenatal care".

6. General considerations for women not on ARVs or with VL detectable (>50IU/ml)

Staff should adhere to their Infection Control Trust policy when providing care for women living with HIV. If a woman living with HIV is not on cART or has a known detectable VL the following should be considered:

- Staff to wear: plastic apron, waterproof gown, visors
- Diathermy – secure all visible bleeding points on entry
- Attempt to open uterus without rupturing the membranes
- If possible, deliver the baby in intact membranes
- If ruptured membranes, apply suction to baby's mouth and nose immediately, whilst still on operating table
- Use blunt needles for suturing of all layers
- Active management of third stage
- Bathe baby as soon as practicable


Risk Assessment Algorithm for choice of Infant Prophylaxis
VERY LOW RISK: AZT (Zidovudine) for 2 weeks
LOW RISK: AZT (Zidovudine) for 4 weeks
HIGH RISK: AZT plus 3TC plus NVP for 4 weeks
(Zidovudine plus Lamivudine plus Nevirapine
Maternal VL known or suspected to be >70 iu/ml at delivery
Yes
No
Baby born after 34 weeks gestation
Yes
Maternal CART duration >10 weeks
Yes
TWO documented maternal VL<70iu/ml at least 4 weeks apart
Yes
Maternal VL<70iu/ml after 36 weeks gestation
Yes
No
Most recent maternal VL <70 iu/ml
No
Yes
HIGH RISK
Maternal viral load from day of delivery found to be <70 iu/ml
Yes
No
Reduce to LOW RISK
Continue HIGH RISK
VERY LOW RISK
Maternal viral load from day of delivery found to be >70 iu/ml
No
Yes
Continue VERY LOW RISK
Intensify to LOW RISK
LOW RISK

7. Post-natal Management

7.1 Neonatal Registrar

The on-call neonatal registrar **should be informed as soon as labour commences and immediately** after delivery.

7.2 Infant post-exposure prophylaxis (PEP)

Administer antiretroviral prophylaxis to the baby **as soon as possible** *(certainly within 4 hours).* The length of treatment depends on the risk of HIV transmission. SEE TABLE 1 and Appendix

7.2.1	VERY LOW RISK
	Two weeks of zidovudine monotherapy is recommended if all the following criteria are met: The woman has been on cART for longer than 10 weeks; AND Two documented maternal HIV viral loads <50 HIV RNA copies/mL during pregnancy at least 4 weeks apart; AND Maternal HIV viral load <50 HIV RNA copies/mL at or after 36 weeks.

7.2.2	LOW RISK
	Extend to FOUR weeks of zidovudine monotherapy If the criteria in 7.2.1 are not all fulfilled but maternal HIV viral load is <50 HIV RNA copies/mL at or after 36 weeks If the infant is born prematurely(<34 weeks) but most recent maternal HIV viral load is <50 HIV RNA copies/ml

7.2.3	HIGH RISK
	Use combination PEP if maternal birth HIV viral load is known to be or likely to be >50 HIV RNA copies/ml on day of birth, if uncertainty about recent maternal adherence or if viral load is not known.

If the baby is unable to feed give zidovudine infusion. This should be changed to the oral preparation once tolerated and continued to completion

If there is known maternal resistance to zidovudine with VERY LOW or LOW RISK, zidovudine is still recommended for infant PEP

If HIGH RISK (combination PEP indicated) and there is a history of documented maternal zidovudine and/or nevirapine resistance, seek expert advice. If advice not immediately available, commence standard 3 drug PEP (zidovudine, lamivudine and nevirapine) until guidance is provided

If unsure discuss with HIV team/HIV specialist paediatrician

If mother known to be HIV-2 infected follow the above advice but if HIGH RISK (combination PEP indicated nevirapine will not be effective. Seek expert advice. If advice not immediately available commence zidovudine, lamivudine and raltegravir

For details of antiretroviral therapy including zidovudine infusion see Appendix 3

7.3 Other factors to consider

- The mother's HIV status alone is not a reason for the baby to receive care in the Special Care Baby Unit. The baby should, whenever possible, stay with mother
- Women living with HIV should be advised that formula feeding is the best protection against HIV transmission but if she wishes to breastfeed then
  BHIVA guidelines should be adhered to. Available at https://www.bhiva.org/file/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rdhttps://www.bhiva.org/file/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rd-interim-update.pdfinterim-update.pdf
- Women should be offered cabergoline to suppress lactation
- If women choose to breastfeed then intensive support should be given to avoid nipple trauma. This should be available from the first feed and provided by the relevant staff. Please discuss with Infant Feeding Coordinator to ensure a support plan is in place.
- Inform the HIV team and Paediatrician with special interest in HIV in office hours that the baby has been born
- The baby does not require CO-TRIMOXAZOLE prophylaxis for Pneumocystis Jiroveci Pneumonia (PCP) unless indicated in the care plan. (See part 10 for CO-TRIMOXAZOLE indications)
- "Day 1" sample (within 48hrs of birth): Send 1ml EDTA sample for "HIV proviral DNA PCR" (Do not use Cord Blood). In view of the genomic diversity of HIV where infant diagnosis will rely on HIV DNA amplification, a maternal 5ml EDTA sample should always be obtained for HIV DNA amplification with, or prior to the first infant sample to confirm that the primers used detect the maternal virus

8. Hospital Discharge

Infant

- Please prescribe the full course of anti-retroviral drugs for the baby on going home, and ensure the mother/father/carer knows when to give this
- The baby can be discharged when well and tolerating oral medication. If unable to tolerate oral antiretroviral medications (see Appendix 3 for antiretroviral treatment). Discuss with Paediatrician with special interest in HIV

- Ensure a feeding support plan is in place with the Infant Feeding Coordinator prior to discharge if breastfeeding.
- Remember to send baby's discharge summary to HIV secretary, ISH department in Singleton. Via email: SBU.ISHmedicalsecretary@wales.nhs.uk

- This enables reporting to National Study of HIV in Pregnancy and Childhood (NSHPC) and Antiretroviral Pregnancy Registry (APR)
- Inform the Antenatal Screening Coordinator of birth and discharge.
- Write a discharge letter to the paediatrician – and arrange follow up 2 weeks post partum

Mother

- Make sure that a follow-up appointment has been made and the mother has enough antiretroviral medications before she goes home (contact HIV secretary on ext 35084 or via phone on: 01792 285017.
- Do not stop antiretroviral medications unless is clearly indicated in care plan
- Ensure mother is aware that formula feeding offers the best protection against transmission to the infant but if she wishes to breastfeed then please follow BHIVA guidelines available at https://www.bhiva.org/file/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rdhttps://www.bhiva.org/file/5f1aab1ab9aba/BHIVA-Pregnancy-guidelines-2020-3rd-interim-update.pdfinterim-update.pdf
- Ensure a feeding support plan is in place with the Infant Feeding Coordinator prior to discharge if breastfeeding.
- To discuss contraception options (beware of possible cART interactions)

9. Immunisation

Infants born to mothers living with HIV should follow the routine national primary immunization schedule.

BCG vaccine should only be given when the exclusively formula-fed infant is confirmed HIV negative at 12–14 weeks. This should be given at birth only if high risk of tuberculosis exposure.

Where the mother is co-infected with HBV, immunization should be as per the Green Book.

10. PCP prophylaxis for infant

Co-trimoxazole prophylaxis should be initiated from 1 month of age if HIV PCR screening is positive at any stage or if the infant is confirmed to be diagnosed with HIV. This should only be stopped if infection is subsequently excluded.

Appendix 1

Maternal and Neonatal Care Plan

Maternal Care Plan

Confidentiality		
GP aware of HIV	Yes ☐	No ☐
Family aware of HIV	Yes ☐	No ☐

Care Team	
Specialists involved in care	**Name**
Consultant Obstetrician	Rob Llewelyn
HIV Physician	Kathir Yoganathan
Paediatrician and Neonatologist	Katherine Burke
HIV Clinical Nurse Specialist	Carly Porter
HIV Pharmacist	Sally Kneath
Antenatal Screening Coordinator	Katie Maine

Antenatal Care

HIV Diagnosis	
Pre-pregnancy ☐	During pregnancy ☐
Date first diagnosed:	

STI Screen		
Chlamydia and Gonorrhoea done at :	2nd trimester ☐	3rd trimester ☐
Blood tests		
Tests	**Date**	**Result**
Syphilis serology		
Hepatitis B Antibody		
Hepatitis C		

Medication

Current antiretroviral regimen				
Drug	**Route**	**Dose**	**Frequency**	**Gestation when started or pre pregnancy**

To continue taking ARVs postpartum? Yes ☐	**No ☐**

Other medications			
Drug	**Route**	**Dose**	**frequency**

Obstetric Management

EDD:	Mode of delivery:	Date of planned LSCS (if needed):

Blood results			
Date	**Gestational age**	**CD4count**	**Viral load**

To give intrapartum intravenous Zidovudine	Yes ☐	No ☐

Post partum management

Breastfeeding advice given Yes ☐ No ☐

Contraception options discussed Yes ☐ No ☐ Specify.....

Follow up with HIV team arranged for .....

Neonatal Care Plan

Antiretroviral medication

* Post Exposure Prophylaxis:			
Drug	**Route**	**Dose**	**frequency**
Zidovudine oral solution	**PO**	**Weight dependent – see appendix 3**	**Twice daily**

***Administer antiretroviral prophylaxis as soon as possible (certainly within 4 hours) and continue for the full course**

Blood tests

Infant HIV diagnostic testing should be undertaken at;

- "Day 1" (within 48hrs of birth): Send 1ml EDTA sample for "HIV proviral DNA PCR" **(Do not use Cord Blood)**. In view of the genomic diversity of HIV where infant diagnosis will rely on HIV DNA amplification, a maternal 5ml EDTA sample should always be obtained for HIV DNA amplification with, or prior to the first infant sample to confirm that the primers used detect the maternal virus
- At 2 weeks if HIGH RISK
- 2 weeks post infant prophylaxis (4-6 weeks of age)
- 2 months post infant prophylaxis (10-12 weeks of age)
- On other occasions if additional risk (e.g. breastfeeding)
- HIV antibody testing for seroconversion should be checked at age 18 months

Appendix 2

Department of Integrated Sexual Health

Singleton Hospital, Swansea. SA2 8QA

Pregnancy Summary

Name: Date of Birth:	Hospital No GU Clinic No

Diagnosis

First Diagnosed HIV positive:	
Hepatitis B status:	
Co-morbidities	

Medications

Antiretroviral therapy	
Other medication	

Blood Tests :

Date:	Gestational Age:
CD4:	Viral Load:

EDD:	Mode of delivery:
STI Screening:	

(**Please see WCP for most Recent Blood Tests)**

Advice on breastfeeding given: (Please circle) **Yes** **No**

Antiretroviral medications to continue postpartum: **Yes** **No**

Future Contraception Discussed: **Yes** **No**

Please send a copy of baby's discharge summary to:

Carly.Porter@wales.nhs.uk

Appendix 3

Antiretroviral treatment for mother and newborn

1. Mother:

PREPARATION OF ZIDOVUDINE (RETROVIR) INFUSION

Each 20 ml vial contains 200 mg ZIDOVUDINE. The final concentration for infusion must be 2 mg/ml diluted with 5% dextrose as follows:

- Withdraw and discard 100 ml of 5% Dextrose from a 500 ml bag (5% Dextrose)
- Add contents of 5 vials of ZIDOVUDINE (total = 1000 mg in 100 ml) to the 5% dextrose bag above
- Concentration is now 1000mg in 500 ml (2 mg/ml) Once diluted, the infusion is stable for 24 hours

ZIDOVUDINE (RETROVIR) INFUSION RATE

Zidovudine infusion to start 4 hours prior to caesarean section
Loading dose of ZIDOVUDINE 2mg/kg over 1 hour
(E.g.70kg woman = 140mgs/hr =70mls/hr)

Note. The loading dose can be given over 30 minutes if necessary

Continuous infusion of 1mg/kg/hr until the umbilical cord is clamped.
(E.g. 70kg woman = 70mgs/hr = 35mls/hr)

OTHER ARV's NEEDED IN CERTAIN SCENARIOS

There should be a supply of Combivir tablets, Raltegravir tablets, Nvirapine tablets and/or Tenofovir tablets in Labour Ward drug room

2. Infant:

2.1 ZIDOVUDINE ORAL SYRUP: ***MUST BE GIVEN WITHIN 4 HOURS OF BIRTH***

Age in weeks	Dose & duration
> 34 weeks	4mg / kg BD for 4 weeks
30 – 33 weeks and 6 days	2mg / kg BD for 2 weeks then 2mgs / kg TDS for 2 weeks
< 30 weeks	2mg / kg BD for 4 weeks

Weight Range (kg)	Oral dose (equivalent to 4 mg/kg) TWICE A DAY	Volume to be given orally TWICE A DAY
2.01–2.12	8.5 mg	0.85 mL
2.13–2.25	9 mg	0.9 mL
2.26–2.37	9.5 mg	0.95 mL
2.38–2.50	10 mg	1 mL
2.51–2.75	11 mg	1.1 mL
2.76–3.00	12 mg	1.2 mL
3.01–3.25	13 mg	1.3 mL
3.26–3.50	14 mg	1.4 mL
3.51–3.75	15 mg	1.5 mL
3.76–4.00	16 mg	1.6 mL
4.01–4.25	17 mg	1.7 mL
4.26–4.50	18 mg	1.8 mL
4.51–4.75	19 mg	1.9 mL
.76–5.00	20 mg	2 mL

4.2 ZIDOVUDINE INFUSION:

ZIDOVUDINE IV should be considered if infant is unable to feed /tolerate oral ZIDOVUDINE

PREPARATION OF ZIDOVUDINE (RETROVIR) INFUSION FOR INFANT

Each 20 ml vial contains 200 mg ZIDOVUDINE. The final concentration for infusion must be 2 mg/ml diluted with 5% dextrose as follows:

- Withdraw and discard 20 ml of 5% Dextrose from a 100 ml bag (5% Dextrose)
- Add contents of 1 vial of ZIDOVUDINE (total = 200 mg in 20 ml) to the 5% dextrose bag above
- Concentration is now 200mg in 100 ml (2 mg/ml)
- Once diluted, the infusion is stable for 24 hours

Age in weeks	Dose & duration

> 34 weeks	1.5 mg / kg 6 hourly – when tolerating feeds start oral therapy Infusion rate over 60min
< 33 weeks	1.5 mg/kg 12hourly - when tolerating feeds start oral therapy Infusion rate over 60min

1.3 TRIPLE PEP: **See indications for triple PEP on page 10**

1.3.1 Infant > 34 weeks

Drug	Dose	Duration
Zidovudine (AZT)	4mg /kg /dose 12 hourly Oral	4 weeks
	If Intravenous needed give 1.5mg/kg/dose 6 hourly	AZT IV is only given until tolerating feeds/ PO triple therapy
Lamivudine (3TC)	2mg /kg /dose 12 hourly Oral	4 weeks
Nevirapine	2mg /kg /dose OD Oral for one week then 4mg/Kg/dose OD for one week then stop (Total 2 weeks)	2 weeks

1.3.2 Infant <34 weeks

Gestation	Drug	Dose & route	Frequency	Duration
30-34 weeks and feeding	Zidovudine (AZT)	2mg/Kg Oral	BD for 2 weeks then TDS for 2 weeks	4 weeks
	Lamivudine (3TC)	2mg/Kg Oral	BD	4weeks

	Nevirapine	2mg /kg /dose OD Oral for one week then 4mg/Kg/dose OD for one week then stop	OD	Total 2 weeks
< 34 weeks and / OR unable to feed	Zidovudine (AZT)	1.5mg/Kg Intravenous	BD - when tolerating feeds start triple oral therapy	4 weeks
< 30 weeks and tolerating feeds	Zidovudine (AZT)	2mg /Kg Oral	BD for 4 weeks	4 weeks
	Lamivudine (3TC)	2mg/Kg Oral	BD	4weeks
	Nevirapine	2mg /kg /dose OD Oral for one week then 4mg/Kg/dose OD for one week then stop	OD	Total 2 weeks

Appendix 4

HIV positive result and management in pregnancy (BHIVA 2018)

Please complete or affix maternal demographics

Unit No:……. /*ISH number .....

NHS No: .....

Surname.....

Forenames .....

Address…….

HIV Result

Test	Date of test	Result
Positive		
Confirmatory sample result		
CD4		
Viral load		

	Comments	Date	Signature and name in capitals
Screening Team appointment (≤ 3 working days of laboratory result / notification)			
Refer to consultant led care			
ASW written information HIV positive in pregnancy offered and discussed along with verbal information on possible significant health risks to the woman and the baby			
Organise interpreter services if English is not first language.			
For complete confirmation of sample, repeat antenatal screening at this hospital appointment (Record result above)			
With consent, inform GP, community midwife of positive result and management plan			
Inform Sexual Health of laboratory result and need for urgent appointment			

	Comments	Date	Signature and name in capitals
Sexual Health appointment **(≤ 2 working days of result given to the woman)**			
Date of appointment with Sexual Health to enable assessment, counselling and so that possible treatment can be commenced promptly.			
Inform Paediatrics (≤ 10 working days of laboratory result / notification)			
Inform paediatrics and create neonatal alert for neonatal management-review of neonate within 4 hours of birth			
An appropriate care plan must be developed by the maternity services in collaboration with Sexual Health			
This should be developed with reference to BHIVA 2018 guidance To be developed in discussion with the woman and with the advice of a Multi-Disciplinary team (obstetrics, paediatrics, sexual health and microbiology). The woman's care must be managed by the Multi-Disciplinary Team in accordance with BHIVA guidelines and led by Sexual Health. The MDT must include obstetrics paediatrics sexual health and microbiology HIV Birth Plan to be completed by MDT and ensure paediatrics aware of birth plan.			
Ensure documentation of results, management plan are in the Maternity Record with the woman's consent			

Appendix 5

Contact Numbers

Obstetrics Team

Consultant Obstetrician with special interest in HIV:
Mr Robert Llewelyn
Robert.Llewelyn@wales.nhs.uk

Mr Llewelyns secretary:
Suzanne.Weerackoon@wales.nhs.uk

Antenatal Screening Midwife
Katie Maiden
Katie.Donovan@wales.nhs.uk

HIV Team

Lead Consultant in GUM & HIV:
Dr Kathir Yoganathan
Tel: 01792 285017 / 35084
Kathir.Yoganathan@wales.nhs.uk

Consultant in GUM & HIV:
Dr Helen Bradshaw
Tel: 01792 285017 / 35084
Helen.Bradshaw@wales.nhs.uk

HIV Consultants' secretary
Sian Griffiths
Tel: 01792 285017 / 35084
Sian.Griffiths94ead@wales.nhs.uk

Sexual Health/Health Advisor/HIV CNS:
Carly Porter

Mobile: 07875 230224
Tel: 01792 285017 / 35097
Carly.Porter@wales.nhs.uk

URGENT OUT OF HOURS QUERIES:
Contact HIV Consultant via Switchboard

Pharmacy Team

Lead Pharmacist Women & Child Health:
Kath Willson 25946
Anne.Willson@wales.nhs.uk

Lead Pharmacist HIV/Sexual Health/Hepatology:
01792 285017/35084/25493
Sally Kneath
Sally.Kneath@wales.nhs.uk

URGENT OUT OF HOURS QUERIES:
Contact On Call Pharmacist via Switchboard

Paediatrics/Neonatology Team

Consultant Neonatologist:
Dr Katherine Burke
Katherine.Burke@wales.nhs.uk

Dr Burkes Secretary
Helen.Banks@wales.nhs.uk
SBUneonatalsecretary@wales.nhs.uk

URGENT OUT OF HOURS QUERIES:
Contact On Call Paediatric/Neonatal Registrar via Switchboard

Virology Team

Consultant Microbiologist:
Dr Bassam Ben-Ismael
Bassam.Ben-Ismaeil@wales.nhs.uk

Operations Manager for Virology:
Jenny Hudson
Jenny.Hudson@wales.nhs.uk

URGENT OUT OF HOURS LAB/VIROLOGY QUERIES:
Contact On Call Registrar for Microbiology via Switchboard

Guideline committee members

Dr Helen Bradshaw, Speciality registrar in GU& HIV Medicine, Singleton Hospital

Mr Robert Llewelyn, Consultant Obstetrician, Singleton Hospital

Sally Kneath, HIV specialist pharmacist, Singleton Hospital

Carly Porter HIV Clinical Nurse Specialist

Dr Kathir Yoganathan, Consultant in HIV GU & HIV Medicine, Singleton Hospital

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Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Guidelines for the Management of HIV Positive Pregnant Women (Antenatal, Intrapartum, Postnatal and Neonatal Care) in Swansea Bay Health Board
Name(s) of Author:	Sally Kneath/ Carly Porter
Chair of Group or Committee approving submission:	Antenatal Forum & Perinatal Forum
Brief outline giving reasons for document being submitted for ratification	Updated guideline
Details of persons included in consultation process:	Antenatal forum members Perinatal forum members
Name of Pharmacist (mandatory if drugs involved):	Sally Kneath
Issue / Version No:	3
Please list any policies/guidelines this document will supercede:	Guidelines for the management of HIV positive pregnant women (Antenatal, Intrapartum, Postnatal and Neonatal Care) In Swansea Bay University Health Board
Date approved by Group:	To be approved
Next Review / Guideline Expiry:	December 2026
Please indicate key words you wish to be linked to document	HIV, PEP, HIV positive in pregnancy, PLWHIV
File Name: Used to locate where file is stores on hard drive	