Postpartum Care for Women Living with HIV

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I have no financial conflicts of interest to disclose.
WELCOME TO THE WEBINAR...
LET’S GET TO KNOW EACH OTHER A LITTLE BETTER
How would you best describe yourself?

1. Public health officer
2. Social worker
3. Case manager
4. Therapist
5. Physician
6. Nurse Practitioner or Physician Assistant
7. Midwife
8. Nurse
9. Researcher
10. Other
Natl Perinatal HIV Hotline & Clinicians Network
1-888-448-8765 (24/7)
Repro ID_HIV listserv
marliese.warren@ucsf.edu
Objectives

By the end of the session, participants will:

1. be able to explain a harm reduction approach to infant feeding
2. understand the epidemiology of loss to follow-up among postpartum women
3. be able to describe interventions designed to increase retention in HIV care for women
Postpartum care for WLHIV

• She is receiving her preferred suppressive ARV regimen (simplified as appropriate).
• She receives a prescription for herself (ARVs, OI prophylaxis) and her baby (PEP) before leaving the hospital.
• She has HIV follow-up appointments for herself and her baby scheduled before leaving the hospital.
• She knows her HIV care and Peds team/s and, if new to her, has met them before leaving the hospital.
Postpartum care for WLHIV

• She has made an informed decision about infant feeding in the setting of HIV.
• She has a supportive community of family and friends to whom she is able to disclose her HIV.
• She has a supportive medical team that understands the complex impact of stigma.
• Her partner/s have been tested for HIV and linked to prevention (PrEP/PEP) or treatment as appropriate.
Postpartum care for WLHIV

• She has an effective form of contraception of her choosing and knows about birth spacing
• She has been assessed for any pregnancy-related trauma
  – https://www.counseling.org/knowledge-center/practice-briefs/articles/postpartum-ptsd#sthash.Te6oqbxC
• She has been screened (and treated) for any STIs (if due)
• She has been screened (and treated) for cervical dysplasia/cancer (if due)
Postpartum care for WLHIV

- She has received mental health screening (and treatment)
  - Edinburgh Postnatal Depression Scale: 10-items (scored 0-3) [https://psychology-tools.com/epds/](https://psychology-tools.com/epds/)
  - SAMHSA toolkit: [https://store.samhsa.gov/shin/content/SMA14-4878/SMA14-4878.pdf](https://store.samhsa.gov/shin/content/SMA14-4878/SMA14-4878.pdf)
- She has been screened (and offered treatment) for substance use: SBIRT [https://www.integration.samhsa.gov/clinical-practice/sbirt](https://www.integration.samhsa.gov/clinical-practice/sbirt)
- Any IPV/trauma has been evaluated and referrals made:
- She has a social worker, case manager, home health nurse, patient navigator, and/or other support services as needed
Overview

• Birth spacing/contraception
• Infant feeding
• Adherence to/retention in care
CONTRACEPTION/BIRTH SPACING
Ideal birth spacing = 18+ months

• 18+ months between delivery and subsequent conception
• Birth spacing <18 months associated with ↑
  – preterm birth
  – neonatal morbidity
  – low birth weight
• In US (2006-10), ~33% pregnancies began <18 months after previous live birth

DeFranco  AJOG 2015; Mayer Birth 1997; Orr Pediatric Perinatal Epidemiology 2000; https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives
Contraception and postpartum

• Ideally discussions and decisions about contraception occur DURING pregnancy, not initiated postpartum

• Collaborative, informed decision making process
  – Online decision making tool: https://www.bedsider.org/methods

• Return to ovulation postpartum
  – Non-lactating: mean return 39-94 days postpartum
  – 20-71% ovulate before first menses
  – I have cared for 2 WLHIV pregnant @ their 6 wk postpartum visit.

Gray J Clinic Endocrinol Metab 1987; Jackson ObGyn 2011
Timing of postpartum contraception

• Implant, DMPA, progesterone-only pills: anytime
• IUD: within 10 minutes of placental delivery or after ~4-6 weeks
• Estrogen-containing method (pills, patch, ring): wait at least 3 weeks b/c hypercoagulability
  – wait 6 weeks if BMI 30+, smoker, 35+yo, cesarean, PPH, immobility, PreEclampsia
# Hormonal Contraception & ART

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<th>Combo hormones/POP</th>
<th>Implant</th>
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| EFV<br>
LNG AUC ↓58-83%<br>NGMN AUC ↓64%<br>ENG ↓ | CAUTION | ★
| RTV-boosted PIs<br>
EE AUC ↓19-48%<br>NE AUC ↓14-34% | CAUTION | ?

★ Pregnancy and implants:<br>12-15% EFV vs. 0% non-EFV (n=570, n=57)

Perry AIDS 2014; Scarsi CID 2016
INFANT FEEDING
Case: A Woman from Ethiopia

• 36 yo G1P0 at 36w4d presents for OB care in the US having just moved in with her sister. Had routine prenatal care in Ethiopia where she was diagnosed with HIV at 20 weeks.
  – Initial CD4 count of 523 and VL 8000.
  – Started on Atripla at 20 weeks
  – VL<20 at presentation
  – Expresses desire to breastfeed

• Plans return to Ethiopia 6 weeks postpartum

Case adapted from Christine Pecci, Pooja Mittal
What is your next step?

1. Panic! (And then remember to call the National Perinatal HIV Hotline.)
2. Tell her she cannot breastfeed because the risk of HIV transmission is high during breastfeeding.
3. Explain that the pediatricians will call Child Protective Services if she breastfeeds.
4. Explore her goals around infant feeding and her understanding of HIV transmission risk.
What do the Perinatal HIV Guidelines say?

“Avoidance of breastfeeding has been and continues to be a standard, strong recommendation for women living with HIV in the United States, because maternal ART dramatically reduces but does not eliminate breastmilk transmission, and safe infant feeding alternatives are readily available in the United States. In addition, there are concerns about other potential risks, including toxicity for the neonate or increased risk of development of ARV drug resistance, should transmission occur, due to variable passage of drugs into breastmilk.”

However...

“However, clinicians should be aware that women may face social, familial, and personal pressures to consider breastfeeding despite this recommendation; this may be particularly problematic for women from cultures where breastfeeding is important, as they may fear that formula feeding would reveal their HIV status. It is therefore important to address these possible barriers to formula feeding during the antenatal period.”

• Similarly, women with HIV infection should be made aware of the risks of HIV transmission via premastication (prechewing or prewarming) of infant food.
Confusing for WLHIV to navigate mixed messages about breastfeeding

Encouragement

Give a breastfeeding mom your loving support.
Breastfeeding and HIV Transmission

• WITHOUT ARV prophylaxis—risk highest in first 4-6 weeks of life
  – 0.7 %/month during months 1-5
  – 0.6 %/month during months 6-11
  – 0.3 %/month during months 12-17

• Breastfeeding and HIV International Transmission Study meta-analysis:
  – After 1 month of age, risk 8.9 transmission per 100 P-Y

• Risk is higher with acute HIV infection.
  – ~14% in chronic infection
  – ~25-30% in acute infection

• Other factors:
  – high maternal plasma (and breast milk) viral load
  – low maternal CD4+ cell count
  – Breast infections (mastitis, abscess)
  – Mixed breast-bottle (in settings where formula NOT AFASS)

Miotti JAMA 1999; Coutsoudis CID 2004
Antiretrovirals and HIV Transmission during Breastfeeding?

• Antiretroviral use during breastfeeding ↓ risk
  – ↓ maternal plasma (and breast milk) viral load
  – Transfer to some ARVs via breast milk = infant PrEP/PEP
  – Infant PEP

• Some of the many unknowns
  – Which ARVs are most protective
    • Penetration into breast milk compartment
  – Optimal infant PEP regimen if breastfed
  – How often to monitor maternal viral load (most suggest monthly) and test infant
  – Importance of exclusive breastfeeding if on ARVs with viral suppression (is mixed feeding a problem if formula safe?)
How effective are ARVs at preventing breast milk transmission?

• Kesho Bora RCT: triple ARV in pregnancy through weaning vs. AZT in pregnancy + SD-NVP in labor
  – Infants SD-NVP at birth and 1 week AZT
  – Protocol revision: 1 week postpartum AZT/3TC to women who got SD-NVP
  – HIV transmission @ 12 months: 5.4 vs. 9.5%

• PROMOTE Pregnant Women & Infant Trial: RCT AZT/3TC + LPV vs. EFV in pregnancy-1 yr BF
  – N=389; 2 cases infant HIV (1 in-utero, 1 BF) both in LPV arm
  – 1 case BF transmission: woman with VL <400 within month of transmission

Kesho Bora. Lancet ID 2011; Cohan AIDS 2015
Breastmilk-ARV pharmacokinetics

• Breastmilk:maternal plasma ratio (BM:MP)
  – NRI: 0.89-1.21 (14 studies, 1159 paired samples)
  – NNRTI: 0.71-0.94 (17 studies, 965 paired samples)
  – PI: 0.17-0.21 (8 studies, 477 paired samples)

• Estimated infant BF levels compared to Peds treatment doses
  – 3TC: 8.4% (95% CI 1.9-15.0)
  – NVP: 12.5% (95% CI 2.6-22.3)
  – EFV: 1.1% (95% CI 0-3.6)

Waitt, J Antimicrob Chemother 2015
Talking about breastfeeding

• An open-ended conversation, not a provider-led mandate about formula
• “In the US, we recommend that women with HIV not breastfeed. Is that an issue or problem for you?” or “Please tell me your thoughts about this.”
• Validate her desire to breastfeed
• Seek to understand her motivation

Levison CID 2014
How I counsel my patients considering breastfeeding

• I will support you, regardless of what you decide.
• My role is making sure you understand the risks so that you can make an informed, conscious decision.
• What is most important to me is that we stay in close communication and that you don’t avoid telling me something out of fear.
• The official recommendation is for women with HIV in the US to avoid breastfeeding.
• There are other options:
  – milk bank covered by Medi-Cal
  – Flash heating (time-consuming; no long-term data)
  – Wet nurse
Human Milk Banking Association of America

https://www.hmbana.org/about-hmbana
How I counsel my patients

• We know that BF has a host of health benefits for the baby, especially in regions of the world where water quality is bad and formula isn’t a safe option.
• I understand the pressure to BF and the messages around about the importance of choosing milk over formula.
• BF can be a beautiful way to bond with your baby. I honor the loss and emotional difficulty of giving up BF.
• There are other ways to bond with your baby, including doing skin-to-skin while bottle feeding.
  – HIVE brochure: Bonding While Bottle-Feeding: https://www.hiveonline.org/wlhiv/bonding_while_bottle_feeding.pdf
Caring For Your Baby: Bonding While Bottle-Feeding

Tips for Mothers Living with HIV In the United States

Can I breastfeed my baby?

The World Health Organization and the Centers for Disease Control strongly recommend that women with HIV in the United States do not breastfeed to prevent passing HIV to their baby.

“When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.” WHO 2007.

How do I bottle feed my baby?

- Consider using donated, pasteurized breast milk from a milk bank to feed your baby
- Talk to your doctor, midwife, or WIC provider about what kind of formulas are available for your baby
- Choose an iron-fortified formula to prevent anemia
- Follow the directions on the side of the formula package. You will need to mix level scoops of powdered formula with water inside of clean bottles.

What is bonding?

Bonding is the emotional connection that a mother makes with her baby. Attachment is the relationship that mom and baby make with each other. Bonding helps you feel connected to your baby and attachment makes baby feel safe. You can bond with your baby without breastfeeding.

How can I bond with my baby?

- **Skin-to-skin:** When bottle feeding take baby’s clothes off down to the diaper and put him skin-to-skin against your chest, cover with a blanket and look into baby’s eyes. This helps with bonding because:
  - Baby stays warm
  - Baby’s heartbeat and breathing will be regular
  - Baby stays calm, less crying
  - More attachment

- **Rooming-in:** Rooming-in is when mom and baby are in the same room together starting right after birth. When moms are with their babies all the time in the first few hours and days of life they bond. This also helps you listen to baby’s cues.

- **Know what your baby wants and when:**
  - When baby puts her hand to her mouth, licks her lips or turns her head to the side and opens her mouth, she is probably hungry.
  - When baby is fussy but has just been fed, check the diaper.
  - When baby cries he might just want to be held; pick baby up, rock, sing, cuddle, and soothe him.

- **Hold baby close:** Baby will be able to recognize your smell and will recognize your voice from when she was inside your womb.

- **Laugh and play with baby:** Playing with baby will help you bond and learn more about your baby.

- **Am I spoiling my baby?** No! Many moms wonder if they can spoil their babies by picking them up when they are crying. The truth is, letting strong emotions build is beneficial to a child’s development.
How I counsel my patients

• Being on antiretrovirals definitely decreases the risk of HIV transmission during BF but does not bring the risk to zero.
• We would want to continue doing monthly viral loads on you throughout breastfeeding.
• There is still much we don’t know about HIV and BF transmission including the best ARV regimen, the best infant PEP regimen, the long-term impact of ARV exposure through breast milk, the optimal amount of HIV testing to do for your baby, whether to recommend exclusive breastfeeding.
How I counsel my patients

• I share the story of the 1 woman in Uganda in PROMOTE trial who transmitted via BF despite having VL <400 copies within a month of transmission
  – LPV doesn’t penetrate into breast milk compartment?
  – She had low level viremia below level of detection for that assay?
  – She became viremic at some point after the <400 result?
How I counsel my patients

• The official recommendation used to be for women with HIV to not get pregnant. Now we know how to prevent HIV transmission during pregnancy and we don’t discourage WLHIV from getting pregnant.

• At some point, we will figure out how to prevent HIV transmission during breastfeeding. We are almost there, but not quite.
Case: Woman from Ethiopia

• After her vaginal delivery, pediatricians were surprised by her desire to breastfeed. On second postpartum day she was worried about her milk not having come in, peds encouraged not breastfeeding, and she switched to formula.

• Issues:
  – No communication to nursery before delivery
  – Will formula feeding be acceptable, feasible, accessible, safe, sustainable once she returns to Ethiopia?
  – How does she feel about her healthcare team?
  – Will this experience influence her future use of healthcare if she returns to the US?
Collaborative Harm Reduction Strategy

Ensures optimal maternal treatment
Prenatal referral to Pediatrician
Coordinates feeding with birth hospital
Helps address stigma, disclosure issues

Educates mother on risks/benefits
Guides nursery pediatricians
Addresses feeding/weaning issues
Infant testing

Understands risks
Virologic suppression
Prepares ahead for complications
Family/community support

Adapted from Levison
Final points about infant feeding

• I have never had a patient ultimately choose to breastfeed, but I feel prepared to support a woman and keep her and her baby healthy if she does.

• I have had some woman choose to use banked human milk.

• Lactation suppression: Standard to prescribed Cabergoline 1mg x1 (ideally w/in 12 hrs postpartum)
  – Careful if Pre-Eclampsia, uncontrolled HTN
  – May need to repeat the dose @1-2 weeks
RETENTION IN CARE
Case: A Young Woman Gets Lost

- 19 yo G3P1 at 27wk presents to ED with heavy vaginal bleeding
- No prenatal care, known HIV infection, no ART
- Baby boy delivered by emergent cesarean for suspected abruption
- HIV viral load 12,930 copies/mL and CD4 674 (25%) [maternal lab results available after delivery]
- Confirmed perinatal HIV infection

Case adapted from Gwen Lazenby, MD
Case: A Young Woman Gets Lost

- 2 years later, patient presented with 17 week IUFD
- No prenatal care
- No ART
- Induction of labor
Case: A Young Woman Gets Lost

- 1 year later, presents with PPROM and PTL at approximately 31 weeks gestation.
- No prenatal care, no ART
- Diagnosed with pre-eclampsia and non-reassuring fetal heart tracing
- Baby girl delivered by repeat cesarean
- Confirmed perinatal HIV infection
Missed opportunities

• Failure to link patient to HIV care or prenatal care
• Failure to initiate ART
• Failure to provide contraception
• Two perinatal HIV infections
Postpartum loss to follow-up and poor ARV adherence = global health crisis!

• Meta-analysis: 51 studies, 20,153 pregnant WLHIV (14 studies in US)
• Adequate adherence (≥80% ARV)
  – Antepartum: 75.7% (71.5%-79.7%)
  – Postpartum: 53.0% (32.8%-72.7%)
• Barriers to adherence:
  – Physical, economic, emotion stress
  – Depression (especially postpartum)
  – Alcohol, drug use
  – ARV dosing frequency or pill burden

Nachega AIDS 2012
Post-partum challenges: HIVE Patient Death Review

2004-2016
• Perinatal transmissions in SF = ZERO!

• Maternal deaths of HIVE clients = NINE!
  – 4 died within 2 years of delivery
  – 8 had significant lifetime trauma and/or IPV
  – 8 had post-partum depression
  – 6 homeless or marginally housed
  – 7 died of HIV-related causes
  – 4 experienced custody loss of their children
  – 4 virally suppressed at delivery

HIVE maternal death review 2016, unpublished data.

www.HIVEOnline.org
Loss to follow-up among postpartum WLHIV in Mississippi

• Retrospective, n=274, n=297 deliveries.
• Median age 25, 89% were black.
• 37% with 2+ HIV provider visits within 1st postpartum year.
• Postpartum follow-up associated with presenting before the 3rd tri (OR 2.1)
HIV Care Postpartum Retention

- HIV Care During Pregnancy: 92% (695/756)
- Viral Suppression At Delivery: 51% (389/756)
- HIV Care within 90 Days of Delivery: 38% (263/695)
- Retention 1 Year Postpartum: 39% (271/695)
- Viral Suppression 1 Year Postpartum: 31% (218/695)
- Retention 2 Years Postpartum: 25% (175/695)
- Viral Suppression 2 Years Postpartum: 34% (233/695)

Adams et al. CID. 2015
Postpartum Retention

• Women engaged in HIV care within 90 days postpartum more likely to remain engaged
  – 1 yr pp, AOR 11.4 (7.7-16.7)
  – 2 yr pp, AOR 6.2 (4.0-9.5)

• Factors associated with no HIV care postpartum
  – HIV diagnosis < 2 years before delivery, 0.6 (0.3-0.9)
  – Inadequate prenatal care, 0.4 (0.2-0.7)

Adams et al. CID. 2015
Care Retention among Women Diagnosed with HIV during Pregnancy

- Retrospective (2008-10), NY State HIV Surveillance Registry, n=254
- 87% HIV care before delivery
- 75% viral suppression @ delivery → 50% viremic in 1st year PP

- Factors associated with no HIV care
  - IDU, RR 5.5 (3-10)
  - Late prenatal care, RR 9.7 (2-45)

- Factors associated with maternal loss to follow up
  - Diagnosis in 3rd trimester, RR 2.2 (1.4-3.5)
  - Cesarean delivery, RR 1.7 (1.1-2.9)
  - White race, RR 1.9 (1.1-3.4)
  - Unsuppressed VL, RR 1.9 (1.3-2.9) (bivariate only)

Structured Guidance for Postpartum Retention in HIV care

- Medical safety net
- Depression screening
- Substance use assessment
- Assess factors associated with need for intensive follow up
- Infant feeding preferences
- Reproductive desires
- Insurance plan transitions

Adapted from CDC’s Elimination of Perinatal HIV Transmission Stakeholders Group
Courtesy of Gwen Lazenby
Elimination of Mother-to-Child Transmission Risk Assessment Tool (ERAT)

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<tr>
<th>Check all that apply</th>
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<td><strong>HIV diagnosis and care</strong></td>
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<td>New HIV diagnosis during pregnancy</td>
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<td>Late HIV diagnosis (in 3rd trimester/postpartum)</td>
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<td>Detectable HIV RNA (viral load)¹</td>
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<td>History of detectable HIV RNA in the past year</td>
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<td>Lack of HIV care engagement prior to or during pregnancy, e.g., 2 or more consecutive missed visits for HIV care</td>
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<td>Pregnant woman with perinatally acquired HIV infection</td>
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<td>Has an HIV positive child</td>
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<td><strong>Obstetric Care</strong></td>
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<td>Missed prenatal care appointments</td>
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<td>Infant feeding concerns, wants to breastfeed</td>
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<td><strong>Social and System</strong></td>
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<td>Partner/family/key support network unaware of HIV diagnosis</td>
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<td>Lack of social support network</td>
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<td>Non-English speaking</td>
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<td>Undocumented legal status</td>
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<td>Low health literacy</td>
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<td>Unstable housing/homeless</td>
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<td>Intimate partner violence</td>
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<td>History of involvement with child protective services</td>
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<td>Recently incarcerated (mother or partner)</td>
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<td>Exchanging sex for money or drugs</td>
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<td>Inability to pay med copays or out of pocket expenses, underinsurance</td>
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<td>Medicaid during pregnancy only, loses coverage postpartum</td>
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<td>Mother/Child receiving services in different jurisdictions and or funding sources, i.e., across state or county lines</td>
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<td><strong>Mental Health/Behavioral Disorder</strong></td>
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<td>Psychological and/or mental illness NOT adequately managed</td>
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<td>Current or recent past history of substance abuse/alcohol abuse</td>
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<td>Developmental delay(s) or intellectual disability</td>
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Interventions to increase Postpartum Retention

• Routine
  – Schedule appointments prior to delivery
  – Dispense adequate ARVs for mom and baby before hospital discharge

• Enhanced
  – Case management
  – Patient navigators

• Intensive
  – Home and community visits
  – Community agency involvement

Adapted from CDC EMCT Care Workgroup
Improving postpartum retention in care for women living with HIV in the United States

Florence M. Momplaisir, Deborah S. Storm, Hervette Nkwhoreze, Olakunle Jayeola and John B. Jemmott

Integrated Behavioral Health Model
- Attitude/beliefs
  - Social norms
  - Self-efficacy
- Behavioral Intention

Ecological Model of Health Behavior
- Patient-doctor relationship
- Social networks
- Neighborhood level poverty, race, crime, housing instability
- Co-location of Obstetric-HIV; Pediatric-HIV care

POSTPARTUM RETENTION IN HIV CARE
Improving Postpartum Retention in Care for WLHIV

• Care coordination and case management
  – “deliberate organization of patient care activities to facilitate the appropriate delivery of healthcare services”
  – Integrated maternal postpartum/infant care: ↑viral suppression @ 1yr postpartum in South Africa
  – Philadelphia, n=898 live births (2005-13), WLHIV with perinatal case management: ↑viral suppression before delivery (aOR 1.90); in HIV care @ 1 yr PP (aOR 1.59), but no difference in viral suppression @ 1yr PP

Momplaisir AIDS 2018; Myer CROI 2017; Anderson AIDS Behavior 2017
Improving Postpartum Retention in Care for WLHIV

• Peer support
  – Many programs in Africa have shown postpartum benefits
  – mothers2mothers (m2m) peer support program: www.m2m.org
  – CenteringPregnancy group visit model = promising model in US

• Technology
  – Text/phone call reminders associated with ↑visit attendance @ 6-10 weeks postpartum
  – US-based “text4baby” associated with ↓self-reported EtOH use postpartum (OR 0.2)

What do WLHIV say they want

• Mixed methods study, 1-on-1 interviews and focus groups
• 18 WLHIV in Alabama
• Asked about barriers and facilitators of postpartum HIV care adherence.
• African-American (83.3%), single (66.7%), income <$1000/month (55.6%)
• Barriers to retention in HIV care:
  – access to and cost of transportation
  – work & childcare schedules
• Facilitators to HIV care adherence:
  – wanting to stay healthy for their own well-being
  – wanting to stay healthy to care of their children,
  – family support
  – appointment reminders

Boehme AIDS Care 2014
Brief Summary

• Women living with HIV are at increased risk of loss to HIV care postpartum

• Woman at increased risk are those
  – Newly diagnosed with HIV
  – Not taking or non-adherent to ARVs
  – Receiving inadequate or presenting late to prenatal care

• Systems for improving retention are necessary
  – Culturally and locally-appropriate
  – Creative
  – Woman and family-centered
  – Begin before postpartum
Other possible interventions not yet studied in postpartum period and/or with WLHIV

• Conditional cash transfers
  – ↑ retention in care, no change in adherence/viral load (Congo)

• Directly observed therapy
  – Cost-effective for pregnant WLHIV with viremia (US)
  – WLHIV in Puerto Rico reported DOT acceptable

• Mindfulness training
  – upcoming RCT among adults with HIV (NE US)
  – Phone-based mindfulness-based stress reduction (MBSR), health coaching

• Trauma-informed therapy

Yotebieng JAIDS 2016, Ciambrone Women & Health 2007; Salmoirago-Blotcher Contemporary Clinical Trials 2017
Postpartum Pilot Project in SF

• Innovative, patient-centered postpartum care model to improve ART provision and virologic suppression among women living with HIV (WLWH) in San Francisco

• Funded by HRSA Ryan White Part D grant, 1 year period

• Carried out by Family Service Network (FSN), a multi-agency collaborative of interprofessional providers serving women, infants, children, and youth (WICY) living with HIV
Comprehensive Post-Partum Planning and Case Conferencing

- Weekly case conference at HIVE Clinic
- Weekly case conference at Family HIV Clinic
- Monthly case conference at FSN collaborative Post-Partum Project meetings
- Review each patient’s case and updates with multidisciplinary team: Case manager, primary care/HIV providers, social worker
- Clinical data collected in advance: appointment and visit history, viral load, self reported adherence problems, depression scale score, changes to social situation
Intensive Case Management

• *One* case manager from our partner agency identified to serve this specific population of post-partum women—get to know prenatal and pediatric providers, become expert in the medical services and post-partum retention issues.

• Case management intervention flexible, responsive—truly patient and family centered.
Intensive Case Management

• Text & phone access to social worker and MD
• Counseling & social services for clients and their families, including assessment and linkage to:
  – Mental health treatment
  – Alcohol/drug treatment, smoking cessation
  – Housing, HIVE hotel stabilization for immediate relief from street homeless
  – Transport & basic needs (food, infant supplies)
  – Legal support: family courts, CPS reunification, restraining orders, probation
  – ADAP, Medi-Cal, financial benefits (SSI, TANF, GA)
  – Parenting support & child-care
  – Asylum and immigration assistance
• Support with HIV disclosure
• Medical care navigation: post-partum, pediatric, primary care appts
Supporting those living with HIV
in vibrant, healthy lives. We await you.
# HIV Reproductive Health and Perinatal Care: Resources and Tools

## Provider support tools and resources

**FXB Center:** Toolkit of resources for HIV preconception through postpartum care created by CDC’s EMCT Comprehensive Clinical Care workgroup [http://fxbcenter.org/resources_library.html](http://fxbcenter.org/resources_library.html)

**Clinician Consultation Center:** Rapid perinatal HIV consultation from practicing providers [http://nccc.ucsf.edu/clinician-consultation/perinatal-hiv-aids](http://nccc.ucsf.edu/clinician-consultation/perinatal-hiv-aids)

**Perinatal ReproID HIV Listserv:** Email forum to connect with providers, discuss difficult perinatal HIV cases, and share tools and protocols [http://nccc.ucsf.edu/clinical-resources/hiv-aids-resources/womens-health/](http://nccc.ucsf.edu/clinical-resources/hiv-aids-resources/womens-health/)

**HIVEonline:** Resources and support for reproductive and sexual wellness for individuals, families and communities affected by HIV [https://www.hiveonline.org/about/](https://www.hiveonline.org/about/)

**ACOG Women and HIV:** HIV information for OB-GYNs and their patients [http://www.womenandhiv.org/](http://www.womenandhiv.org/)

## Community support tools and resources

**The Well Project:** Online HIV resources and support for women and girls [http://www.thewellproject.org/](http://www.thewellproject.org/)

**HIVEonline:** Resources and support for reproductive and sexual wellness for individuals, families and communities affected by HIV [https://www.hiveonline.org/about/](https://www.hiveonline.org/about/)

**Positive Women’s Network USA:** A national membership body of women living with HIV and our allies that exists to strengthen the strategic power of all women living with HIV in the United States. [https://pwn-usa.org/about/who-we-are/](https://pwn-usa.org/about/who-we-are/)
Gratitude

• YOU!
• Southeast AETC
• My colleagues at the National Perinatal HIV Hotline and National Clinicians Consultation Center
• My colleagues at HIVE
• Colleagues who shared slides
  – Gwen Lazenby, Judy Levison, Monica Hahn, Becca Schwartz, Pooja Mittal, Christine Pecci
Thank you!
To learn more, please visit www.nccc.ucsf.edu
Common models of prenatal-HIV care

- Co-location: patient goes to one clinic
  - prenatal provider comes to HIV clinic
  - HIV provider comes to prenatal clinic
- Separate clinics: patient goes to both clinics on same or different campuses
- One clinic/clinician during pregnancy
  - Prenatal provider does the primary HIV care during pregnancy → refers back to primary HIV provider postpartum
  - Primary HIV provider does the prenatal care
    - Can often continue HIV care postpartum (woman +/- infant)
- And then after delivery...
  - Infant may be seen at different clinic/campus from mom’s care
  - Sometimes 2 sites (Peds primary care + HIV-rule out management)
- How can we help women navigate our disconnected healthcare system?