

HIV and Sexual Health in Pregnancy

Manchester
Maternity Hospitals
Information Pack
3rd Edition



Writers

Sharon Wilson Manchester Specialist Midwifery Service

Bridget Hughes Manchester Public Health Development Service

Note

This information should be used in conjunction with:

- 1 The Greater Manchester HIV in Pregnancy and Neonatal HIV Policy 2010
www.sexualhealthnetwork.co.uk
- 2 Current BHIVA guidelines for the management of HIV in pregnancy and the prevention of mother to child transmission of HIV www.bhiva.org

Acknowledgements

Thanks to Faye Macrory, Consultant Midwife for her specialist input.

Special thanks go to Josanne Cowell, Public Health Development Advisor for her hard work and patience in the production of this pack.

First edition October 2003

Second edition October 2006

Third edition September 2011

Copyright Manchester Mental Health and Social Care Trust, 2011

Contents

Introduction	3	HIV in pregnancy and labour	20
● Confidentiality and disclosure of information	3	● Antenatal management	20
HIV antenatal testing guidelines	4	● Labour and delivery	20
● Focused discussion	4	● Postnatal management	21
● Insurance	5	● Contraception	21
● Interpreters	5	● Reporting	21
● Partners of pregnant women	6	Infection Control	22
● Risk factors	6	● Universal precautions	22
Negative women with HIV exposure risk in pregnancy	7	● After delivery	23
● The 'window period'	7	● HIV exposure policy	23
● Women at higher risk during pregnancy and whilst breast feeding	7	HIV and neonatal care	24
● Referrals	7	● Follow up for baby	24
● Care plans	8	● Disclosure	24
● Babies born to a negative woman in higher risk category	8	Safeguarding	25
● Breast feeding mothers	8	● Infants at risk from HIV	25
Referral pathways	9	● Criteria for referral to social services	25
● For women at risk of HIV during pregnancy or whilst breast feeding	9	● Multidisciplinary team	25
● Negative HIV result	10	● Plan Level 1	26
● Indeterminate HIV result	11	● Plan Level 2	26
● Positive HIV result	12	Referral pathway for parents who may not comply with treatment or intend to breastfeed against advice	27
Supporting pathway information	13	Syphilis in pregnancy	28
● HIV positive result	13	● Background	28
● Indeterminate HIV results	13	● Congenital syphilis	28
● Women in Styal Prison	14	● Role of Clinical Lead Midwife	29
● Pre-conceptual care for women who are known HIV positive	14	● Syphilis positive result	29
Responsibility of the health professional	15	● Referral pathway	30
● Prevention of HIV and transmission risk	15	Contacts	31
● Confidentiality	15	Additional contacts	31
● Disclosure of HIV status to third party	16	References	32
● Follow up and medical management	16	Appendix 1	
HIV medication and adherence	17	● Useful web based information	33
HIV transmission routes	17	Appendix 2	
● Sex	17	● Adults and children estimated to be living with HIV 2009	34
● Blood products	17	Glossary	35
● Mother to baby	17		
● Exposure risks	18		
● Safer sex	19		
● Infant feeding	19		

Role of the Clinical Lead HIV /Sexual Health Midwife

The Clinical Lead Midwife works within the Specialist Midwifery Service, based in the Zion Community Resource Centre and has a responsibility for a caseload of HIV positive pregnant women from the three Manchester hospitals. The post is responsible for monitoring standards of care and training midwives, doctors and other health professionals. This post also provides specialist advice regarding the management of HIV positive pregnant women and their babies.

Contact details

Manchester Specialist Midwifery Service
Zion Community Resource Centre
Specialist Midwifery Service
339 Stretford Road
Hulme
M15 4ZY

0161 226 6669

Sharon Wilson

0777 334 8393

sharon.wilson@cmft.nhs.uk

Manchester Public Health Development Service (MPHDS)

The Public Health Development Service is a citywide service engaging in both strategic development of the public health agenda in the city, as well as the management and delivery of key programmes of public health work with the aim of reducing health inequalities. One important area of work is sexual health and harm reduction particularly in Manchester, a city with high levels of deprivation and social exclusion, where people tend to have poorer health and limited access to services.

The PHDS has a dedicated sexual health team who actively promote work within hard to reach groups as part of its local strategy implementation.

Contact details

1st Floor
Fallowfield Library
Platt Lane
Fallowfield
Manchester
M14 7FB

0161 248 1750

www.mphds.org

Introduction

This information has been designed to provide staff with:

- HIV testing in pregnancy
- The management of women who are found to be HIV positive in pregnancy
- Subsequent follow up care for their babies
- How to get support and access resources

It should be read in conjunction with the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

The aim of the DoH (1999) was to increase the voluntary uptake of HIV testing in antenatal settings to 80% in an endeavour to identify HIV positive pregnant women. Women would then be offered antiretroviral treatments in pregnancy in order to reduce the vertical transmission rate. Offering the test to everyone normalises HIV testing and raises awareness amongst the general population about this major public health issue.

Confidentiality and disclosure of information

Manchester has three maternity hospitals across the city:

Central - St Mary's Hospital
South - Wythenshawe Hospital
North - North Manchester General Hospital

This information pack is a citywide document. There may be in-house variations but otherwise there is an expectation that all staff will refer and adhere to the guidance contained within the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010, particularly with issues of confidentiality and disclosure.

In addition to hospital medical records, information is also recorded in hand-held notes. It is vital that nothing regarding the woman's HIV status is recorded without discussion and the woman's explicit permission given. The information recorded may be seen by family and friends. The result should be filed in the hospital records and the reasons for this fully explained to the woman.

HIV status should be revealed to other professionals only on a 'need to know basis' and verbal disclosure should be discreet and sensitive.

All staff are bound by professional and employment guidelines regarding confidentiality of all patient information. Any breach of this will be viewed seriously and may be a disciplinary offence.

HIV antenatal testing guidelines

Aim: to increase the uptake of voluntary confidential HIV testing in pregnancy.

An HIV test must be offered to ALL women during their antenatal care as an integral part of routine antenatal screening. This will usually be done at the booking appointment but can be repeated at any time during pregnancy, during labour or in the post natal period.

In cases where HIV tests are undertaken in labour or during the post natal period, it is possible to fast track results. HIV positive results would require confirmation. (Greater Manchester HIV in Pregnancy and Neonatal Policy 2010, Appendix 8)

All women should have access to the HIV, pregnancy, you and your baby leaflet. This leaflet should also be available in clinic areas. Written information given prior to the woman's booking interview allows her time to give more thought to HIV testing issues and to formulate any questions she may wish to ask.

Focused discussion

“The primary purpose of pre-test discussion is to establish informed consent for HIV testing. Lengthy pre-test HIV counselling is not a requirement, unless a patient requests or needs this.”

The essential elements that the pre-test discussion should cover are:

- The benefits of testing to the individual
 - Details of how the result will be given
- (BHIVA 2008)

Imparting information about HIV improves uptake rates, therefore midwives should:

- Re-affirm that the test is offered to everyone
- Ask whether the woman has received and read the 'HIV, pregnancy, you and your baby' leaflet
- Clarify that the woman understands the implications of having the test
- Confirm that informed verbal consent for HIV testing has been given
- Be aware that written consent is not required
- Ask if the woman has any further questions
- Document that HIV testing has been offered, declined, accepted or is to be re-visited
- Advise and document that the result of the test will be given at the next antenatal appointment
- Advise that if the test is declined it will be re-offered at the next antenatal appointment or by 28 weeks gestation
- Specimens taken at 24/40 gestation or later should be marked as urgent and the result should be received by the requester within 24 hours of the sample being received by the laboratory (Infectious Diseases in Pregnancy 2011)

For audit purposes it must be made clear that the request is via the antenatal setting. It should be stated that no results, for any blood test being done, would be given over the telephone.

Any woman requesting information or advice beyond the competence or confidence of the midwife should be referred on for additional in-depth discussion with the Clinical Lead Midwife. It is the responsibility of involved staff to feel equipped to discuss HIV testing. Extra teaching sessions can be arranged for those who feel they would benefit from more information.

Checklist for practitioners

- Prior to offering the test it is preferable that practitioners attend an 'HIV awareness' training session
- Ensure the woman has read, and understood the information in the 'HIV, pregnancy, you and your baby' leaflet
- Document in the medical case notes following discussion with the woman whether screening is to be accepted or not
- Follow local policy in terms of requesting HIV test
- If the woman declines HIV screening ensure that the reason why is documented in the medical case notes. The subject must be sensitively re-offered at the next visit or by 28 weeks gestation
- If the woman remains 'unsure', document this accordingly in the case notes. It must be re-offered again at the next appointment and particularly after the baby is born, if a test has been declined
- Anonymous HIV screening will not be offered. If a woman has more concerns she may be referred directly to the Clinical Lead Midwife or an HIV Consultant
- Blood for HIV screening may be taken at any stage, even in labour. Relevant contact numbers may be found on the HIV guidelines for referral flowcharts
- HIV testing can also be offered to postnatal women prior to discharge
- Positive HIV results will not, under any circumstances, be given over the telephone. It should be explained and documented that the woman will receive negative results at the next antenatal clinic appointment
- Results will only be kept in the medical case notes
- Women concerned about implications of HIV testing on life policies or mortgages should see below
- If 24 weeks gestation or later specimen should be marked 'Urgent' and a result received within 24 hours of the sample being received by the laboratory

Insurance

The Association of British Insurers code of practice 1994 states that questions regarding whether an individual has ever had an HIV test or a negative result should not be asked. Applicants should however declare any positive results if asked as would be the case with any other medical condition (ABI 2004).

Interpreters

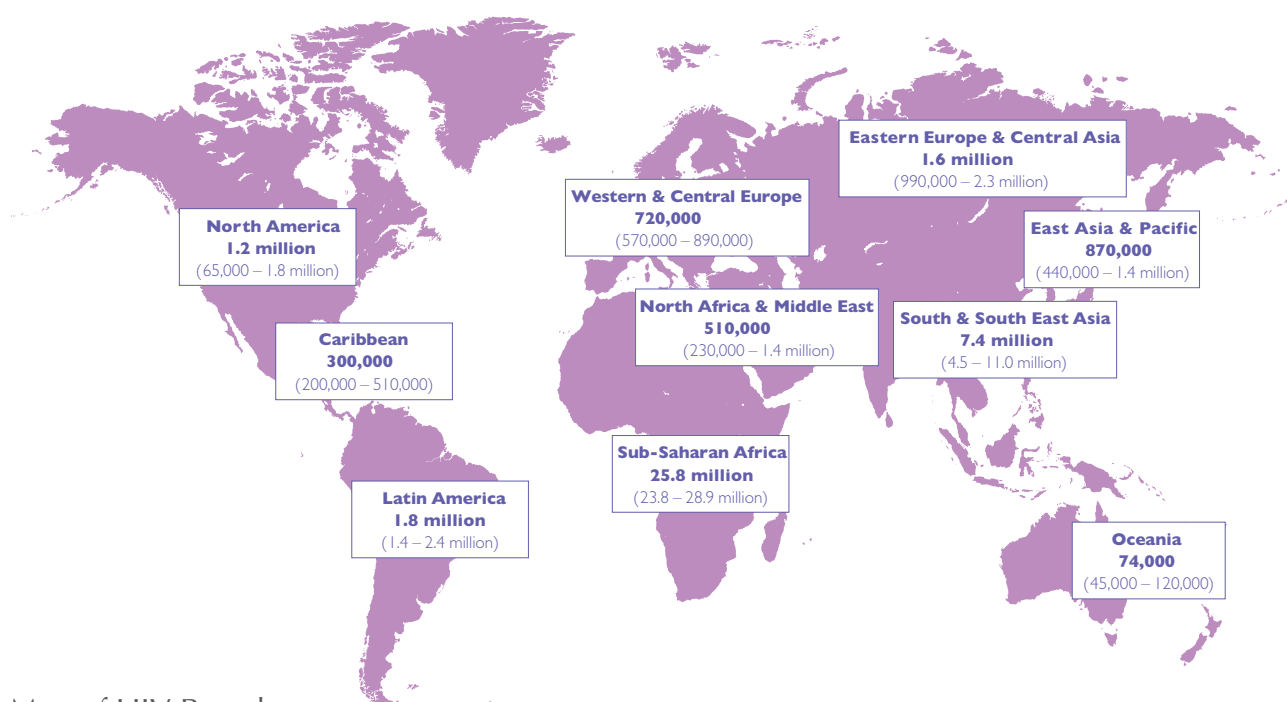
Trust policy states that an interpreter should be present if a woman does not speak English. A family member is not appropriate to act as interpreter and all women should be given an opportunity to be seen on their own with an interpreter to discuss issues of, for example, risk of domestic abuse or sexually transmitted infections.

Partners of pregnant women

It would be seen as good practice to offer partners of pregnant women information about HIV and details of where to access testing, for example in the GUM clinics. This is especially important to discuss with couples from high prevalence areas or who have increased risk factors for HIV.

Risk factors

Midwives have to be equipped to offer HIV testing to women from high prevalence areas such as Sub-Saharan Africa with sensitivity and confidence. It is known that many women from such areas have been sexually assaulted (WHO 2006). Other women may be aware that their partners are HIV positive. Midwives can laminate the 'HIV, pregnancy, you and your baby' leaflets to aid discussions and a map can be used to point out areas of risk to women to encourage them to take a test.



Map of HIV Prevalence

Adults and children estimated to be living with HIV as of end 2009.
See Appendix 2 for large version of HIV prevalence map

Negative women with HIV exposure risk in pregnancy

The aim of this guidance is to reduce the risk of mother to child transmission of HIV by identifying women:

- At risk from sero-converting during pregnancy and breast feeding, i.e. HIV positive partner
- Who are at high risk of HIV and book late in their pregnancy

The 'window period'

After primary infection with HIV, there is a period of up to three months before HIV antibodies can be detected. This is called the 'window period.' During this time further tests are necessary to confirm HIV diagnosis (NAM 2009).

Women at higher risk during pregnancy and whilst breast feeding

Women have a named midwife in pregnancy to whom they may choose to disclose sensitive information. The information within the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010 is designed to maintain confidentiality, continuity of care and to provide women with immediate expert advice and support.

Referrals

All referrals will be sent to the Clinical Lead Midwife who will fast track an appointment for the woman to the HIV Clinical Nurse Specialist and HIV Consultant within the GUM or Infectious Diseases Department (ID) for appropriate follow up.

Any woman who declines referral to GUM can be managed by the Clinical Lead Midwife, with referral directly to the HIV Consultant in the event of any detectable HIV virus or sexual health concerns.

Referral criteria

- Disclosure of rape during pregnancy
- Disclosure of rape 3 months prior to the pregnancy
- Women who are aware that a sexual partner is HIV positive
- Women who continue to have unprotected sex with an HIV positive partner
- Disclosure of sharing of needles/syringes during pregnancy or within a three month time period prior to pregnancy
- Women who have had a blood transfusion/operation in a country with high prevalence of HIV, three months prior to pregnancy

For management of women at higher risk during pregnancy or whilst breastfeeding please refer to the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

Care plans

Care plans are to be placed in maternal notes for instructions regarding infant feeding and future follow up if appropriate. The plans are to be copied to the HIV Consultant, Paediatrician and Obstetrician.

In the event of a known HIV positive partner no information should be placed in the maternal notes without specific consent.

Babies born to a negative woman in higher risk category

Babies born to women who are at high risk of HIV must be referred to the Clinical Lead Midwife, HIV Consultant and Consultant Paediatrician on call for a decision regarding management.

If the HIV exposure risk is disclosed during labour, the HIV team must be contacted urgently in order for them to make a medical assessment that may affect management in labour. Some babies may require prophylactic antiretroviral medication.

Additional referral criteria:

- Baby delivered to an un-booked high risk mother who has no baseline virology from booking bloods
- Mother with clinical signs of HIV infection
- High-risk mother who could be in the window period i.e. within three months of HIV exposure (please see previous criteria for HIV exposure)

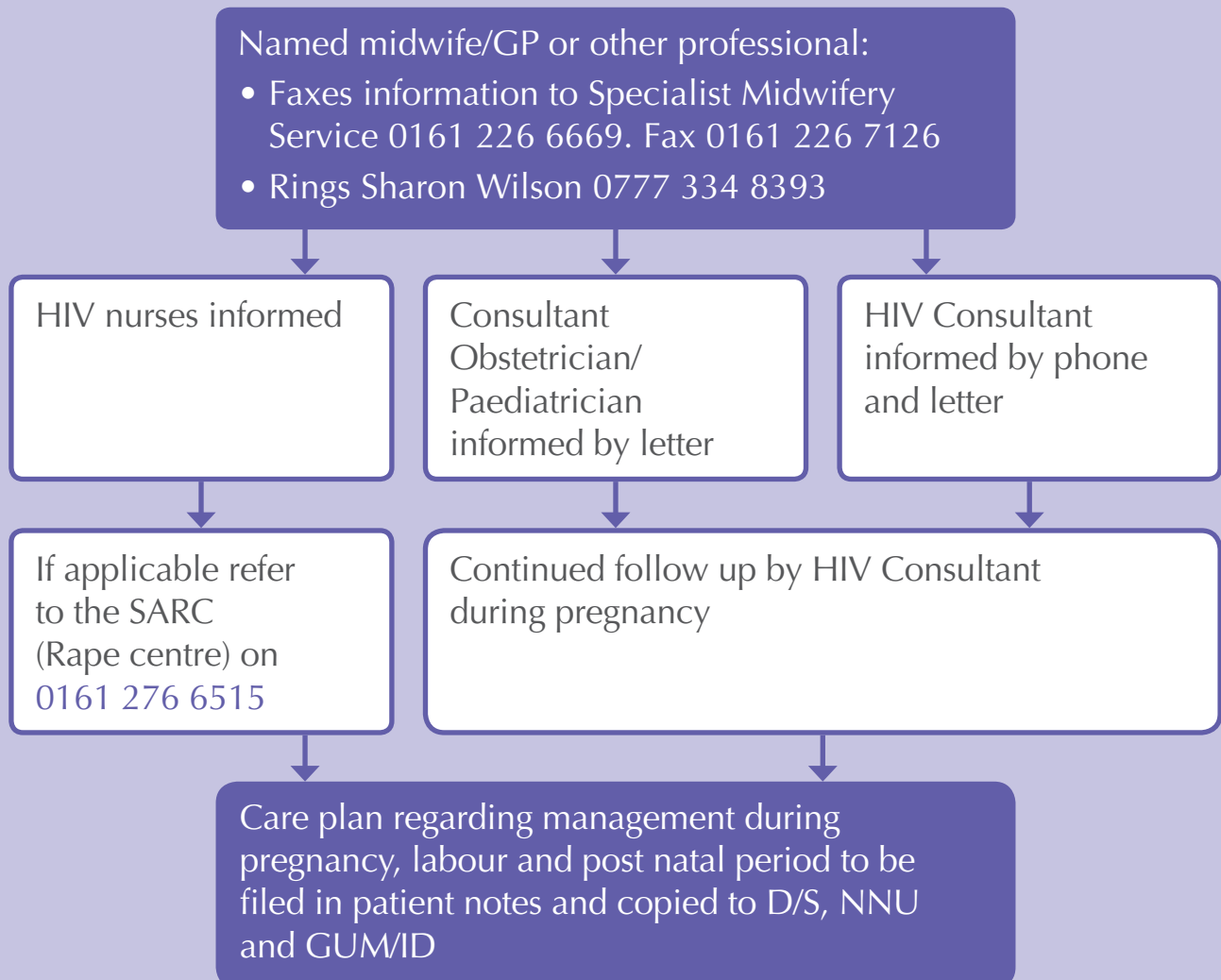
Breast feeding mothers

Every effort must be made to maintain lactation in mothers who are breast feeding but awaiting HIV results. Under no circumstances is a baby to be given a bottle unless there is a definite maternal HIV diagnosis. Please refer to local breast feeding policy and refer to the breast feeding co-ordinator for further advice.

For management of babies born to a negative woman in a higher risk category please refer to the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

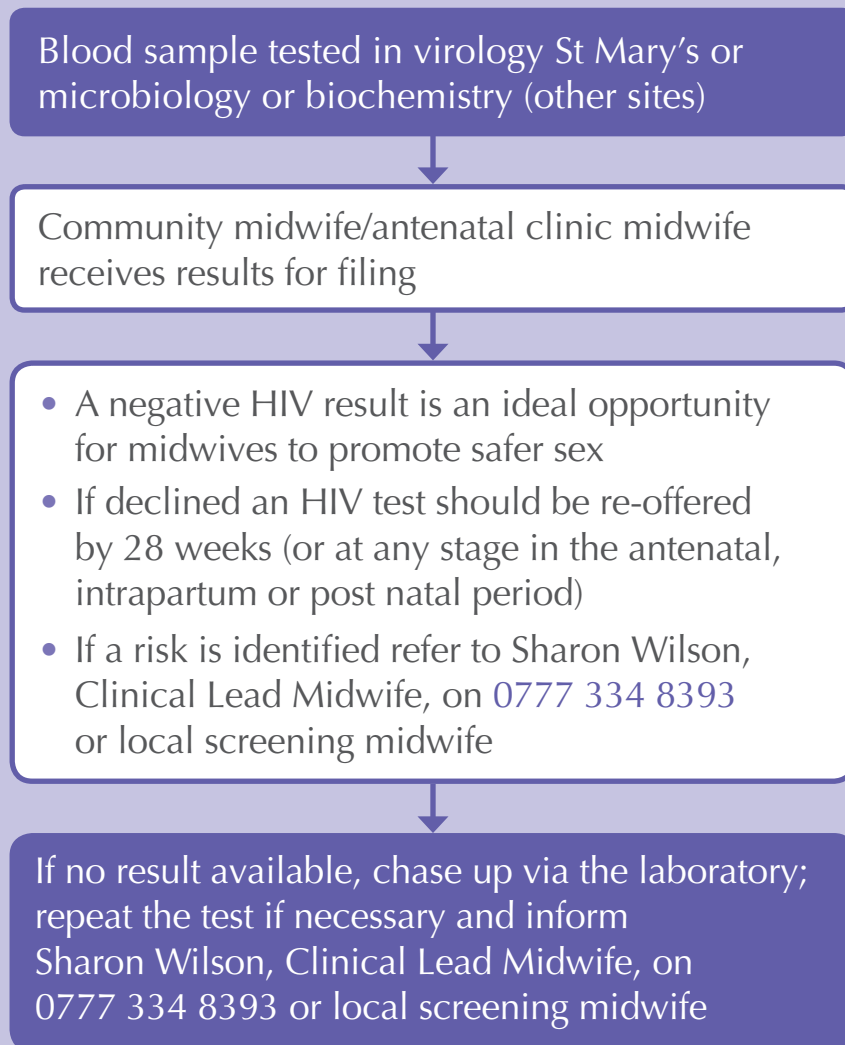
Referral pathways

For women at risk of HIV during pregnancy or whilst breast feeding



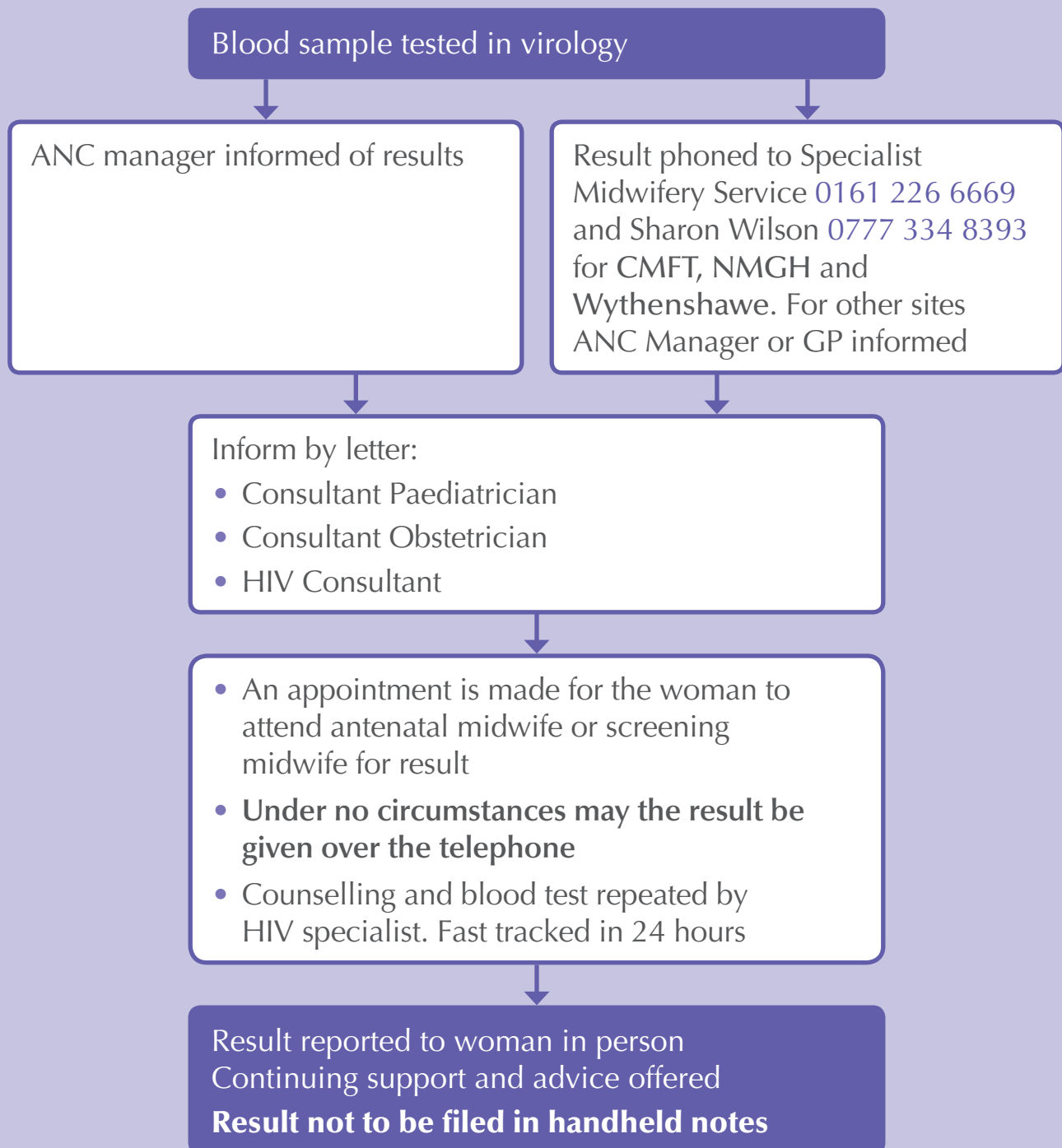
Referral pathways

Negative HIV result



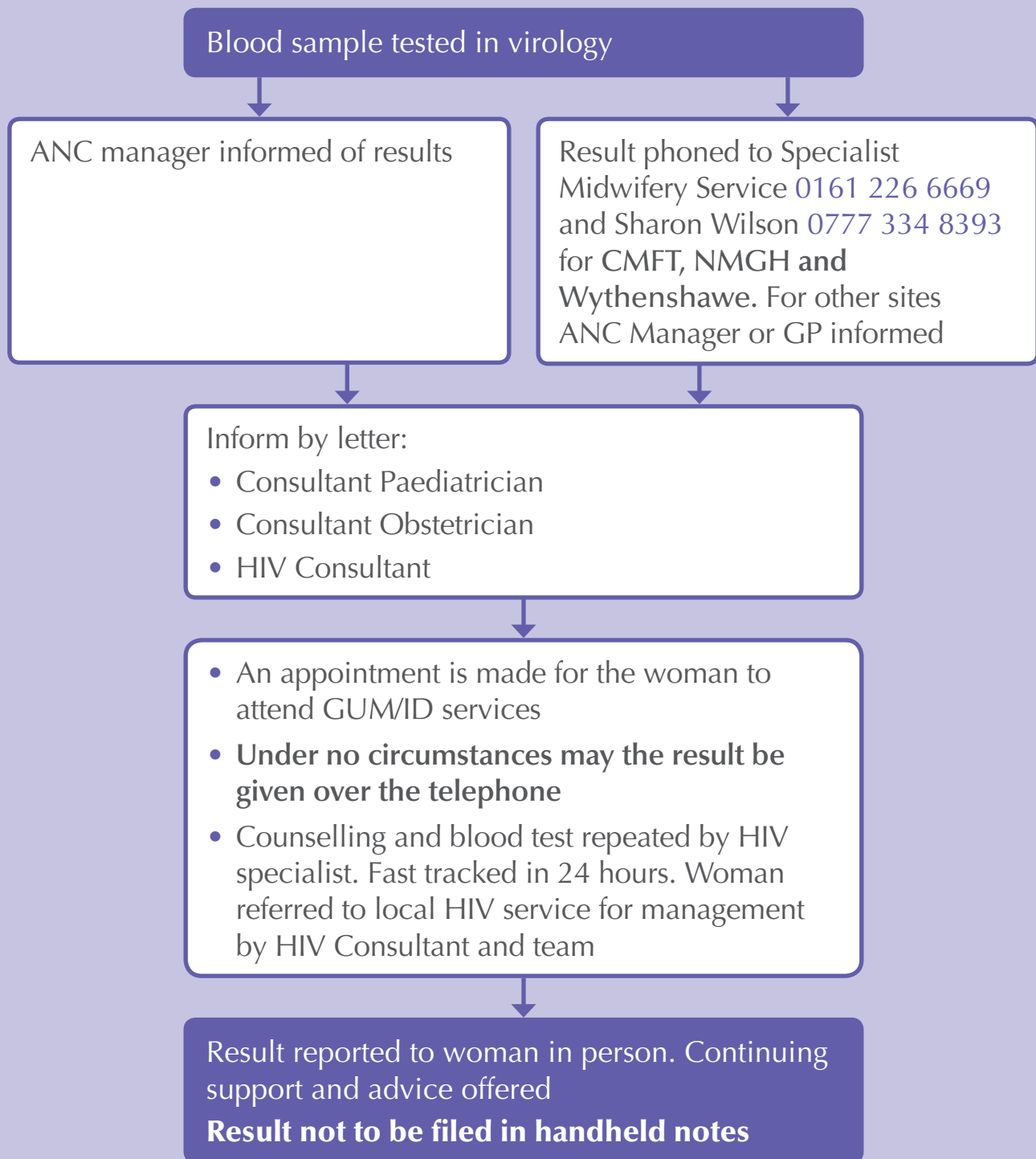
Referral pathways

Indeterminate HIV result



Referral pathways

Positive HIV result



Supporting pathway information

HIV positive result

All women are counselled by the Clinical Lead Midwife and in her absence an HIV Consultant or the HIV specialist nurses. This information is pivotal to enable the woman and her partner to make choices to reduce the risk of vertical transmission of HIV from 25-30% to less than 1%. (BHIVA 2008)

- The HIV positive result is phoned via the laboratory to Manchester Specialist Midwifery Service
- A letter should be sent to the patient via obstetric secretary and EDD checked. The patient should be called urgently if very near to term
- A second letter should be sent via the secretary if the patient did not attend (DNA)
- A registered letter should be sent out or a community midwife contacted if there are further DNAs
- If there is no contact, an alert should be sent via Social Services and Local Supervising Authority to inform health professionals that the woman requires information and treatment to protect her and her unborn baby from HIV
- If a patient is seeking asylum or has uncertain status, her address should be checked via National Association of Asylum Seekers
- The patient should be referred to the Clinical Lead Midwife and HIV Consultant
- The Clinical Lead Midwife will ensure all aspects have been discussed with the patient and documented. Written information should be given and HIV voluntary support numbers provided
- Appointments can be made for voluntary organisations with the patients consent, confirmatory HIV letter can be provided
- Clinical Lead Midwife to liaise with the health advisor and community midwife and provide support. If there are concerns regarding social circumstances, a home visit should be made by the community midwife
- The woman should be helped to prepare for infant feeding and avoidance of breast feeding

Indeterminate HIV results

These results are reported as 'unclear' and should be repeated urgently. The woman should be asked to return to the hospital as with an HIV positive result. Please refer to Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

- A repeat HIV antibody test is taken and sent as urgent to the laboratory
- The virologist is contacted and will receive the result, fast tracked within two to four hours
- The woman is recalled and the result is given
- If the result is negative the woman may need further support

Women in Styal Prison

Women who are diagnosed as HIV positive whilst in prison have unique needs and sensitive communication is necessary to ensure that confidentiality is maintained.

- Liaison should be with HMP Styal, prison healthcare, community midwives and health visitor
- Some women may decline written information and prison visits may be required by the Clinical Lead Midwife in these cases to offer support and ongoing information
- Separate arrangements are to be made for HIV medication to be transported to the healthcare department within the prison
- Discussions around disclosure to partners may be inappropriate due to short prison visits
- Baby medication to be held by the healthcare department and adherence to treatment re-enforced
- OPD appointments to be checked and baby to be taken at correct times to ensure collection times for blood samples

Please note that women may not have had the opportunity to disclose HIV status to their partner whilst in prison. Every effort will be made to ensure confidentiality and appropriate support in the event of disclosure to a partner whilst in hospital.

Pre-conceptual care for women who are known HIV positive

There are an increasing number of women known to be HIV positive who are becoming pregnant. Many of the women access the Clinical Lead Midwife or HIV Consultant for pre-conceptual advice.

For management of known HIV positive women please refer to the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

Responsibility of the health professional

Prevention of HIV and transmission risk

The health professional has a responsibility to impart vital information to the person infected with HIV in order for them to protect others and reduce the risk of prosecution.

The Crown Prosecution Service reinforces this by stating that there are a number of factors which may be relevant to the issue of recklessness. These may include whether the defendant's use of a condom reduced the risk of transmission; the extent of the defendant's awareness of his/her infection at the time when the sexual activity occurred and therefore the degree of risk of transmission; and whether the defendant relied upon any medical and professional guidance he/she received. What weight, if any, might be given to each of these factors will depend on the specific circumstances of each case. (CPS 2009)

The defendant's knowledge and understanding of their infection and its communicability may be relevant to the issue of recklessness. It is not uncommon for infected people to not fully understand the implications of their condition. The greater his/her understanding is of the infection, the easier it will be to establish recklessness.

In determining the extent of the defendant's knowledge of his/her infection prosecutors may have to take into account factors such as whether he/she received adequate counselling, including risk reduction counselling, and whether the defendant knew the infection was transmissible and how it may be transmitted.

A known barrier for HIV disclosure is fear of domestic abuse. (WHO 2006) Research suggests that 1 in 4 women will experience domestic abuse in their lifetime, with 30% of all domestic abuse beginning in the first pregnancy. It is the responsibility of the HIV counsellor to ensure routine enquiry around domestic abuse and signpost women to support services such as Women's Aid.

Confidentiality

There is an expectation that confidentiality is respected at all times. The HIV status is shared with the multidisciplinary team on a need to know basis. It is seen as imperative in the safeguarding of children to share important information that could affect a baby's wellbeing. (DFES 2006) The community midwife and health visitor should be involved from an early stage to offer support for an HIV positive pregnant women.

Disclosure of HIV status to third party

Every effort must be made to support the woman to disclose to her sexual partner/s in order to protect their health. In the event of non-disclosure a doctor 'may' breach confidentiality for the protection of others. (GMC 2006) Any one practitioner should not take this action unilaterally without a decision by the multidisciplinary team.

There have been ten convictions in England and Wales under section 20 of the offences against the persons act 1821, all for the reckless transmission of HIV. The transmission is deemed to be reckless where a person, who knows that he/she is infected with a sexually transmissible infection, and is aware that there is a risk in transmitting that sexually transmissible infection to another person, nevertheless, took that risk and engaged in sexual activity with the other person. This other person did not consent to the risk of transmission and as a result of that sexual activity becomes infected with that sexually transmissible infection, thereby suffering grievous bodily harm. (CPS 2009)

Follow up and medical management

Women are referred to the relevant HIV team and seen by an HIV Consultant. There should be liaison between the HIV team facilitated by the Clinical Lead Midwife. The HIV team will review the women at different stages during the pregnancy. This is usually:

- Early in pregnancy
- At twenty weeks prior to commencing on antiretroviral therapy
- At intervals throughout the pregnancy
- At thirty-five weeks to plan for delivery along with the multidisciplinary team

Measures should be put in place to track vulnerable women who due to displacement or uncertain immigration status are difficult to contact. There should be close collaboration with the refugee/asylum midwife, community midwives and health visitors. The Clinical Lead Midwife should raise an alert via Social Services and LSA to find women who are in need of medical care or if there are concerns regarding safeguarding.

HIV medication and adherence

HIV medicine is an evolving field with many uncertainties regarding the use of antiretroviral therapy. The treatment is often individualised to account for disease progression. Unlike many treatments, HIV medication relies on a minimum of 95% compliance from the patient to prevent long-term morbidity. (NAM 2011)

Medication is commenced at approximately 20 weeks gestation although preparing for this can take many weeks. It is important to continually work with women's personal expectations and goals whilst on therapy, to explore the barriers to adherence.

Compliance can be improved by understanding social circumstances, such as immigration. The HIV team, compliance nurse and pharmacy will provide advice and continuing support during pregnancy.

Adherence and timeframes are paramount to treatment. It is therefore important that women be permitted to hold their own medication and that of their baby whilst in hospital as their regimes will not correspond to the hospital medication charts and drug rounds.

HIV transmission routes

Sex

Established routes

- By having sexual intercourse (vaginal or anal) without a condom with a person who is HIV positive

Possible routes

- By having unprotected receptive oral sex with ejaculation with an infected person

Uncommon routes

- Infected semen or vaginal fluids in the eyes
- Sharing sex toys
- Unprotected oral sex

Blood products

Uncommon routes

- By donations of blood, tissue or organs from an HIV infected person
- Surgical and invasive products
- By sharing needles with an HIV infected person
- Tattooing
- Needle stick and sharps injuries

Mother to baby

- A HIV positive woman can infect her baby during pregnancy, labour, delivery or by breast feeding

Exposure risks

Activity	Risk-per-exposure
Vaginal sex, female-to-male, studies in high-income countries	0.04% (1:2380)
Vaginal sex, male-to-female, studies in high-income countries	0.08% (1:1234)
Vaginal sex, female-to-male, studies in low-income countries	0.38% (1:263)
Vaginal sex, male-to-female, studies in low-income countries	0.30% (1:333)
Vaginal sex, source partner is asymptomatic	0.07% (1:1428)
Vaginal sex, source partner has late-stage disease	0.55% (1:180)
Receptive anal sex amongst gay men, partner unknown status	0.27% (1:370)
Receptive anal sex amongst gay men, partner HIV positive	0.82% (1:123)
Receptive anal sex with condom, gay men, partner unknown status	0.18% (1:555)
Insertive anal sex, gay men, partner unknown status	0.06% (1:1666)
Insertive anal sex with condom, gay men, partner unknown status	0.04% (1:2500)
Receptive fellatio	Estimates range from 0.00% to 0.04% (1:2500)
Mother-to-child, mother takes at least two weeks antiretroviral therapy	0.8% (1:125)
Mother-to-child, mother takes combination therapy, viral load below 50	0.1% (1:1000)
Injecting drug use	Estimates range from 0.63% (1:158) to 2.4% (1:41)
Needlestick injury, no other risk factors	0.13% (1:769)
Blood transfusion with contaminated blood	92.5% (9:10)

(NAM Publications, 2011)

Safer sex

All HIV positive women will be offered a full sexual health screen during pregnancy, as prompt treatment is important for their sexual health and that of their partner.

During pregnancy women should be aware of how to protect themselves against STIs through the use of condoms and/or dental dams. However, for pregnant women who are HIV positive, condoms provide the only protection against transferring the virus to a negative partner or from acquiring an infection with a different strain of the HIV virus. Super-infection with a different drug resistant virus is a possibility. (NAM 2011) The transmission of a virus that is difficult to treat poses an increased risk to the unborn baby and the future health of the woman.

If a woman's partner is found to be HIV positive as well, they should still be advised to use a condom. This will provide protection from other sexually transmitted infections that could further complicate the pregnancy. For example, infections such as Bacterial Vaginosis have been shown to increase the risk of premature rupture of membranes and preliminary data suggests that it may stimulate HIV transmission in vitro. (BHIVA 2008)

Taking antiretroviral treatment does not prevent the woman from passing the virus to an HIV negative person.

It is essential for the woman to use condoms to avoid the spread of HIV through sexual contact.

Infant feeding

HIV is present in breast milk and can be transmitted to the neonate both through cell free virus and via HIV infected cells in the milk. Sub-clinical mastitis in the mother will increase the amount of virus to which an infant is exposed. (BHIVA 2008) Although the concentration of the virus in breast milk may be low, the quantities of milk consumed are high, leading to a substantial viral exposure in the baby. Mixed feeding increases the risk of transmission by increasing the permeability of the gut in the infant.

In circumstances where safe affordable alternatives exist, HIV positive women should be advised not to breast feed their babies. There may be a range of cultural issues that make this a difficult course of action for some women. Questions from family and friends, who may not be aware of the HIV status of the women, may prove difficult to answer. Additional support may be required from the HIV team regarding choice of feeding.

The preparation for infant feeding must be discussed during the antenatal period and the woman advised to buy a steriliser, milk and bottles. It is important to also discuss the benefits of cabergoline for suppression of lactation.

Any woman who declares that she will breastfeed despite this advice must be referred to the Clinical Lead Midwife for further discussion and case planning via the MDT. Reference should be made to the BHIVA/CHIVA (2008) statement on infant feeding and the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

HIV in pregnancy and labour

Antenatal management

Shared care will include consultants in obstetrics, HIV, paediatrics and a clinical lead midwife. Apart from a few exceptional circumstances, all women will be on antiretroviral therapy (ART).

HIV infected women requesting invasive prenatal diagnosis (maternal age, increased downs syndrome screening) need to be counselled by a fetal medicine specialist/consultant obstetrician. Liaison with an HIV consultant is important as administration of antiretroviral therapy (ART) to cover the procedure is recommended, although there is no data on transmission rates with or without ART.

Labour and delivery

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

Unless the mother is on AZT monotherapy during the antenatal period, IV AZT is not required for women with an undetectable viral load at 36 weeks gestation regardless of the mode of delivery.

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

For management of HIV in pregnancy and labour please refer to the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

For management of the baby please see page 24.

Postnatal management

- The baby will receive medication at birth
- Babies should be bathed in the same delivery room as this may help to reduce transmission
- After delivery there is no need for the women to be segregated. Discretion should be used by the midwife in the administration of ART to mother and baby
- On transfer to the ward it is important that the mother has enough tablets to recommence her ART. **If supplies of tablets are low this should be treated as a matter of urgency.**

Contraception

Barrier methods are encouraged in addition to any other methods. ART reduces the efficacy of the combined OCP and therefore the use of IUCDs are advocated.

On postnatal transfer to the community, information or codes relating to the woman's HIV status **must not** be entered on the discharge papers.

The woman's HIV status is only to be disclosed to other health care professionals **with the woman's informed consent**. It is seen as a matter of importance that the woman's GP, health visitor and community midwife are made aware of her status so that the baby can safely access immunisation programmes.

Community midwives should exercise caution in the completing of PKU forms. It is not necessary to enter confidential information regarding the baby's medication. In the extremely unlikely event of an abnormal result the information can then be provided with the second sample.

Reporting

Clinicians caring for HIV positive women and their children have a responsibility to report women prospectively to the UK National Study of HIV in Pregnancy and Childhood (NSHPC) and the International Drug Registry (Antenatal Pregnancy Registry) and infants to the British Paediatric Surveillance Unit (BPSU) after birth.

Infection control

Universal precautions when adhered to reduce the risk of occupational exposure to HIV and other blood borne infections. Prospective surveys show risk of HIV sero-conversion after a needle stick or sharps injury involving known HIV infected blood to be 1:300 (DH 2008).

Whilst double gloving is not universally recommended surgeons and staff who are involved in 'high risk' surgical procedures may use double gloving for known HIV positive patients. It does not prevent stab injuries but creates a 6 fold decrease in inner glove puncture, therefore offering some protection in reducing the amount of blood exposure.

Risk reduction strategies are particularly relevant in obstetrics and gynaecology where there is the highest reported rate of occupational exposure to patient's blood.

Appropriate level of precautions to be taken for any procedure should be determined according to the extent of possible exposure and not because of knowledge of the person's HIV status. (HSE 2008)

Universal precautions

- Cover open cuts, sores or dermatitis with waterproof dressing
- Wear gloves whenever there is a risk of contact with blood and body fluids
- If your skin comes in contact with blood or other bodily fluids, wash with soap and water straight away
- Protective eyewear should be worn during operative procedures and delivery
- The usual personal protective equipment (PPE) should be worn when undertaking any invasive procedure. Always ensure theatre gowns are properly secured and tied and aprons are worn underneath for added protection
- Appropriate protective foot wear e.g. boots should be worn in theatre
- Gauntlets should be used for manual removal of placenta
- Take care to prevent injuries when handling sharps. Handle them as little as possible and use a needle holder when suturing. Do not recap used needles, use sharps boxes and keep these as close to the place of use as possible
- Kidney dishes should always be used for passing scalpels during caesarean section

After delivery

- Examination of the placenta carries the risk of blood splashing, especially if dropped. PPE should be worn until this examination is complete
- Clear up blood spillages using appropriate guidance from hospital policy
- Handle newborn babies with gloves until they have been bathed
- Advise women how to handle and dispose of sanitary pads safely

HIV exposure policy

Immediately after the exposure:

- Wound or non-intact skin should be washed with soap and water without scrubbing
- Puncture wounds should be encouraged to bleed and the wound must not be sucked
- Exposed mucus membranes such as eyes should be irrigated and contact lenses removed

In the event of occupational exposure to HIV or other blood borne infections the health care worker should report immediately to the Occupational Health Department or Accident and Emergency out of hours.

The Trust policy in exposure to blood borne viruses should be implemented, whereby testing, counselling and post exposure prophylaxis can be given if appropriate.

HIV and neonatal care

Follow up for baby

A paediatrician need not attend the birth unless there is another indication. The mother should be offered skin-to-skin contact with her baby as soon as possible after the birth. The baby should be bathed as soon as reasonably possible after delivery, as this may be helpful in reducing transmission.

Medication

The paediatrician will write up the neonatal prescription sheet when the baby is born. Medication should be given within four hours of birth.

Antiretroviral regimes

Please refer to the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

Adherence to HIV medication

The medication must be given at the times prescribed. It is extremely important that no doses are missed. Women should be instructed how to administer the medication to their babies as soon as possible.

If the mother presents in preterm labour i.e. before drugs are prescribed, inform the HIV Consultant on call, the Consultant Paediatrician and the Clinical Lead Midwife.

After transfer of the mother and baby to the postnatal ward the paediatrician will perform the usual baby check and prescribe take home medication.

For management and follow up for baby please refer to the Greater Manchester HIV in Pregnancy and Neonatal Policy 2010.

Disclosure

No information about the baby's medication should be written on the discharge papers, as this is an indicator of the mother's status.

GPs will be notified of all babies who have received antiretroviral medication to enable them to monitor for long-term side effects. Parents who request no GP contact can have their children referred to a community paediatric specialist for follow up.

NB. Neonatal BCG is a live vaccine and therefore contraindicated until the result of the four month HIV PCR test is known.

All other vaccinations can be given to the baby at the usual immunisation times.

Safeguarding

Most women comply well with interventions and drug treatments and are prepared to give prophylactic antiretroviral therapy to the baby to reduce the risk of vertical transmission from 25-30% to less than 1%. For a variety of reasons e.g. faith and belief, some women do not accept the HIV risk and decline treatment for their baby. Every child has a right to health and safety and this should be seen as an important aspect in safeguarding children. (Every Child Matters 2006)

Infants at risk from HIV

The main aim is to safeguard babies who are at risk of HIV infection and to reduce the risk of mother to child transmission of HIV.

Criteria for referral to social services

- Client declines neonatal treatment
- Non-engagement with HIV/antenatal services
- Client declines antenatal antiretroviral medication
- Client declares intention to breast feed the baby against advice from HIV team
- Client's partner declines treatment for the neonate

Multidisciplinary team

- Clinical Lead Midwife
- Obstetrician/Paediatrician/HIV Consultant
- Community Midwife
- Health Visitor
- HIV Liaison Nurse
- Named Senior Nurse Child Protection
- Named Midwife Child Protection
- Special Care Paediatric Nurses
- Social Worker

The role of the multidisciplinary team is to discuss the issues and provide an individual plan of care for the notes.

Plan Level 1

- Women who decline antenatal HIV treatment but agree to neonatal prophylaxis
- Women who do not access services but agree to neonatal prophylaxis
- Women who need nursing support to organise treatment for neonate e.g. looked after young person
- Women with whom there are other child protection concerns

Plan for Delivery

Women who have declined antenatal antiretroviral treatment will have a detectable viral load and should be advised to opt for an elective caesarean section with an IV AZT infusion.

If a woman declines delivery by C/S she should be advised to accept IV AZT when labour becomes established or membranes rupture.

Management of the neonate

The neonate medication should be prescribed as per HIV protocol and administered within four hours of birth by the midwives on the postnatal ward. On discharge from hospital the:

- Community paediatric nursing team should administer the twice daily doses of HIV drugs in the home for the duration of the treatment period
- Community midwife and health visitor should ensure that the baby is taken to the follow up appointments

There should be a contingency plan for social services or police to remove the baby to the hospital in the first instance if there is no access to administer HIV medication. Social services should then be able to place the baby in foster care for the duration of the treatment period.

Plan Level 2

- Women who decline neonatal treatment
- Women who have partners who decline neonatal treatment
- Women who state an intention to breast feed against professional advice

Plan for Delivery

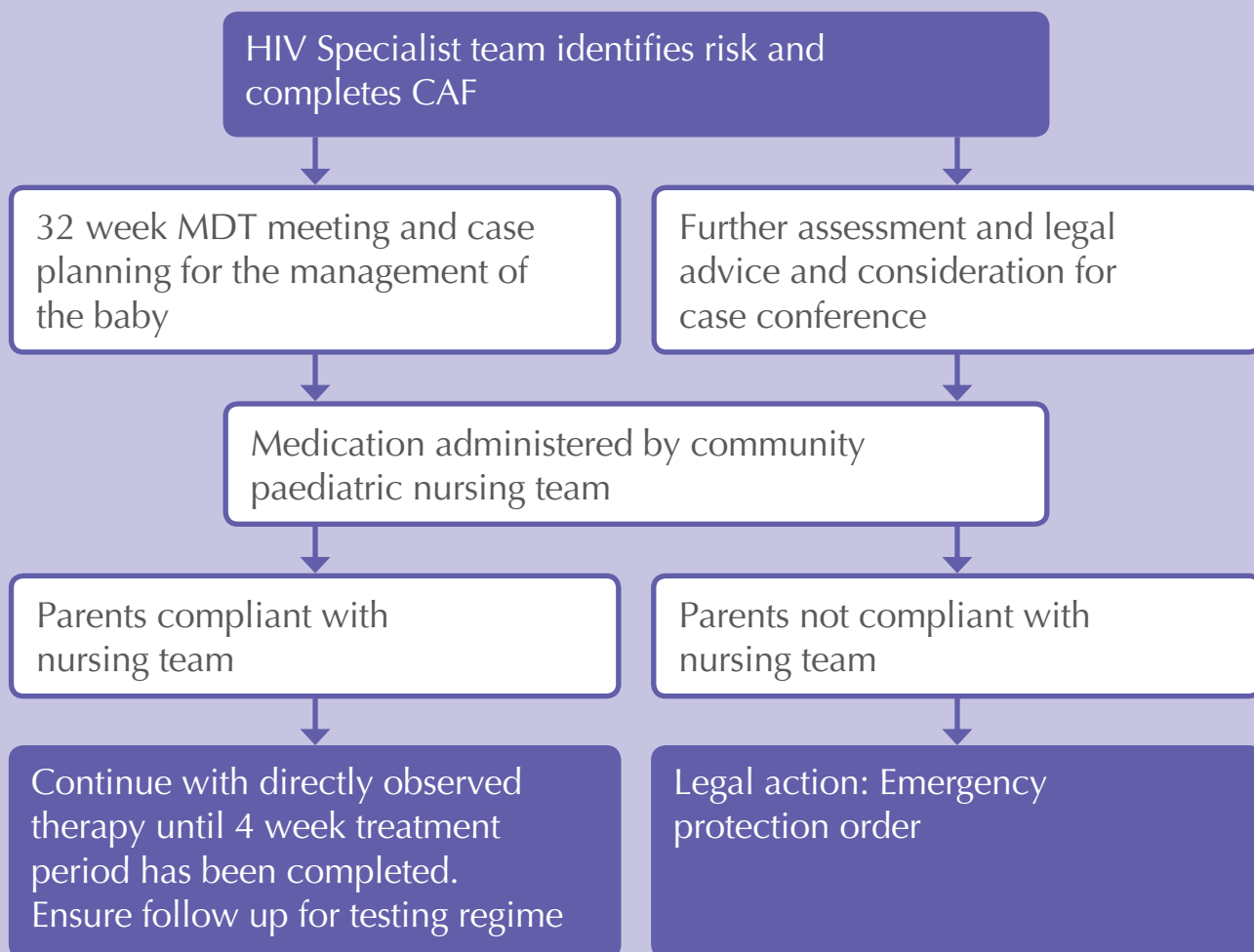
As plan 1

Management of the neonate

- Legal advice must be sought with regards to options to safeguard the child at birth and the necessity for a multiagency child protection plan
- Treatment order and drugs to be administered within four hours of birth to continue for 4 weeks as neonatal protocol

Referral pathways

For parents who may not comply with treatment or intend to breast feed against advice



Syphilis in pregnancy

Background

3,762 diagnoses of infectious syphilis were made in 2007, more than in any other year since 1950. Over 1,500 new cases of syphilis have been diagnosed in the North West in the last 5 years. Most outbreaks are in Manchester, London and Brighton and whilst approximately 73% of current cases are amongst men who have sex with men, syphilis is also increasing amongst heterosexuals. The increased number of syphilis cases in women of reproductive age has resulted in an increase in cases of congenital infection. (Health Protection Agency 2010)

GUM consultants raised concern in September 2003 that syphilis positive pregnant women were not receiving prompt treatment and this posed a particular risk to the neonate. Referral pathways were prepared and the consultant virologist now informs the Clinical Lead Midwife of any positive syphilis results.

A recent case review of maternal notes indicates that more women are declining testing for syphilis. There have also been an increasing number of HIV positive women co-infected with syphilis.

Congenital syphilis

The HPA in collaboration with the UCL Institute of Child Health and the British Paediatric Surveillance Unit is undertaking surveillance of congenital syphilis in children under 2 years of age between January 2010 and December 2012. The survey aims to accurately estimate the incidence of congenital syphilis, identify factors associated with cases of congenital infection and inform efforts to improve healthcare systems to ensure that women and their babies are managed appropriately. The investigation complements a study of antenatal screening pathways being undertaken by the Syphilis Task Group, a sub-committee of the National Screening Committee.

Some important facts include:

- Between 2000 and 2007, diagnoses of infectious syphilis in women rose by 474% (from 78 to 448)
- As incidence has risen cases of congenital syphilis have emerged
- In recent years around 6 cases have been reported each year through genitourinary medicine clinics but this probably only represents 30% to 50% of the cases that occur
- Cases can be prevented through antenatal screening and appropriate treatment
- Control methods are highly cost effective but are dependent on well structured healthcare pathways
- The re-emergence of congenital syphilis reflects a failure of prenatal care delivery systems as well as syphilis control programmes and concerns have been raised about the effectiveness of the present control strategies. In particular, control efforts have been restricted by the absence of comprehensive systematic national surveillance of congenital syphilis

This study aims to instigate surveillance of congenital syphilis to accurately estimate the incidence of congenital syphilis, identify factors associated with cases of congenital infection and inform efforts to improve healthcare systems to ensure that women and their babies are managed appropriately.

Role of Clinical Lead Midwife

In the management of syphilis screening, the Midwife should ensure that:

- The woman has seen the written information and has been informed about the process of receiving negative and positive results and the possibility of repeat testing
- That the following is documented: date of syphilis test offer; accepted/declined; whether a blood sample was taken for screening; and the date of the test

If the syphilis test is declined, the woman should be informed and the midwife should document that screening will be reoffered at a later stage of pregnancy, and the reasons for the decline should be explored.

Screening should be re-offered, ideally by 28 weeks gestation. The Screening Co-ordinator may get involved in this process.

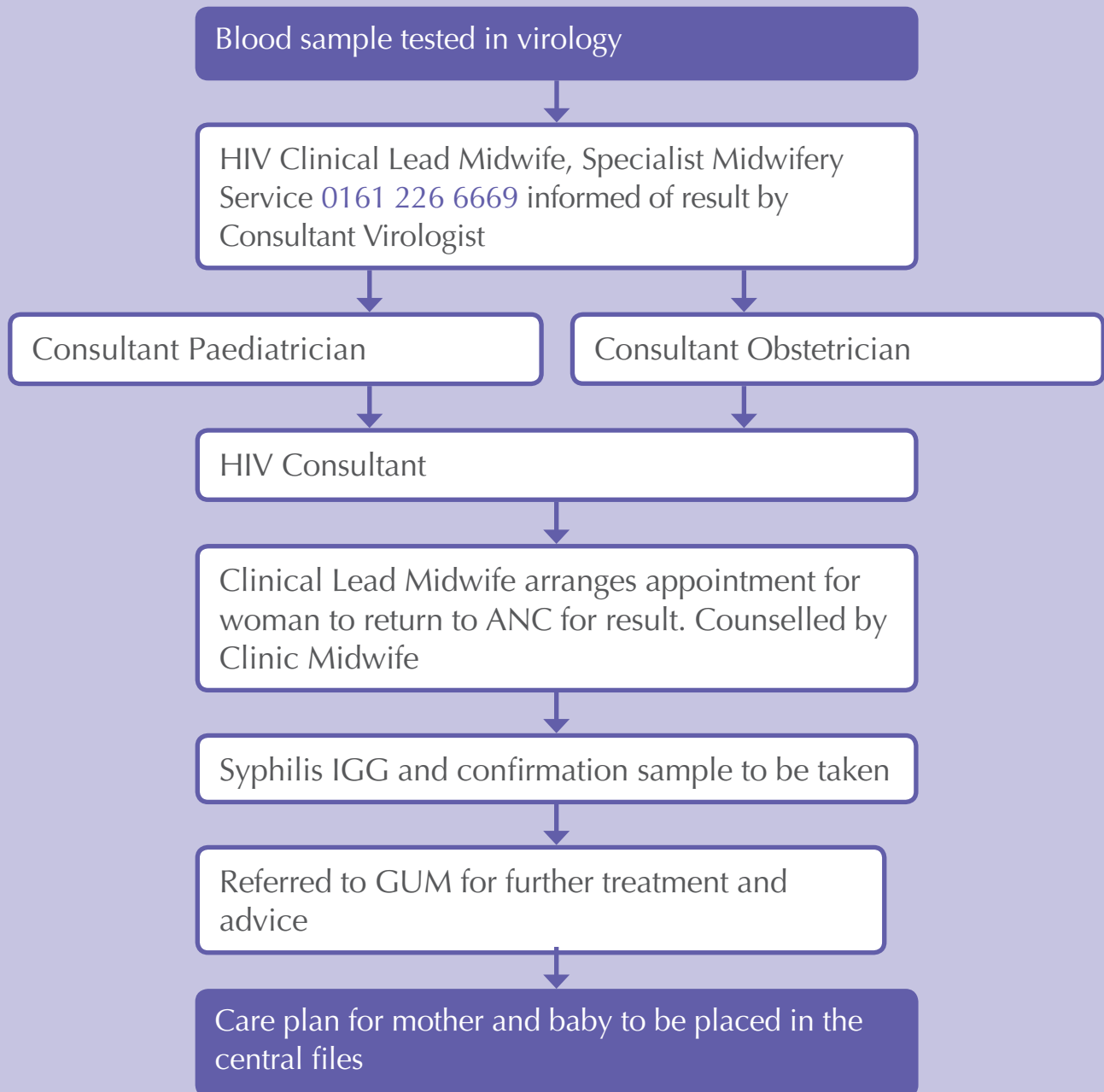
Specimens taken at 24 weeks or later should be marked 'urgent' and a result received within 24 hours of the sample being received by the laboratory. (Infectious Diseases in Pregnancy Screening Programme)

Syphilis positive result

- The positive syphilis result is received from the consultant virologist
- The result should be relayed to the clinic manager at the relevant hospital
- A letter should be sent to the patient to attend ANC for a repeat blood test
- Copies of the letter are sent to the GUM consultant and health advisor in the GUM
- After review by the obstetrician, an appointment should be made for the woman to be reviewed by the GUM consultant
- The woman is then reviewed in the GUM department
- A plan for treatment of mother and baby, to be outlined in the maternal notes, will be provided by the Clinical Lead Midwife

Referral pathway

Syphilis positive result



Contacts

Manchester Specialist Midwifery Service 0161 226 6669

- Faye Macrory, Team Manager/Consultant Midwife
- Sharon Wilson, Clinical Lead Midwife HIV/Sexual Health

North Manchester Hospital Switch Board 0161 795 4567

- Infectious Diseases Consultant via North Manchester switchboard 0161 795 4567
- Ian Nixon/Jill Delaney, HIV Liaison Nurses 0161 720 2638
- Katie Rowson, HIV Paediatric Nurse 0161 720 2638
- Cynthia Murphy, Research 0161 720 2218
- Sharon Wilson, Clinical Lead HIV/Sexual Health Midwife
0161 226 6669 Mobile 0777 334 893
- Ingrid Corcass/Pauline Henderson, Screening Midwives 0785 578 4789
- Dr Tan, Consultant Paediatrician via North Manchester Switchboard
- Dr Paddy McMaster, Consultant Paediatrician via North Manchester Switchboard
- Miss Rice, Consultant Obstetrician via North Manchester Switchboard

St Mary's Switchboard 0161 276 1234

- Dr Kingston/Dr McQuillan or GUM Consultant on call via MRI switchboard
- Dr Chan, Consultant Obstetrician via St Mary's switchboard
- Sharon Wilson (as above)
- Jenny Robinson, Screening Midwife 0161 276 6081
- Dr Sarwar, Consultant Paediatrician via St Mary's switchboard

Wythenshawe Switchboard 0161 998 7070

- Consultant Obstetrician via switchboard
- Dr Al-Zidgali, Consultant Paediatrician via switchboard
- Sharon Wilson (as above)
- Margaret Quireshi, Screening Midwife 0161 291 2958

Additional contacts

African AIDS Helpline 0800 096 7500

Body Positive (North West) 0161 882 2200

BPAS 0845 730 4030

Brook Manchester 0161 237 3001

George House Trust 0161 274 4499

Lesbian and Gay Foundation 0845 330 3030

Marie Stopes International 0845 300 8090

National AIDS Trust (NAT) 0207 814 6767

Positively Women 0207 713 0222

Terrence Higgins Trust 0845 122 1200

The BHA 0845 450 4247

Sexual Health and Harm Reduction Team (PHDS) 0161 248 1750

References

- Addressing Violence Against Women in HIV Testing and Counselling (WHO 2006)
- Advisory Committee on Dangerous Pathogens Protection against blood-borne infections in the workplace: HIV and Hepatitis (HSE 2008)
- Association of British Insurers (1994). *ABI statement of practice – underwriting life insurance for HIV/AIDS*
- Association of British Insurers (2004). *Statement of best practice on HIV and insurance*. Hui-Ling Kerr, Nicola Stewart, Alistair Pace, and Sherief Elsayed
- BHIVA/CHIVA statement on infant feeding in the UK (2010)
- British HIV Association guidelines for immunisation of HIV-infected adults 2008 <http://www.bhiva.org/Immunization2008.aspx>
- Brook G, Main J, Nelson M, Bhagani S et al. British HIV Association guidelines for the management of coinfection with HIV-1 and hepatitis B or C virus 2010. *HIV Medicine (2010)*, 11, 1–30
- Crown Prosecution Service (2011) A review of the CPS Policy and Guidance on the sexual transmission of infection (One Year On)
- Davison S, Mieli-Vergani G, Kelly D. Perinatal hepatitis C infection: diagnosis and management. *Arch Dis Child (2006)*, 91, 781–785
- de Ruiter A, Mercey D, Anderson J, Chakraborty R et al. British HIV Association and Children’s HIV Association guidelines for the management of HIV infection in pregnant women 2008. *HIV Medicine (2008)*, 9, 452–502
- Department of Health (1998) Guidance for clinical healthcare workers protection against infection with blood-borne viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis
- Department of Health (2008) Guidance on post-exposure prophylaxis guidance from the UK CMO (EAGA)
- HPA (2011)
- Infectious Diseases in Pregnancy Screening Programme: Summary of Programme Standards (2011)
- McQuillan O, Babu C, Kingston M, Fitzgerald C *et al.* Guidance for the investigation of fertility for HIV patients (including access to sperm washing). Manchester: Greater Manchester Sexual Health Network (available electronically at www.sexualhealthnetwork.co.uk) (2011)
- National AIDS Manual 2011 Fact Sheet on Adherence NAM
- RCOG 2010 Green top guidelines
- Sharps Injury Reporting amongst Surgeons Pub Med
- UK National Guidelines for HIV Testing 2008 BHIVA 2008
- Working together to safeguard children (2006) DFES

Appendix 1

Useful web based information

www.bhiva.org

British HIV Association. A multi-disciplinary organisation dedicated to the advancement of HIV treatment in the UK. Includes link to CHIVA

www.nhivna.org

National HIV Nurses Association. The NHIVNA aims to provide an academic and educational forum for the dissemination of original nursing research in the field of HIV/AIDS

www.unaids.org

UNAIDS, the Joint United Nations Programme on HIV/AIDS, brings together the efforts and resources of ten UN system organisations to the global AIDS response

www.avert.org.uk

AVERT is an international HIV and AIDS charity based in the UK, providing information on HIV and AIDS worldwide

www.who.int

The World Health Organisation is the United Nations specialised agency for health. It was established on 7 April 1948

www.ght.org.uk

George House Trust is the North West's largest HIV charity providing assistance to people infected and affected by HIV

www.barnados.org.uk

Health through Action project supports children/young people and their families living with or affected by HIV in and around Manchester

www.thebha.org.uk

The BHA works with Black and Minority Ethnic communities on HIV prevention and information

www.bpnw.org.uk

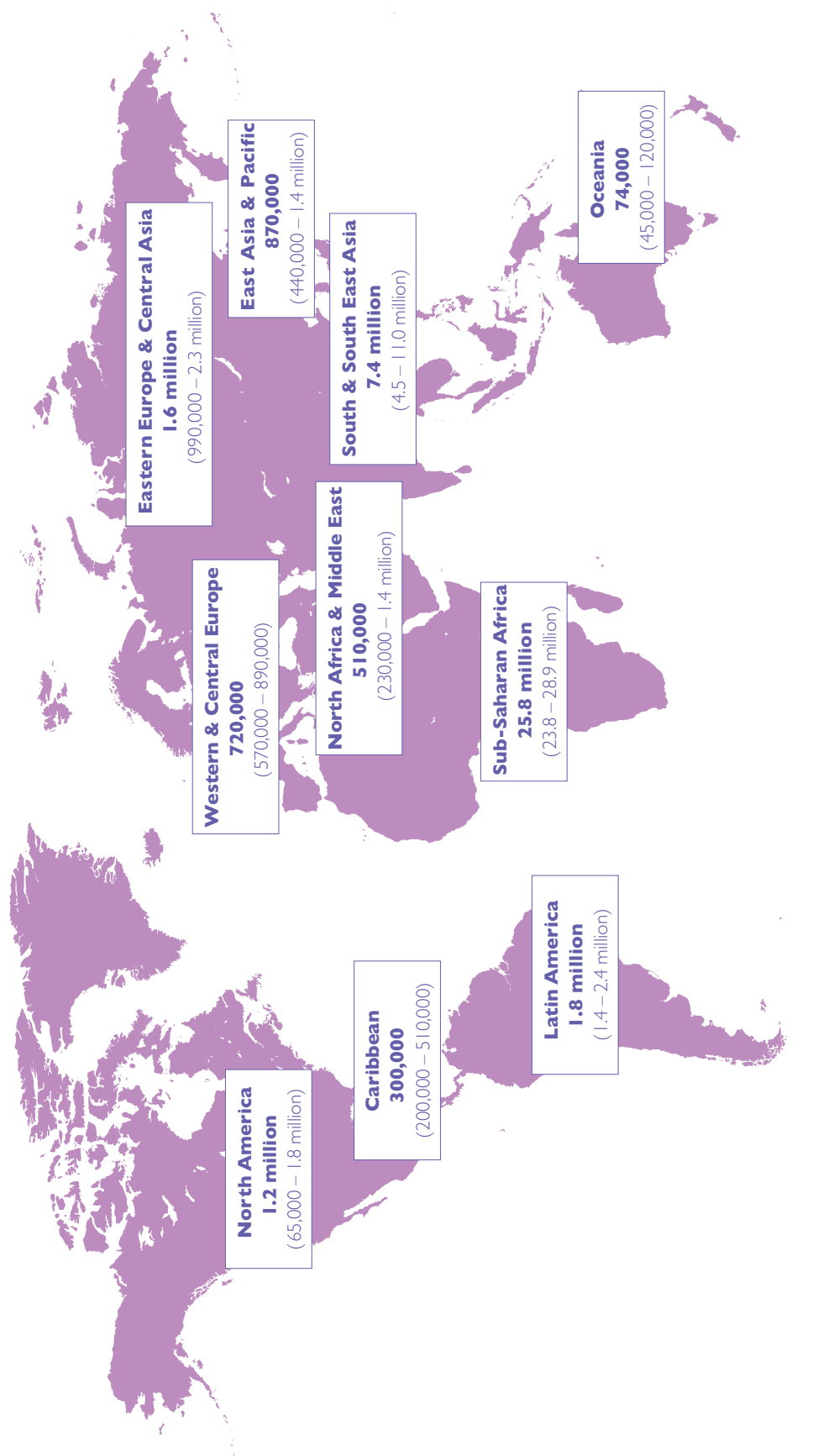
Body Positive North West offers support to anyone living with HIV, whether they are directly affected or are a friend, family member or partner of an HIV positive person

www.hpa.org.uk

The Health Protection Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other arms length bodies, the Department of Health and the Devolved Administrations. It is merging with Public Health England in April 2012

Appendix 2

Adults and children estimated to be living with HIV 2009



Glossary

ANC	Antenatal clinic
ARM	Artificial rupture of membranes
ART	Anti-retroviral therapy
AZT	Zidovudine
BHIVA	British HIV Association
BPSU	British Paediatric Surveillance Unit
CHIVA	Children's HIV Association
CMFT	Central Manchester Foundation Trust
C/S	Caesarean section
CPS	Crown Prosecution Service
DNA	Did not attend
DH	Department of Health
DS	Delivery suite
EDD	Expected date of delivery
GM	Greater Manchester
GU	Genito-Urinary
GUM	Genito-Urinary Medicine
GMC	General Medical Council
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
ID	Infectious diseases
IUCDs	Intra uterine contraceptive device
IV	Intravenous
LSA	Local Supervising Authority
MDT	Multi disciplinary team
NAM	National AIDS Manual
NMGH	North Manchester General Hospital
OCP	Oral contraceptive pill
PPE	Personal protective equipment
STIs	Sexually transmitted infections



Produced by Manchester Public
Health Development Service
Copyright Manchester Mental Health
and Social Care Trust 2011.



MANCHESTER
CITY COUNCIL

Manchester Mental Health 
and Social Care Trust