

## **BHIVA pregnancy guidelines 2018: non-technical summary**

### **HIV in pregnancy**

The British HIV Association (BHIVA) produces medical guidelines about HIV treatment and care. All guidelines review the evidence for the best care. These guidelines are for clinicians providing HIV care, but it is important that you know what is in them, and what they might mean for you if you are thinking about becoming pregnant or having a child when you are diagnosed with HIV. This non-technical summary aims to provide the main points of how you and your baby should be cared for, so not all the recommendations in the guidelines are included. You can check the full guidelines for more detail at:

<https://www.bhiva.org/pregnancy-guidelines>.

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#### **What is covered in the HIV and pregnancy guidelines?**

- Involvement in decision-making and general recommendations
  - What antiretroviral treatment combinations are recommended during and after pregnancy
  - Recommendations for the care and monitoring of women living with HIV during pregnancy and birth, and afterwards
  - Recommendations for the care of babies born to women living with HIV and infant feeding
  - Recommendations for the care of women living with HIV after they have given birth
  - Recommendations for the care of women with HIV and hepatitis
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#### **Involving mothers in decision-making**

The guidelines emphasise that you can be involved in all decisions about your care and pregnancy and that peer support from other people living with HIV is important. There is a network of women living with HIV who are trained as mentor mothers who can share their knowledge and experience to encourage you to be involved in the choices you make around your pregnancy and health (<https://4mmm.org/>). Some clinics also have peer navigators and there are other HIV organisations that can also support you during pregnancy and birth, and beyond.

#### **General recommendations**

Women living with HIV should be looked after by a multidisciplinary team during and after pregnancy and this should be led by a named healthcare professional. You should be offered peer support and asked about your mental health throughout pregnancy and after birth.

You should have the same routine pregnancy monitoring as women who are not living with HIV (ultrasound scans as per national pregnancy guidelines). You should be offered tests for

other sexually transmitted diseases and have the same tests as other women living with HIV who are not pregnant (CD4 count and viral load).

### **Treatment**

All pregnant women living with HIV should start combination antiretroviral therapy. This should be continued after giving birth and throughout life. Women who are diagnosed with HIV when pregnant should start treatment as soon as possible, especially if they have a high viral load; this is so that the virus can reach a level of undetectability as soon as possible.

Women who are not on treatment when becoming pregnant are recommended to start tenofovir plus emtricitabine or abacavir plus lamivudine along with a third agent. The third agents recommended in pregnancy are atazanavir (with ritonavir) and efavirenz as there is the most information about how safe these are in pregnancy, but there are alternatives listed in the main guidelines.

If you are satisfied with your antiretroviral combination and have an undetectable viral load you should be able to continue taking the same medication. However there are exceptions because the effectiveness of some medications can be reduced when you are pregnant. For example, combinations that include the booster cobicistat may need to be changed as cobicistat does not boost effectively enough in pregnancy, and raltegravir 1200 mg once daily should be changed to raltegravir 400 mg twice daily.

Women who start antiretroviral treatment during pregnancy and do not reach an undetectable viral load should be tested for HIV resistance, have their medications reviewed by a doctor or pharmacist and be supported with taking their medications.

### **Care during pregnancy and birth**

Pregnancy monitoring (including ultrasound scans) should follow national pregnancy guidelines. Invasive tests on the unborn baby (such as amniocentesis and chorionic villus sampling) should be delayed until you have an undetectable viral load, if possible.

According to national guidelines published by the National Institute for Health and Care Excellence (NICE: <https://www.nice.org.uk/guidance/ng192/chapter/Recommendations>), women should plan with their care team how they would like to give birth, weighing up the risks and benefits of vaginal birth and caesarean section. Women on HIV treatment who have an undetectable viral load (below 50 copies/mL) near the end of pregnancy can aim to have a vaginal delivery unless there is another reason related to the pregnancy not to. If your viral load is between 50 and 400 copies/mL, your care team may recommend a caesarean section. If your viral load is 400 copies/mL or more you should plan to have a caesarean section to minimise the risk of passing HIV to your baby.

### **Infant care**

You will be asked to give your baby medication for between 2 and 4 weeks after birth to reduce the chance of HIV being transmitted. If your viral load is undetectable throughout the pregnancy and when you give birth, this will be a single drug called zidovudine, which is

given in a liquid form into the baby's mouth. Your care team may recommend a combination of three medications for the baby in certain circumstances if your viral load was not undetectable.

Your baby should have an HIV test at birth, and then at 6 weeks, 12 weeks and between 18 and 24 months after birth. If you choose to breastfeed, your baby will be tested more frequently.

If you have been newly diagnosed with HIV during a pregnancy, your other children should be offered HIV testing if appropriate (and your partner).

### **Infant feeding**

HIV can be passed to the baby through breastmilk. To avoid the risk of postnatal transmission of HIV it is recommended that your baby is fed exclusively with formula milk. This may be provided if you cannot afford bottles and sterilising equipment, but schemes vary from clinic to clinic.

You can choose whether to take the drug cabergoline just after birth to stop your breasts from producing milk, to make you more comfortable.

Women with an undetectable viral load (below 50) who take their medication regularly every day may choose to breastfeed after weighing up the risks and benefits. Women with an undetectable viral load who choose to breastfeed should be supported by their clinical team to do this in the safest way possible (for a maximum of 6 months).

### **Care after giving birth**

A named member of the clinical team should review your health 4–6 weeks after you have given birth, including an assessment of your mental health needs. All women living with HIV should continue their antiretroviral medication and be offered contraception.

All women living with HIV should have a smear test 3 months after they give birth, and then every year.

### **Care of women with HIV and hepatitis**

Women with HIV and hepatitis B or C should have extra tests and monitoring during pregnancy and receive a combination therapy that contains tenofovir. Women with an undetectable HIV viral load and hepatitis B or C can plan a vaginal delivery.

Babies born to women with HIV and hepatitis B should be immunised against hepatitis B, and may need extra treatment to prevent hepatitis B.

Currently, hepatitis C treatment cannot be given in pregnancy. Women with HIV and hepatitis C who are planning to get pregnant should be prioritised for treatment.

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## Glossary

**Multi-disciplinary team:** a clinical team consisting of people with different skills and expertise; for example, HIV doctor, specialist midwife, pharmacist, health advisor, specialist nurse, obstetrician, paediatric doctor, support worker, social worker, peer navigator and community nurse specialist.

**Peer supporter:** a person living with HIV who is trained to support others.

**Sexually transmitted infection:** an infection you can get from having sex with someone.

**CD4 count:** the number of a specific type of white cell in the blood, which is low in advanced HIV infection.

**HIV viral load:** the amount of HIV in the blood.

**Antiretroviral therapy:** a combination of medications that treat HIV.

**Hepatitis B:** a viral infection that affects the liver. It is transmitted through contact with body fluids, such as blood, saliva and urine, and can be passed from mother to child.

**Hepatitis C:** a viral infection that affects the liver. It is transmitted through contact with blood, sharing drug-taking equipment and through having sex, and can be passed from mother to child.

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## Further information and support

4M trains women living with HIV as Mentor Mothers to provide peer support to women throughout and after pregnancy (<https://4mmm.org/>). Community organisations in the UK that produce information and resources about HIV treatment include HIV i-Base (<https://www.i-base.info>), Terrence Higgins Trust (<https://www.tht.org.uk>) and NAM (<https://www.aidsmap.com>).

## About BHIVA

The British HIV Association (BHIVA) is an organisation for health professionals in the UK. Members include doctors, nurses, researchers, pharmacists and community advocates. Since 1995, BHIVA has been committed to providing excellent care for people living with and affected by HIV. BHIVA is a national advisory body on all aspects of HIV care and provides a national platform for HIV care issues. To help promote and monitor high standards of care, BHIVA publishes a range of clinical guidelines:

<https://www.bhiva.org/guidelines.aspx>.

Information about how BHIVA guidelines are developed can be found at:

<https://www.bhiva.org/clinicalguidelines.aspx>.