Screening to reduce HIV transmission from mother to baby

From a public health perspective, targeting pregnant women for screening provides an ideal opportunity to prevent the spread of human immunodeficiency virus (HIV). Midwives are ideally placed to recommend and offer antenatal screening as part of the National Universal HIV Screening Policy (Department of Health, 1999). The rationale behind antenatal screening is to reduce transmission of HIV from an infected mother to her baby, a process that can occur during pregnancy, labour and through breastfeeding.

HIV testing in Bradford

Bradford has a multicultural population of about 500,000 people, which includes a large Asian community, asylum seekers and students from sub-Saharan Africa. Africa is home to nearly 70 per cent of adults with HIV globally and 80 per cent of children with HIV (UN AIDS, 2000).

There are 5,500 live births in Bradford annually. Providing midwifery care in the city is very challenging, due to the complex needs of the local population.

Reasons for screening

In 1997, an unlinked, anonymous, dried blood spot survey revealed that 70 per cent of HIV infections in pregnant women were undiagnosed at the time of delivery. Many women found out about their infection only when their child became symptomatic with HIV or was diagnosed with Aids (DoH, 1999).

The survey was a longitudinal epidemiological study conducted over 10 years to determine the prevalence rates of HIV without examining the contentious issue of consent. Pregnant women were asked at the time of booking an appointment if their blood could be screened anonymously for HIV.

If untreated, children with HIV will develop chronic disease, and about 20 per cent will either develop Aids or die in the first year of life. By the age of six years, a further 25 per cent will have died (DoH, 1999). The long-term prognosis for children with HIV is not known. However, there are reports of children remaining symptom-free into their teenage years.

Research has shown that interventions such as antiretroviral therapy, given to mothers in pregnancy, as well as having an elective Caesarean birth and refraining from breastfeeding, can reduce mother-to-baby transmission from 20–25 per cent to about one per cent (Lyall et al, 2001).

Midwives have a key role in informing women about their choices with regard to antenatal HIV testing – if pregnant women are unaware of their HIV status, they cannot benefit from interventions that greatly reduce the risk of their babies being infected.

Targets

In 1999, an NHS circular (DoH, 1999) stated that ministers had accepted the recommendations of an expert group – the Intercollegiate Working Party for Enhancing Voluntary Confidential HIV Testing in Pregnancy. The group was set up to develop targets aimed at reducing mother-to-baby HIV transmission.

Midwives were informed that by 2002, national targets aimed to reduce the number of babies who acquired HIV from an infected mother by 80 per cent. By December 2002, all pregnant women were to be offered and encouraged to have an HIV test as part of their antenatal care: the objective was a 90 per cent uptake.

The targets are now monitored by strategic health authorities with the aim of increasing uptake of antenatal HIV testing and ensuring that pregnant women with HIV are offered advice, support and treatment, thereby reducing the risk of vertical transmission to the baby.

Ethical issues about consent

In Bradford, each year 5,500–6,000 women book antenatal care. HIV testing is now offered to all these women and a 98 per cent uptake has been achieved. However, as many of the women speak little or no English, the high uptake raises ethical issues about consent.

English is a second language for a high percentage of Bradford’s population and some people do not speak any English. This poses a challenge for midwives, in terms of discussing options for antenatal screening and testing.

Some language difficulties can be overcome by using bilingual support workers (interpreters). The authors acknowledge that this is not ideal and we question whether ‘true consent’ is obtained using this indirect method of communication.

HIV is a sensitive subject and discussing it via a third party, such as an interpreter, could be seen as an ‘infringement of confidentiality’. Some midwives in Bradford are unhappy at being unable to communicate directly with clients and have undertaken language classes in Urdu to help overcome these difficulties.

Bradford has adopted an opt-out HIV testing policy (testing is routine after verbal consent, unless declined), which may be why there is a 98 per cent uptake.

Whether this approach is ethical has been the subject of many articles on antenatal screening. However, it can be argued that this approach serves to normalise HIV testing as a routine part of antenatal care.

Managing the process

An opt-out approach removes the fear some midwives may have of being accused of ‘stigmatising’ and ‘categorising’ women. However, in taking this approach it is important to make

References


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women aware that they are entitled to decline having the test without having to justify their decision.

Traditionally, health professionals have made the assumption that women who decline testing are likely to be in a higher risk category. However, Simpson et al (1999) found that women gave a range of reasons for declining, such as it was ‘not necessary, as I have no chance of being positive’ and ‘I have been in a stable relationship for a long time’.

Simpson et al (1998) also found that the problem with an opt-in approach (women have to actively choose to be tested) was that some felt their decision might be taken as an admission of high-risk behaviour.

Further problems relate to interpretation of the purpose of antenatal HIV testing; while women may seek testing as reassurance that all is well with the pregnancy, health care professionals may associate it with government targets and identifying ‘at-risk’ pregnancies.

The role of the counsellor Rapid advances are being made in antenatal screening and testing, and midwives are expected to have a broad knowledge of a wide range of tests. Maintaining up-to-date knowledge can be a challenge and some health professionals feel ill-equipped to convey information to women and to obtain consent.

Throughout the NHS, practising midwives feel that inadequate resources and time constraints negatively affect their role as counsellors, particularly when it comes to issues surrounding antenatal screening and consent.

Midwives in Bradford have embraced the role of adviser, rather than counsellor, and are aware of their accountability when giving information and advice.

If women require further information about HIV screening, they are referred to a health adviser at the genitourinary medicine (GUM) clinic, who has the time and the wider knowledge necessary to meet their needs more appropriately.

Dealing with positive results In Bradford, we aim to provide culturally sensitive and nonjudgemental midwifery services. There are practical issues surrounding the management of a positive test result for HIV, which have prompted us to put in place the following standards within our services:

- The antenatal screening coordinator ensures that the woman is given her diagnosis in a comfortable and relaxed environment. If the woman is in shock or in denial, it is important not to bombard her with information or pressurise her into making decisions. Patient information leaflets are provided (www.aidsmap.com);
- Confidentiality and communication between multidisciplinary professional groups may give cause for concern, so information is shared on a need-to-know basis only. Antenatal care is provided by the lead consultant and the antenatal screening coordinator, to reduce the number of people who need to know the diagnosis;
- Arrangements are usually made for the woman to be seen within two days of the initial diagnosis by a consultant specialist at the GUM clinic. Women are advised to make a list of questions to ask at their first appointment. Where possible, the antenatal screening coordinator accompanies the client to her first appointment at the GUM clinic to help reduce anxiety;
- Contact details for the antenatal screening coordinator, GUM health advisers, and local and national support organisations are provided after diagnosis. In Bradford, a local voluntary organisation acts as a support agency, providing social support and signposting to relevant services for people with HIV and AIDS;
- All women with a positive diagnosis are admitted to the same ward, where the staff are familiar with treatment regimens and protocols. Planned antiretroviral therapy for the mother and baby is usually stored on the antenatal ward four weeks before a scheduled delivery. Clinical guidelines for the care of the mother and baby are available on the hospital’s intranet site.

Conclusion Antenatal HIV screening services need to be culturally sensitive and nonjudgemental, offering information, choice and support to women, whether or not they choose to be tested for HIV. In Bradford, uptake has exceeded the targets set by the DoH (Table 1).

This success may be the result of the excellent in-house training and education offered by the trust. Mothers are provided with up-to-date information, advice, support and care, all of which are accessible, equitable and evidence-based.

| TABLE 1. WOMEN IN BRADFORD WHO HAVE HAD ANTENATAL SCREENING FOR HIV |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Bookings | Offered HIV screening | Refused | Uptake |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| January–June 2002 | 3,131 | 3,131 | 47 | 98.5% |
| July–December 2002 | 45 |

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