

Administration of corticosteroids, antibiotics for group B streptococcus prophylaxis, intravenous magnesium sulphate for neuroprotection and tocolysis, if indicated, should be administered according to local and national guidelines [37,39,41].

10.9 Mode of delivery

Recommendations

- We recommend that a decision regarding recommended mode of delivery should be agreed with the pregnant woman/person after review of the last measured plasma viral load, which is usually the plasma viral load measured at 36 weeks (Grade 1C).
- Following the agreement on mode of delivery, we recommend that a birth plan is clearly documented in the medical notes of the pregnant woman/person (see <https://bhiva.org/clinical-guideline/pregnancy-guidelines/>). This should be drafted before the third trimester and finalised by 36 weeks' gestation (Grade 1D).
- We recommend that planned vaginal delivery should be supported where HIV viral load is <50 copies/mL in the absence of obstetric contraindications (Grade 1C).
- We recommend that vaginal birth after caesarean section (VBAC) can be offered where HIV viral load is <50 copies/mL (Grade 1C).
- We recommend planned caesarean section where HIV viral load is 50–399 copies/mL, taking into account the actual viral load, the trajectory of the viral load, length of time on treatment, adherence, obstetric factors and the views of the woman/person (Grade 1C).
- We recommend caesarean section where HIV viral load is ≥400 copies/mL (Grade 1C).

Auditable outcomes

- Proportion of women/people living with HIV who undergo caesarean section because of a viral load of >50 copies/mL to prevent vertical transmission.
- Proportion of women/people living with HIV who have a documented birth plan by 36 weeks.

Rationale

Published cohort data from the UK and other European countries have shown vertical transmission rates of <0.5% in women with a plasma viral load <50 copies/mL taking ART, irrespective of mode of delivery [42-47]. These studies support the practice of recommending planned vaginal delivery for women/people on ART with a viral load <50 copies/mL.

The NSHPC (now ISOSS) investigated HIV vertical transmission rates in women delivering between 2000 and 2011 ($n=2000$); for all modes of delivery, risk of transmission was significantly higher when viral load was 50–399 copies/mL than when fully suppressed (<50 copies/mL) [47]. Excluding five *in utero* transmissions, the vertical rate among women with viral loads of 50–399 copies/mL was 0.26% (2 of 777) following elective caesarean section and 1.1% (2 of 188) following planned vaginal delivery ($P=0.17$).

In an analysis from the ANRS French Perinatal cohort of 8977 women delivering on ART during the period 2000–2010, no difference in unadjusted vertical transmission rates by mode of delivery was found among 3075 women delivering at term (>37 weeks) with a viral load <50 copies/mL (0.3% for