Worcestershire Acute Hospitals NHS Trust

Screening and Multidisciplinary care of the pregnant woman known to be HIV Positive

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Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by

Introduction

Note: This pathway has been reviewed in line with the service specification no. 15 NHS Infectious Diseases in Pregnancy Screening Programme.

The purpose of screening for HIV in pregnancy is to enable those diagnosed with HIV to take up interventions that reduce the risk of mother-to-child transmission and improve their own health. Rates of vertical transmission without prophylactic therapy are 15-20% in the UK and Europe.

Rationale for universal antenatal HIV testing

A woman's knowledge that she is HIV positive enables her to:

- make choices about whether she wants to conceive or not
- benefit from interventions to reduce mother-to-child transmission
- access specialist health care to minimise current and future HIV related illness

Pregnancy is not thought to influence the course of HIV disease in pregnant women

Major interventions to reduce mother to child transmission

- Antenatal antiretroviral therapy to reduce maternal viral load
- Screening for, or minimising risk of, Sexually Transmitted Infections, premature labour,
- Chorioamnionitis
- Minimising duration of ruptured membranes
- Consider delivery by elective Caesarean section
- Early bathing of baby
- Anti-retroviral prophylaxis for baby started as soon as possible after birth, for 4 weeks
- Avoidance of breastfeeding.

Antenatal Care

Antenatal screening

- All women should be offered HIV testing as part of routine booking bloods in the first trimester and as early as possible in the late bookers.

- The offer acceptance/decline of screening should be documented in the pregnancy hand held notes and on the maternity information system (NSC leaflet 'Screening Tests for You and Your Baby' should be given at the point of offer).If the woman is un-booked and or her HIV status is unknown on admission, including if admitted in labour, a rapid test for HIV is recommended and a reactive result should be acted on immediately.

- Pregnant women who are HIV positive should have additional blood tests for hepatitis C, varicella zoster, measles and toxoplasma.

- Hepatitis B and pneumococcal vaccination is recommended for all individuals who are HIV positive and can be safely administered in pregnancy(this will be arranged if required with collaboration between BBV team and Consultant Obstetrician).Influenza vaccination can also be safely administered in pregnancy and the decision to immunise depends on the time of year.

  Any declines for HIV screening will be followed up by the Screening Coordinator.

Informing the woman and the relevant staff of HIV positive result

- All HIV positive results are conveyed from WAHNHST virology lab to the Antenatal Screening Coordinator via email/phone.

- The screening coordinator informs the Consultant in Infectious Diseases and Obstetric Consultant of result via email.

- The screening coordinator will arrange for the woman to attend the hospital within 10 working days for the results to be discussed and make a plan of care (this is either with the screening coordinator or the Obstetric Consultant).

- The Blood borne Virus (BBV) Team arrange a separate appointment with the woman to attend their specialist clinic.. At this appointment any additional bloods that will be required will be organised by this team.

Maintaining Confidentiality, Disclosure & Recording HIV status

- It has to be recognised that HIV status is still seen as a sensitive issue by many people in society and maintaining confidentiality is very important. Women should be reassured that they will receive a confidential service. However the information relevant to the pregnancy and treatment will be discussed within the MDT. Woman's permission will be sought before speaking to anyone else. It is good practice for the care to be shared by as small a team as possible.

- Positive HIV result should be documented on the alert sheet in the front of the Hospital Records and on the maternity information system (Bluespier) and note whether any of the woman's family are aware of the diagnosis.

- It is important that sufficient information is recorded in the notes to ensure appropriate care if a woman is admitted unexpectedly.

- Information about how the client wishes to be contacted should be recorded, should this become necessary, i.e. phone call to mobile or home landline or by letter etc.

- All HIV positive pregnant women should be encouraged to disclose their HIV status to their partner but this may be viewed as a process rather than an event. The issue of disclosure of the HIV diagnosis to her partner should be handled with sensitivity.

- There are situations where a newly diagnosed HIV-positive woman refuses to disclose to a current sexual partner, or appears to want to delay disclosure indefinitely. This can give rise to very complex professional, ethical, moral and potentially, legal situations. There may be a conflict between the duty of confidentiality to the index patient and a duty to prevent harm to others. Breaking confidentiality in order to inform a sexual partner of the index patient's positive HIV status is sanctioned as a 'last resort' by both the WHO, GMC and BMA. However it is not to be taken lightly as it could have the negative impact of deterring others from testing due to fear of forced disclosure and loss of trust by patients in the confidential doctor–patient relationship. The woman must be told of the disclosure and the clinician must be prepared to justify it. Information must not be disclosed to others, for example relatives, who are not at risk of infection. It is important to accurately record discussions and disclosure strategy in difficult cases. Difficult disclosure cases should be managed by the MDT and advice may be sought from the trust legal department prior to disclosure. This allows consideration of different approaches and a shared responsibility for the process.

- Patients should be encouraged to inform the staff of their HIV status at the time of emergency admission as case notes may not be available at all times.

- **HIV- Antepartum care plan** should be commenced. It contains important information regarding patient's circumstances, treatment and latest blood results. This should be placed in the pink envelope in hospital held maternity records.

- **Multidisciplinary care:** HIV positive pregnant women should be jointly followed up by Consultant Obstetrician and Infectious Diseases Consultant.

- Women should be advised that appropriate management as mentioned below reduces risk of mother to child transmission from 25–30% to less than 1%:

➢ Anti-retroviral therapy as per BIHVA guidelines:

  - For women who require HIV treatment for their own health, their prescribed Highly active anti-retroviral therapy (HAART) regimen should be continued throughout pregnancy and postpartum.

  - For women who do not require HIV treatment for their own health, HAART should be initiated by week 24 at the latest and ideally between 16-20 weeks of gestation and discontinued at delivery.

➢ Appropriate management of delivery.

➢ Avoidance of breastfeeding,

- **Fetal Anomaly Screening:** The woman should receive the same pretest discussion as anyone else. A mid-trimester anomaly scans should be offered to all women in accordance with national guidelines for the general population

- **Prenatal Diagnosis by chorionic villus sampling (CVS) or amniocentesis:** It is recommended that women who are HIV positive and who are considering invasive diagnostic testing should be counselled in a tertiary fetal medicine unit and the advice of the HIV physicians sought about reducing the risk of HIV transmission. Ideally, with a lesser rate of transmission, an amniocentesis is the preferred method of diagnostic testing.

- **Antenatal Paediatric Referral:** should be completed at hospital booking visit and may need to be updated later in pregnancy if there is any change in the clinical situation.

  If a woman is diagnosed as HIV positive and also **misuses alcohol / illicit drugs,** drug and alcohol misuse MDT should also be involved in her care. See guideline on the management of drug / alcohol misuse in pregnancy

- **Screen for genital tract infection:** Women should be screened for genital tract infections at booking and again at 28 weeks. Any infection detected should be treated accordingly, even if asymptomatic.

- **Frequency of antenatal checks** should be dictated by the clinical picture. There is usually no clinical reason for the woman to be seen exclusively in a consultant antenatal clinic throughout the pregnancy. Shared care with the Community midwife is often perfectly appropriate up to 32 weeks unless otherwise indicated.

  External cephalic version can be offered to women with HIV if viral load <50

- **Fetal growth monitoring** should be as per the trust guidelines.

- **Multidisciplinary Team (MDT) Meeting** should be arranged after 24 weeks of gestation to plan care for on-going pregnancy and delivery. MDT should include Consultant Obstetrician, Consultant Physician Infectious Diseases (ID), HIV clinical nurse specialist, Screening Midwife, Antenatal clinic midwife, Anaesthetist, Consultant paediatrician, Pharmacist, infection control link midwife, CMW, Midwife from Delivery suite and postnatal ward. These meetings should share advice about the woman's needs and plan of care. The recommended plan of care will be recorded prominently in the obstetric notes. This should include details of any requests or concerns in relation to her care that the woman may have.

- **Medication:** After the MDT Pharmacy will provide medication for Mother and Baby and place on Delivery suite. If not available on Delivery Suite at time of admission contact Pharmacy for supply. If Pharmacy closed emergency drugs are available in Hospital emergency drugs cupboard via Hospital bleep holder. The on-call Pharmacist can be contacted out of hours via switchboard if needed.

NB: The appropriate medication and post exposure prophylaxis pack (P.E.P Pack) is permanently in stock in pharmacy and is also available in the emergency pharmacy cupboard. In the event of an unplanned admission of a woman already known to the team or a woman who has not been booked for care at any WAHNHST site anti-viral medication can be obtained out of hours, from the emergency pharmacy cupboard. The hospital bleep holder can be contacted and can collect this. The P.E.P. Pack can likewise be collected in the event of a needle stick incident.

- **Blood transfusion:** HIV positive patients must only receive CMV-negative blood products. Please inform Blood Bank of this necessity both on the request form and by telephoning blood bank directly.

- **Final viral Load:** If latest viral load at 36 weeks or later is undetectable no more bloods need to be taken prior to delivery but ensure adherence to medication. These women will need to take routine medication on the day of delivery

- **Mode of delivery:**

A decision on mode of delivery should involve the mother, the HIV Consultant and the Consultant Obstetrician in a detailed risk assessment. Decisions about mode of delivery depend on the woman's present and past obstetric history, her viral load, CD4 count, and her preferences. Decisions about mode of delivery may also be influenced by the knowledge that the woman will be returning to live in a part of the world where repeat caesarean sections are not easily available.

- Discussion regarding mode of delivery should take place by 28 weeks gestation and provisional plan documented in the patient's notes.

- Decision regarding mode of delivery should be reviewed at 34-36 weeks in pregnancy depending on viral load, obstetric indications and maternal preferences.

- For women with a plasma VL of <50 HIV RNA copies/mL at 36 weeks, and in the absence of obstetric contraindications, a planned vaginal delivery is recommended.

- For women with a plasma VL of 50–399 HIV RNA copies/mL at 36 weeks, pre-labour CS (PLCS) should be considered, taking into account the actual VL, the trajectory of the VL, length of time on treatment, adherence issues, obstetric factors and the woman's views.

- Where VL is >400 HIV RNA copies/mL at 36 weeks, elective caesarean section is recommended.

- This plan should be reviewed when the woman presents in labour, after confirming that any recently performed viral load.

- In the absence of a documented mode of delivery plan or, in the event of uncertainty about viral load results, urgent advice should be sought from the HIV physicians and the consultant Obstetrician.

- **VBAC** may be considered for women on HAART whose viral load is <50 copies/ml

- In addition to obstetric indication **Elective LSCS** is recommended for :

    - All women taking ZDV monotherapy

    - Women on combination therapy with detectable viraemia

- All women co-infected with Hepatitis C

- A course of Steroid injections are required for the woman if elective caesarean section is booked prior to 39 weeks gestation to promote fetal lung maturity.

Timing of Delivery

Decision regarding timing of induction of labour and delivery should be based on obstetric indications with the exception of delivery by elective caesarean section at 38 weeks to prevent labour and/or ruptured membranes for:

- Women taking HAART who have a plasma viral load greater than 50 copies/ml.
- Women taking ZDV monotherapy as an alternative to HAART.
- Women with HIV and hepatitis C virus co-infection.

Induction of labour

The decision for induction of labour should be made by the Consultant Obstetrician; There is no contraindication to membrane sweep or prostaglandin use in HIV positive women with undetectable viral load. IOL can be a lengthy process and often involves artificial rupture of membranes (ARM). Before arranging induction of labour consider carefully the timeframe during which you expect labour and delivery to be achieved. Membranes should be left intact as long as possible. See labour management below.

Antenatal admissions

HIV MDT including obstetrician, Physician, HIV clinical nurse specialist and infection control link midwife should be informed of all antenatal and Intrapartum admissions. If woman is admitted out of hours this should be done on the following working day.

- **Hyperemesis Gravidarum**

  There is increased incidence of vomiting in pregnancy while on Anti-retroviral therapy (ART). There are no known drug interactions between anti-emetics and ART. Fluid and electrolyte imbalance should be corrected, anti-emetics should be prescribed and HIV physician & clinical nurse specialist should be informed. May need to temporarily alter/ stop medication after discussing with HIV physician.

- **PET/ Sepsis/ Abnormal Biochemistry/Liver function tests**

  If a patient on antiretroviral treatment is admitted unwell for any reason (especially sepsis or pre-eclampsia), serum lactate, amylase and liver function tests should be checked in addition to any other indicated investigations. Lactic acidosis is a life threatening complication of antiretroviral therapy which it is important to exclude. Inform the infectious diseases team, on-call consultant and the consultant in-charge of antenatal care about the woman's admission.

  Abnormal LFT could be a sign of drug toxicity from antiretroviral therapy in women who present in the third trimester with signs and symptoms of pre-eclampsia, cholestasis or other liver dysfunction. Any woman presenting in the third trimester with vomiting, malaise or oedema should be investigated for acidosis, hepatitis, and pancreatitis and disseminated intravascular coagulation. An urgent opinion should be sought from the HIV physician.

- **Premature Labour (PTL)**

  Women should be counselled about the increased risk of preterm delivery associated with HAART. Preterm labour & delivery increases the risk of mother to child transmission.

  These women should be reviewed by the senior obstetric staff on-call, who should have a low threshold for diagnosing and managing preterm labour.

  There are no contraindications to the **use of short-term steroids** in women with HIV to promote fetal lung maturity where premature delivery is contemplated. Usual contraindications to the use of steroids apply. At gestations when antenatal corticosteroids are important for fetal outcome, careful consideration will need to be given to whether delivery should be delayed until these are effective. It is essential to liaise closely with infectious diseases consultant.

  All women with threatened or established preterm labour and those with preterm prelabour rupture of membranes (PPROM) should have a genital infection screen performed and any infections, even if asymptomatic should be treated.

- **In established PTL;** if most recent viral load is undetectable (<50)

  Treat as usual with corticosteroids.
  If SROM aim to deliver within 4 hours.
  If membranes are intact; Avoid rupture of membranes aim for vaginal delivery within 8 hours (consider Caesarean section)

Preterm pre-labour rupture of membranes (PPROM)

- If viral load is <50 (i.e. fully suppressed), there is a 1% risk of mother-to-child transmission following SROM for 4 hours. With unsuppressed viraemia, the risk increases by 2% every hour after that. Discuss the plan of care for this patient with the Consultant on call immediately PPROM is confirmed. Whether this is the case for patients with prolonged SROM is not clear.

- Contact the on call Infectious Diseases/GU Consultant with regard to IV zidovudine treatment if viral load is not fully suppressed or is unknown.

- For women presenting with threatened preterm labour, multidisciplinary team advice (consultant obstetrician, HIV physicians and paediatricians) should be sought so that, if preterm labour supervenes, there is a detailed plan of care.

- Infants born below 32 weeks of gestation may be unable to tolerate oral medication, so administering anti-retroviral therapy to the mother just before and during delivery will provide prophylaxis to the neonate.

- Where PPROM occurs before 34 weeks of gestation, oral erythromycin should be started. Consideration should be given to starting broad-spectrum intravenous antibiotics if any signs of chorioamnionitits. Evidence of chorioamnionitis and fetal distress are indications for prompt delivery. In other cases, the decision as to whether to expedite delivery should be made after multidisciplinary team consultation.

- Where PPROM occurs after 34 weeks of gestation, delivery should be expedited. Augmentation may be considered if the viral load is less than 50 copies/ml and there are no obstetric contraindications.

Term pre-labour SROM

- If viral load is fully suppressed (<50) on HAART, arrange augmentation with oxytocin immediately or consider delivery by emergency Caesarean section if vaginal delivery within 4 hours is very unlikely.

- If viral load is >50 (not fully suppressed) and the mother is taking HAART, delivery should be by emergency Caesarean section with IV Zidovudine.

HIV status unknown in labour

If the woman's HIV status is unknown, a rapid test for HIV is recommended and a reactive result should be acted on immediately. HIV positive who are diagnosed during labour, urgent advice should be sought from the HIV physicians regarding optimum HAART; if vaginal delivery is not imminent the woman should be delivered by caesarean section and where possible, should be timed with respect to anti-retroviral administration. A confirmatory test should be taken, together with samples for CD4 count, viral load and resistance testing. The paediatricians should be informed so that neonatal care can be planned**.**

Delivery by elective caesarean section

- Check the availability of the P.E.P. pack (in pharmacy emergency cupboard and A&E).

- Clerking, consent and preoperative preparation will be the same as for anyone else.

- Check latest viral load result when attend for clerking: If the woman has undetectable viral loads at 36 -38 weeks no more bloods need to be taken prior to the delivery but ensure adherence to medication. These women will need to take routine medication on day of delivery and will not need I.V Zidovudine prior to elective caesarean section.

- Women SHOULD always take their antiretroviral medication pre-operatively despite being "Nil by Mouth".

- Caesarean section should be performed by an experienced obstetrician.

- Blunt as opposed to sharp dissection should be favoured where possible and special care should be taken while opening the uterine cavity to avoid the risk of neonatal injury, which considerably increases the neonatal risk.

- **If required Intravenous Zidovudine in the perioperative period or Intrapartum period should be administered as follows:** Zidovudine 400mg in 200 ml 5% glucose (remove 90ml from a 250ml bag/bottle of Dextrose 5% and add 40ml of zidovudine injection 10mg/ml to give 400mg in 200ml). Give 2mg per kilo of current body weight for at least one hour (ie 1ml/kg of the above infusion over 1 hour) and then 1 mg per kilo per hour (0.5ml/kg/hour)until the cord is clamped.

  If intravenous ZDV is indicated, the infusion should be started 4 hours before beginning the caesarean section and should continue until the umbilical cord has been clamped.

Patients who require treatment with IV Zidovudine must be admitted the night before delivery so that the infusion of Zidovudine can be started early in the morning of delivery. An IV cannula should be inserted as a priority to enable treatment to be commenced promptly.

Intrapartum management & emergency caesarean section

- On admission to delivery suite check antenatal screening results. If no results available or client not screened check Hospital notes and ICE for results. Women who present in labour with unknown HIV status, including those who arrive un-booked and those who previously declined an HIV test, rapid/ same day test should offered.
- If accepts testing between 9-5pm take blood on clotted sample(Gel Gold Tube)

  Out of hours ring Consultant Microbiologist on call to request rapid test and take as above.

- If positive call Consultant ID/GU Physician to discuss treatment
- If the woman is known HIV positive, medication should be available on delivery suite.
- During pharmacy opening hours drugs available from pharmacy, out of hour's emergency drugs kept in Emergency drugs cupboard available through Hospital bleep holder.
- For all needle stick injuries P.E.P pack available in A&E department and emergency drugs cupboard.
- The woman should continue her antiretroviral therapy throughout the Intrapartum period.
- HIV positive woman admitted in labour with ruptured membranes is a medical emergency and should be dealt with urgency and as a priority.
- If labouring, the membranes should be left intact until delivery is imminent.
- External cardiotocography should be used where continuous electronic fetal monitoring is clinically indicated.
- Fetal scalp electrodes should not be used.
- Fetal blood sampling should also be avoided. It should be borne in mind that the risk of vertical transmission of HIV is increased after emergency vaginal obstetric intervention.
- Emergency caesarean section should be performed by the most experienced obstetric staff available.
- Maternal blood should be sent for plasma viral load as soon as possible after delivery.
- Inform the Neonatal Unit that this patient is in labour so that neonatal antiretroviral treatment can be promptly prescribed and administered.
- Please discuss any HIV patient in labour with the Consultant Obstetrician on call so that a plan of care can be made.

- Duration of ruptured membranes- If viral load is <50 (i.e. fully suppressed), there is a 1% risk of mother-to-child transmission following SROM for 4 hours. With detectable viraemia, the risk increases by 2% every hour after that. Discuss the plan of care for this patient with the Consultant on call immediately SROM is confirmed.

- Length of labour In order to reduce mother-to-child transmission, established labour should be limited to 8 hours duration. Membranes should be left intact for as long as possible. This may require the use of oxytocin with intact membranes.

- Once labour has been established for 8 hours with no prospect of imminent delivery, emergency Caesarean section should be considered and discussed with the Consultant Obstetrician on call.

- Fetal Monitoring HIV infection per se is not an indication for continuous electronic fetal monitoring. EFM should only be used for obstetric indications.

  Fetal scalp electrodes (FSE) and fetal blood sampling (FBS) should be avoided (increased risk of mother-to child transmission).

- Instrumental delivery Ventouse deliveries should be avoided if possible to avoid scalp trauma. Episiotomy is not contraindicated. A minority of ventouse deliveries may be achieved with an intact perineum, but there may be more trauma to the fetal scalp than with forceps.

- Third stage the third stage of delivery should be actively managed to minimize the risk of post-partum haemorrhage. In particular, an oxytocin infusion (40 units' oxytocin in 500ml 0.9% Saline) should be considered following caesarean section.

- Analgesia There is no contraindication to any type of analgesia routinely prescribed during labour

Post-partum management of HIV positive woman

- A single room is not essential but it is preferable to facilitate confidentiality.
- Women should be given supportive advice about formula feeding. HIV positive mothers should be strongly advised not to breast feed. Breast milk substitutes are usually recommended. Discussion should include any issues that the woman may have regarding infant formula feeding, such as cost of formula milk and equipment, or pressure from family members to breastfeed.
- An immediate dose of Cabergoline 1mg should be given to suppress lactation
- Contraceptive advice should be given in immediate postpartum period
- MMR & Varicella zoster immunisation may be indicated according to CD4 count

Care of the baby at delivery

See also SWMNN Guideline for the management of infants born to an HIV positive mother

http://www.newbornnetworks.org.uk/southern/

- As with other routine antenatal serology, maternal HIV status should be recorded in neonatal notes.
- Prompt consideration should be given to testing any newborn infant whose mother's HIV status is unknown (and especially if she has repeatedly declined the antenatal testing).
- Paediatrician to attend delivery.
- Cord should be clamped as soon as possible after delivery and cut with care to avoid contamination with maternal blood.
- Resuscitation should be as gentle as possible to maintain the infant's skin integrity and avoid contamination with maternal blood.
- Bath baby immediately after delivery.
- **Send cord blood** to Microbiology for HIV testing. This should be marked with biohazard stickers.
- Vitamin K injection should be given (with the parents' permission) after the baby has been bathed.

Management of HIV – Positive women with Herpes

Management of Genital Herpes in Pregnancy guideline – a consensus guideline between the British Association for Sexual Health and HIV (BASHH) and the Royal College of Obstetricians and Gynaecologists (RCOG) published in 2014 – This covers a section on the management of HIV-positive women with genital herpes.

See the link below to read the guideline

https://www.rcog.org.uk/globalassets/documents/guidelines/management-genital-herpes.pdf

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD_____ CONS_____

Worcestershire NHS
Acute Hospitals NHS Trust

PERINATAL RETROVIRUS INFECTION
ANTEPARTUM CARE PLAN

EDD: ...../...../.....

SPECIALIST CARE TEAM

Specialists	Name	Contact Number
Midwives*		
Obstetrician		
GU / ID Physician		
Paediatrician		
Paediatric Nurse		
Pharmacist		

* The named midwives can usually be contacted between 09:00 and 17:00 hours Monday to Friday.

Date of Diagnosis: ...../...../.....

Timing of diagnosis: ☐ Prior to pregnancy **OR** Gestation at diagnosis ..... wks

GP ☐ Aware ☐ Not aware

Family ☐ Aware ☐ Not aware *(tick this if any members unaware)*

Birth Partner ☐ Aware ☐ Not aware

Name: .....

ANTENATAL DISCUSSIONS

	DISCUSSED
Vertical Transmission	☐
Antiretroviral Therapy (ART)	☐
Management of Labour/Mode of Delivery	☐
Criteria for trial of vaginal birth	☐
Benefit of Caesarean section if above criteria not met	☐
Avoidance of breast feeding	☐
Neonatal ART	☐

ANTENATAL CHECKLIST

Paediatric alert forms ☐ Booking ☐ 36 weeks

GU infection screens taken ☐ 28 / 40

36 week pre-delivery blood tests taken: Date:.....

CD4 count ☐ Sent

Viral load (Ultra-sensitive assay) ☐ Sent

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD_____ CONS_____

ANTI RETROVIRAL DRUGS

Drug	Dosage	Frequency	Gestation when started **or** pre-pregnancy

BLOOD TESTS

Date	Gest. (wks)	CD4	Viral Load	Hb	Platelet	WCC	Other	Initials

SWABS

Date	Gest. (wks)	Chlamydia	BV	GC	H.S.V	T.V	Result Treated
							☐ No ☐ Yes
							☐ No ☐ Yes
							☐ No ☐ Yes