8.3 Management of SROM

8.3.1	In all cases of term pre-labour SROM, delivery within 24 hours should be the aim.	1C
8.3.2	If maternal HIV viral load is <50 HIV RNA copies/mL, immediate induction or augmentation of labour is recommended in women who have pre-labour SROM, with a low threshold for treatment of intrapartum pyrexia. Obstetric management should aim for delivery within 24 hours of SROM.	1C
8.3.3	For women with SROM and a last measured plasma viral load of 50–399 HIV RNA copies/mL, immediate CS is recommended, but should take 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
8.3.4	For women with SROM and maternal HIV viral load ≥400 HIV RNA copies/mL, immediate CS is recommended.	1C
8.3.5	The management of preterm SROM at ≥34 weeks is the same as that of term SROM, except that women at 34–37 weeks' gestation will require group B streptococcus prophylaxis in line with national guidelines.	1C
8.3.6	When premature SROM occurs at <34 weeks: • Intramuscular steroids should be administered in accordance with national guidelines; • Where HIV viral load is not controlled, this should be optimised; • There should be multidisciplinary discussion about the timing and mode of delivery.	1C

8.4 Use of intrapartum intravenous infusion of zidovudine

8.4.1	Intrapartum intravenous zidovudine infusion is recommended in the following circumstances:	
	For women with a viral load >1000 HIV RNA copies/mL plasma who present in labour or with SROM or who are admitted for PLCS.	1C
	For untreated women presenting in labour or with SROM in whom the current viral load is not known;	1C
	The use of intrapartum intravenous zidovudine infusion can be considered in women on cART with a plasma HIV viral load between 50 and 1000 HIV RNA copies/mL.	1C

8.5 Place of birth

8.6.1	All women living with HIV are recommended to give birth in a facility that has direct access to paediatric care (i.e. a co-located birth centre or obstetric unit).	1D

8.6 Water birth

8.7.1	There is scant safety evidence to support water births in women living with HIV; however, women who choose a water birth should be supported to achieve this where the viral load is <50 HIV RNA copies/mL.	1D

Section 9. Neonatal management

9.1 Infant PEP

See Appendix 3 for dosing recommendations

9.1.1	VERY LOW RISK	1C
	Two weeks of zidovudine monotherapy is recommended if all the following criteria are met: • The woman has been on cART for longer than 10 weeks; AND • Two documented maternal HIV viral loads <50 HIV RNA copies/mL during pregnancy at least 4 weeks apart; AND • Maternal HIV viral load <50 HIV RNA copies/mL at or after 36 weeks.	
9.1.2	LOW RISK	1C
	Extend to 4 weeks of zidovudine monotherapy: • If the criteria in 9.1.1 are not all fulfilled but maternal HIV viral load is <50 HIV RNA copies/mL at or after 36 weeks; • If the infant is born prematurely (<34 weeks) but most recent maternal HIV viral load is <50 HIV RNA copies/mL.	
9.1.3	HIGH RISK	1C
	Use combination PEP if maternal birth HIV viral load is known to be or likely to be >50 HIV RNA copies/mL on day of birth, if uncertainty about recent maternal adherence or if viral load is not known.	
9.1.4	Neonatal PEP should be commenced as soon as possible after birth, and at least within 4 hours.	1D
9.1.5	In the context of known maternal resistance to zidovudine with VERY LOW or LOW RISK, zidovudine monotherapy is still recommended for infant PEP.	1D
9.1.6	If HIGH RISK (combination PEP indicated) and there is a history of documented maternal zidovudine and/or nevirapine resistance, seek expert advice. If advice is not immediately available, commence standard three-drug PEP (zidovudine, lamivudine and nevirapine) until guidance is provided.	1D

9.1.8 Infant PEP and HIV-2

9.1.8	If a woman is known to have HIV-2 infection, follow the above advice as for HIV infant PEP but if HIGH RISK (combination PEP indicated) nevirapine will not be effective. Seek expert advice. If advice is not immediately available, commence zidovudine, lamivudine and raltegravir until guidance is available (see Appendix 3).	2C

9.1.9 Infant PEP beyond 4 weeks

9.1.9	Infant PEP should not be given beyond 2 weeks for VERY LOW-RISK or 4 weeks for LOW-RISK infants even if the infant is breastfed.	1C
	PEP should not be restarted unless significant subsequent exposure (e.g. maternal viral load detectable during breastfeeding). Seek expert advice regarding need for PEP following breast milk exposure during an episode of maternal viraemia.	1D

9.2 Pneumocystis pneumonia (PCP) prophylaxis

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

9.3 Immunisation

9.3.1	Immunisations should be given as per the national schedule outlined in the Green Book.	1C
9.3.2	Rotavirus vaccine is not contraindicated (unless HIV diagnosis has been confirmed and infant is severely immunosuppressed).	1C
9.3.3	If there is VERY LOW or LOW RISK of HIV transmission and BCG at birth is indicated as per UK guidelines, this should not be delayed.	1D

9.4 Infant feeding

9.4.1	In the UK and other high-income settings, the safest way to feed infants born to women with HIV is with formula milk, as there is no on-going risk of HIV exposure after birth. We therefore continue to recommend that women living with HIV feed their babies with formula milk (but see also section 9.4.4).	1D
9.4.2	Abstaining from breastfeeding can have financial and psychological repercussions for women, requiring support from the HIV MDT.	1C
	Women advised not to breastfeed for their baby's health should be provided with free formula feed to minimise vertical transmission of HIV.	1D

9.4.3 Suppression of lactation

9.4.3	Women not breastfeeding their infant by choice, or because of viral load >50 HIV RNA copies/mL, should be offered cabergoline to suppress lactation.	1C

9.4.4 Choosing to breastfeed in the UK

9.4.4	Women who are virologically suppressed on cART with good adherence and who choose to breastfeed should be supported to do so, but should be informed about the low risk of transmission of HIV through breastfeeding in this situation and the requirement for extra maternal and infant clinical monitoring.	1D
	When a woman decides to breastfeed, she and her infant should be reviewed monthly in clinic for HIV RNA viral load testing during and for 2 months after stopping breastfeeding.	1D
	Maternal cART (rather than infant pre-exposure prophylaxis [PrEP]) is advised to minimise HIV transmission through breastfeeding and safeguard the woman's health.	1D

9.5 Diagnosis of infant HIV status

9.5.1 Non-breastfed infants

9.5.1.1	Molecular diagnostics for HIV infection should be performed on the following occasions:	1C
	• During the first 48 hours and prior to hospital discharge; • At 6 weeks (or at least 2 weeks after cessation of infant prophylaxis*); • At 12 weeks (or at least 8 weeks after cessation of infant prophylaxis*); • On other occasions if additional risk including at 2 weeks of age if HIGH RISK at delivery. *BHIVA guidelines on duration of PEP have changed for VERY LOW-RISK infants (see section 8.1).	
9.5.1.2	Antibody testing	
	• If the mother's antibody status is not documented, an HIV antibody test should be performed on the first sample received from the infant. • HIV antibody testing for seroreversion should be checked at age 22–24 months. • Although an HIV antibody test may be negative before this time, engagement in care with follow-up of the infant should continue until at least 18 months of age.	

9.5.2 Breastfed infants

9.5.2.1	Molecular diagnostics for HIV infection should be performed on the following occasions:	
	• During the first 48 hours and prior to hospital discharge;	1C
	• At 2 weeks of age;	1D
	• Monthly for the duration of breastfeeding;	1D
	• At 4 and 8 weeks after cessation of breastfeeding.	1D
9.5.2.2	Antibody testing • If the mother's antibody status is not documented, an HIV antibody test should be performed on the first sample received from the infant. • HIV antibody testing for seroreversion should be checked at age 22–24 months, or at a	1C

	minimum of 8 weeks after cessation of breastfeeding, if this is later. Engagement in care should continue until this time.	

9.5.3 Management of infants diagnosed with HIV

	• Infants with a positive test for HIV should be started on cotrimoxazole prophylaxis from 4 weeks of age.	
	• Infants with a positive test for HIV should be referred urgently to a specialist centre for management of HIV according to Children's HIV Association (CHIVA) and Paediatric European Network for Treatment of AIDS (Penta) guidelines.	
	• A positive HIV diagnosis in an infant should be fed back to the obstetric unit where the infant was born to allow investigation of any avoidable factors in transmission.	

9.6 Neonatal management in maternal hepatitis co-infection

9.6.1	Follow national guidance for management of maternal HBV in pregnancy and for prevention of transmission of HIV to the infant (see also section 7.1).	1D
9.6.2	Follow usual practice for investigation and management of maternal HCV in pregnancy (see also section 7.2).	1D

9.7 HIV exposed but uninfected (HEU)

9.7.1	In light of evidence for possible increased infectious morbidity in HIV exposed but uninfected (HEU) children, timely routine vaccination should be ensured and general practitioners (GPs), health visitors and secondary care physicians should be made aware of possible increased risk in order to inform decisions when assessing risk in primary care.	1D

Section 10. Postpartum management of women

10.1 Antiretroviral therapy

10.1.1	All women are recommended to continue cART postpartum.	1A

10.2 Support services

10.2.1	Women should have their support needs assessed postpartum and be referred to appropriate services in the Trust, community and/or voluntary groups without delay.	1D

10.3 Postnatal follow-up of women

10.3.1	All women should be reviewed in the postnatal period by a named member of the MDT within 4–6 weeks.	1C