vaginal delivery, 0.3% for caesarean section and 0.3% for non-caesarean section; *P*=1.00). Among 707 women who delivered at term with a viral load of 50–399 copies/mL, there was also no significant difference in transmission by mode of delivery (1.0%, 1.0% and 2.5% respectively; *P*=0.24). The authors did not comment on the timing of transmission in the infants diagnosed with HIV [48].

By contrast, data from the European Collaborative Study of 5238 women delivering from 1985 to 2007 showed that prelabour caesarean section was associated with an 80% decreased risk of vertical transmission after adjusting for ART and prematurity among 960 women delivering with a viral load <400 copies/mL (adjusted OR 0.2, 95% CI 0.05–0.65). There were only two transmissions among 599 women delivering with a viral load <50 copies/mL (transmission rate 0.4%) [42].

A potential explanation for the different conclusions in these two studies regarding the effect of mode of delivery on vertical transmission when plasma viral load at delivery is <400 copies/mL is that there may be a significant difference in the viral load distribution <400 copies/mL between studies. This highlights the fact that it is not possible to infer that vertical transmission rates from studies using a viral load assay with a cut-off value <400 copies/mL can necessarily be applied to individuals with plasma viral loads of 50–399 copies/mL using current assays with lower limits of detection of 50 copies/mL or less.

Although neither of the most recent UK and French analyses showed a statistically significant difference in vertical transmission by mode of delivery for women with plasma viral loads between 50 and 399 copies/mL, in the UK/Ireland dataset the risk of vertical transmission for women delivering vaginally was about twice that of those delivering by caesarean section, and this increased to 4-fold when *in utero* transmissions are excluded. Therefore, we recommend that caesarean section should be considered in this group taking into account the actual viral load, the trajectory of the viral load, length of time on treatment, adherence issues, obstetric factors and the views of the woman/person.

Given the conflicting data regarding the effect of mode of delivery on vertical transmission when viral load is <400 copies/mL, together with the data from the UK study showing a 2.4-fold increased risk of transmission for every 1-$\log_{10}$ unit increase in viral load associated with vaginal delivery [45], the writing group continues to recommend caesarean section for all women/people with a viral load ≥400 copies/mL.

In the absence of randomised trial data in women/people with HIV who undergo VBAC, support for a benefit of vaginal birth, including VBAC, compared with caesarean section is limited to expert judgement. Therefore, where a vaginal birth has been recommended on the basis of ART and viral load, delivery management of the woman/birthing parent, including a decision regarding VBAC, should be as for individuals without HIV in line with national guidelines [49].

## 10.10 Timing of birth

**Recommendations**

- We recommend that where induction of labour or prelabour caesarean section is undertaken and plasma viral load is <50 copies/mL, the usual obstetric considerations should apply regarding timing of delivery (Grade 1C).
- We recommend that where caesarean section is undertaken at a viral load of >50 copies/mL to prevent vertical transmission, delivery should be considered from 38 weeks' gestation (Grade 1C).