Royal College of Obstetricians & Gynaecologists

Information for you

Published in December 2013

HIV and pregnancy

About this information

This information is for you if you have been diagnosed with HIV (human immunodeficiency virus) and you are pregnant or planning to have a baby. If you are a partner, relative or friend of someone who is in this situation, you may also find it helpful.

This information tells you:

- what HIV can mean for you and your baby
- what are the most effective ways of:
    - protecting your baby in the womb, during birth and in the first weeks of life
    - treating you during pregnancy and labour
- about planning for pregnancy.

What is HIV and what could it mean for my baby?

HIV is a type of virus called a retrovirus that prevents the body's immune system from working properly and makes it hard to fight off infections. If you have the virus, this is known as being HIV positive.

The virus can be passed from one person to another through the exchange of body fluids including blood, semen, vaginal fluids and breast milk.

You can pass the virus on to your baby through the placenta while you are pregnant, during the birth and through your breast milk. The care you will receive aims to reduce the risk of passing HIV on to your baby.

All women are offered a test for HIV early in pregnancy.

What extra antenatal care can I expect if I am HIV positive?

You will be offered specialist care and regular health checks. You should be cared for by a team of specialists that includes:

- a doctor who specialises in HIV
- an obstetrician (a doctor who specialises in the care of pregnant women)
- a specialist midwife
- a paediatrician (a doctor who specialises in children's health).

You and your baby will be monitored during your pregnancy, and this may include extra ultrasound scans. The amount of virus (viral load) and antibodies to HIV (CD4) in your blood will be monitored, as will drug levels if you are on treatment.

Infection and vaccination

If you are HIV positive, it is important to know whether you are immune to certain infections. Like other pregnant women, you will be recommended to have tests in early pregnancy for hepatitis B, rubella (German measles) and syphilis. However, you will also be offered tests for hepatitis C, varicella zoster (chickenpox), measles and toxoplasmosis.

All pregnant women are offered the whooping cough vaccine. You will also be recommended to have vaccinations for hepatitis B (if you are not immune) and pneumococcus, and the flu vaccine (in the autumn/winter months). These are safe in pregnancy.

The vaccines for chickenpox, measles, mumps and rubella are not safe in pregnancy and therefore you will be offered them after your baby is born, if you are not immune.

If you are receiving treatment for HIV for your own health, you may be recommended to have antibiotics to reduce your chance of developing pneumonia.

You should be offered a swab for vaginal infections early in pregnancy and then again around the 28th week of your pregnancy. If the swab shows infection, you should be offered treatment to reduce the risk of passing on HIV to your baby.

Down syndrome

All women are offered a screening test for Down syndrome. If your test shows you are at increased risk of having a baby with Down syndrome, you will be referred to a fetal medicine unit to discuss your options further. There is a risk that further tests may transfer HIV to your baby. This will be discussed with you fully.

Gestational diabetes

If you are taking certain medications for HIV in early pregnancy, you may be advised to have a test for gestational diabetes (diabetes that is first diagnosed in pregnancy) between 24 and 28 weeks. You can find out more about this from the RCOG patient information *Gestational Diabetes*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/gestational-diabetes-information-you.

Can I reduce the chance of passing on HIV to my baby?

Yes. You can greatly reduce the risk of passing on HIV to your baby if you:

- have treatment with anti-retroviral drugs (see below)
- avoid breastfeeding and choose to bottle-feed your baby with formula milk
- have a caesarean section if your specialist team recommends it.

Should I have anti-retroviral treatment in pregnancy?

Yes. The drugs used to treat HIV infection are known as anti-retrovirals. Sometimes three or more types are used together, which is known as highly active anti-retroviral therapy (HAART). Your doctors will offer you anti-retrovirals during your pregnancy and at the birth of your baby (if you are not taking them already) to help reduce the chance of passing the virus on to your baby. Anti-retroviral treatment may also be of benefit to your own health.

If you do not have anti-retroviral treatment, there is a much greater risk that you will pass on the virus to your baby.

Is anti-retroviral treatment safe in pregnancy?

For you

Anti-retroviral drugs are generally safe but they can sometimes have side effects, including stomach and digestive problems, diabetes, rashes, extreme tiredness, high temperature and breathlessness. It is important to tell your doctor or midwife if you experience any unusual symptoms while you are pregnant.

Anti-retroviral drugs can also sometimes cause liver problems. If you have started HAART in pregnancy, you should have regular blood tests to check that your liver is working normally. Some drugs may reduce the levels of iron in your blood (anaemia) and you may be advised to have iron supplements.

You are more likely to go into labour early if you are taking HAART.

For your baby

Anti-retroviral treatment itself does not appear to be harmful for babies. Not taking the medication is much more likely to be harmful for your baby, because the risk of passing HIV on to your baby will be much higher.

What anti-retroviral treatment should I have?

You will be recommended to take those drugs considered best for you. You will also be advised when you should start and stop taking them. You may be in one of the following circumstances:

- **You are already taking anti-retrovirals**
  Your doctors will recommend that you take HAART during pregnancy and after you have had your baby. If you were taking this before pregnancy, you should not stop your medication.
- **You are not taking anti-retrovirals**
  You should be offered treatment to stop you passing on the virus to your baby. The usual treatment is HAART, as described above. Treatment with a single anti-retroviral drug (zidovudine) may be considered if your viral load is less than 10 000, your CD4 count is more than 350 and you are prepared to have a caesarean section.
  Your doctor will usually recommend that you start the treatment between 14 and 24 weeks of your pregnancy and continue until your baby is born.

What is the best way to give birth to my baby?

Your team will discuss with you the best way to give birth. The treatment you are taking, your viral load and CD4 count at 36 weeks and previous pregnancies will be taken into account.

- You should be able to have a vaginal delivery, even if you have had a caesarean section before, if you are taking HAART, have a viral load less than 50 and a CD4 count more than 350.

- If you are taking HAART and your viral load is between 50 and 399, your doctors may recommend a caesarean section, usually at 38 weeks. This will depend on the pattern of your viral load, how long you have been on treatment and your wishes.
- You will be advised to have a caesarean section, usually at 38 weeks, if:
    - you are taking HAART and have a viral load of 400 or more
    - you are taking zidovudine alone
    - hepatitis C virus is detected in your blood.

If your doctors advise a planned caesarean section but you want a vaginal birth, your wishes should be respected. However, as with all women, if there are concerns about you and your baby during labour, you may need an emergency caesarean section.

Whatever method you choose, a sample of your blood should be taken at the time of the birth to check the amount of the virus in your blood.

What happens if I have a planned caesarean section?

If you are taking HAART, you should continue to take this as advised by your doctor.

You should be prescribed zidovudine through a drip, which will be started a few hours before your caesarean section. It should continue until your baby is born and the umbilical cord has been clamped.

Because you are likely to have your caesarean section before 39 weeks, you should be offered a course of two to four corticosteroid injections over a 48-hour period to lessen the chance of breathing problems for your baby. You can find out more about this from the RCOG patient information *Corticosteroids in Pregnancy to Reduce Complications from Being Born Prematurely*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/corticosteroids.

If your contractions start before your planned caesarean section, you should come straight to hospital. The caesarean section will be done as soon as possible. Occasionally, labour may be too advanced and it may be safer for you and your baby to have a vaginal birth.

What happens if I have a planned vaginal birth?

You should be given HAART treatment throughout your labour. The earlier in labour that your waters break, the higher the risk of passing HIV on to your baby.

You should be prescribed an infusion of zidovudine if your waters have broken or if you are known to have a very high viral load.

If you go past your due date and your viral load cannot be detected, it may be possible to have labour started off (induced).

What if my waters break early?

After 37 weeks

- **Planned vaginal birth**
  If your waters break before you go into labour and your viral load is less than 50, it may be possible to induce labour with a drip to start contractions. This will be started straightaway.
- **Planned caesarean section**
  If your waters break before your planned caesarean section, you should come straight to hospital. The caesarean section will be done as soon as possible.

Before 37 weeks

If your waters break before your contractions start, your team will discuss with you whether it would be better for your baby to be born rather than waiting. This will depend on how far you are in your pregnancy and your individual risk of transmitting HIV to your baby. You can find out more about this from the RCOG patient information *When Your Waters Break Early*, which is available at: **www.rcog.org.uk/womens-health/clinical-guidance/when-your-waters-break-early**.

What treatment will my baby need after birth?

Your baby should be given anti-retroviral drugs within 4 hours and this should be continued until he or she is between 4 and 6 weeks of age.

Your baby should be tested for HIV during the first 2 days, on discharge from hospital, at 6 weeks and at 12 weeks. If these tests are negative and you are not breastfeeding, your baby does not have HIV. A further test to confirm this will be done when your baby is 18 months old.

What is the best way to feed my baby?

You can greatly reduce the risk of passing on HIV if you do not breastfeed and do not use your own expressed breast milk. This is the single most important means of reducing the risk to your baby. If you are HIV positive, it is safer to use formula milk.

Will anyone else be told about my HIV status?

Your healthcare team needs to be aware that you are HIV positive, so that they can provide the best care possible for you and your baby.

If you have not yet told your sexual partner that you are HIV positive, the team will encourage and support you to do so, in order to reduce the risk of passing on HIV.

They should not tell anyone about your HIV status without your permission. They should respect your right to confidentiality and use care and sensitivity where information about you could be disclosed to your partner or relatives.

The only exception is if you are putting your partner at risk. In these circumstances, health professionals may tell a sexual partner about your HIV status. Your healthcare team must discuss this with you first. They must weigh up any risks involved for you (such as violence and/or abuse) before they decide what to do.

What should I do if I am planning to have a baby?

- If either you or your partner is HIV positive, you should be advised about safer sex practices and the use of condoms to prevent transmission of HIV.
- You should be offered prepregnancy counselling and advice on conception options with a team, which should include a fertility specialist and an HIV specialist.
- You will be advised to wait until your viral load is low and to make sure any infection is treated.
- All women are advised to take folic acid (400 micrograms daily) for 3 months before they get pregnant. If you are taking co-trimoxazole, you will be advised to take the higher dose of folic acid (5 mg daily).
- If the male partner is HIV positive:
    - the risk of transmitting HIV to the woman is almost zero if he is taking HAART, has had a viral load of less than 50 for at least 6 months and has no other infections and unprotected intercourse occurs just at the fertile time of the woman's cycle; in this

situation, sperm washing may not reduce the risk of transmitting HIV and may actually reduce the likelihood of getting pregnant
    - you may wish to consider assisted conception with sperm washing or donor sperm if there is a high chance of transmitting HIV.

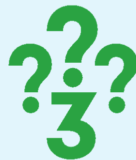
Is there anything else I should know?

If you are HIV positive, you should get contraceptive advice from the specialist team after you have had your baby.

Women with HIV infection are recommended to have yearly cervical smears.

Making a choice

Shared Decision Making



If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

http://www.advancingqualityalliance.nhs.uk/SDM/

Other information and support organisations

Evidence-based information about HIV is available from:

- British HIV Association (BHIVA): www.bhiva.org/PregnantWomen2012.aspx
- NAM, a UK-based organisation: www.aidsmap.com.

There are charities and organisations that offer support which may include emotional, educational and practical support. If you like, they will put you in touch with other women who have been in a similar situation.

Support organisations include:

- Positively UK
  345 City Road, London ECIV ILR
  Helpline: 020 7713 0444
  Website: positivelyuk.org
  Email: info@positivelyuk.org

- Terrence Higgins Trust
  314–320 Gray's Inn Road, London WC1X 8DP
  THT Direct helpline: 0808 802 1221
  Website: www.tht.org.uk
- NAM
  77a Tradescant Road, London SW8 1XJ
  Telephone: 020 3242 0820 (during office hours)
  Website: www.aidsmap.com
  Email: info@nam.org.uk
- Body & Soul
  99 Rosebery Avenue, London EC1R 4RE
  Telephone: 020 7923 6880
  Website: bodyandsoulcharity.org

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG guideline *Management of HIV in Pregnancy* (June 2010). The guideline contains a full list of the sources of evidence we have used. You can find it online at: www.rcog.org.uk/womens-health/clinical-guidance/management-hiv-pregnancy-green-top-39. This information is also based on the BHIVA guideline *Guidelines for the Management of HIV Infection in Pregnant Women 2012* (www.bhiva.org/PregnantWomen2012.aspx) and the 2013 National Institute for Health and Care Excellence (NICE) guideline *Fertility: Assessment and Treatment for People with Fertility Problems* (www.nice.org.uk/cg156).

The RCOG produces guidelines as an educational aid to good clinical practice. These guidelines present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available.

This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

This information has been reviewed before publication by women attending clinics in London and Brighton.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.

© Royal College of Obstetricians and Gynaecologists 2013