Advocacy and Collaboration:

First HIV pregnancy for a regional service

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AIMS & ADVOCACY: Reasons to manage locally

The aim of this study was to manage suitable pregnancies locally through advocacy and collaboration. While HIV positive pregnant mothers have been managed in other rural settings, this was the first for our regional health service.
Goals of this approach are:

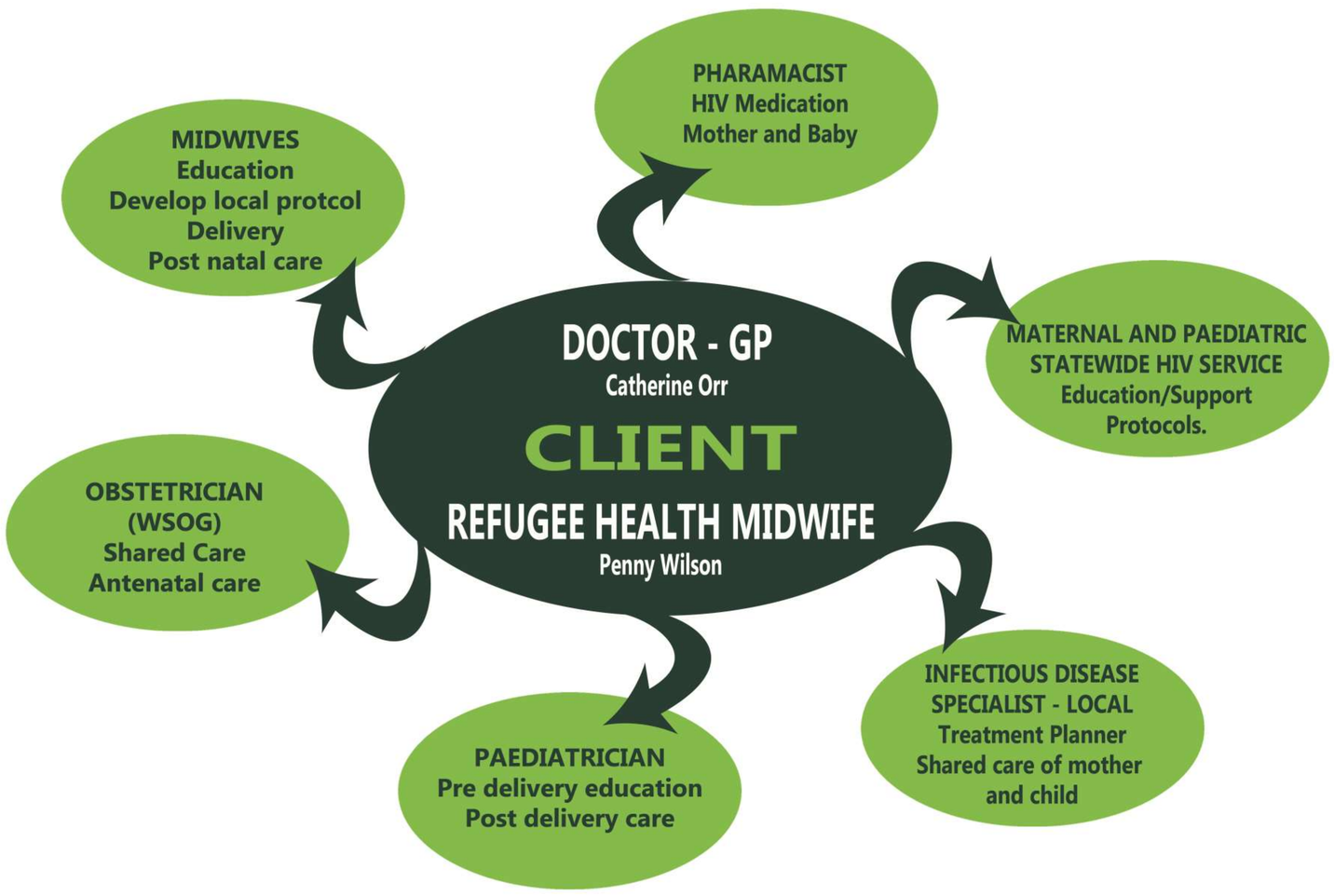
- Preventing identification of HIV status in local ethnic community
- Reduction of stigma
  Facilitate delivery in the local hospital like all pregnancies
- Reduce challenges of travel for medical care
- Holistic care with trusted known care providers
- Development of local HIV in pregnancy policy[1]
- Identification of future HIV pregnancies and need for local services to be up skilled

BACKGROUND:

Gateway Health Multicultural Clinic (GHMC) provides a health service for recently arrived refugees via Australia's Humanitarian Program, secondary resettlement refugees and asylum seekers.
This includes a significant number of women living with HIV, diagnosed both pre and post arrival and is largely due to sexual assault experienced in conflict regions . Many of these women were of child-bearing age.

RESULTS & OUTCOMES:

The Refugee Health Midwife (RHRM) & GP advocated strongly for the lady to deliver locally. With the collaboration of Rural health services and Tertiary services, a multidisciplinary team was formed, including RHRM, GP, Infectious Diseases Specialist, Obstetrician, Midwives, Paediatrician and Pharmacist. Education and support were provided to the local health service and care providers by both local and tertiary specialists.
The client delivered a healthy baby in November 2015. She had a post partum hemorrhage but recovered well postnatally. The baby was bottle fed, (hiding this from the community). HIV testing was carried out as per guidelines at birth, 6 weeks and 3 months. These tests were negative.



CASE STUDY:

Mrs X was diagnosed overseas with HIV in 2012. She presented in 2015 to Gateway Health Multicultural Clinic (GHMC) for management of her HIV. Referral was made to Infectious Diseases Specialist. Her viral load was 28,4000 copies/ml with a CD4 count of 320. She presented to GHMC with an accidental pregnancy at 16 weeks. She was commenced on anti-retroviral medication at 18 weeks gestation with Truvada and boosted atazanavir. At 34 weeks her viral load was <20 copies/ml and CD4 count was 413. Her pregnancy was uneventful and the decision was made to deliver vaginally fully supported by all members of the multidisciplinary team. She bottle fed the baby as per guidelines.

CONCLUSION:

Collaboration and advocacy allowed the successful management of the pregnancy of a lady living with HIV and delivery of her child, breaking the cycle of transmission in the context of her local regional community. Her pregnancy, first HIV in the region, led the local health services to develop and implement their own policy for HIV: Maternal and Neonatal Care[1] paving the way for future HIV pregnancies in the region to be delivered locally.

1. Human Immunodeficiency Virus (HIV) Management of positive women—Intrapartum and Infants Procedure, Albury Wodonga Health 2015