Preventing Perinatal HIV Transmission Institute
Session 3: Getting to Zero - Practical Approaches in Preventing Perinatal HIV Transmission

Friday, December 14, 2018

HIV/AIDS Bureau (HAB)
Health Resources and Services Administration (HRSA)

Division of HIV/AIDS Prevention (DHAP)
Center for Disease Control (CDC)

Disclosures

Presenter(s) has no financial interest to disclose.

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Commercial Support was not received for this activity.

Learning Objectives

At the conclusion of this activity, the participant will be able to:

Understand Elimination of Mother to Child Transmission Framework

Explore how capacity building assists in leveraging agency resources and provider skills

Examine opportunities for collaboration between federal partners

Obtaining CME/CE Credit

If you would like to receive continuing education credit for this activity, please visit:

http://ryanwhite.cds.pesgce.com

Health Resources and Services Administration (HRSA) Overview

- Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically vulnerable through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

- Every year, HRSA programs serve tens of millions of people, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care

HIV/AIDS Bureau Vision and Mission

Vision

Optimal HIV/AIDS care and treatment for all.

Mission

Provide leadership and resources to assure access to and retention in high quality, integrated care, and treatment services for vulnerable people living with HIV/AIDS and their families.

Ryan White HIV/AIDS Program

- Provides comprehensive system of HIV primary medical care, medications, and essential support services for low-income people living with HIV
  - More than half of people living with diagnosed HIV in the United States – more than 550,000 people – receive care through the Ryan White HIV/AIDS Program
- Funds grants to states, cities/counties, and local community based organizations
  - Recipients determine service delivery and funding priorities based on local needs and planning process
- Payor of last resort statutory provision: RWHAP funds may not be used for services if another state or federal payer is available
- 84.9% of Ryan White HIV/AIDS Program clients were virally suppressed in 2016, exceeding national average of 55%

Source: HRSA. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2015; CDC. HIV Surveillance Supplemental Report 2016;21(No. 4)

HRSA Ryan White & Global HIV/AIDS Programs

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Updated Perinatal HIV Prevention Framework & Priorities

- **Margaret Lampe, RN, MPH, CPH**
- *Perinatal HIV Activity Lead*
- *Division of HIV/AIDS Prevention; Centers for Disease Control and Prevention*

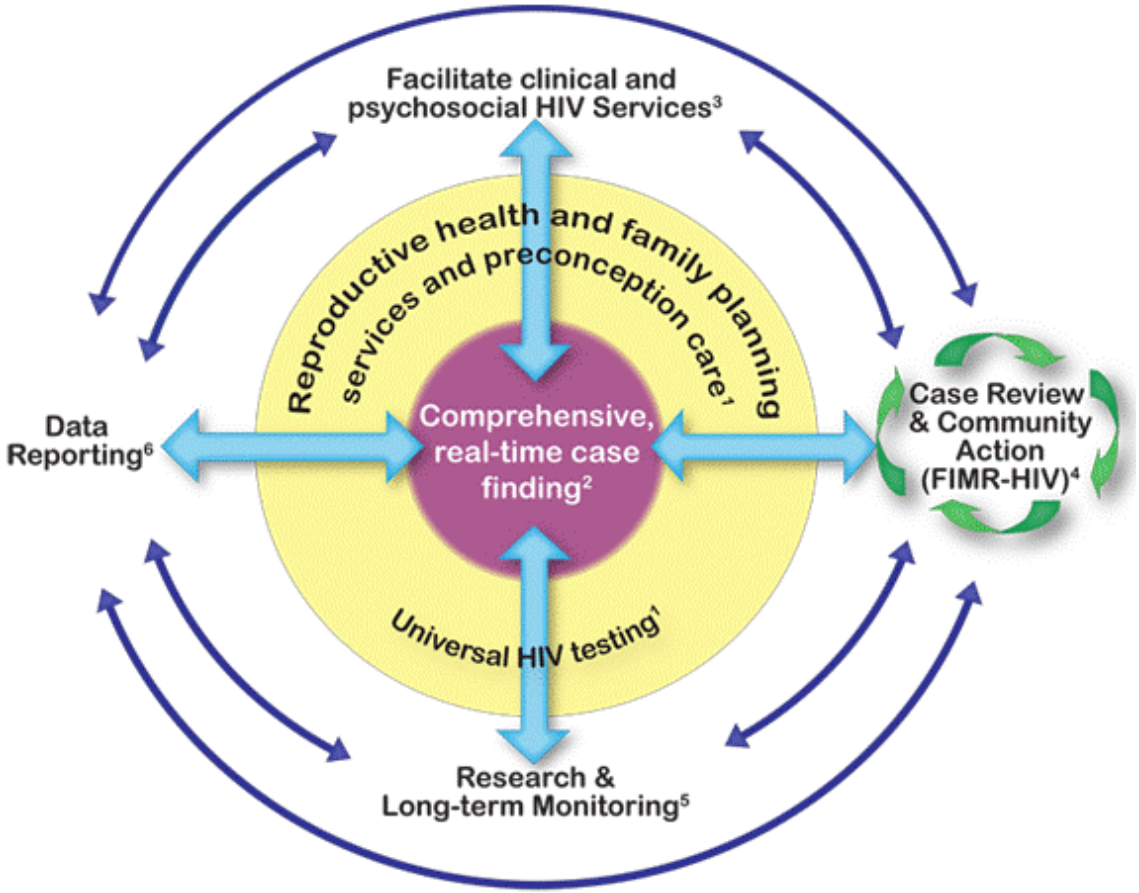
HRSA Ryan White & Global HIV/AIDS Programs

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Describe three HIV disparities among US women
2. Describe three objectives of CDC's updated perinatal HIV prevention framework
3. Understand three priorities for advancing perinatal HIV prevention in the United States

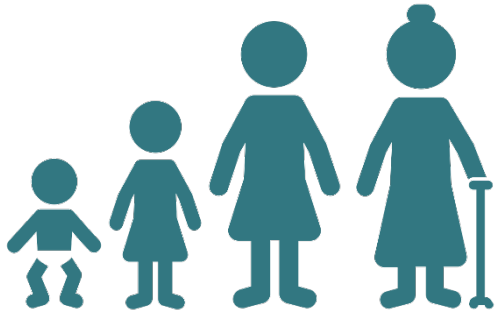
Framework to Eliminate Perinatal HIV Transmission in the United States. v. 1.0



Nesheim S, Taylor A, Lampe M, et al. Pediatrics. Vol 130, Num 4, October 2012.

Life Course Theory

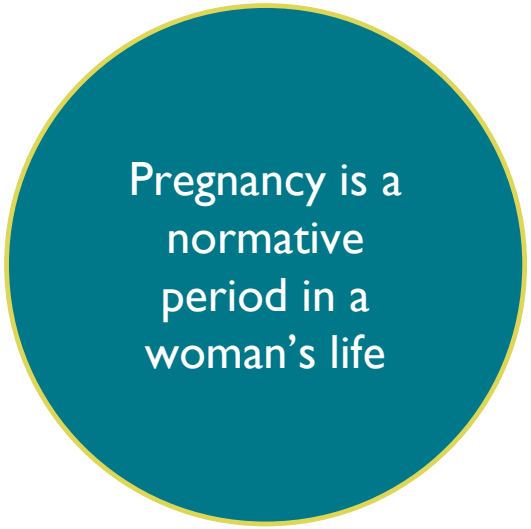
- **Conceptual framework used to explain health and disease patterns**
  - Health status is a continuum connected throughout the life course
  - Physical or social exposures during transitionary periods have long-term health consequences
- **Challenges western medical model**
- **Used to understand health disparities**



Ben-Shlomo et al. (2002). A life course approach to chronic disease epidemiology. *International Journal of Epidemiology*, 31(2), 285-293

World Health Organization. (2000). The implications for training of embracing a life course approach to health.

Life Course Theory and Perinatal HIV Transmission



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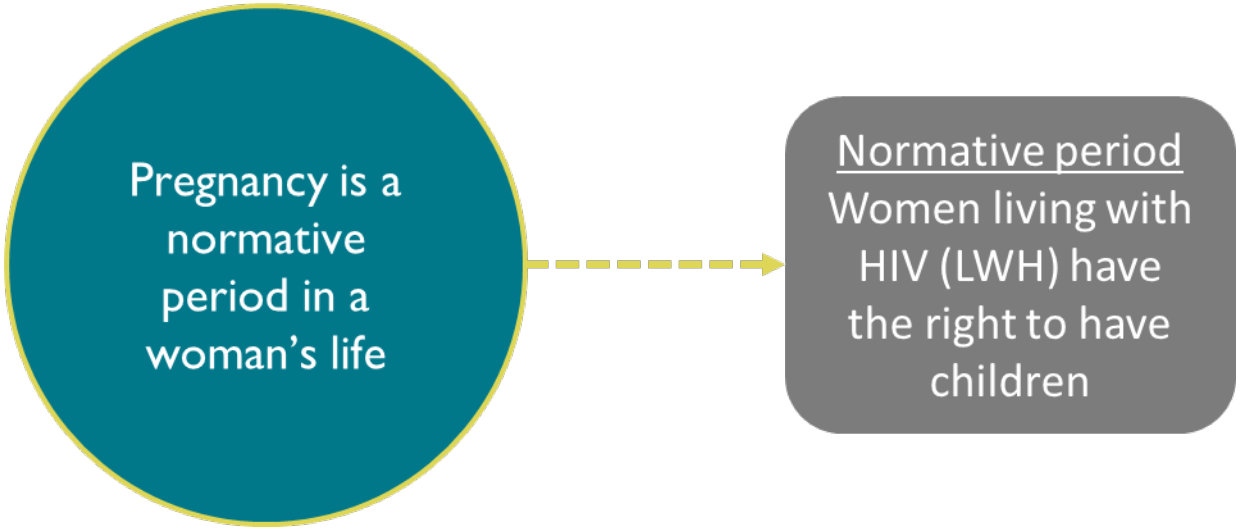

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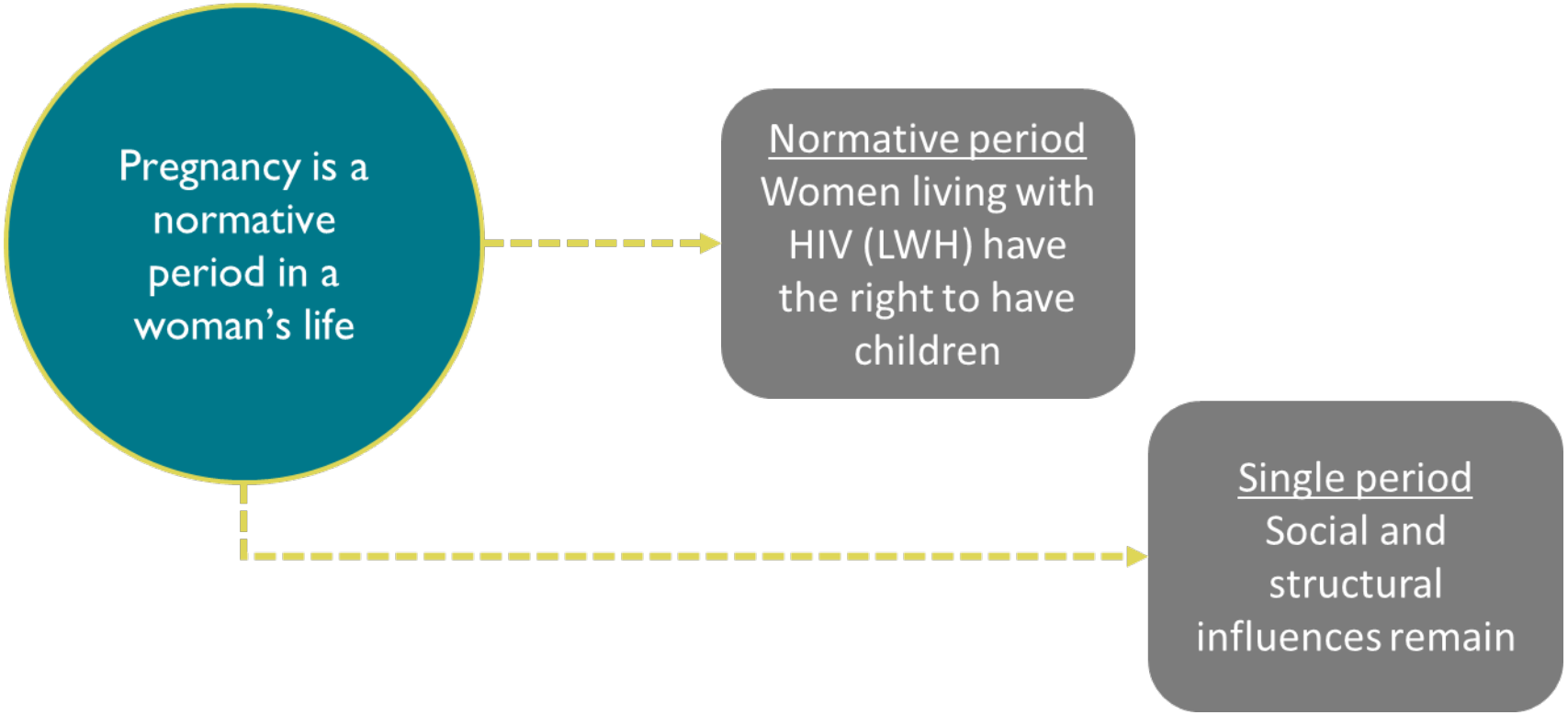

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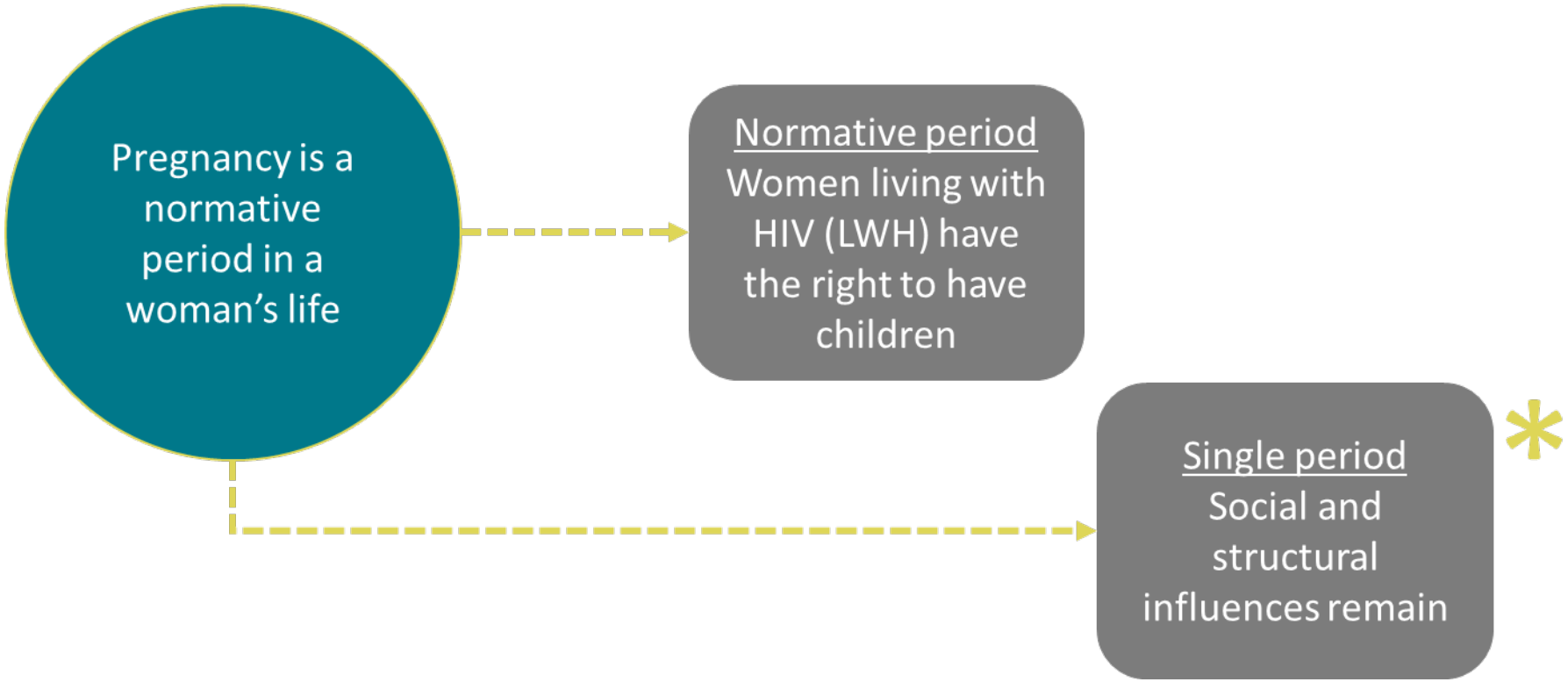
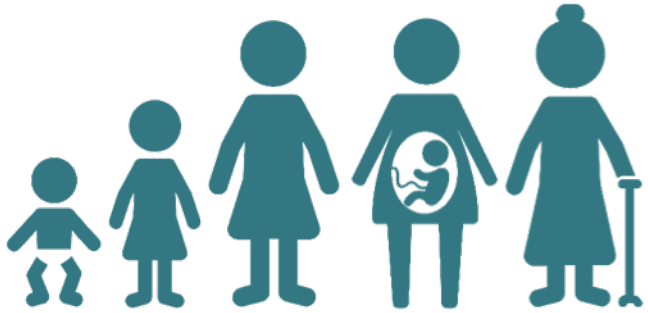


Pregnancy is a *Single* Period

- **Early diagnosis and linkage to care before pregnancy are critical**
- **Among all women**
  - 88% received HIV diagnosis
  - 64% received some care
  - 50% retained in care
  - 48% virally suppressed
- **Social and structural determinants prevent access to care**



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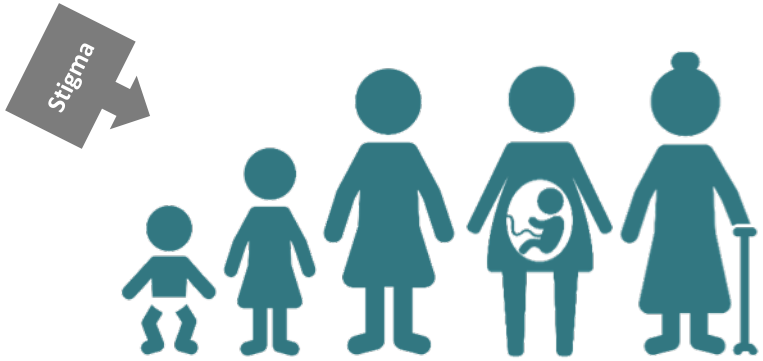

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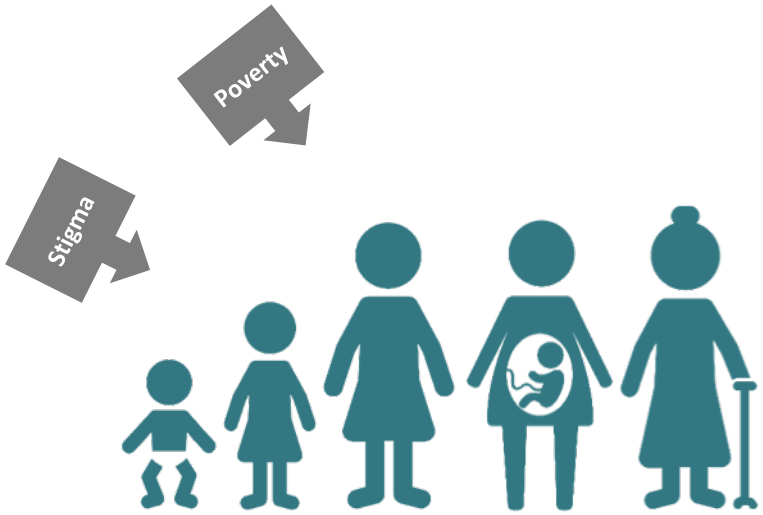

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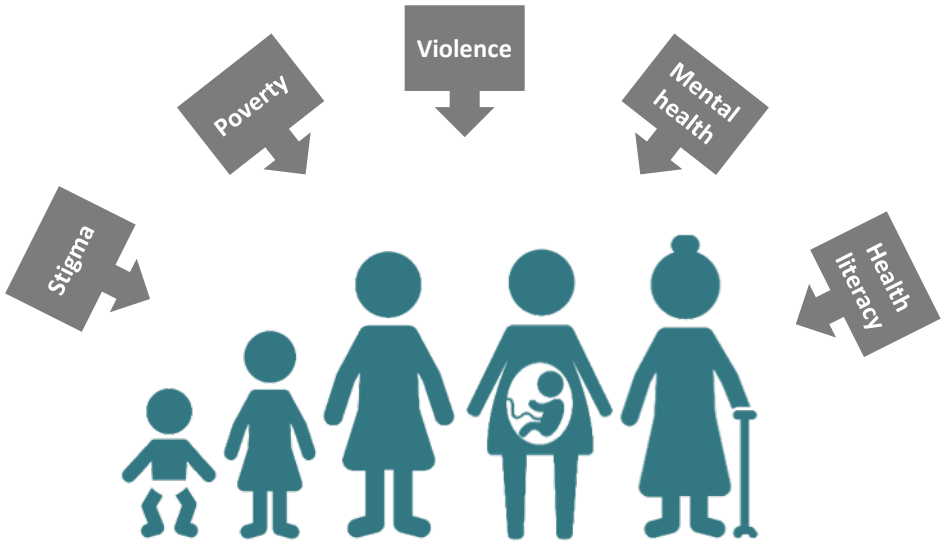

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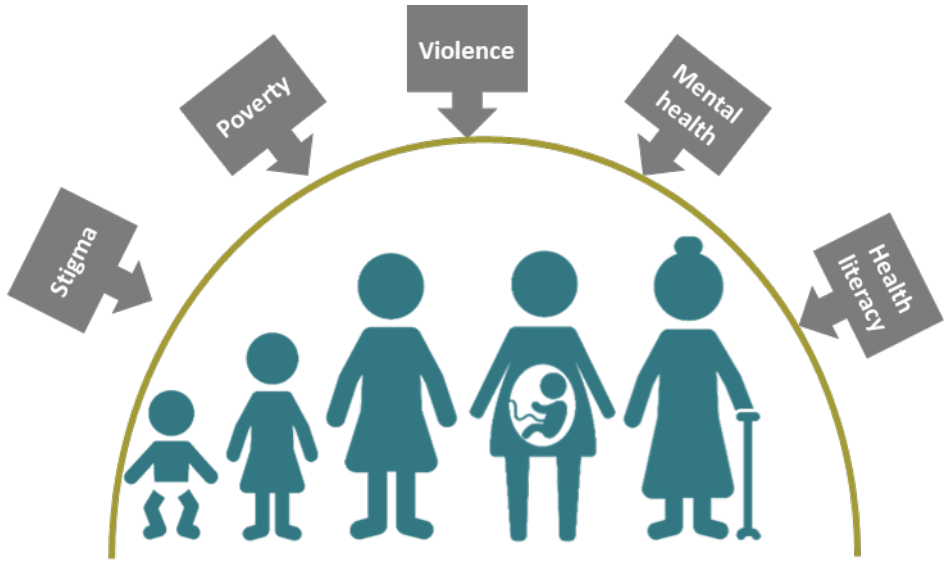

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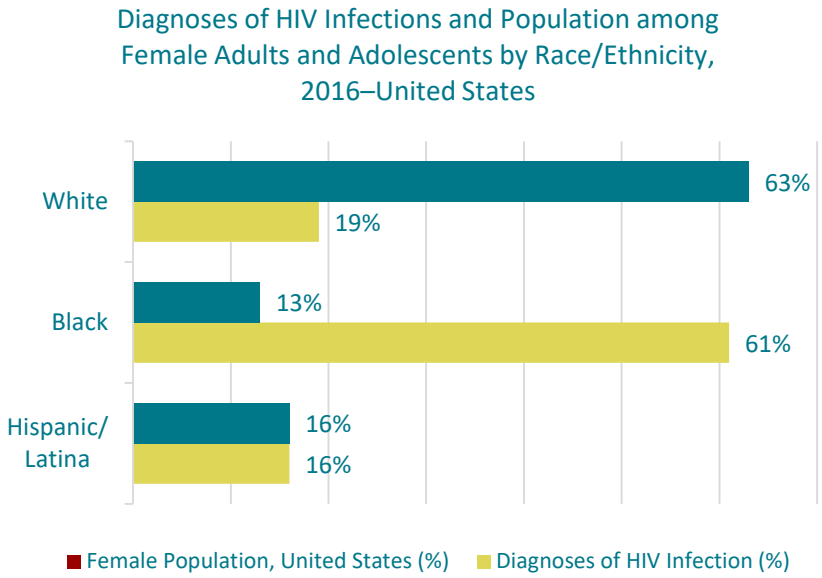
HIV Disparities among Women in the United States

- **Among women, black women**
  - Disproportionately diagnosed
  - Proportionally fewer engaged in care, virally suppressed
- **Social and structural determinants prevent access to care**
- **Strategies transmission that reduce HIV disparities among women will reduce disparities in perinatal**



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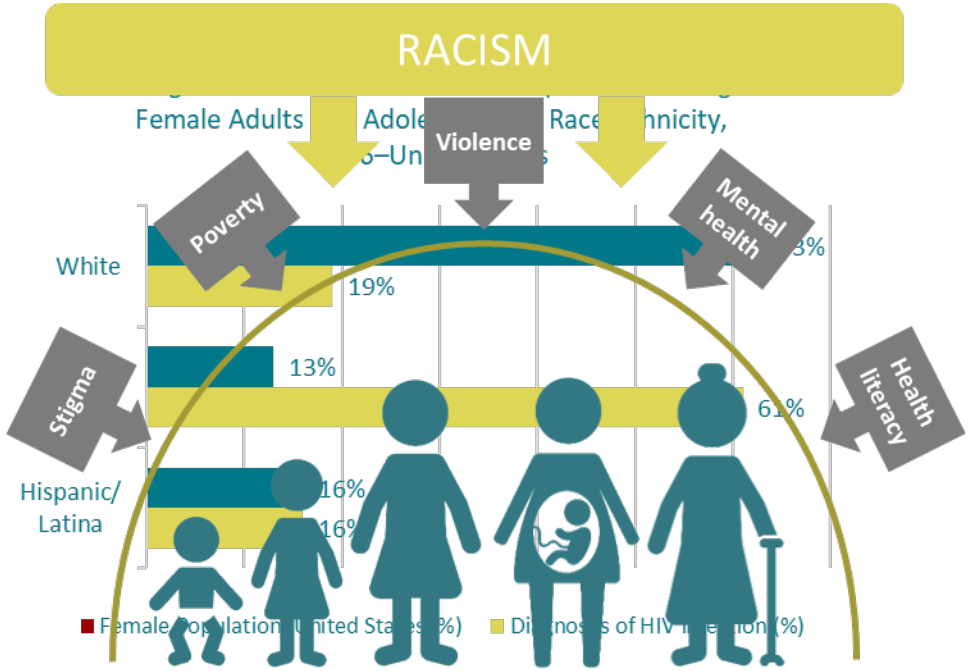

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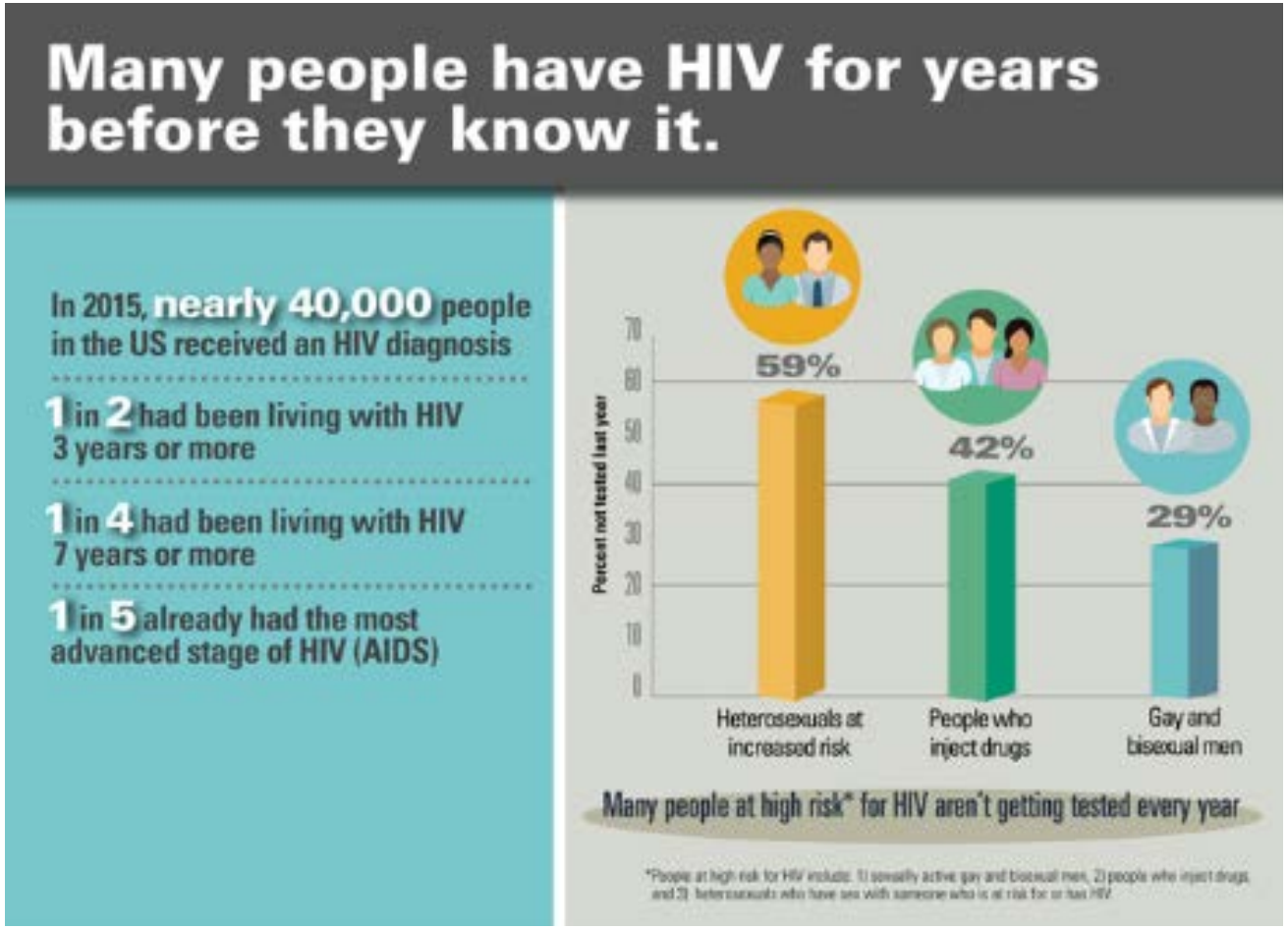

Median years with HIV at time of diagnosis among males, 2015

Heterosexual contact:
4.9 years

Male-to-male sexual contact:
3.0 years

Vital Signs: Human Immunodeficiency Virus Testing and Diagnosis Delays — United States
MMWR. 66(47);1300–1306

10 Objectives

- Decrease the time to diagnosis for men who have sex with women (MSW) & for women living with HIV
- Increase rates of viral suppression among MSW and CBA women
- Increase access to and utilization of preconception care and family planning services among MSW and CBA women living with HIV
- Decrease HIV incidence among MSW & CBA women
- Decrease # unintended pregnancies among women living HIV+ pregnant women/exposed infants

10 Objectives (Cont'd)

- Increase % pregnant women with HIV known to Health Departments
- Increase rates of HIV testing among pregnant women
- Improve measures of the perinatal HIV prevention cascade
  - Increase the # of pregnant women with HIV who are virally suppressed, have a cesarean delivery as indicated, and whose infants receive ARV prophylaxis and/or ART (cascade)
- Maintain or reduce the number of infants with perinatal HIV
- Increase % of infants with HIV who are in "remission"

Three priorities

1. Improve Perinatal HIV Surveillance Systems

2. Integrate and Improve HIV and Mental Health/Substance Abuse Care

3. Provide Comprehensive Treatment and Prevention Services for HIV and Sexual & Reproductive Health

Capacity Building to Leverage Resources and Skills

Explore how capacity building assists in leveraging agency resources and provider skills to reduce perinatal HIV transmission

Question

Which of the following RWHAP Parts provides services to pregnant women and their infants?

A. Part A
B. Part B
C. Part C
D. Part D
E. All of the Above

Sharing Our Experiences

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Sharing Our Experiences

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Sharing Our Experiences

Suzanne Kaufman, MPH, BSN, RN, AACRN
Director, Perinatal HIV Prevention Program
NYS Department of Health | AIDS Institute | Division of HIV & Hepatitis Health Care
Suzanne.kaufman@health.ny.gov

Sharing Our Experiences

Partnerships:

- HRSA HAB with the University of California San Francisco - Perinatal HIV Hotline and Warm Line
- HRSA's Maternal Child Health Bureau (Title 5)
- HRSA's Office of Women's Health - Intimate Partner Violence can impact engagement in care with pregnant women when they are most vulnerable
- HRSA's Bureau of Primary Health Care

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Getting to Zero – Practical Approaches in Preventing Perinatal HIV Transmission

Carolyn Chu, MD, MSc, AAHIVS, FAAFP

Clinical Director, National Clinician Consultation Center (NCCC)

Consultant, National Perinatal HIV Hotline

HRSA Ryan White & Global HIV/AIDS Programs

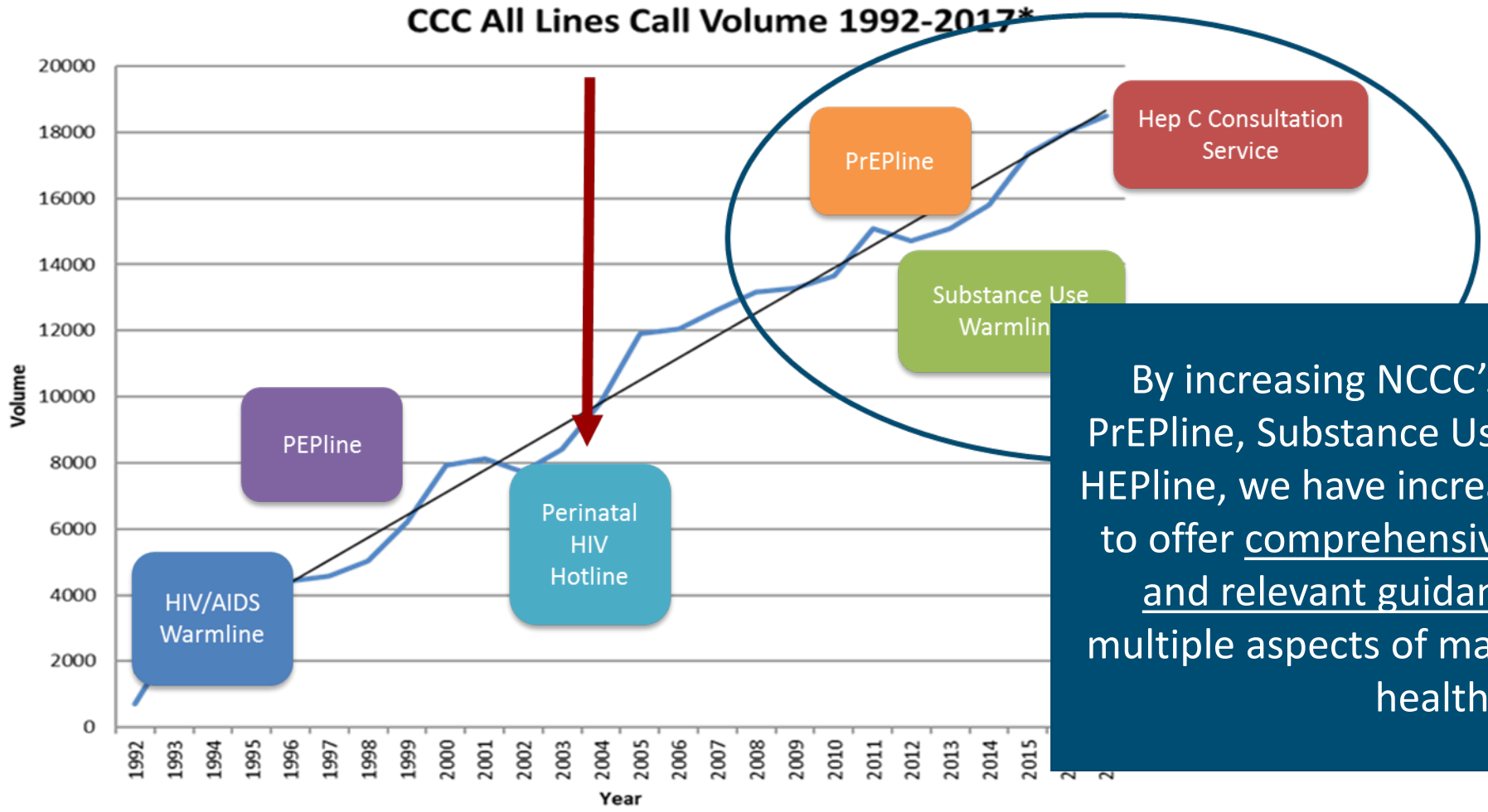
Who is the NCCC?

Our mission: *To improve health outcomes by building the capacity of healthcare providers through expert clinical consultation and education*

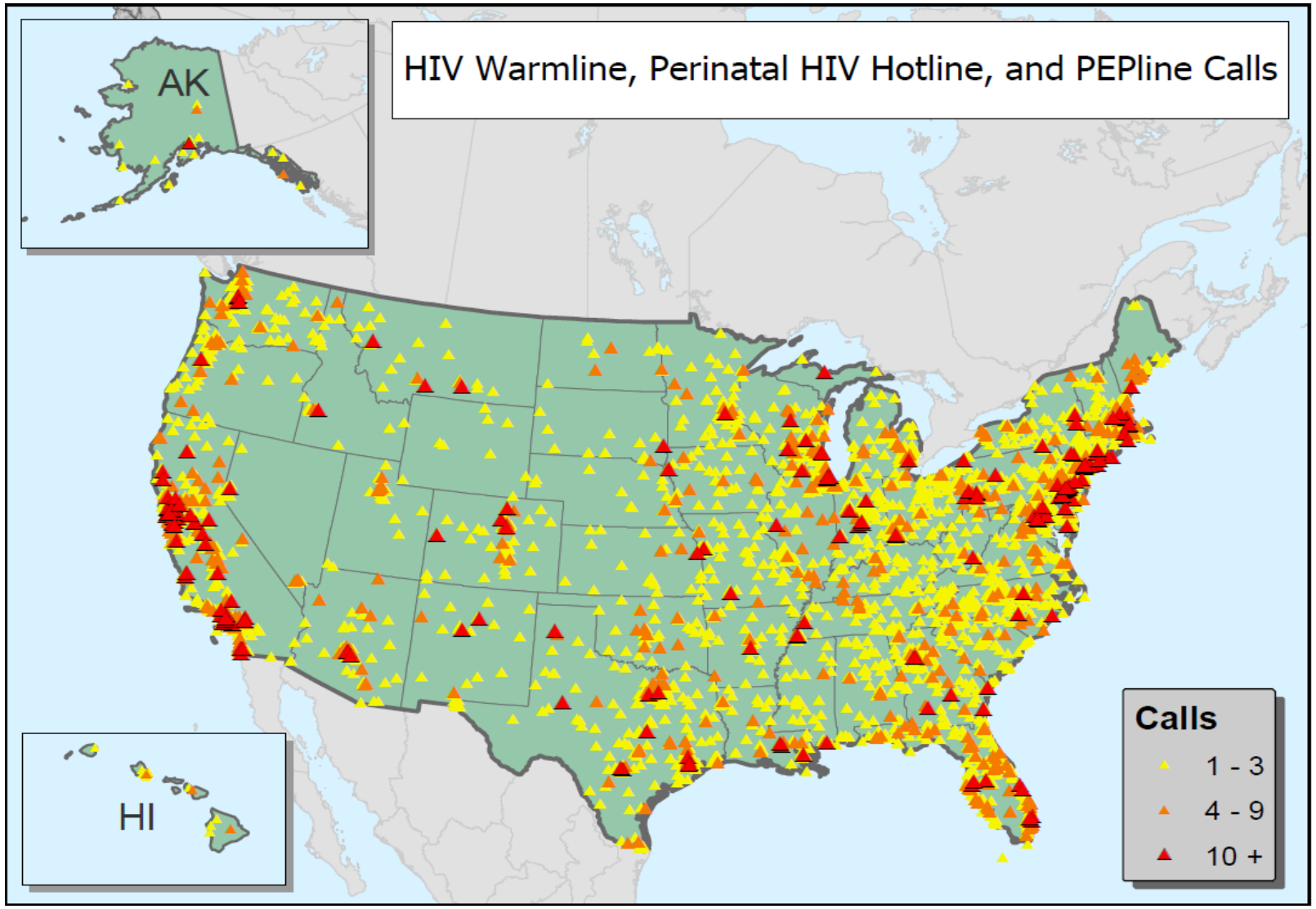
We are:

- The national tele-consultation/education arm of the AETC Program, offering FREE clinical decision support to U.S.-affiliated health care providers for 25+ years
- Composed of multi-disciplinary, inter-professional teams → 500+ collective years of direct clinical experience in HIV, viral hepatitis, and substance use
- A wrap-around/"one-stop" resource for expert-level, individually-tailored consultation
- Practical, and offer point-of-care guidance that can be implemented in resource-limited and resource-rich settings!

What does the NCCC do?



By increasing NCCC's scope via the PrEPline, Substance Use Warmline, and HEPline, we have increased our capacity to offer comprehensive, cutting-edge, and relevant guidance to address multiple aspects of maternal and infant health!



We can provide assistance to any type of clinical provider (regardless of their training, experience, and practice setting).

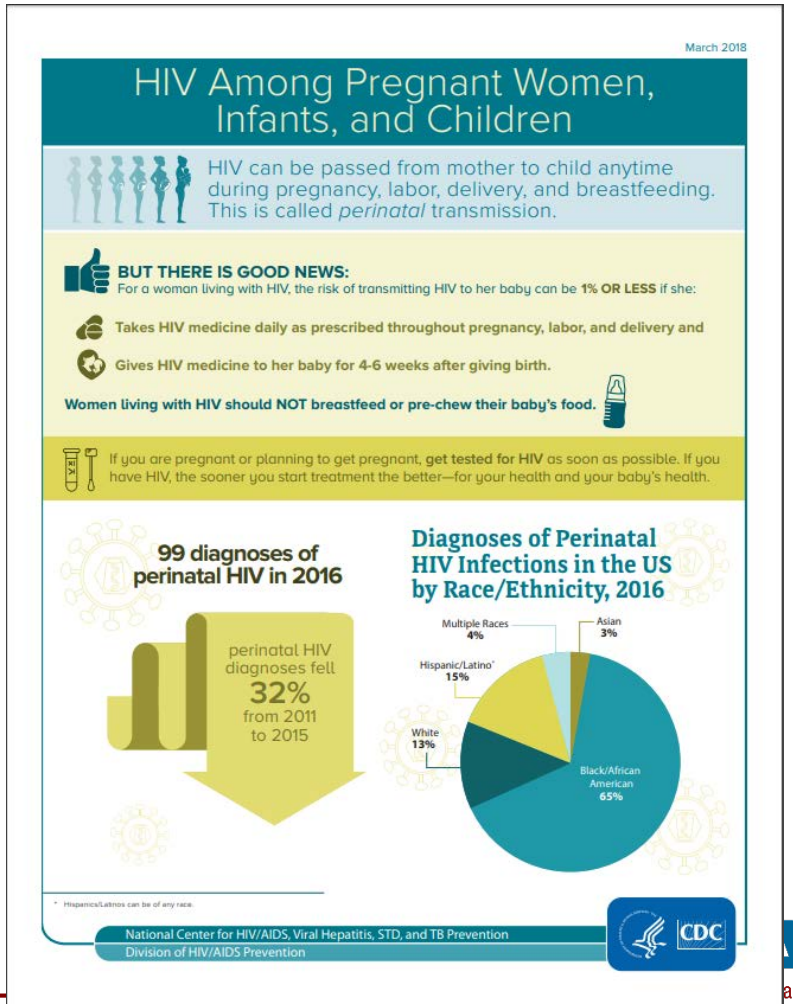
We are also a resource for the 6 U.S.-affiliated Pacific Jurisdictions as well as U.S. clinicians working abroad.

Why you should know about the National Perinatal HIV Hotline!

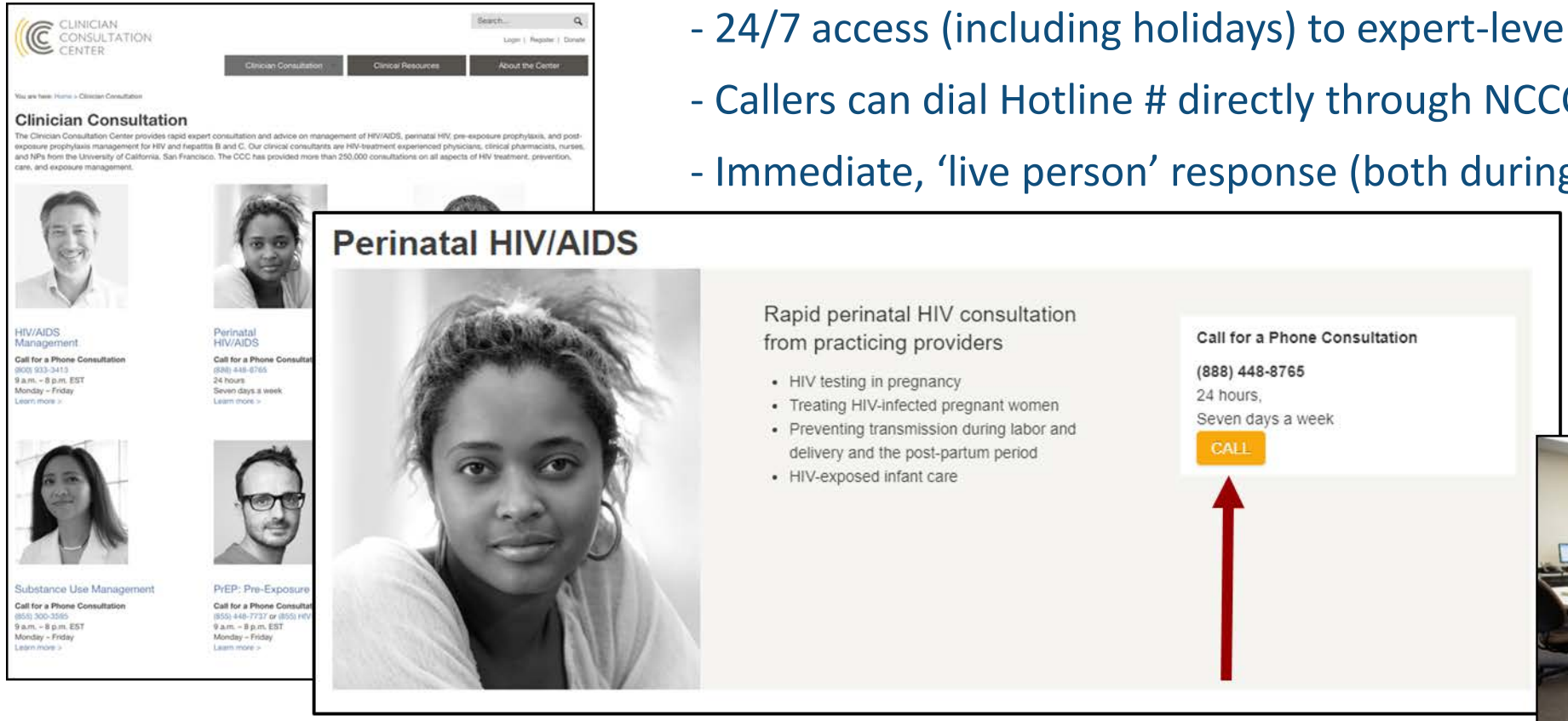
Treatment of women living with HIV who are pregnant/ postpartum (or desiring pregnancy) is a **quickly-evolving field**.

Management of HIV-exposed infants involves **critical decision-making that is timely and informed** by rapidly-changing research findings and best practices.

Many communities do not have robust local or regional knowledge, experience, and infrastructure to comprehensively prevent/address perinatal transmission.

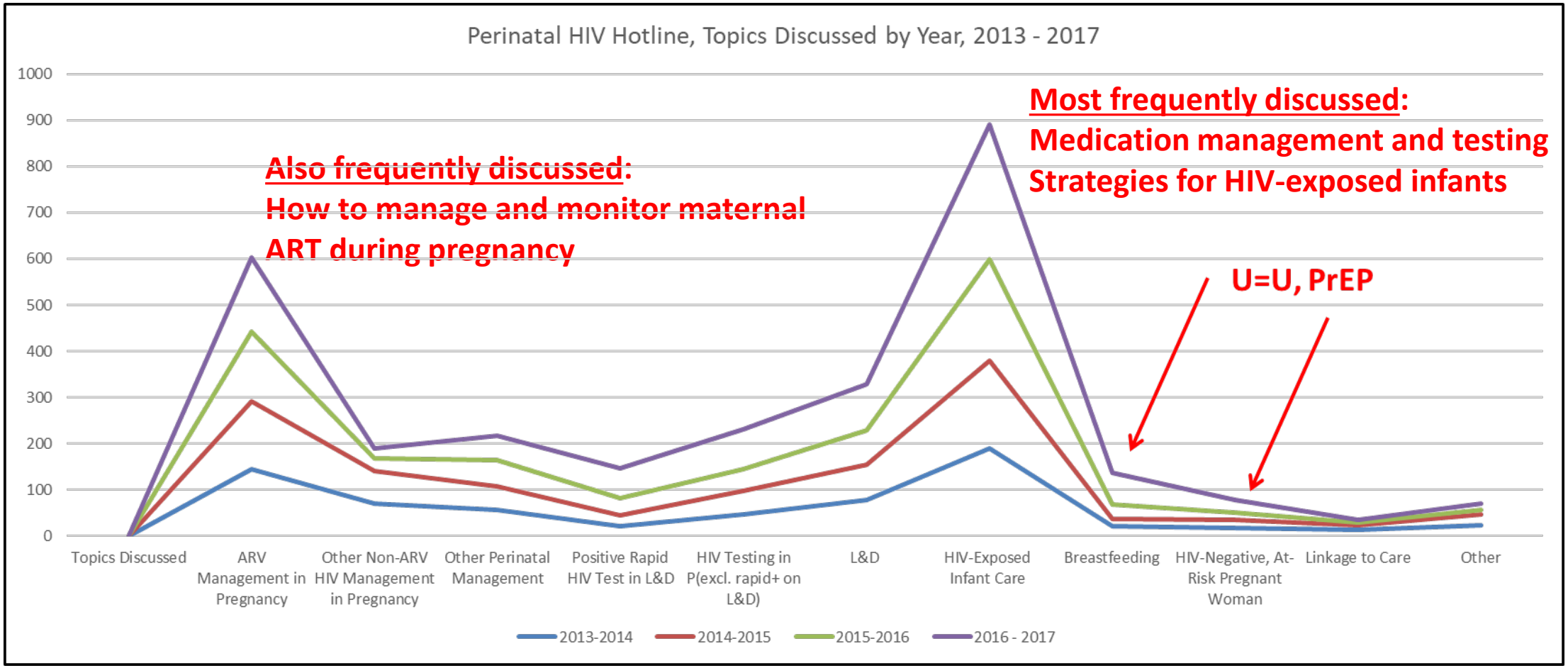


How does the National HIV Perinatal Hotline work?



- 24/7 access (including holidays) to expert-level clinical consultation
- Callers can dial Hotline # directly through NCCC website, nccc.ucsf.edu
- Immediate, 'live person' response (both during office hours & after-hours via answering service)

Trends in Hotline call topics



Case Study 1: How can our Hotline help YOU?

Integrate us into your EHR, protocols, and/or order sets! Although we do not record PHI, our case notes are highly organized and detailed; helps support "warm hand-offs"!

BAR CODE

NAME

DOB

MRN

PCP

T-PO0001

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Intrapartum Physician Orders for HIVE Patients Only
Family Birth Center

Patient ID/Addressograph

Adverse Drug Events (including allergies): _____
Non- Drug Allergies: _____
Patient weight: _____ kg

GENERAL Orders

☑ Alert HIVE clinical staff of admission (email: monica.hahn@ucsf.edu, phone: 415-813-1873 M-F 8a-5p)
☑ If HIVE clinical staff is unavailable and there are urgent clinical questions, call the National Perinatal HIV Hotline 1-888-448-8765, available 24/7.
☑ Weigh patient x 1

ANTIRETROVIRAL Orders

☐ **Zidovudine (AZT), IV:**
Loading dose: 2 mg/kg/hour = _____ mg over one (1) hour
Maintenance dose: 1 mg/kg/hour= _____ mg per hour until cord clamped

Patient should continue PO antiretrovirals with sips, even if NPO

Indication for antiretroviral medications: ☐ *Maternal prophylaxis (PrEP or PEP)* ☐ *Maternal treatment*

← HIVEonline.org

COMMONWEALTH HEALTHCARE CORP. • COMMONWEALTH OF THE NORTHERN MARIANAS • Established October 2011

HRSA
Ryan White & Global HIV/AIDS Programs

Case Study 2

Winter 2018 NCCC-Southeast AETC collaboration to develop and present month-long webinar series to increase provider awareness of, and knowledge regarding, perinatal HIV

Topics included: Pre-Conception

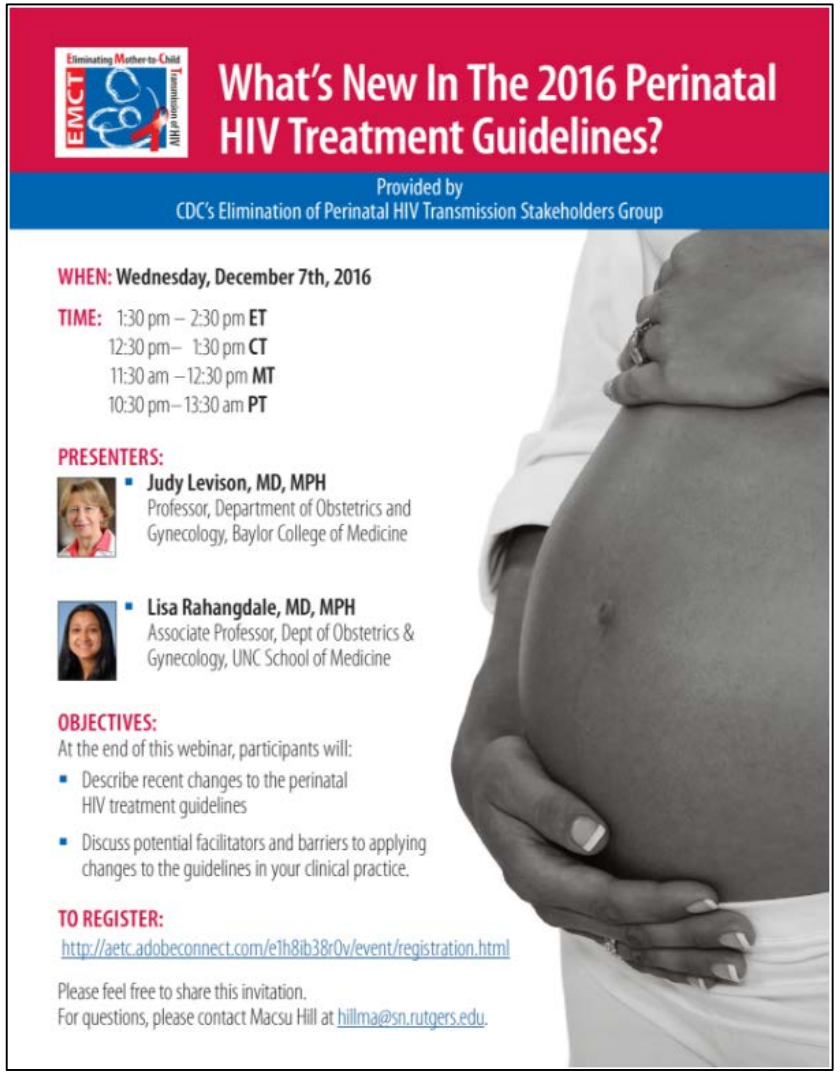
Pregnancy Management

Labor & Delivery

Postpartum Care

Care of the HIV-Exposed Infant

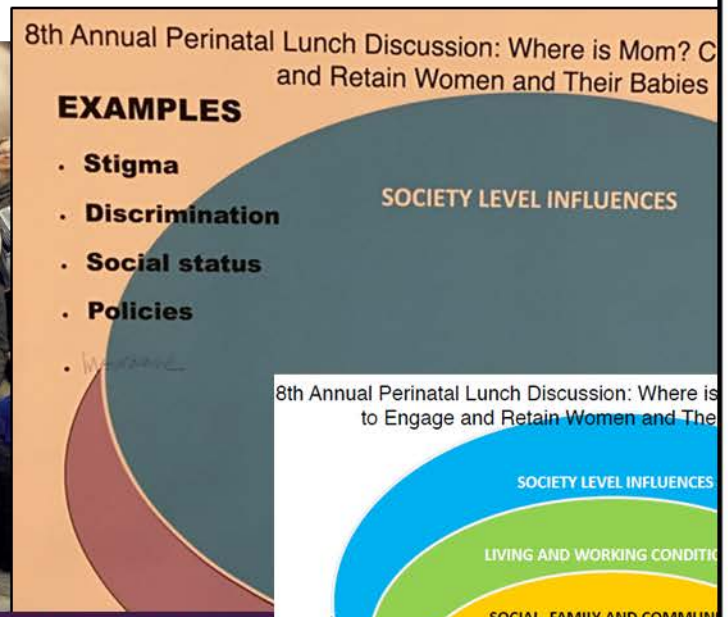
After webinar series, 36% increase in calls to Hotline from providers in Southeast U.S!

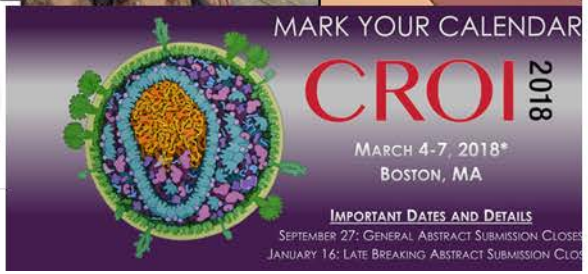


https://www.seaetc.com/education-training/archived-webinars/

Case Study 3

Join our national “ReproID Listserv”, and/or attend our annual CROI Perinatal HIV Hotline Roundtable!





Viewpoint

Does U=U for breastfeeding mothers and infants? Breastfeeding by mothers on effective treatment for HIV infection in high-income settings

Catriona Waitt, Nicola Low, Philippe Van de Perre, Fiona Lyons, Mona Loutfy, Karoline Aebi-Popp

Can the campaign Undetectable=Untransmittable (U=U), established for the sexual transmission of HIV, be applied to the transmission of HIV through breastfeeding? European AIDS Clinical Society and, to some extent, American guidelines now state that mothers with HIV who wish to breastfeed should be supported, with increased clinical and virological monitoring. This Viewpoint summarises existing evidence on transmission of HIV through breastfeeding, differences in HIV dynamics and viral load between breastmilk and plasma, and the effects of antiretroviral therapy on infants. At present, insufficient evidence exists to make clear recommendations for the required frequency of clinical and virological monitoring for mother and infant in a breastfeeding relationship or for the action to be taken in the event of viral rebound. We propose a roadmap for collaborative research to provide the missing evidence required to enable mothers who wish to breastfeed to make a fully informed choice.

Lancet HIV 2018
Published Online
June 27, 2018
http://dx.doi.org/10.1016/S2352-3018(18)30098-5

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cwaitt@liverpool.ac.uk

Background

In October, 2017, the European AIDS Clinical Society (EACS) stated that if "a woman insists upon breastfeeding, we recommend follow-up with increased clinical and virological monitoring of both the mother and the infant", in an updated guideline.[1] US guidelines were updated in March, 2018, to describe how to counsel and to support women who make this choice, while clearly recommending against breastfeeding in general.[2] These recommendations recognise both the increasing numbers of women with HIV who are virologically suppressed on combination antiretroviral therapy (ART) and wish to breastfeed their children, and the framework of respect for human rights.

Globally, effective cART in pregnancy and post partum has resulted in a marked reduction in rates of mother-to-child transmission (MTCT) of HIV, such that elimination of MTCT is now embraced as a realistic goal.[3] Since 2015, global guidelines have recommended that pregnant women with HIV start combination ART as soon as possible and remain on it for life.[4] MTCT rates less than 1% have consistently been reported from high-income countries where most mothers who are HIV-positive do not breastfeed.[5–7]

The updated US guideline states that women "who desire to breastfeed should receive patient-centred, evidence-based counselling on infant feeding options".[2] But do we know enough to provide this evidence-based advice? People who are HIV-positive and virologically suppressed on cART, cannot sexually transmit the virus to others. The Undetectable=Untransmittable (U=U) campaign, launched in early 2016,[8] led to changes in HIV prevention advice given to serodifferent sexual partners. The success of U=U for sexual transmission raises the question of its applicability to other contexts, such as in breastfeeding.

In this Viewpoint we address major questions that need to be answered to produce evidence-based recommendations for breastfeeding with HIV in high-income settings.

Breastfeeding guidelines differ between high-income and low-income regions

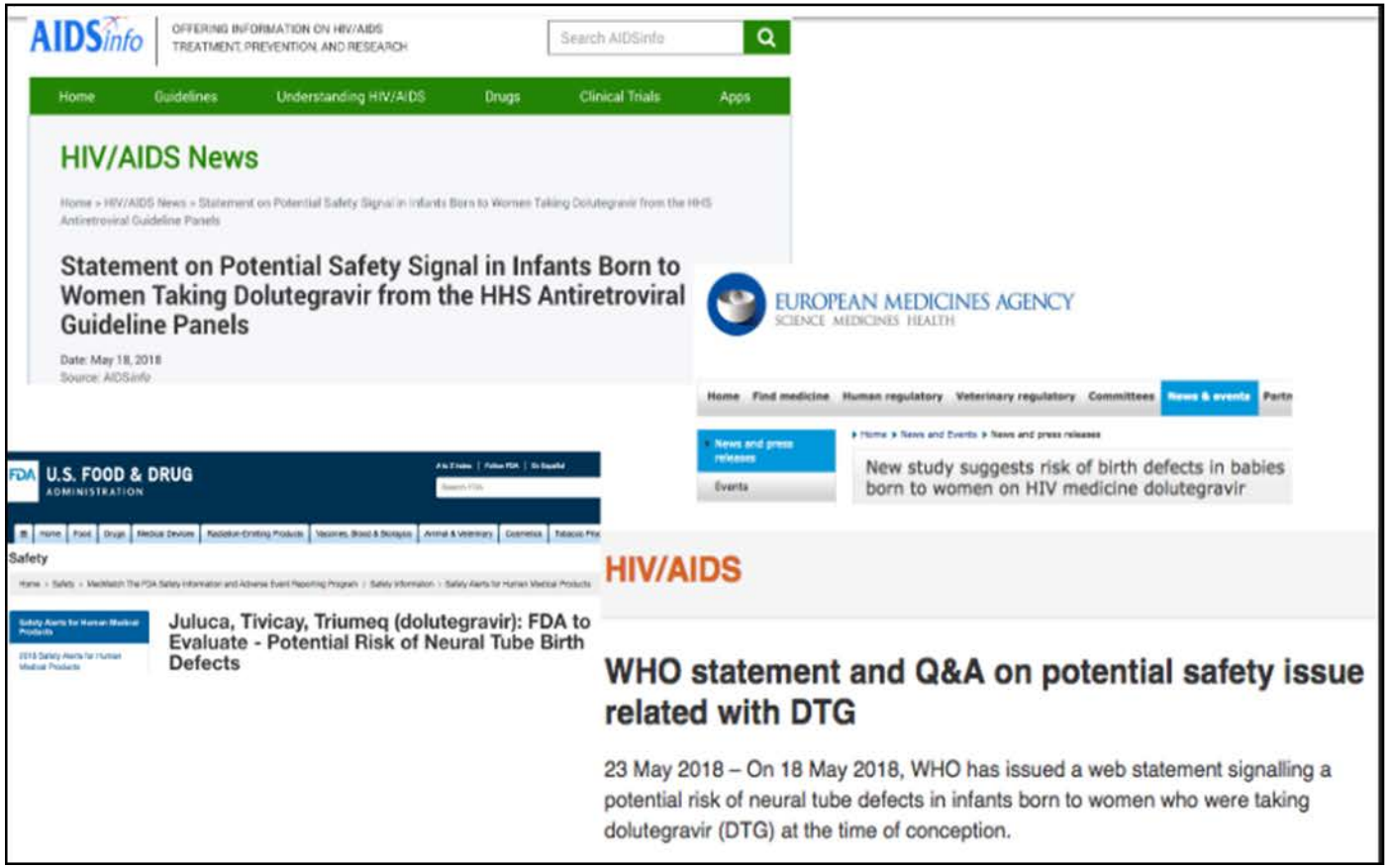
Clinical guidelines from high-income countries all recommend against breastfeeding with HIV, even though recent updates acknowledge that women who choose to breastfeed should be supported.[2,9,10] In low-income settings, WHO recommends breastfeeding for at least 6 months and continuing up to 12 months or 24 months.[11] The recommendations are based on the same sources of data, but the balance of benefit versus harm of breastfeeding differs. In low-income settings, the morbidity and mortality from infection in infants receiving formula milk outweighs the risks of HIV transmission through breastmilk, because of unclean water and lost protection from maternal antibodies in breastmilk.[12]

The risk of HIV transmission through breastfeeding

The risk of HIV transmission through breastfeeding in high-income countries remains unknown because randomised, controlled trials of prevention of MTCT (PMTCT) using combination ART are not feasible. A 2017 meta-analysis of six studies in low-income settings in which mothers started ART before or during their most recent pregnancy, estimated a postnatal HIV transmission rate of 1·08% (95% CI 0·32–1·85) at 6 months, with higher rates from mothers who commenced ART in the later stages of pregnancy.[13] The Promoting Maternal Infant Survival Everywhere (PROMISE) trial in southern Africa,[14] comparing maternal combination ART with prolonged infant nevirapine, (until 18 months post-delivery or cessation of breastfeeding) reported MTCT of 0·3% (95% CI 0·1–0·8) at 6 months and 0·7% (0·3–1·4) and 12 months in the maternal ART arm.[15]

Case Study 4

The NCCC is well-equipped to quickly disseminate systematic, informed guidance – recent example: dolutegravir and neural tube defect safety alert



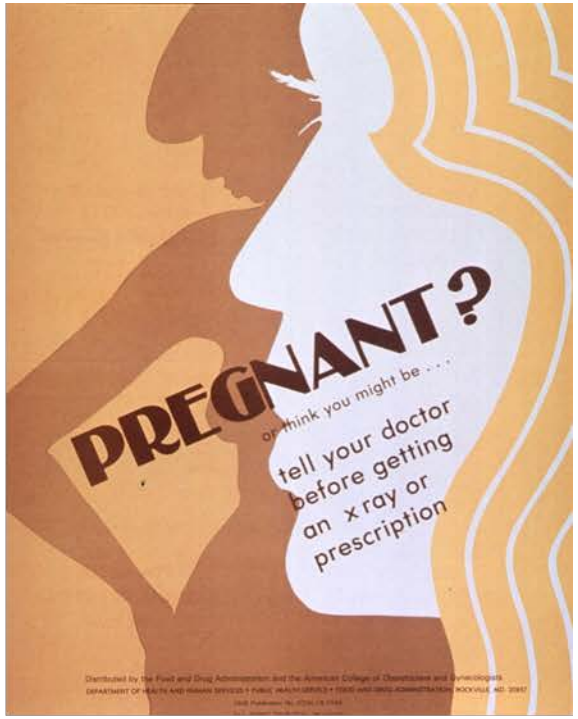


Image: National Library of Medicine

Caller Feedback

Excellent, timely, balanced advice while giving me freedom to decide in a "gray" situation. Very worthwhile service we are lucky to have! Thank you!

Very thorough, up to date, balanced information with the rare gift of presenting all that without saying there is only one correct answer. My patient delivered and her baby has had 2 negative [HIV] tests so far. Thanks very much for your help.

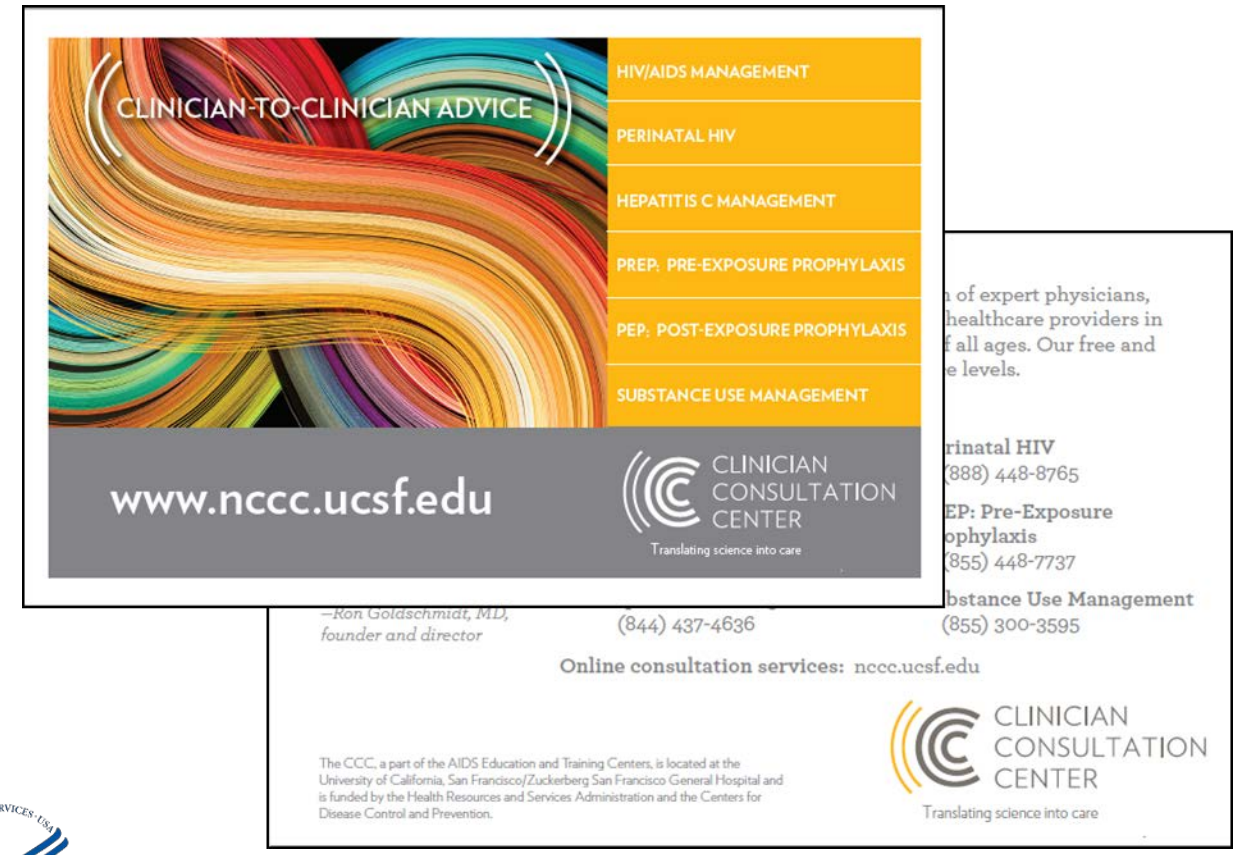
I am very grateful for the existence of the National Perinatal HIV Hotline. Even as a pediatric infectious diseases physician who cares for PLWH, I find the advice and experience of your consultants incredibly helpful for challenging situations.

Thank you. Everyone I dealt with was extremely professional and helpful. They provided verbal support and emailed additional literature for reference. I would highly recommend your service and will not hesitate to use it again.

Meet our team

Looking for Perinatal Hotline materials?

Contact Marliese.Warren@ucsf.edu or Carolyn.Chu@ucsf.edu



Thank you!

To learn more, go to: nccc.ucsf.edu

Perinatal HIV Hotline 888-448-8765
HIV Warmline 800-933-3413
PrEPline 855-HIV-PREP
HEPline 844-HEP-INFO
Substance Use Warmline 855-300-3595

QUESTIONS & ANSWERS

Contact Information

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Madia Ricks, OTCD	

Perinatal HIV Institute

- **Session 1 (12910): Where Are We Now?**
  Wednesday December 12, 2018 @ 1:30pm – 3:00pm

- **Session 2 (12871): Addressing the Missed Opportunities**
  Thursday, December 13, 2018 @ 1:30pm – 3:00pm

- **Session 3 (12908): Getting to Zero**
  Friday, December 14, 2018 @ 10:15am – 11:45am

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