

Auditable outcomes

- Proportion of women/people living with HIV who are supported to achieve delayed cord clamping.
- Proportion of women/people living with HIV who receive intravenous zidovudine in labour.

Rationale

Given that infants born to women/birthing parents with HIV will require both PNP as soon as possible after birth and within 4 hours (see Section 11) and a blood test, the writing group recommends that all women/people living with HIV give birth in a facility that has direct access to neonatal care (i.e. a co-located birth centre or obstetric unit).

Traditionally amniotomy, fetal scalp electrodes and blood sampling, instrumental delivery and episiotomy have been avoided in women/people with HIV because of theoretical transmission risks. Data from the pre-effective ART era have been reviewed, and show little or no risk for many of these procedures. Trial data since the advent of effective ART are not available.

The NSHPC (now ISOSS) reported data on operative vaginal deliveries between 2008 and 2016; of 3023 deliveries, 251 infants were delivered using forceps or vacuum; one infant was diagnosed with HIV, but the timing of infection is unclear and other risk factors were present [12]. This is consistent with previously reported transmission rates in this population, and the numbers are too small to draw further conclusions.

Several cohort studies which predate effective ART did not show increased risk of vertical transmission with various obstetric procedures such as instrumental delivery, artificial rupture of membranes, fetal scalp electrodes, and pH blood sampling [15,24,51]. In a retrospective study from Spain, predominantly in the pre-ART era, HIV transmission occurred in 26.3% of infants exposed to fetal scalp monitoring (electrodes or pH sampling or both) compared with 13.6% exposed to neither type of monitoring (RR 1.94, 95% CI 1.12–3.37) [52]. However, prolonged rupture of membranes was a significant contributor to the risk of transmission associated with this invasive monitoring.

In the absence of trial data for women/people with HIV who undergo an operative vaginal delivery, support for a benefit of any type of operative vaginal delivery compared to caesarean section for women/people or their infants is limited to expert judgement and extrapolation from other datasets. It is generally accepted that low cavity traction forceps are associated with lower rates of fetal trauma than vacuum-assisted deliveries and therefore may be favoured. In women/people with a viral load <50 copies/mL it is unlikely that the type of instrument used will affect transmission risk and thus the one the operator feels is most appropriate should be used as in the general population without HIV (and following national guidance [35]).

A Cochrane review published in 2018 examined obstetric outcomes following immersion in water during the first and second stages of labour (15 trials included). Outcomes related to HIV were not specifically reviewed. Overall, there was little or no difference in spontaneous vaginal birth, instrumental birth or caesarean delivery with water immersion in the first stage (moderate- to low-quality evidence), but immersion in the first stage may reduce the use of regional anaesthesia (moderate-quality evidence). For women immersed in the second stage of labour, there was little or no difference between groups for spontaneous vaginal birth. There was one reported death in the immersion group in one trial. The infant was born alive to a woman living with HIV who was treated 2 weeks prior to birth for vaginal infection.