6.2 Woman is not already on cART: when to start

6.2.1	All pregnant women, including elite controllers, should start ART during pregnancy and be advised to continue lifelong treatment.	1A
6.2.2	All women not on cART should commence cART: • As soon as they are able to do so in the second trimester where the baseline viral load ≤30,000 HIV RNA copies/mL; • At the start of the second trimester, or as soon as possible thereafter, in women with a baseline viral load of 30,000–100,000 HIV RNA copies/mL; • Within the first trimester if viral load >100,000 HIV RNA copies/mL and/or CD4 cell count is less than 200 cells/mm^3. All women should have commenced cART by week 24 of pregnancy.	1C

6.3 Woman is not already on cART: what to start

6.3.1	Women are recommended to start tenofovir DF or abacavir with emtricitabine or lamivudine as a nucleoside backbone.	2C
6.3.2	It is recommended that the third agent in cART should be efavirenz or atazanavir/r, as these are agents with the most safety data in pregnancy.	1C
	Rilpivirine (25 mg od), raltegravir (400 mg bd) or darunavir/r (600/100 mg bd) may be used as alternatives.	1C
	Darunavir/r should be prescribed at the twice daily dose (600/100 mg bd) if known resistance, and consideration should be given to using this higher dose if darunavir is initiated in pregnancy.	2C
	Dolutegravir (50 mg od) may be considered from 6 weeks' gestation which must be confirmed.	1C
	Tenofovir alafenamide may be prescribed for women after the first trimester of pregnancy	1C
	Zidovudine monotherapy is not recommended and should only be used in women declining cART with a viral load of <10,000 HIV RNA copies/mL and willing to have a caesarean section (CS).	1A
	PI monotherapy, darunavir/cobicistat, atazanavir/cobicistat and elvitegravir/cobicistat are not recommended in pregnancy.	1C
6.3.3	It is recommended that an integrase inhibitor-based regimen be considered as the third agent of choice in patients: • With high baseline viral load (>100,000 HIV RNA copies/mL); Where cART is failing to suppress the virus.	2C

		1C

6.4 Late-presenting woman not on treatment

6.4.1	A woman who presents after 28 weeks should commence cART without delay.	1B
6.4.2	If the viral load is unknown or >100,000 HIV RNA copies/mL, a three- or four-drug regimen that includes raltegravir 400 mg bd or dolutegravir 50 mg od is suggested.	2D
6.4.3	Management of an untreated woman presenting in labour at term. • All women should be given a stat dose of nevirapine 200 mg;	1B
	• and commence oral zidovudine 300 mg and lamivudine 150 mg bd;	1B
	• and raltegravir 400 mg bd;	2D
	• and receive intravenous zidovudine for the duration of labour. Please also see section 9.1.3 for HIGH-RISK neonatal management.	2D
6.4.4	In preterm labour, if the infant is unlikely to be able to absorb oral medications consider the addition of double-dose tenofovir DF to the woman's treatment described in recommendation 6.7.3 to further load the infant.	2C
6.4.5	Women presenting in labour/with spontaneous rupture of the membranes (SROM)/requiring delivery without a documented HIV result must be advised to have an urgent HIV test. A reactive/positive result must be acted upon immediately, with initiation of interventions to prevent vertical transmission of HIV without waiting for further/formal serological confirmation.	1D

6.7 Pharmacokinetics of antiretrovirals in pregnancy

6.7	No routine dose alterations are recommended for antiretrovirals during pregnancy if used at standard adult licensed doses, apart from raltegravir, which should be given as 400 mg bd.	1C
	Consider TDM particularly if combining tenofovir DF and atazanavir/r.	2C
	If dosing off licence, consider switching to standard dosing throughout pregnancy or regular TDM.	2C

6.8 Stopping ART postpartum

6.8.1	Stopping ART after delivery is not recommended; women who wish to stop ART should be counselled on the risks and managed as per the BHIVA guidelines for the treatment of HIV-positive adults with antiretroviral therapy.	1B

6.9 HIV-2

6.9.1	Case discussion with experts with experience of managing HIV-2 is recommended for all women.	1D
6.9.2	A boosted PI-based regimen such as twice daily darunavir/r is recommended in women with HIV-2.	1C

Section 7. HIV and hepatitis virus co-infections

7.1 Hepatitis B virus (HBV)

7.1.1	On diagnosis of new HBV infection, confirmation of viraemia with quantitative HBV DNA, 'e' antigen status as well as hepatitis A virus (HAV), HCV and hepatitis D virus (HDV) screening and tests to assess hepatic inflammation/fibrosis and liver function are recommended.	1C
7.1.2	LFTs should be repeated at 2 and 4 weeks after commencing ART to detect evidence of hepatotoxicity or immune reconstitution inflammatory syndrome (IRIS) and then monitored regularly throughout pregnancy and postpartum.	1C
7.1.3	Because there is no evidence of any adverse effect on maternal or neonatal health if women become pregnant while taking ART dually active against HBV, treatment should be continued.	1C
7.1.4	Tenofovir DF and emtricitabine or lamivudine should form the backbone of an antiretroviral regimen in treatment-naïve patients with wild-type HIV/HBV co-infection and no contraindication to any of these drugs.	1B
7.1.5	If tenofovir DF is not currently part of cART it should be added or tenofovir alafenamide /emtricitbine can be added after the first trimester.	1B
7.1.6	Lamivudine/emtricitabine may be omitted from the antiretroviral regimen and tenofovir DF given as the sole anti-HBV agent if there is clinical or genotypic evidence of lamivudine/emtricitabine-resistant HBV.	1C
7.1.7	Lamivudine or emtricitabine should not be used as the only active drug against HBV in cART because of the likelihood of emergent HBV resistance to these agents.	1B
7.1.8	Emtricitabine has potentially increased antiviral benefits compared to lamivudine, appears to be equally safe during pregnancy and hence is the preferred option to be given with tenofovir DF in women with HBV and HIV.	2D
7.1.9	In all HAV non-immune women with HBV and HIV, HAV vaccination is recommended, after the first trimester as per the normal schedule (0 and 6 months);	1A
	unless the CD4 cell count is <300 cells/mm^3, when an additional dose (0, 1 and 6 months) may be indicated.	1D

7.1.10	cART active against both HBV and HIV should be continued postpartum in all women with HBV and HIV.	1A
7.1.11	Hepatitis flares that occur after delivery should be managed conservatively with careful monitoring.	2D
7.1.12	In the absence of obstetric complications, normal vaginal delivery can be recommended if the woman has fully suppressed HIV viral load on cART, irrespective of HBV viral load.	1C
7.1.13	Neonatal immunisation with or without hepatitis B immunoglobulin (HBIG) should commence within 24 hours of delivery. The national infant HBV schedule should then be followed.	1A

7.2 Hepatitis C virus (HCV)

7.2.1	On diagnosis of new HCV infection, confirmation of HCV viraemia with quantitative RNA and genotype, assessment of hepatic inflammation/fibrosis and liver function and concomitant liver disease should be performed.	1C
7.2.2	LFTs should be repeated at 2 and 4 weeks after commencing ART to detect evidence of hepatotoxicity or IRIS and then monitored regularly throughout pregnancy and postpartum.	1C
7.2.3	Women with both HCV and HIV should not be treated for HCV with ribavirin-based directly acting antiviral (DAA) therapies, and all women who discover they are pregnant while receiving treatment should discontinue HCV therapy immediately.	1B
7.2.4	Women with both HCV and HIV of child-bearing age wishing to become pregnant should be expedited to have DAA-based HCV therapy.	2D
7.2.5	Vaccination against HBV is recommended for all women with both HCV and HIV after the first trimester, unless already immune.	1C
7.2.6	In all HAV non-immune women with both HCV and HIV, HAV vaccination is recommended, after the first trimester as per the normal schedule (0 and 6 months);	1A
	unless the CD4 cell count is <300 cells/mm^3, when an additional dose (0, 1 and 6 months) may be indicated.	1D
7.2.7	In the absence of obstetric complications, normal vaginal delivery can be recommended if the woman is receiving effective cART for HIV, irrespective of HCV viral load.	2C
7.2.8	cART should be continued postpartum in all women with both HCV and HIV regardless of HCV viraemia, fibrosis stage or CD4 cell count.	1A

Section 8. Obstetric management

8.1 Antenatal management

8.1.1	Fetal ultrasound imaging should be performed as per national guidelines regardless of maternal HIV status.	1D
8.1.2	The combined screening test for fetal aneuploidies and non-invasive prenatal testing (NIPT) for those who screen as high risk is recommended as this has the best sensitivity and specificity and will minimise the number of women who may need invasive testing.	1A
8.1.3	Invasive prenatal diagnostic testing should not be performed until after the HIV status of the woman is known, and should ideally be deferred until HIV viral load has been adequately suppressed to <50 HIV RNA copies/mL.	1C
8.1.4	If not on cART and the invasive diagnostic test procedure cannot be delayed until viral suppression is achieved, it is recommended that women should commence cART to include raltegravir and be given a single dose of nevirapine 2–4 hours prior to the procedure.	1D
8.1.5	External cephalic version (ECV) can be offered to women with plasma viral load <50 HIV RNA copies/mL.	2D

8.2 Mode of delivery

For women taking cART, a decision regarding recommended mode of delivery should be made after review of plasma HIV viral load results at 36 weeks.

8.2.1	For women with a plasma viral load of <50 HIV RNA copies/mL at 36 weeks, and in the absence of obstetric contraindications, planned vaginal delivery should be supported.	1C
8.2.2	For women with a plasma viral load of 50–399 HIV RNA copies/mL at 36 weeks, pre-labour CS (PLCS) should be considered, taking into account the actual viral load, the trajectory of the viral load, length of time on treatment, adherence issues, obstetric factors and the woman's views.	1C
8.2.3	Where the viral load is ≥400 HIV RNA copies/mL at 36 weeks, PLCS is recommended.	1C
8.2.4	In women for whom a vaginal delivery has been planned and labour has commenced, obstetric management should follow the same guidelines as for the HIV-negative population, apart from duration of ruptured membranes (see section 8.3).	1C
8.2.5	Vaginal birth after CS (VBAC) can be offered to women with a viral load <50 HIV RNA copies/mL.	1D
8.2.6	Where the indication for CS is the prevention of vertical transmission, CS should be undertaken at between 38 and 39 weeks' gestation.	1C
	Where PLCS is undertaken only for obstetric indications and plasma viral load is <50 HIV RNA copies/mL, the usual obstetric considerations apply and the CS will usually be performed after 39 weeks' gestation.	1C