Standard Operational Procedure for the Management of Human Immunodeficiency Virus (HIV) In Pregnant Women

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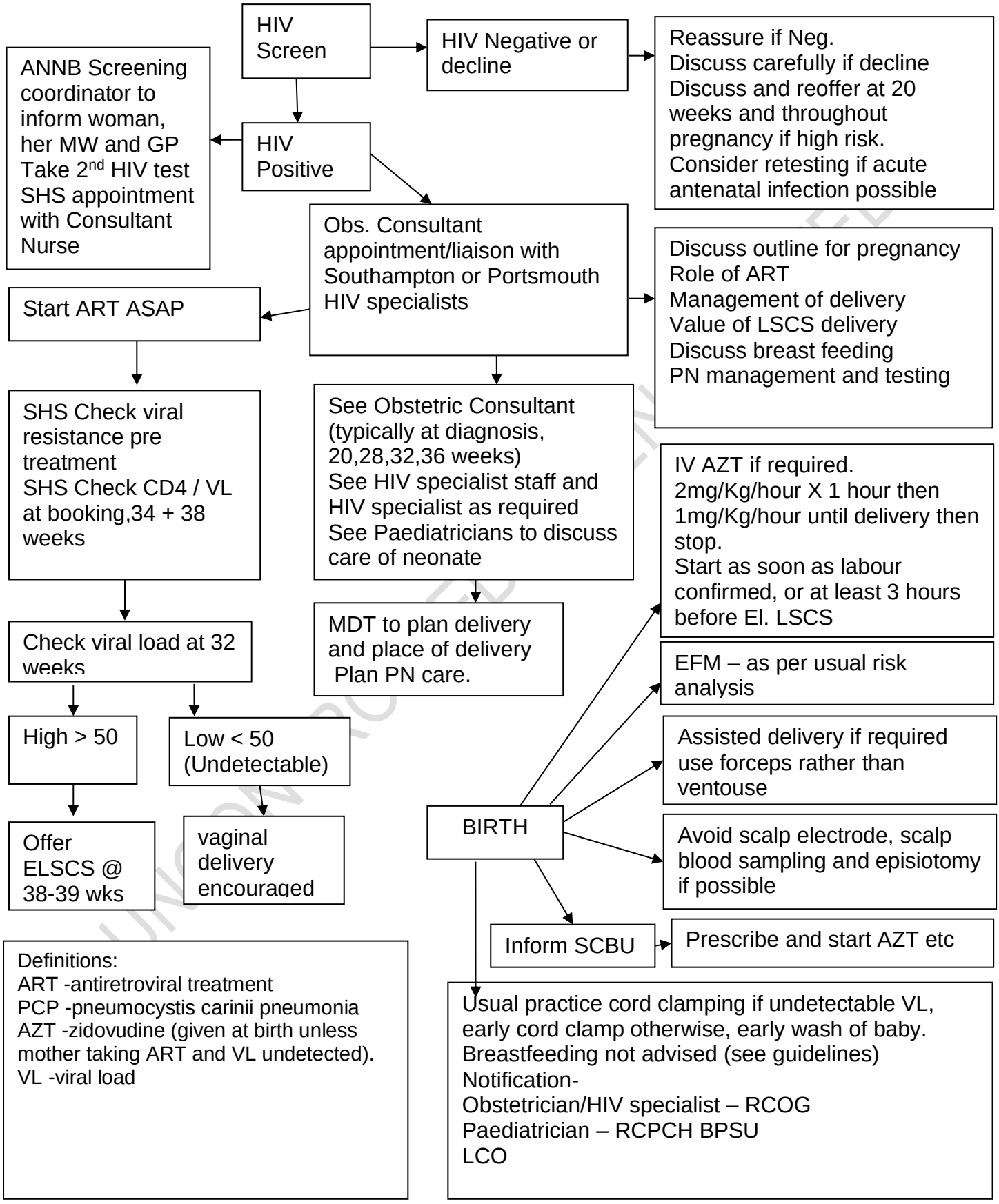
Version:	SOP v1
Status:	Ratified
Effective from:	13th April 2021
Review:	13th April 2024

Flow Chart of Management of HIV in Pregnancy



1. Purpose and Background

Human immunodeficiency Virus (HIV) is a retrovirus which, if left untreated, leads to immunosuppression and eventually to acquired deficiency syndrome (AIDS).

After primary infection with HIV there is a period of up to 3 months before HIV antibodies can be detected. HIV, in an infected person, is present in body fluids and organs including blood, semen, vaginal and cervical secretions, cerebrospinal fluid and breast milk.

Mother-to-child transmission is now rare in the UK following widespread antenatal screening, antiretroviral treatment in pregnancy and avoidance of breastfeeding. If untreated the mother-to-child transmission is around 25%. With early diagnosis, effective treatment and subsequent viral suppression, the risk is now very low (under 0.5%)

The management of HIV pregnant women requires a multidisciplinary team (MDT), approach to discuss the issues and provide an individual plan of care.

2. Scope:

This document is for use by all obstetricians and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this SOP
- Attend any mandatory training pertaining to the SOP

It is the responsibility of the department to:

- Ensure the SOP is reviewed as required in line with trust and national recommendations
- Ensure the SOP is accessible to all relevant staff

4. Procedure:

Care of an HIV Positive Woman and her Baby

4.1 Antenatal Care

4.1.1 Women known to be HIV positive should ideally have a prenatal review and discussion with their HIV, Obstetric and Paediatric consultant team.

4.1.2 Antenatal positive screening result

- A reactive (i.e. equivocal or possibly positive) result will be notified to the Local Screening Coordinator (LCO) via nhs.net email. The LCO will arrange for the information to be given to the woman in person; not over the phone.
- A second sample should be taken (using a gold top blood bottle) and marked as “urgent” to clarify if the result is a true positive. NB: Auto immune disorders such as lupus can sometimes flag up a low positive result which later turns out to be negative.
- The woman can be offered referral to the Consultant Nurse in the Sexual Health Service (SHS) for further information and counselling at this early stage.
- If the second blood test is negative, a repeat should be arranged 6 weeks later. If that test is also negative, a further repeat is included with the 28 week routine antenatal blood test.

4.1.3 Antenatal Diagnosis

- The LCO will be notified immediately of a confirmed positive result. The LCO will liaise with the woman’s obstetric consultant and the HIV specialist nurse in the Sexual Health department.
- Referral to the safeguarding team and Mental Health Specialist Midwife may be appropriate and should be considered as statistics suggest women with HIV have an increased incidence of issues such as poor mental health and domestic violence.
- The woman’s care will require a multidisciplinary team (MDT) consisting of:-
    - Obstetric consultant
    - Southampton or Portsmouth HIV consultant
    - Sexual health Consultant Nurse
    - Screening coordinator/ assigned midwife
    - Consultant paediatrician
    - GP and Primary Health Care Providers

4.1.4 Confidentiality

The woman will be strongly advised of the need for good communication and liaison between members of the MDT and that her primary health carers will be aware and informed of care on a “need to know” basis.

HIV status will be recorded clearly in the antenatal notes unless the woman specifically requests otherwise. This information is vital if the woman were to present unconscious or unable to give a clear history.

4.1.5 Referral to Sexual Health Service (SHS)

-Is made where the following will be arranged:-

- Full sexual health screen
- Additional blood tests for hepatitis C, varicella zoster, measles and toxoplasmosis
- Baseline viral loads (VL) and CD4 cell counts (all VL and CD4 counts are performed by SHS) followed by
- CD4 count monthly until VL < 50 (undetected);
- HIV VL after booking/diagnosis, 34 and 38 weeks
- Assessment of FBC, U&E’s, and LFT’s.
- Viral resistance testing is performed at diagnosis and before initiation of treatment.
- Medication needs will be assessed by the HIV specialist and the monitoring of plasma viral load and drug toxicities will be undertaken as directed.
- Hepatitis B and pneumococcal vaccination may be recommended (safe in pregnancy) The GP will be notified.
- The HIV specialist nurse will be involved with discussion about healthy lifestyle, preventing transmission, safer sex, and safer drugs.
- Every effort will be made to support the woman to disclose to her partner/s in order to protect their health. The SHS team will assume responsibility of partner notification. The GP will be responsible for testing of other children (if relevant).
- Women receiving ART in pregnancy will be registered by SHS clinicians with the Antiretroviral Pregnancy Registry

4.1.6 Obstetric Antenatal Care

- The woman will be fully involved in the plan of care and birth plan. These will be discussed and recommended by the MDT and filed in her notes for her care provider to read, follow and check for any updates.
- Normal antenatal care should continue with the named midwife.
- Fetal ultrasound imaging should be performed as per national guidelines.
- Obstetric reviews will be at diagnosis (for new diagnosis) or 10-14wks for known HIV and at 32-36wks or more frequently if required. Reviews by the HIV Consultant will usually be monthly.
- The HIV consultant will offer ART to all women who are HIV positive, will make any necessary changes to treatment and will inform the woman and obstetric consultant.
- All women taking ART at the time of booking should be screened for gestational diabetes at booking and at 28 wks.
- Invasive testing should usually be avoided given the additional risks of vertical transmission. Women who are HIV positive considering invasive prenatal diagnostic testing should be counselled by the Fetal Medicine Unit in Southampton.
- HIV related complications should be considered as a cause of acute illness in a pregnant woman whose HIV status is unknown.
- Breastfeeding is not advised and suppression of lactation should be discussed in the antenatal period and preparation made for bottle feeding.
- If the viral load is undetectable or <50 breastfeeding can be considered if the woman accepts the small increase in risk, is prepared to stay on ARVs and agrees to monthly tests of herself and her baby. Antenatal hand expression could be beneficial
- ECV can be offered to women with a viral load <50 copies/ml with a breech presentation at >36+0 weeks in the absence of obstetric contraindications.
- Antiretroviral drugs are generally thought safe to use in pregnancy but can cause side effects. There are potential overlapping presentations between these adverse side effects and complications of pregnancy e.g. pre-eclampsia, cholestasis and other signs of liver dysfunction. Early liaison between obstetric and HIV consultants will help avoid misdiagnosis.

- Some studies suggest that women taking HAART in pregnancy are at increased risk of gestational diabetes, pre-eclampsia and preterm delivery. If an HIV positive woman is ever admitted unwell in pregnancy, staff should consider the possibility of HIV related illness or Antiretroviral Therapy (ART) related problems

4.1.7 Safeguarding and Social Services

involvement may be required especially in cases where:

- The client declines neonatal treatment
- There is non-engagement with HIV/antenatal services
- Client declines antenatal antiretroviral medication
- Client declares intention to breast feed the baby against advice from HIV team
- Client's partner declines treatment for the neonate.

4.1.8 Notification

Clinicians caring for HIV positive women and their infants have a responsibility for the following notifications:-

- To the UK National study of HIV in pregnancy and Childhood (NSHPC) at the RCOG. This is an anonymous audit process and does not require consent.
- To the integrated screening outcomes surveillance service (ISOSS)
- All women who receive ART in pregnancy should be registered prospectively with the Antiretroviral Pregnancy Registry, which, in Europe is managed by GlaxoSmithKline (SHS clinicians to do).
- Royal College of Paediatrics and Child Health (RCPCH) - British Paediatric Surveillance Unit (BPSU) after birth.

4.2 AntiretroviralTherapy (ART)

- Please refer to The British HIV Association (BHIVA) "Guidelines for the Management of HIV infection in Pregnant Women 2018" for detailed guidance. http://www.bhiva.org/pregnancy-guidelines-consultation.aspx
- The aim of HIV treatment in pregnancy is to maintain the health of the mother and prevent transmission to the baby. This is achieved by suppressing the HIV replication (the HIV viral load) to the lowest possible level with the use of

ART medication. All women with HIV in pregnancy will be offered ART straight away regardless of CD4 count.

- Women already taking ART and prophylaxis against pneumocystis pneumonia (PCP) should not discontinue their medication.
- They will need to continue with ART once the baby is born.
- AZT administration in labour or following SROM if required should be commenced with a degree of urgency.

4.3 Labour and delivery

- Mode of delivery is determined by viral load at around 34-36wks. 80% of transmission occurs after 36wks and during labour and delivery. It is important to check the HIV results of all women on the labour ward to ensure they receive the appropriate care.
- If an unbooked woman arrives on labour ward and agrees to an HIV test this should be fast tracked as urgent to ensure appropriate interventions are followed to prevent MTCT.
- A plan of care should be made and the mode of delivery decided by the team by 34 weeks gestation. This should be discussed with the woman and secured in the CTG envelope of her notes.
- An up to date maternal sample for plasma VL and CD4 count should be available at delivery. **All women presenting in labour should have blood taken for proviral DNA- this is essential for processing baby's first HIV test.** Out of hours any blood tests required should be discussed directly with the on call microbiologist
- The obstetric consultant should be informed of the admission.
- All ART medication should be given on time and no doses missed.
- Alert the neonatal team of the imminent delivery

4.3.1 Vaginal delivery

- Is encouraged for woman who accept the small but uncertain risk of transmission, who are taking ART and have VL <50 HIV RNA copies/ml plasma at 36wks with no obstetric complications.
- There is no need for continuous CTG unless indicated for obstetric reasons.

- There is no contraindication to membrane sweep or to the use of prostaglandins.
- VBAC may be considered for those on ART whose plasma viral load is less than 50 copies/ml.
- Wherever possible avoid invasive procedures such as fetal blood sampling and fetal scalp electrodes.
- Artificial rupture of membranes (ARM) should be delayed as long as possible and avoided unless there are concerns about prolonged labour and the need for augmentation of labour with ARM and syntocinon.
- There should be good progress in labour > 2cm/hour minimum.
- If instrumental delivery is indicated, low cavity forceps are preferable to ventouse to reduce the risk of broken skin on the scalp.
- The need for an episiotomy should be balanced against the risk of a prolonged 2nd stage. If performed, care should be taken to avoid maternal blood contamination. Wipe the baby's face clear of secretions during the delivery to prevent transmission through the mucous membranes.
- An emergency LSCS should be performed for the usual obstetric reasons; in particular to avoid a vaginal delivery that is likely to be difficult or prolonged.
- To prevent excessive bleeding and the further risk of viral transmission, active management is recommended. The cord should be clamped early to reduce the possibility of maternal cells transferring into the fetal circulation.
- Unless there is another indication all placentas should be incinerated.

4.3.2 ELSCS at 39 weeks is recommended for women who:-

- Have detectable viral loads (> 50 copies /ml) after 32/34 weeks.
- Are HIV positive but in whom, for whatever reason, the VL in the 3rd trimester is not known.
- Have other obstetric/medical reasons.
- Are taking AZT monotherapy.
- Have hepatitis coinfection.

If IV zidovudine (ZDV) is indicated it should be started 4 hours before the CS and continued until the umbilical cord has been clamped.

The surgical field should be kept as haemostatic as possible and care should be taken to avoid rupturing the membranes until the head is delivered through the surgical incision.

Peripartum antibiotics are given as per national guideline for the general population.

4.3.3 SROM

The risk of HIV transmission should be set against the risk of preterm delivery. Preterm infants are more likely to be affected with HIV, which may be attributed to chorioamnionitis or increased susceptibility to HIV infection. The duration of membrane rupture before delivery is a consistent risk factor for vertical transmission. After membrane rupture in later pregnancy (after 30-32 weeks) delivery is recommended rather than conservative management. Consideration should be given to starting IV AZT and nevirapine until delivery is achieved or whilst consideration is being taken.

- Viral load <50 copies/ml- If planning vaginal birth offer early IOL. If planning ELCS arrange category 4 CS.
- Viral load >50 copies/ml- 999 copies/ml - consider immediate category 2/3 CS.
- Viral load >1000 cpoies/ml-category 2/3 CS recommended with AZT cover and consideration of combined antiretroviral therapy.

Steroids should be used as indicated by the usual obstetric indications.

4.3.4 PROM

Women who present with pre-labour rupture of membranes should have early induction of labour (usually within six hours).

4.3.6 Infection Control

- Follow universal precautions and wear personal protective equipment (PPE) n when undertaking an invasive procedure or dealing with body fluids/spillages.
- Protective eyewear should be worn during operative procedures.
- Appropriate protective footwear e.g. boots should be worn in theatre.
- Gauntlets should be worn for the manual removal of placentas.

- Take care handling sharps, use a needle holder when suturing. Do not recap used needles, use sharp boxes and keep them as close to the place of use as possible.
- Kidney dishes should always be used for passing scalpels during C S.

4.3.7 HIV exposure Policy

- Wash wound thoroughly with soap and warm running water. Do not scrub or use antiseptics
- Puncture wounds should be encouraged to bleed freely by squeezing gently.
- Exposed mucous membranes such as eyes should be irrigated copiously with tap water after removing any contact lenses.
- Report the exposure incident immediately to Occupational Health 8.30-1600 Monday – Friday Tel 552421 (A+E out of hours) together with details of the source patient for risk assessment. Post exposure prophylaxis must be given within one hour and is available 24/7
- Report incident immediately to the duty Manager
  Complete an accident/incident form as soon as possible

4.4 Care of the baby

- The umbilical cord should be clamped and cut as soon as possible after birth.
- Handle newborn babies with gloves until they have been bathed.
- Babies should be bathed as soon as possible in the same delivery room to reduce transmission. Exclusions are babies who are :- preterm, small for dates, requiring resuscitation, distressed in utero, who are unwell or have a low temperature below 36.5°C.
- If otherwise well the baby should receive their Vitamin K prophylaxis orally; IM carries the theoretical risk of introducing viral particles from the skin.
- HIV status alone is not a reason for admission to the neonatal unit. Most HIV exposed babies are of normal birth weight and do not have abnormal clinical findings.
- A paediatrician will need to write up the neonatal post exposure prophylaxis(PEP)prescription in readiness. The baby should receive PEP medication as soon as possible and within 6 hours of birth. Medication must

be given at the times prescribed and generally for a period of 4 weeks; no doses should be missed. The mother should be involved in how to administer this medication to her baby as soon as possible

- Most neonates should be treated with ZDV monotherapy but those at high risk of HIV infection should be treated with triple therapy PEP
- Prophylaxis against PCP is recommended only for infants at high risk of HIV infection.
- In the event of a maternal postnatal HIV positive result, the baby should receive triple therapy post exposure prophylaxis (PEP) as soon as possible as it may only be effective if given before 48-72 hours.
- Infants should be tested at 1 day, 6 weeks, and 12 weeks of age. If all these tests are negative and the baby is not being breastfed, the parents can be informed that the child is not HIV infected. A confirmatory HIV antibody test is performed at 18 months of age.
- Neonatal day one tests should include FBC, LFTs, glucose , pH and lactate, viral load.
- Neonates who are born to HIV positive women are reported to the National Study of HIV in Pregnancy and Childhood.
- Baby clinic appointments should be arranged prior to discharge.
- GP's will be notified of all babies who have received antiretroviral medication to enable them to monitor the long term side effects.
- Community midwives should exercise caution in the completing of PKU forms.
- Babies born to women with an undetectable VL (<50) can proceed with the usual vaccination programme. However **neonatal BCG is a live vaccine and therefore contraindicated** until the baby is known to be HIV Negative.
- All mothers known to be HIV positive should be advised to exclusively bottle feed their babies. Breast feeding is not recommended even with a low VL; mixed feeding presents an even greater risk of MTCT as formula changes the normal gut flora. In rare instances where a mother on effective ART with a repeatedly undetectable VL (<50) chooses to breastfeed, this should not constitute grounds for automatic referral to child protection teams.

4.4.1 Postnatal Care

- Following LSCS or vaginal birth women should receive the usual support and care on postnatal wards
- Women not breastfeeding their infant by choice, or because of HIV RNA>50 copies/mL should be offered cabergoline to suppress lactation.
- Women should have support needs assessed postpartum and be referred to appropriate services in the Trust, community and/or voluntary groups without delay
- Women should have mental health needs assessed postpartum and those assessed as having mental health issues should be referred to appropriate services in the Trust, community and/or voluntary groups without delay.
- ART should be continued after delivery.
- A 6 week postnatal appointment should be made for HIV/ANC review to discuss how she and her family are coping, to monitor her health and ensure continuing HIV follow up.

4.4.2 Contraception

It is important to offer a specialist planning referral to the Consultant Nurse in the SHS and prevention of transmission / safer sex advice.

Some hormonal contraceptives are reduced in efficacy by the use of ARV's and women need to be able to talk openly about their status.

Use of diaphragm and spermicidal is not recommended as it increases the chance of mucosal irritation, lesions and sores; this may make transmission to an HIV negative partner more likely.

Male/female condoms, implants, intrauterine devices, depo-provera and the Mirena can all be recommended or sterilisation.

5 Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.

- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Referral to care pathway within 10 days of a positive result	Evidence of an appointment within 10 days of a HIV positive result	This will be done for every woman who has an HIV positive result in pregnancy	N/A	LCO	Screening steering group

7. Related Documents:

Guidelines/SOP's:-

- Guidelines for the Management of Maternal Antenatal Screening Tests

Policies:-

- Hand Hygiene
- Infection prevention and control
- Safe handling Disposal of sharps
- Sharps injury
- Decontamination of reusable medical devises
- Use of personal protective equipment

Patient Information:
See appendix B

8. References:

- BHIVA Guidelines for the Management of HIV infection in Pregnant Women 2018 www.bhiva.org
- HIV Guidelines in consultation www.://www.bhiva.org/pregnancy-guidelines-consultation.aspx
- RCOG green top guideline no.39

9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

Date of Issue	Version	Next Review Date	Date Approved	Director Responsible for Change	Nature of Change
15.03.18	1.0	6th March 2021	6th March 2018	Clinical Director for SWCH	Approved at Maternity CSG

Appendix A

HIV Summary Care Sheet

DOSH Number: **Parity:** **EDD:**

HIV Diagnosis:
Before Pregnancy (when):
During Pregnancy (when):
Positive/ Negative:
Other Relevant Diagnosis:

Neonatal Plan:
Bloods:
AZT Monotherapy: Y/N
Combination Therapy: Y/N **Partner**

Feeding:
Formula Feeding Recommended: Y/N

Other Relevant CO- Infections
Herpes: YN
Hep B or C: Y/N
Other:
CIN:

Plan for Pregnancy
Usual Pathway:
Additional reviews/ Events: Y/N
ART's started (Gestation/ Date:
Which ART?

Plan for Delivery:
Await spontaneous labour: Y/N
Induction of Labour (DATE)
Elective Caesarean (DATE)
AZT before labour/ caesarean: Y/N

Date	Gestation	VL	CD4

SIGNED:
DATE:

Use of Antiretrovirals for HIV in Pregnancy and Labour

1. ART to start immediately (to include zidovudine).
2. IV zidovudine indicated for all women at delivery unless taking ART and VL undetectable**. Zidovudine: 2mg/Kg/hour IV over one hour (loading dose) followed by 1mg/Kg IV hourly (maintenance) until cord clamped.**
3. IV zidovudine infusion (if required as per 2) should begin 3 hours before beginning of elective LSCS and should continue until cord clamped**.**
4. Postnatal treatment of baby**:-**
   a) Where mother has received reliable and effective ART antenatally for at least 4 weeks prior to delivery and the maternal VL
   is < 10,000copies per ml
      - Zidovudine (AZT) monotherapy
      - 4mg/Kg dose given twice daily for 4 weeks
      - In premature infants (> 30 but < 36 weeks gestation give 2 mg/Kg oral AZT BD for first two weeks, then 2 mg/Kg tds for next two weeks.
      - For infants < 30 weeks gestation use 2mg/Kg BD for 4 weeks
      - In sick infants unable to tolerate oral medication
        At term: provide IV AZT 1.5mg/Kg QDS,
        If premature give IV AZT 1.5 mg/Kg BD

   b) In the following circumstances triple combination ART (AZT + 3TC + Nevirapine) for 4 weeks is advised:
      - Women who present in labour or after birth with no prior treatment.
      - Maternal VL is > 10,000 copies per ml prior to birth.
      - Where antiretrovirals have not been used antenatally.
      - If ART therapy has not been used for less than 4 weeks prior to delivery.
      - Consideration in the following circumstances:
        If intrapartum IV AZT has not been administered for some reason, if there are documented risk factors e.g. PROM, premature delivery, chorioamnionitis, placental abruption, invasive monitoring of fetus, breast feeding.

c) Neonatal triple combination therapy

Term infant: Zidovudine 4mg/Kg every 12 hours for 4 weeks

3TC (Lamivudine) 2mg/Kg every 12 hours

Nevirapine 4 mg/Kg once daily for 2 weeks and then stop.

Consider use of cotimoxazole as PCP prophylaxis. If perinatal management has been optimised and therefore perceived risk of transmission thought to be low, use of cotrimoxazole is not justified. Thus in the above schedule of ART treatment those neonates that received AZT monotherapy would not normally be offered cotrimoxazole. Those infants receiving triple combination ART should be offered unless subsequent events have shown the risks of transmission to be low.

Cotrimoxazole dose: Infants > 2 Kg 120mg once per day, 3 days per week (Monday, Wednesday, Friday).

< 2 Kg 60 mg once per day, 3 days per week.

5. Diagnostic tests for HIV to be performed day 1, at 6 weeks, at 4 months. On day 1 these tests should include FBC, LFT's, glucose, pH and lactate and VL

6. Breast feeding remains a major risk factor for transmission, however data about scale of risk in women with very low (<50 copies) or undetectable VL is currently incomplete.

	Antenatal and Intrapartum Treatment	Method of Delivery	Breast Feeding	Neonatal Management
HIV diagnosis in pregnancy CD4 Count > 350	ART therapy in pregnancy to start immediately Consider IV Zidovudine in labour	LSCS 3 unless VL < 50	Not recommended	4 Weeks oral zidovudine 4 Consider oral cotrimoxazole until HIV status known 4 Diagnostic tests for HIV 5
HIV diagnosis in pregnancy CD4 count < 350	ART therapy in pregnancy to start immediately Consider IV zidovudine in labour PCP prophylaxis (usually cotrimoxazole with folate supplementation 400ug OD)	LSCS 3 unless VL<50	Not recommended	4 weeks oral zidovudine 4 Consider oral cotrimoxazole until HIV status is known 4 Diagnostic tests for HIV 5
Known HIV not on treatment	ART therapy in pregnancy IV zidovudine in labour	LSCS 3	Not recommended	4 weeks oral zidovudine 4 Consider oral cotrimoxazole until HIV status is known 4 Diagnostic tests for HIV 5
Known HIV on combination therapy	Consider unknown teratogenic effect of ART during first 12 weeks, if stopped restart at 12 weeks Consider IV zidovudine in labour	LSCS 3 unless VL < 50	Consider with care	4 weeks oral zidovudine4 Consider oral cotrimoxazole until HIV status known 4 Diagnostic tests for HIV 5
Mother presents in labour, known HIV but no VL or CD4 data	Blood for CD4 count and VL must be taken before starting any ART IV zidovudine in labour 2 Nevirapine 200mg once ASAP Consider continuing ART until CD4 and VL known	Probable LSCS	Not recommended	4 weeks triple combination ART 4 Cotrimoxazole until HIV status known 4 Diagnostic tests for HIV 5
Maternal HIV diagnosis made within 48 hours of delivery	Await full assessment including CD4 and VL		Not recommended	4 weeks triple combination ART4 Cotrimoxazole until HIV status known 4 Diagnostic tests for HIV 5

Appendix B

Useful Telephone numbers

Consultant Microbiologist- Isle of Wight (IOW)	Ext 4186
Consultant Nurse SHS IOW	Ext 4202
Antenatal Screening Coordinator IOW	Ext 4332
Dr Blume, Portsmouth	alison.blume@solent.nhs.uk
Lead HIV consultant, Fetal and Maternal Medicine Southampton	023 8120 4727/4228
Paediatrician, Neonatal Unit, Princess Anne Hospital Southampton	023 8120 4643/6001
HIV Specialist Consultant, Southampton elizabeth.foley@solent.nhs.uk	
Clinical Nurse Specialist HIV Southampton	can be contacted via 023 8103 0379
Health Advisors michelle.wotman@nhs.net dan.stock@nhs.net	02380 540288

Information for women and families

Positively UK http://positivelyuk.org/women/	02077130444
Mambo https://www.mambo.org.uk/	
CHIVA https://chiva.org.uk/	
Naz Project http://naz.org.uk/	02087411879

Helplines

Terrence Higgins Trust http://tht.org.uk/	0808 8021200

Information about AIDs

www.bhiva.org
www.rcog.org.uk
www.unaids.org
www.tht.org.uk
www.aidsmap.com
www.avert.org.uk
www.nat.org.uk

Patient support leaflets can be found on the BHIVA and RCOG websites.