

Summary of BHIVA guidelines HIV treatment for pregnant women: Mode of delivery

BHIVA (the British HIV Association) is an organisation that represents healthcare professionals working in HIV in the UK. Its [guidelines](#) set out the medical and other care people living with HIV can expect to receive in the UK. You can find out more about the process used to develop the guidelines here: [How BHIVA guidelines are developed](#).

BHIVA's [Guidelines for the management of HIV infection in pregnant women 2012](#) set out evidence-based clinical practice for treating and managing HIV infection in women who are already pregnant. These guidelines also specify the treatment and care of the newborn baby in relation to preventing HIV transmission. HIV clinic staff, following recommendations in these guidelines, will be providing the best possible treatment and care to their patients, taking into account individuals' situations as well as what is known about the most effective treatments during pregnancy. Your doctor should discuss your treatment options with you.

- This symbol identifies a strong BHIVA recommendation for treatment or care.
- This symbol identifies treatment or care that BHIVA suggests is appropriate: a recommendation with weaker evidence or some conditions attached.

GPP identifies a 'good practice point' – a recommendation drawn from everyday clinical experience rather than research-based evidence.

This factsheet summarises the recommendations relating to mode of delivery – that is, recommendations on the safest way for a baby to be born. Find out about BHIVA recommendations relating to HIV treatment during pregnancy and after a baby is born in [Factsheet 5: HIV treatment for pregnant women: HIV treatment](#), and about care and support before and after a baby is born in [Factsheet 7: HIV treatment for pregnant women: Antenatal and postnatal care](#). There is also detailed information on HIV treatment during pregnancy for women who also have hepatitis B or hepatitis C in [Factsheet 8: HIV treatment for pregnant women: HIV treatment, hepatitis and pregnancy](#).

Making the decision about your baby's birth

If you are on combination HIV treatment (also called highly active antiretroviral treatment, or HAART), you and your doctor will make the decision about how your baby can be delivered when you are 36 weeks' pregnant. Your doctor will look at your [viral load](#) test results and discuss options with you. The exception to this is if you have taken AZT (zidovudine, *Retrovir*) monotherapy to prevent mother-to-baby transmission, in which case you will need to have a caesarean section.

Vaginal delivery

● If you are on combination HIV treatment and you have an [undetectable viral load](#) at 36 weeks of pregnancy, the guidelines say that you can plan for a vaginal delivery.

This is a change of emphasis since the last BHIVA guidelines on treatment and care during pregnancy and birth. A review of the evidence showed that having a vaginal delivery does not increase the risk of HIV transmission when viral load is below 50 copies/ml (considered undetectable). The change recognises that many women would like to try to have a vaginal delivery if possible.

● If you have had a caesarean in the past, but have an undetectable viral load, you should be offered a vaginal delivery. (This is often called a VBAC – vaginal birth after caesarean.)

There may be medical reasons unrelated to HIV that mean it would be safer for you or your baby for you to have a caesarean. Your doctor will also consider any non-HIV-related reasons for or against a vaginal delivery, including your views and preferences.

● If you have a viral load between 50 and 399 copies/ml at 36 weeks, your doctor should look at various factors before making a decision with you. These include:

- whether your viral load has been falling over time.
- how long you have been on HIV treatment.
- how well you are [adhering](#) to it (whether you are taking it as prescribed, every day).
- any non-HIV-related reasons for or against a vaginal delivery.
- your views and preferences.

● In this situation, your doctor will consider a pre-labour [caesarean section](#) (PLCS), also known as an elective caesarean.

How is a vaginal delivery managed when you have HIV?

● If a vaginal delivery is suitable for you, once your labour has started, it should be managed in the same way it would be for a woman without HIV. This means you can choose the option of having your baby in a [midwifery-led birth centre](#), or [at home](#), if there are no other reasons why this wouldn't be suitable. There do need to be facilities for testing your baby for HIV and starting him or her on anti-HIV drugs very soon after the birth, wherever your baby is born.

If a baby is breech, it means that she or he is lying with their bottom downwards. This makes a vaginal delivery more complicated. A procedure called [external cephalic version](#) (ECV) can be used to turn the baby.

● ECV can be performed safely in women with HIV. It is normally carried out after 36 weeks of pregnancy.

There are monitoring methods and procedures sometimes used during labour and vaginal deliveries that are more 'invasive'; that is, they may break the skin or other body tissue. These include:

- amniotomy. This is where the amniotic sac surrounding the baby, which contains fluid, or 'waters', is ruptured by hand or by using a small tool.
- fetal scalp monitoring. A small clip is placed on the baby's head to monitor their heart rate.
- using instruments such as [forceps or a ventouse](#) (vacuum extractor) to help deliver the baby.
- [episiotomy](#). The doctor or midwife makes a small cut in the vagina to help the baby to be born.

In the past, BHIVA guidelines recommended against these procedures because there was, in theory, a risk of HIV transmission. A review of the evidence has shown little or no risk.

● These procedures can be used if you have an undetectable viral load and if it is thought to be beneficial for your baby.

Caesarean delivery

● If you have a viral load of 400 copies/ml or above at 36 weeks' pregnancy, the guidelines recommend you should have a pre-labour [caesarean section](#) (PLCS).

● If you are on AZT monotherapy (see [Factsheet 6: HIV treatment for pregnant women: HIV treatment](#) for more information), the guidelines recommend you should have a PLCS, even if you have an undetectable viral load.

● If you are to have a PLCS to avoid mother-to-baby transmission of HIV, this should take place at 38 or 39 weeks of pregnancy. (It may be decided that you need a caesarean for another, non-HIV-related reason. If that is the case, doctors will discuss with you when this should happen.)

● If you have a viral load that is over 10,000 copies/ml, you will be given [AZT](#) intravenously while the baby is being delivered.

● If you have been on AZT monotherapy during your pregnancy, you may also be offered intravenous AZT during your caesarean section. But you and your doctor may decide

that you will carry on taking it orally (by mouth), as you have been doing.

Premature (early) labour or waters breaking before your labour starts

The baby develops inside a bag of fluid called the [amniotic sac](#). When the baby is ready to be born, the sac breaks and the fluid drains out through the vagina (often referred to as the waters breaking).

If your waters break before you go into labour

● In this situation, if you are more than 37 weeks pregnant your baby should be delivered as soon as possible. This is because there is an increased risk of you or your baby developing an infection after your waters have broken.

● If your viral load was undetectable at your last viral load test, labour should be induced (started artificially) immediately.

● Antibiotic treatment should be given as soon as there is any sign that you are developing an infection.

There are national guidelines on the management of induction and premature labour for all women. These should be followed.

● If your viral load was between 50 and 999 copies/ml, your doctor will consider whether you should have a caesarean section immediately. Various factors will be taken into account, including:

- whether your viral load has been falling over time.
- how long you have been on treatment.
- how well you are [adhering](#) to it.
- any non-HIV-related reasons for or against a vaginal delivery.
- your views and preferences.

● If your viral load was over 1000 copies/ml, you should have a caesarean section immediately.

● If your waters break before you go into labour, and you are between 34 and 37 weeks pregnant, the recommendations for action stay the same as those set out above.

● In addition, you should be given antibiotic drugs to prevent your baby getting a bacterial infection called group B streptococcus (GBS; all women who go into labour before they are 38 weeks pregnant may be offered this treatment, called GBS prophylaxis).

If your waters break when you are less than 34 weeks pregnant

● You may be given injections of drugs called steroids. These help to develop your baby's lungs so that they are better able to breathe after they are born. This is a treatment that all pregnant women may be offered if their baby will be born early.

● If necessary, doctors will try to bring your viral load down as quickly as possible.

● The multidisciplinary team that has been providing your antenatal care (see [Factsheet 7: HIV treatment for pregnant women: Antenatal and postnatal care](#)) will get together to discuss when and how your baby should be born.

● If your baby is not going to be born immediately, you may also be given an antibiotic (erythromycin) to reduce the risk of you or your baby developing an infection (this is normal procedure for any woman in this situation).

● If you go into labour or your waters break, and your viral load is over 10,000 copies/ml, you should be given [AZT](#) (zidovudine, *Retrovir*) intravenously while your baby is being delivered.

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The full version of the guidelines is available to download from the BHIVA website at: www.bhiva.org/TreatmentofHIV1_2012.aspx

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NAM's information is intended to support, rather than replace, consultation with a healthcare professional. Talk to your doctor or another member of your healthcare team for advice tailored to your situation.

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