UNIVERSITY HOSPITAL WISHAW
WOMEN'S SERVICES DIRECTORATE

PROTOCOL
FOR
Antenatal HIV Screening Programme

Reviewed by:	NHS Lanarkshire Pregnancy & Newborn Communicable Disease Screening, Immunisation and Vaccination Programmes Audit Group
Ratified by:	Maternity Clinical Effectiveness Subgroup
Date:	November 2021
Review date:	November 2024

NHS Lanarkshire

Contents	Page No.

Preface

This document sets out the NHS Lanarkshire programme for screening pregnant women for HIV infection. It was developed during 2003 by a working group. It has been revised and updated in line with BHIVA guidance published in 2018.
A guideline on management of infants born to HIV infected mothers, developed by the West of Scotland MCN and adopted by the Neonatal Unit at Wishaw General Hospital can be accessed via First Port on the Neonatal page and by searching under clinical guidelines. Ensure the guidance retained on the Neonatal page is the most recent version.

Introduction

The aim of antenatal HIV screening is to reduce the risk of transmission from an infected mother to her child. If the mother is found to be positive, appropriate management can reduce the risk of HIV transmission to the child from 25% to less than 1%. The interventions include anti-retroviral treatment in pregnancy, careful obstetric management, appropriate decision making regarding mode of delivery, avoidance of breast feeding and treatment of the baby. Early identification and treatment of women with HIV is also beneficial as they can make an informed choice about continuing with their pregnancy and receive appropriate healthcare themselves.

Background

HIV in children leads to chronic disease and approximately 20% of children infected with HIV develop AIDS related illnesses within the first year of life. The HIV Health Promotion Strategy recommended that antenatal screening for HIV should be offered routinely to all pregnant women. Routine HIV screening is part of an integrated programme of antenatal screening offered to all pregnant women.

The rationale for the recommendation that universal HIV screening has been implemented in Lanarkshire is:

- National guidance indicates it is the best way to prevent cases of vertical transmission.
- The lifetime cost of caring for a child with HIV is very costly and interventions that decrease the risk of transmission from mother to child would avoid these costs.

Management Arrangements

Management of the operational delivery of this programme is the responsibility of the Senior Midwife for Community and Out Patients. This responsibility may be delegated with commensurate authority to another member of staff.

Contact details for the Senior Midwife for Community and Out Patients are as follows: -

University Hospital Wishaw
Women's Services
50 Netherton Street
Wishaw
ML2 0DP
Tel 01698 361100 extension 7226

Locally and nationally agreed standards for the delivery of the programme should be achieved.

Routine monitoring of the programme and provision of feedback to staff delivering it

Routine monitoring of the programme and provision of feedback takes place on a monthly basis. Screening data is reported to the specialist midwife for the pregnancy and newborn communicable disease screening and infant immunisation programmes and after the data is processed, information is sent to members of the NHS Lanarkshire Pregnancy and Newborn Communicable Disease Screening, Immunisation and Vaccination Programmes Audit Group. The Senior Midwife for Community and Out Patients with lead responsibility for the day to day operational delivery of this programme is a member of this group and forwards information to midwifery staff/medical staff.

Continuous quality improvement

In order to promote continuous quality improvement in this programme staff involved in delivering it should:

- Communicate suggestions for improving the programme to the Senior Midwife for Community and Out Patients or her deputy.
- Report adverse events related to the programme to the Senior Midwife for community and out patients or her deputy.
- The Senior Midwife for Community and Out Patients or Deputy should take any immediate action that may be indicated based on comments received and report routinely to the NHS Lanarkshire Pregnancy and Newborn Communicable Disease Screening, Immunisation and Vaccination Programmes Audit Group.

Remit of the NHS Lanarkshire Pregnancy and Newborn Communicable Disease Screening, Immunisation and Vaccination Programmes Audit Group

- To audit the performance of the NHS Lanarkshire Pregnancy and Newborn Communicable Disease (Syphilis, Hepatitis B and HIV) Screening, Immunisation and Vaccination Programmes against standards for these programmes published by NHS Health Improvement Scotland (HIS), and against locally agreed standards for aspects of these programmes which are not covered by HIS standards.
- To bring to the attention of senior managers any resource requirements that the Audit Group consider necessary for satisfactory performance of the programmes and which relevant heads of departments, services or divisions have not been able to secure.
- To report annually on the performance of these programmes to the NHS Lanarkshire Pregnancy Screening Steering Group.

The Audit Group usually meets every 3 months. Members of this group represent the various disciplines involved in the delivery of the programme. Contact details of the group members as listed in appendix 1

Education and Training

Staff involved in the delivery of this programme:

- Should be aware of this protocol.
- Should have access to the most recent version of this protocol.
- Should be adequately trained to deliver this protocol.
- Should provide comments about adverse events related to this programme to the Senior Midwife for Community and Out Patients
- Should submit suggestions of ways in which the programme could be improved, to their line manager.

Patient Information

"You're pregnant, scans and tests" booklet should be made available to the woman prior to offering screening. An electronic version as well as alternative formats can be accessed by accessing the Health Scotland website, NHS Scotland or via: http://www.healthscotland.com/documents/30532.aspx

Booking Visit

Consent to screening

- Screening should be offered to all antenatal women.
- Opportunity should be given to discuss **screening** tests offered.
- Occasionally the woman may require to have a 2nd blood sample taken. The woman should be made aware at booking that a further sample may be required for confirmatory testing which will exclude or confirm infection and is part of the routine screening process.
- Consent should be obtained prior to testing using Badgernet page 'Blood tests, actions and results' page.
- Reassure the woman that all results are confidential
- If this is a woman presenting late for booking visit or has an uncertain estimated date of delivery (EDD), midwife should then ensure this test should be sent **urgently** for processing and staff should ensure result is followed up as soon as possible. If infection is detected, this result should be communicated to LHAHC staff **urgently**
- If woman requests more detailed information about screening then, she can be referred to Lanarkshire HIV, AIDS and Hepatitis Centre (LHAHC) at University Hospital Monklands (Tel: 01236 712247 or 01236 712246 or e-mail to ID-BBVservice@lanarkshire.scot.nhs.uk if not urgent) The Community Midwife can make this referral.

Screening Decline

- If HIV testing is declined then a reason for this should be obtained by the patient and clearly documented in the electronic maternity record Badgernet on the 'Blood tests, results and actions' page.
- Notification of screening decline should be reported directly to the specialist midwife for the pregnancy and communicable disease screening programmes verbally and via email to BBVMaternity@lanarkshire.scot.nhs.uk using the decline form as part of the audit trail
- The decline should be indicated by the midwife undertaking the discussion on the microbiology form and submitted to UHW laboratory
- Declined test(s) should be discussed and offered again at every antenatal review but certainly at 16, 28 and 36 weeks as a minimum. It should also be offered in labour and after delivery. If the woman wishes HIV testing, it should not be delayed and be performed at the earliest opportunity, notified to labs services and sent as an **urgent** sample. The result should be discussed with the woman and documented clearly in her Badgernet record and should certainly be completed prior to discharge from hospital in very late presentation to services.

Late booker, unbooked or disclosure of infection

- If this is a woman who previously declined screening presenting late for booking visit or has an uncertain estimated date of delivery (EDD), midwife should then ensure this test result is followed up as soon as possible. If infection is detected, this result should be communicated to LHAHC staff **urgently**
- If past history of HIV or other increased risk factors exist (including blood borne viruses etc.) then this information should be included in all communications and correspondence. Ensure this is recorded clearly on the Lab request form information section. Application of danger of infection labels should be applied to the sample in line with laboratory sampling requirements. Details of specific lab requirements can be found on First Port under Laboratories page.

Laboratory responsibility for initial HIV screening samples reported as indeterminate by UHW and subsequently confirmed as HIV 1 / 2 infection not detected by WSSVC

- If the initial screening sample is reported by UHW lab as 'indeterminate', the lab will send the sample to WSSVC for testing.
- Microbiologist will determine if confirmatory 2nd sampling is required at this stage.
- Lab services will forward the initial screen report from WSSVC when it is available.
- An 'indeterminate' sample result at UHW labs automatically triggers an electronic notification to the managed BBVMaternity@lanarkshire.scot.nhs.uk inbox held by the specialist midwife. The result can then be viewed on line via the regional portal when available.
- If the community midwife identifies an indeterminate result at UHW while obtaining results for screening from the LIMS IT Technidata browser or clinical portal the community midwife should notify the specialist midwife for the pregnancy and newborn communicable disease screening programme (as failsafe), who will obtain a result from WSSVC and provide further advice if required
- All indeterminate results should have a report from WSSVC which should be scanned to the Badgernet record and record the no infection detected outcome in the 'Blood tests, results and actions page' when reported.
- **It is the responsibility of the requestor(Obstetrician) to discuss the result with the patient and determine if there is a clinical indication to repeat the sample**
- The WSSVC laboratory will notify any results reported as not detected to Lanarkshire.microbiologists@lanarkshire.scot.nhs.uk where further investigation will be undertaken

Laboratory responsibilities for patients with initial sampling at UHW requiring confirmatory sampling

- Microbiology service will report the initial screening sample as 'indeterminate' on the LIMS IT Technidata browser page as well as clinical portal. The booking sample will be sent for confirmatory testing at WSSVC.

  Of note within the microbiology service, the microbiology flowchart refers to such samples as reactive.

- The request for confirmatory sampling will be made from the Microbiologist to the Senior Midwife for Community and Out Patients or her delegated staff member with responsibility by telephone on the contact details listed on appendix 2 of this protocol

- The senior midwife for community and out patients or the specialist midwife will contact the community midwife and request a 2nd sample is obtained with consent as soon as possible (EDTA sample).

  The reason for the 2nd sample is to confirm HIV status. It is also possible to have a falsely indicated infection result due to a variety of reasons. The woman should be advised of this and be made aware that the 2nd sample is required for more detailed testing to confirm or exclude HIV infection. The woman should be notified as soon as possible of the result.

- The confirmatory sample will be sent **urgently** to University Hospital Wishaw (UHW) and forwarded directly to the West of Scotland Specialist Virology Centre (WSSVC).

- A report confirming results for both specimens will arrive back in laboratory and be notified to the BBVMaternity@lanarkshire.scot.nhs.uk inbox. The specialist midwife will inform the community midwife, obstetrician and ID specialist. Arrangements will be undertaken for the woman to be reviewed at the antenatal clinic to discuss results and refer to specialty services for further management.

Medical/Midwifery/LHAHC responsibilities for women with detected HIV infection

- The specialist midwife will notify the Obstetrician via email that results required urgent review. The Obstetrician can then view the results.

- The specialist midwife will inform the Community Midwife by telephone of the confirmed result. A copy of the confirmed report from WSSVC will be scanned into Badgernet record and recorded in the 'blood Tests and Actions' page. The result should **not** be published to the maternal notes until after the diagnosis is provided.

- Further liaison will take place to arrange a joint appointment with the relevant geographical Consultant Obstetrician, Community Midwife and LHAHC Clinical Nurse Specialist Staff to give the result verbally to the woman (partner etc. cannot be present at this initial discussion as disclosure of her status without consent is a breach of confidentiality).

In some circumstances, the diagnosis may be required to be provided by another Obstetrician in the absence of the geographical Obstetric Consultant with clinical responsibility. Diagnosis should not be delayed.

During this review, appropriate discussion will take place about the diagnosis and the management of the pregnancy. All aspects of this review will be accurately recorded in Badgernet clinical note as well as on the **SPAIIN** checklist which is generated following the recording of the maternal status. Any preferences of the woman should be clearly documented and clearly include the patient wishes regarding confidentiality.

During Covid restrictions consideration must be given around the how the diagnosis will be provided. Arrangements will be facilitated by the specialist midwife or other delegated member of staff in her absence and confirmed to all involved to ensure the diagnosis is provided in a confidential and appropriate way

- The Obstetrician will formally refer the woman to specialist services.
- Midwife will refer to the Neonatologist as soon as possible, the review will be undertaken following subsequent antenatal and specialist care and following discussion at the MDT. This review will be undertaken in the 3rd trimester and will ensure the woman is aware of the infant management plan.
- The Obstetrician will notify the GP **(only if the woman gives consent)**.
- All detailed management information between specialties are normally located under 'correspondence' in clinical portal. A copy of these can be retained in Badgernet as a scanned document when available.
- Only appropriate/requested staff involved in direct clinical care should be aware of the woman's HIV status.
- In new cases of infection, the woman will be commenced on combined Anti-Retroviral Therapy (cART) in line with BHIVA guidance. The medication offered would be appropriate to blood results (Resistance Testing) and is determined by the specialist team.
- Women with previous known infection and already on cART will continue on therapy. For some women the regimen may change during pregnancy.
- The aim of cART is to ensure the woman has an undetectable viral load at time of delivery and reduce the risk of vertical transmission.

  Specialty services undertake the relevant viral load monitoring, however, the viral load (VL) may require to be performed by maternity services at specific gestations. VL testing should not be delayed. Details on relevant sampling bottles for VL testing can be found on First Port, Laboratory- Lab handbook
- LHAHC Clinical Nurse Specialist will provide further information and follow up for the woman within the specialty service. While the speciality service ensures HIV infection is managed, the service also undertakes a number of measures to provide extensive support following the diagnosis. The specialist nurse will support them with the diagnosis and offer assistance from clinical psychology, dietician (if required) and refer them to approved voluntary organisations.

Waverley Care facilitates the provision of free infant formula milk until the infant is 1 year of age to support the recommendation to formula feed and minimise the risk of vertical transmission. The organisation also delivers peer led support programmes.

Delivery management

Management of the delivery will be discussed at the MDT meeting and consider maternal preferences, Obstetric and medical issues. The following bullet points indicate key considerations:

- The Care Plan offers a choice of Lower Uterine Segment Caesarean Section (LUSCS) at 38 – 40 weeks' gestation or a trial of labour aiming for a Vaginal Delivery.
- If the maternal Viral Load is not undetectable by time of delivery, an intravenous infusion of ART would be commenced prior to delivery in hospital. This would commence one hour prior to labour and continue until one hour post-delivery. All women will continue on oral cART treatment following delivery.
- If the clinical situation differs from the MDT plan, the obstetric consultant should be informed immediately. Further management can be supported by revision of BHIVA pregnancy guidance and liaison with Infectious Disease Consultant. Pregnancy guidance can be found on the BHIVA website under clinical guidelines(www.bhiva.org)
- Following delivery, a sample of blood should be obtained from the baby within 24-48 hours of delivery and before discharge from hospital. It is essential that there is confirmation of receipt of this sample by laboratory prior to discharge. This will minimise the risk of avoidable repeat sampling. Cord blood is **not** suitable.
- The baby should have his/her eyes, nose and face cleaned at birth and be bathed as soon as possible, preferably within one hour of birth.
- The baby will be weighed and commenced on ART within 2-4 hours of delivery and will continue PEP as outlined in the pre -birth review in Badgernet (recorded by Neonatologist) and in accordance with BHIVA guidance. This may range from 2 – 4 weeks depending on the maternal clinical risk factors. More specific detail of infant management is included in the document 'Management of infant born to a woman living with HIV infection' which can be located on the Neonatal page of First Port.
- Formula feeding infants of women with HIV is the standard national and local recommendation. Breastfeeding is **not** recommended. A service level agreement exists with a voluntary organisation to support women living with HIV and provide free infant formula milk until the infant is 1 year of age. This document can be found on First Port maternity page.

Contact Tracing

- LHAHC Nursing Staff will enquire with the woman to follow up contacts for risk of infection.

Individual Care Plan

The Consultant Obstetrician, Consultant Neonatologist and LHAHC Consultant Physician will formulate a Care Plan for the ante natal, intra natal and post-natal period. The plan should state the Medical and Obstetric management of the individual woman and her baby following delivery in accordance with the recommendations from the British HIV Association (BHIVA). This should be discussed with the woman and documented in the specialist service Hospital Case Notes. A copy will be sent to the GP (**only if the woman gives consent**). The Consultant Neonatologist will also discuss the implications for the baby with the mother. The **SPAIIN** checklist should also be updated to incorporate the plan by both Obstetric and midwifery staff ensuring all key requirements are met.

Unexpected clinical events

Transfer of care, known HIV infection

In this scenario, details of the previous specialty care provider **must** be recorded and further detail of medication should be recorded in the **SPAIIN** checklist in Badgernet. Other information as per disclosure of infection also requires to be recorded. The details should be notified to the specialist midwife for communicable disease screening. **Urgent** referral to local specialty is required to liaise regarding previous care and recommend further antenatal management.
https://www.bhiva.org/pregnancy-guidelines

Late booker

If presenting in labour whether preterm or term gestation with an HIV diagnosis, management should be discussed urgently and directly with the Obstetrician, Infectious Disease Consultant, Neonatologist, Pharmacist, and Microbiologist and follow the guidance in the revised BHIVA guidance for management of HIV in pregnancy**:** **https://www.bhiva.org/pregnancy-guidelines**

Infant Feeding

All pregnant women with confirmed HIV infection are provided with the best evidence based information on infant feeding. BHIVA and CHIVA continue to recommend **no breastfeeding** if a woman is living with HIV in the UK.
The risk of vertical transmission during pregnancy is managed by maternal compliance with anti-retroviral medication and specific MDT advice for delivery. The avoidance of breastfeeding further reduces the risk of vertical transmission.

If a woman expresses a wish to breast feed, this should be followed up urgently, communicated to the specialist midwife and specialty services to schedule further opportunity to discuss risks versus benefits.

In this circumstance, services would like to advise women in their informed choice. This approach would ensure that the advice and support offered are clearly outlined and recorded.

This advice can only be provided by specialist staff.

The infant and maternal management for women who despite the strongest recommendation to formula feed choose to breastfeed requires very specific maternal and infant follow up. Significant monitoring is required.

In this instance care should be taken to offer support to avoid a situation where the woman does not follow advice and participate in follow up monitoring.
Specific management will be recorded in the maternal Badgernet record and neonatal OPD records.

Screening of and subsequent management of pregnant women living with HIV

Setting and / or responsible person	KEY ACTIVITY
Community Midwife	• Pre-booking visit literature
Community Midwife	• Routine pre-test information and record of consent to screen in Badgernet • Booking blood test obtained • Complete **SPAIIN** checklist in Badgernet for women disclosing known infection status • Recommend no breastfeeding
Wishaw General Hospital Lab & Specialist Virology Centre	• Screen & Confirmatory testing for all reactive results • Confirmatory results will be notified to UHW lab services • UHW labs notify BBVMaternity@lanarkshire.scot.nhs.uk inbox
Consultant Obstetrician Consultant Neonatologist & LHAHC Consultant Physician	• Discuss results with woman • Notify cases to GP (**if consent given**) & Consultant Neonatologist • Draft Individual Care Plan • Complete SPAIIN checklist in Badgernet at booking, 20 weeks,36 weeks, delivery or late presentation to care • Recommend no breastfeeding
Consultant Neonatologist	• Discuss implications for baby with mother • Recommend no breastfeeding • Arrange appropriate treatment for baby • Draft Individual Care Plan for baby • Follow up care of baby
Department of Public Health	• Ensure effectiveness of screening programme • Audit and monitoring
GP/Health Visitor (if consent given)	• Follow-up care of mother and baby post delivery
Lanarkshire HIV, AIDS and Hepatitis Centre (LHAHC)	• Offer specialist HIV advice, clinical assessment and HIV therapy • Discuss evidence base recommendation of no breastfeeding and refer to Waverley Care services for support, advice and provision of free infant formula milk.
Pregnant mother	• Knowing her HIV status and take appropriate measures to reduce the risk of transmission of HIV • Understands the national guidance and recommendation to formula feed her baby • Understand management of infant at delivery and follow up testing required

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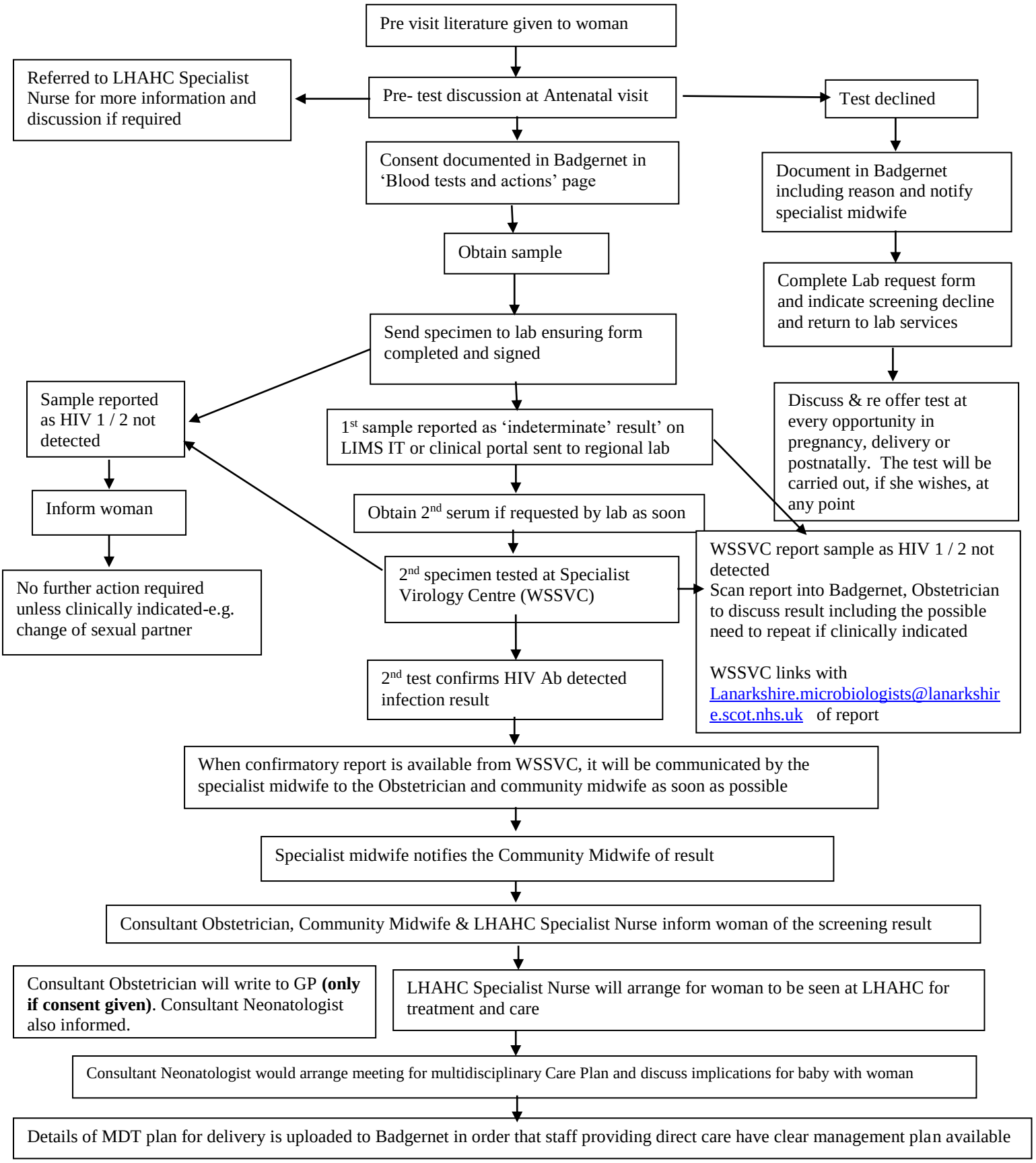
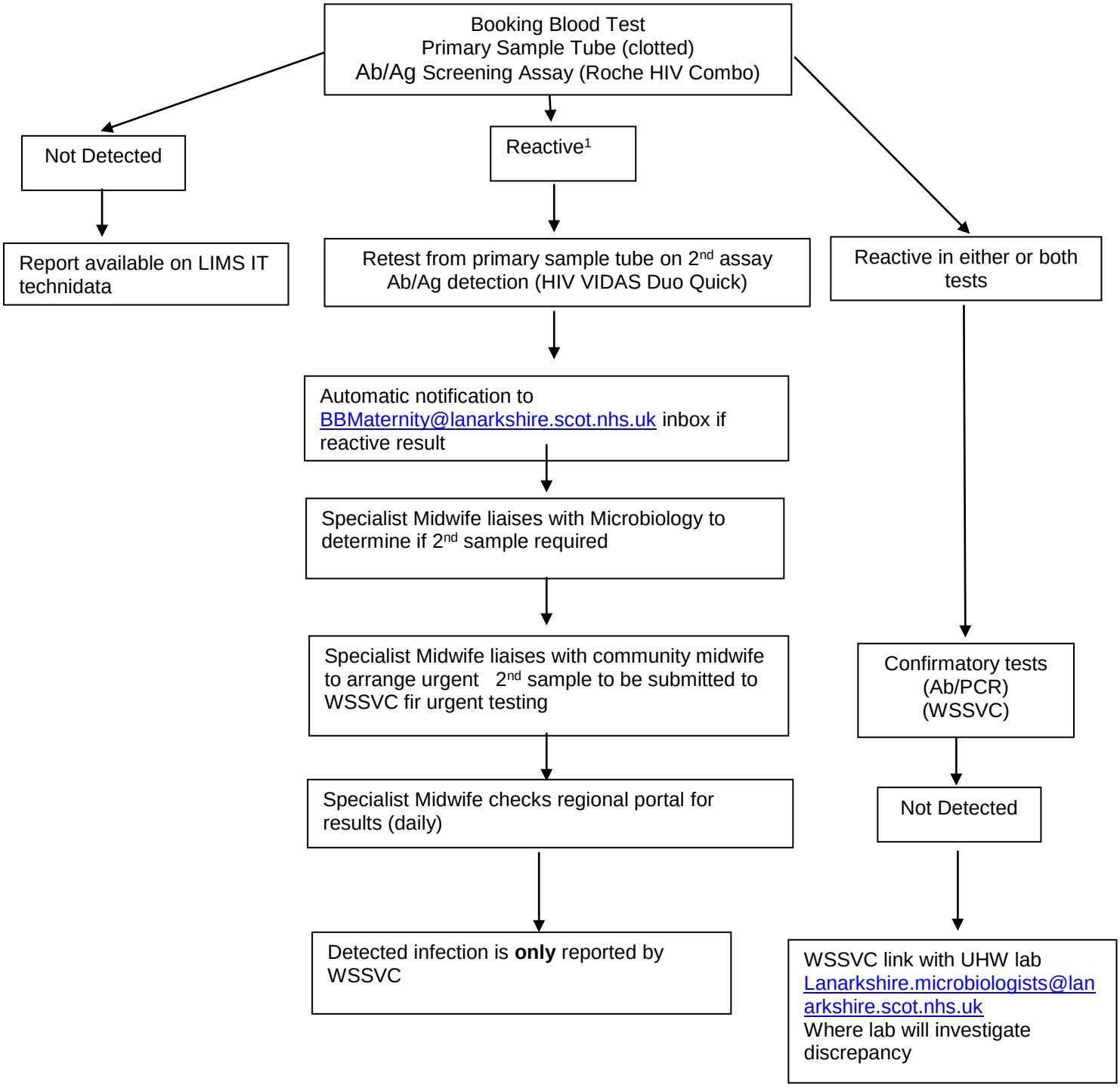
FLOWCHART OF SCREENING PREGNANT WOMEN FOR HIV



MICROBIOLOGY FLOWCHART



[1]NB- Microbiology flowchart references reactive sample result at UHW as this applies to departmental requirements, clinical staff will view results as indeterminate on browser systems

Appendix 1

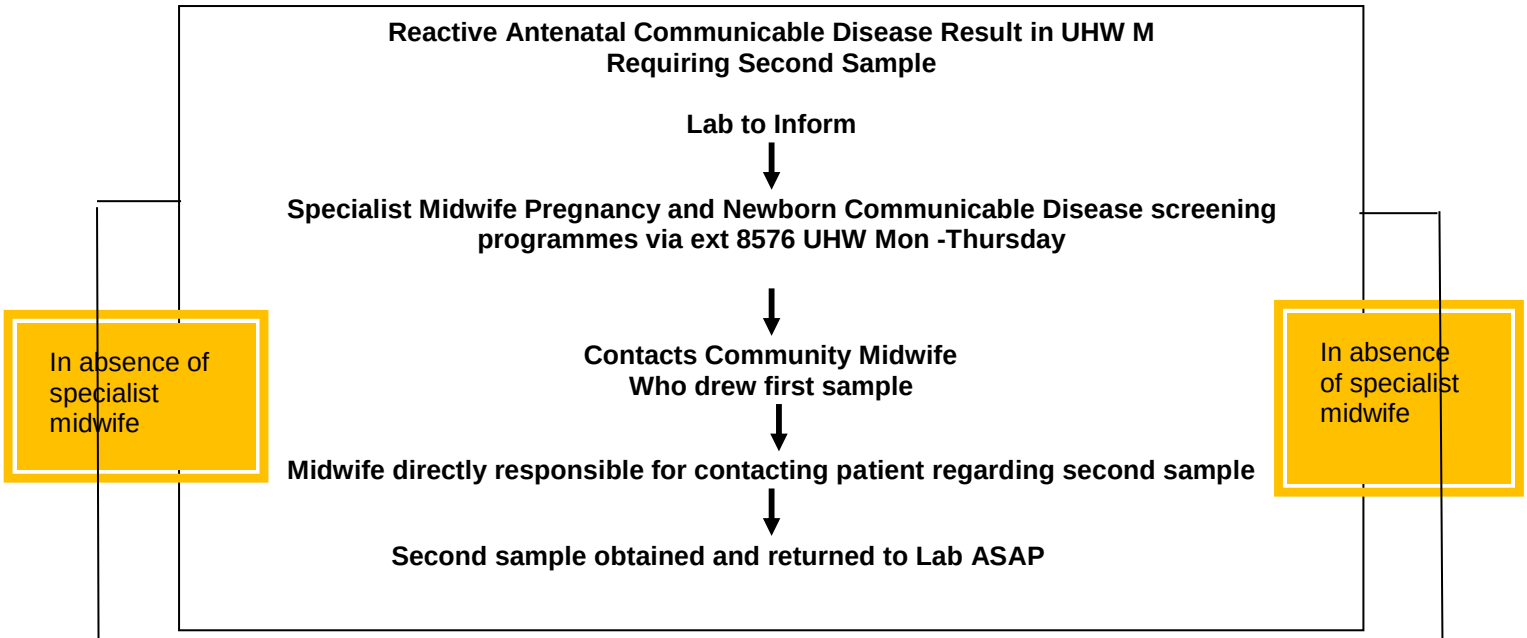
Audit Group Members

Name	Title	Hospital base	Email
Dr Rosemary Abara	Neonatal Consultant	UHW	Rosemary.Abara@lanarkshire.scot.nhs.uk
Jonathon Campbell	Clinical Quality	UHW	Jonathan.Campbell@lanarkshire.scot.nhs.uk
Elisa Stewart	Technical Manager, Microbiology dept.	UHW	Elisa.Stewart@lanarkshire.scot.nhs.uk
Dr Laura Gillespie	Sexual Health Consultant	Coathill Hospital	Laura.Gillespie2@lanarkshire.scot.nhs.uk
Dr Pamela Hunter	Microbiology Consultant	UHW	Pamela.Hunter@lanarkshire.scot.nhs.uk
Dr Nicholas Kennedy	Infectious Disease Consultant	UHM	Nicholas.Kennedy@lanarkshire.scot.nhs.uk
Dr John Logan	Consultant in Public Health	Kirklands Hospital, NHSL Headquarters	john.logan@lanarkshire.scot.nhs.uk
Dr Surindra Maharaj	Obstetric Consultant	UHW	Surindra.Maharaj@lanarkshire.scot.nhs.uk
Maureen Burns	Senior Nurse North Locality	Motherwell Health Centre	Maureen.Burns2@lanarkshire.scot.nhs.uk
Louise Pollock	Specialist Midwife for CD screening programmes	UHW	louise.pollock@lanarkshire.scot.nhs.uk
Trish Tougher	BBV Network Manager	Kirklands Hospital, NHSL Headquarters	Trish.tougher@lanarkshire.scot.nhs.uk
Heather Weir	Senior Midwife for Community and Out - patients	UHW	Heather.Weir2@lanarkshire.scot.nhs.uk
Sharon Woods	Lead BBV Specialist Nurse	UHM	Sharon.Woods@lanarkshire.scot.nhs.uk

Details correct as of 2021_09_20

Appendix 2

Lab Result Communication Pathway



In the absence of the Specialist midwife for the pregnancy and newborn communicable disease screening programmes, please notify:

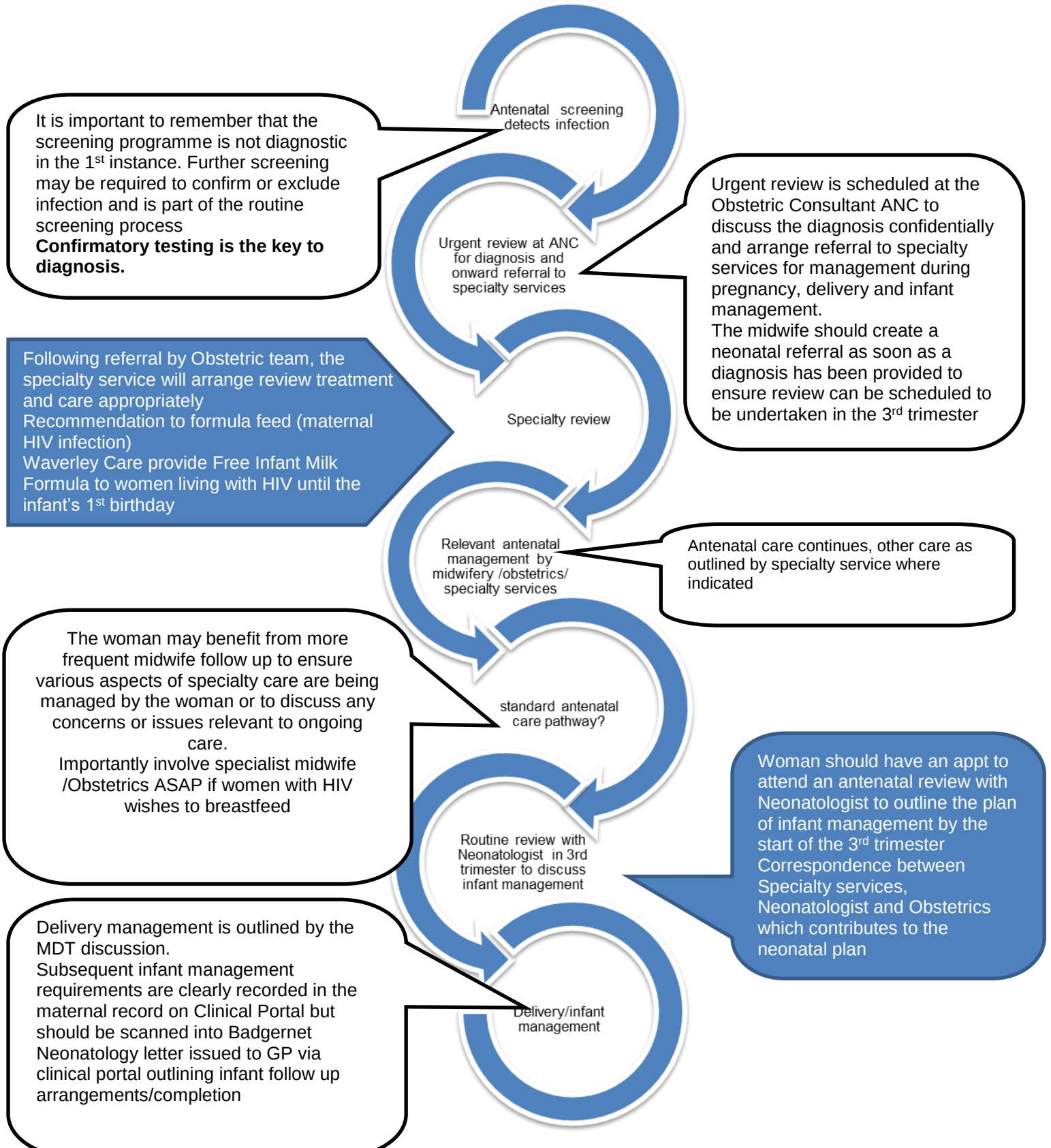
1. Unit Co-ordinator who is available 24 hours a day via DECT phone Ext 7890, Page 017 or Office Ext 7214(UHW)
2. Senior Midwife for community and out patients via ext 7226(UHW)

In the absence of patient's Community Midwife:

1. Contact Team Leader urgently. Team Leader can either deal directly with this or delegate.
2. Contact patient regarding obtaining second sample and arrange for this to be obtained and forwarded to Lab ASAP.
3. If delay in contacting patient regarding obtaining second sample, midwife should notify Team Leader and/or inform the Senior Midwife for Community and Out Patients
4. Attempt contact again **daily**
5. If a delay in obtaining second sample, contact Lab and Specialist Midwife.
6. Inform the Senior Midwife for Community and Out Patients of progress.
7. Badgernet record should include date/time of telephone calls, house visits made, any reason for patient not presenting for repeat sample.

Appendix 3

Midwife diagram- HIV Diagnosis



Appendix 3

Midwife Flow chart

New diagnosis

Obstetric staff **urgently** review at earliest ANC
Diagnosis given by obstetrician, ensuring patient confidentiality and onward referral to Infectious Disease Department

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Woman urgently reviewed at ID dept., treatment, care and support of diagnosis provided.

Starts on cART between 16-24 weeks, monitored by ID during pregnancy with some bloods performed at ANC
Compliance of cART essential

Detailed discussion around confidentiality, partner notification, management in pregnancy, delivery and infant management.

Regular review and monitoring at ID and antenatal clinic MDT meeting-indicates delivery management plan to minimise risk of vertical transmission

Evidence based recommendation to formula feed- no breast feeding (BHIVA guidance) - specialty refer to Waverley Care to arrange free infant formula milk provision

Free infant formula milk provision via UHM ID dept. and Waverley Care

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Antenatal referral at point of diagnosis to neonatology for review in 3rd trimester to discuss recommendations for delivery and infant management and including recommendation to formula feed* ensure to refer early as clinic does not run each month

⇩

Previous diagnosis

Obstetric staff review at earliest ANC
Obstetrician to discuss results, confidentially and refer to Infectious Disease Dept.

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Women who conceive on cART continue on therapy. On rare occasions medication may be changed by ID services.

Compliance of cART essential

Routine care as per local policy during antenatal episode

All points listed for new diagnosis are required
Woman aware of management plan for delivery which is determined by combination of Obstetric, Specialty service recommendations and woman's preference

Local HIV policy outlines key features/requirements for c/s versus trial of vaginal delivery

Evidence based recommendation to formula feed- no breast feeding (BHIVA guidance) - specialty refer to Waverley Care

⇩

Antenatal referral at point of diagnosis to neonatology for review in 3rd trimester to discuss recommendations for delivery and infant management and including recommendation to formula feed* ensure to refer early as clinic does not run each month

⇩

Management of Delivery/Labour

- As per MDT plan (search in clinical portal under correspondence and scan into Badgernet)
- Alert obstetrician +/- neonatologist if deviation from scheduled MDT plan
- Further labour management guidance can be found in BHIVA Guidance in Pregnancy document to assist management but further advice should be sought from infectious disease dept. if any doubt
- If late diagnosis in labour escalate to Obstetrics/Infectious Disease/Neonatology and Pharmacy

Appendix 3 Continued

Infant management at delivery (Infant of woman living with HIV infection)

- Formula feeding recommended
- Infant bathed at birth, weighed, prescribed and administered Post Exposure Prophylaxis within 2-4 hours of birth- do not delay administration of PEP
- Infant serology within 48 hours of delivery but certainly prior to discharge from unit and maternal Viral Load required at same time
- Infant PEP dependent on mother's risk factor antenatally and determined by Neonatologist

HIGHER RISK- Infant PEP for 4 weeks* Criteria as per Neonatal MCN Guidance
LOW RISK – Infant PEP for 4 weeks* Criteria as per Neonatal MCN Guidance
VERY LOW RISK- Infant PEP for 2 weeks* Criteria as per Neonatal MCN Guidance
*criteria as per Neonatal MCN Guidance 'Management of Infants born to women with HIV' First Port, Neonatal Page, under Guidance

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Infant management and follow up

- At discharge the infant continues on PEP as prescribed
- Formula feeding recommended
- NNU OPD at 6 weeks, 12 weeks 6 months, 22 months
- Midwife to monitor compliance with PEP administration

Health visitor role:

- Regular review to ensure compliance with infant PEP and is formula feeding
- In event of concern of compliance link with snr management and ensure accurate records maintained.
- Ensure follows NNU advice on vaccinations

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Woman continues on cART for life and returns to ID specialty care postnatally for ongoing management

Appendix 4 Abbreviation List

ANC	Antenatal Clinic
ART	Antiretroviral therapy
ASAP	As soon as possible
BHIVA	British HIV Association
cART	Combined antiretroviral therapy
CHIVA	Children's HIV Association
EDD	Estimated Date of Delivery
EDTA	
GP	General Practitioner
HIV	Human immunodeficiency virus
HIS	Health Improvement Scotland
ID	Infectious Disease specialty service
LHAHC	Lanarkshire HIV and Hepatitis Centre
LIMS IT Technidata	Laboratory Information Management System
LUSCS	Lower uterine caesarean section
MCN	Managed Care Network
MDT	Multi-Disciplinary Team
PEP	Post exposure prophylaxis
SPAIIN	Scottish Paediatric and Auto Immune Network
WSSVC	West of Scotland Specialist Virology Centre