



CLINICIAN CONSULTATION CENTER  
Translating science into care

**AETC**  
Southeast



# Postpartum Care for Women Living with HIV

Deborah Cohan, MD, MPH

Professor, Dept of ObGYN, Family & Community Medicine



CLINICIAN-TO-CLINICIAN ADVICE



CLINICIAN CONSULTATION CENTER

Translating science into care

I have no financial conflicts of interest to disclose.





CLINICIAN CONSULTATION CENTER  
Translating science into care



**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/>
  - SAMHSA toolkit:  
<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>
- Any IPV/trauma has been evaluated and referrals made:
  - <https://www.thenationalcouncil.org/consulting-areas-of-expertise/trauma-informed-primary-care/>
- 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





CLINICIAN CONSULTATION CENTER

Translating science into 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

# 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.








# 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

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

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



CLINICIAN CONSULTATION CENTER

Translating science into care



# 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



## 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.”

National Perinatal HIV Guidelines, Nov 2017; accessed 1/19/18:

<https://aidsinfo.nih.gov/guidelines/html/3/perinatal/185/postpartum-follow-up-of-women-living-with-hiv-infection>

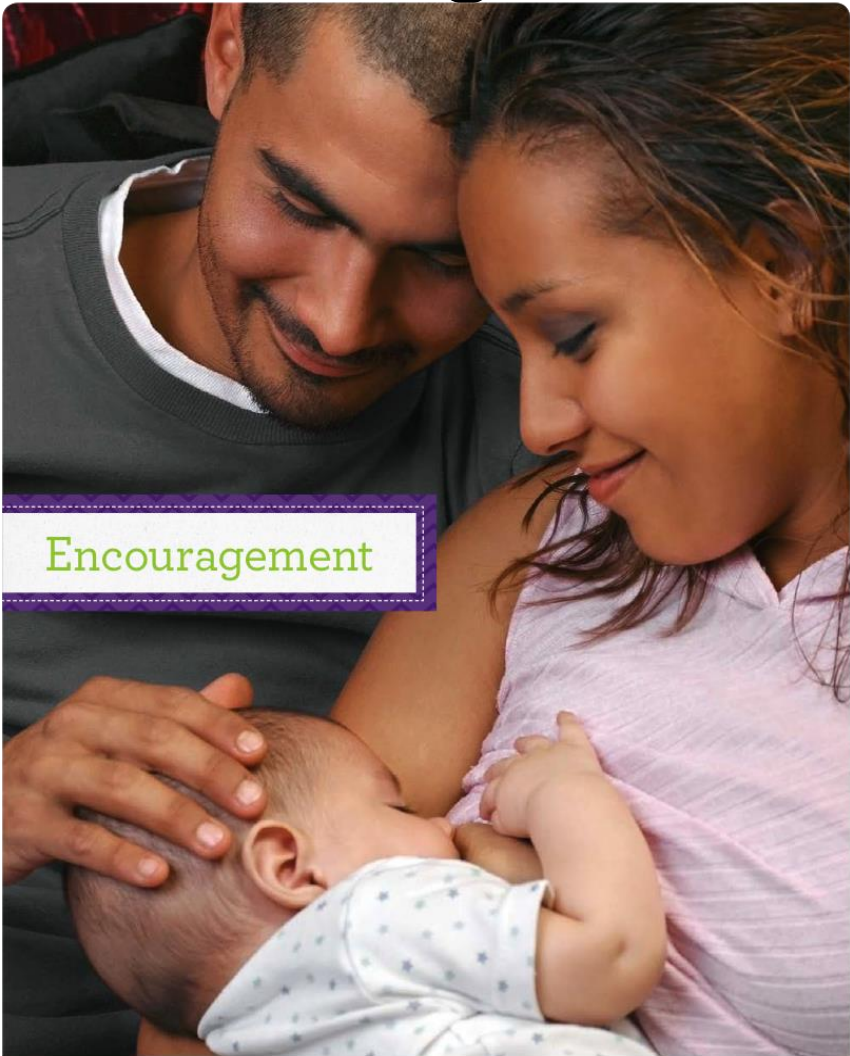


# However...

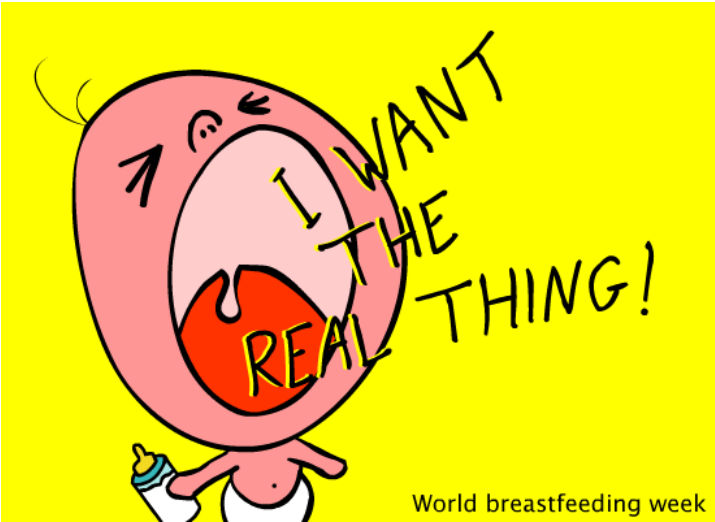
“However, clinicians should be aware that women may face social, familial, and personal pressures to consider breastfeeding despite this recommendation; this may be particularly problematic for women from cultures where breastfeeding is important, as they may fear that formula feeding would reveal their HIV status.<sup>35,36</sup> 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



World breastfeeding week

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)

# 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



# 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)



# Talking about breastfeeding

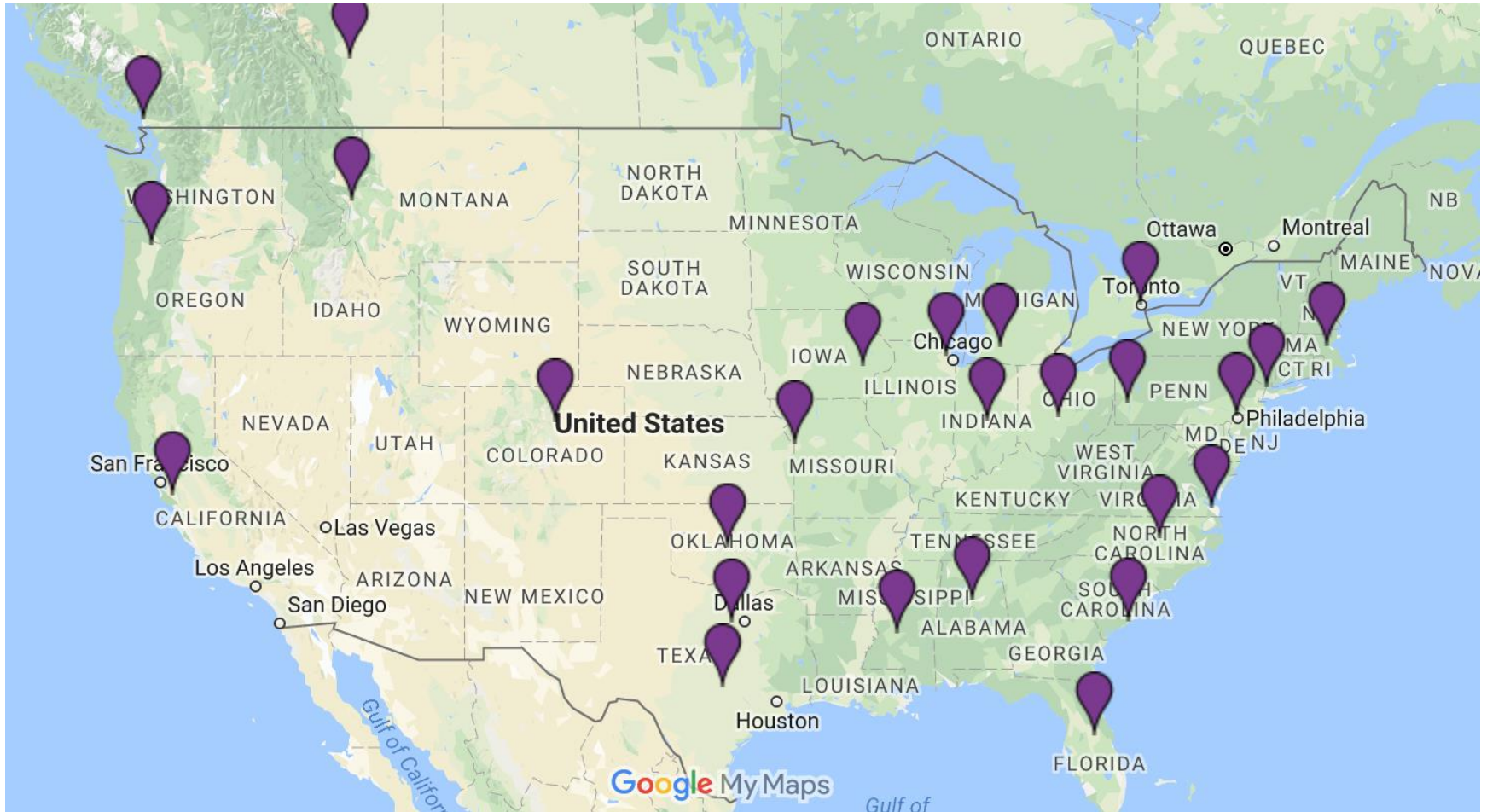
- An open-ended conversation, not a provider-led mandate about formula
- “In the US, we recommend that women with HIV not breastfeed. Is that an issue or problem for you?” or “Please tell me your thoughts about this.”
- Validate her desire to breastfeed
- Seek to understand her motivation



# 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](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 stays **calm**, less crying
  - Baby's heartbeat and breathing will be **regular**
  - 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 cry. The truth is that distinct, consistent, and loving care and holding is what babies need to grow up healthy and happy.





## 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.

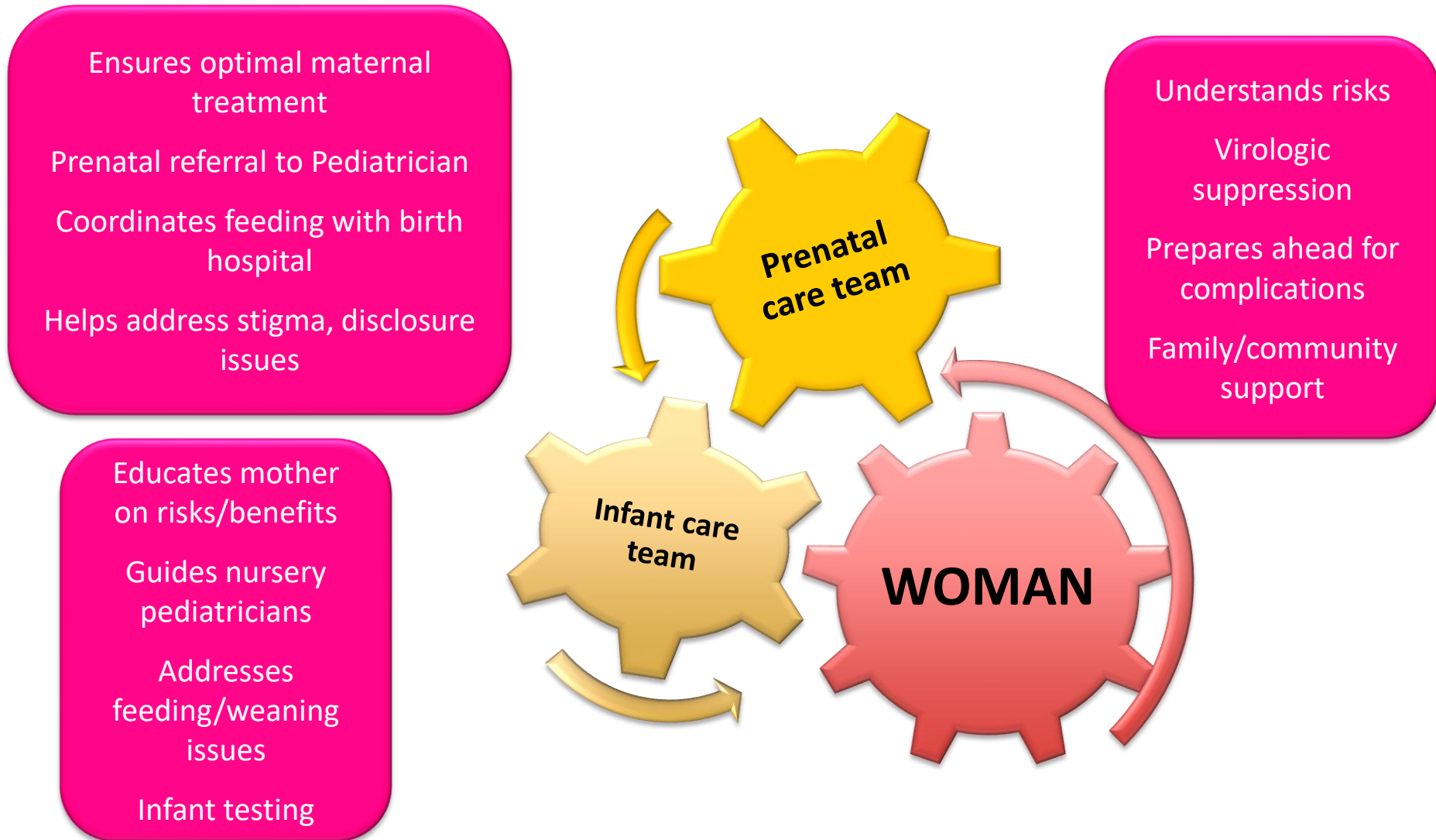




## Case: Woman from Ethiopia

- 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



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



CLINICIAN CONSULTATION CENTER

Translating science into care

# 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: 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 PPRROM 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 ( $\geq 80\%$  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

# 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

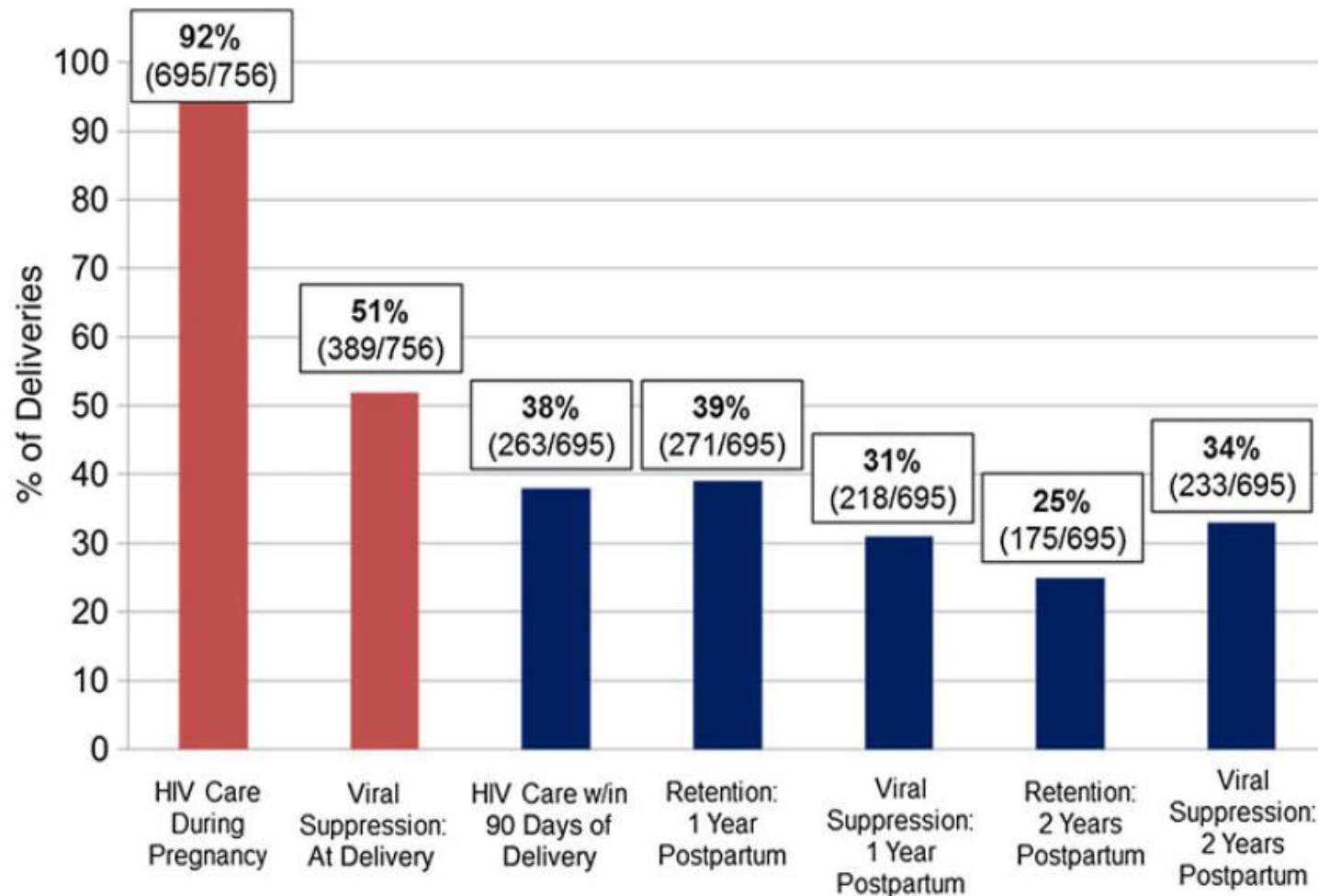
HIVE maternal death review 2016, unpublished data.



## 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 1<sup>st</sup> postpartum year.
- Postpartum follow-up associated with presenting before the 3<sup>rd</sup> tri (OR 2.1)

# HIV Care Postpartum Retention





## 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)

# 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 1<sup>st</sup> 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 3<sup>rd</sup> 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

# Elimination of Mother-to-Child Transmission Risk Assessment Tool (ERAT)

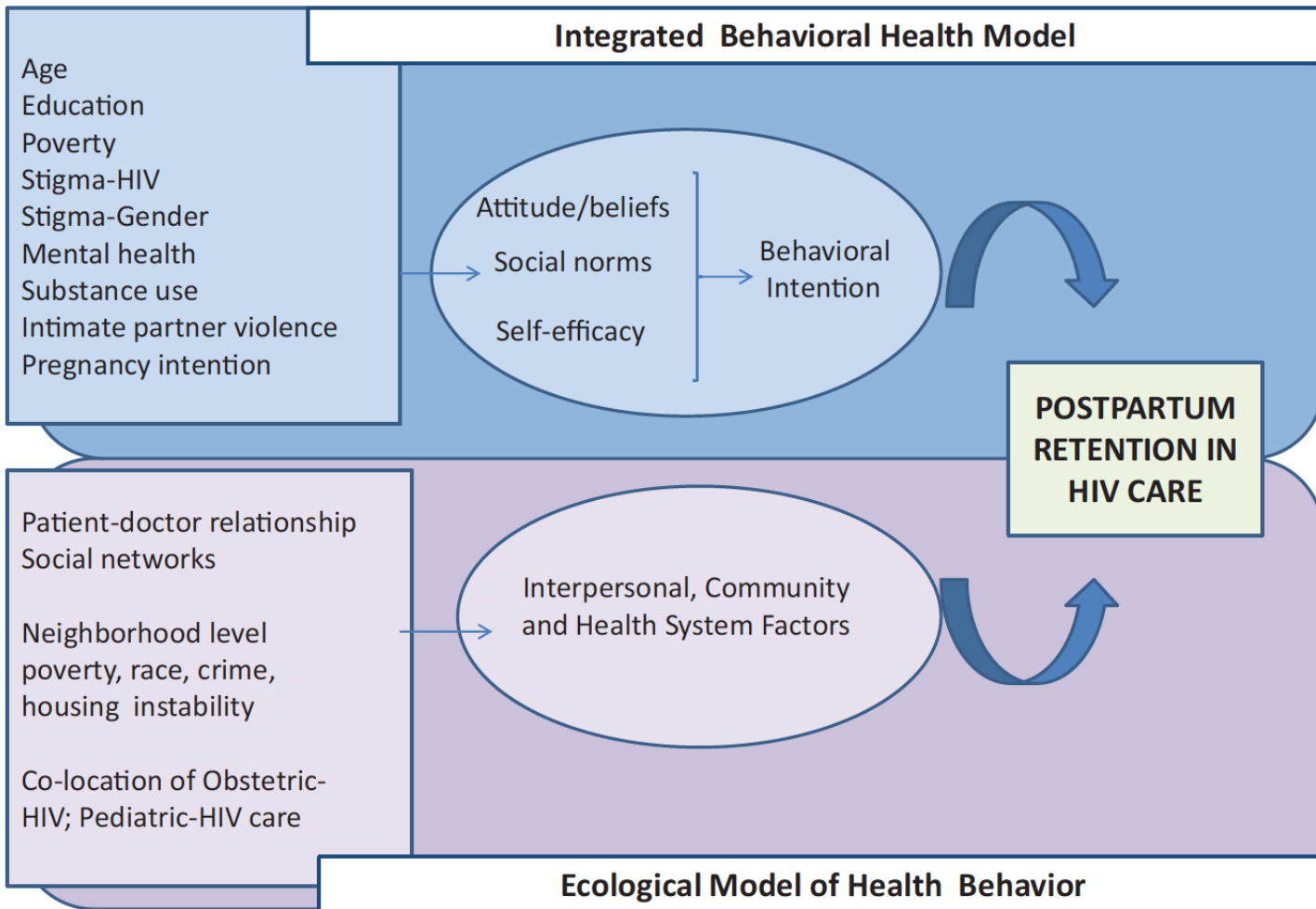
Check all that apply	Comments
<b>HIV diagnosis and care</b>	
New HIV diagnosis during pregnancy	
Late HIV diagnosis (in 3 <sup>rd</sup> trimester/postpartum)	
Detectable HIV RNA (viral load) <sup>1</sup>	
History of detectable HIV RNA in the past year	
Lack of HIV care engagement prior to or during pregnancy,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

# 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

# Improving postpartum retention in care for women living with HIV in the United States

Florence M. Momplaisir<sup>a</sup>, Deborah S. Storm<sup>b</sup>, Hervette Nkwihoreze<sup>a</sup>,  
Olakunle Jayeola<sup>c</sup> and John B. Jemmott<sup>d</sup>



# 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



# 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](http://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



# 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

# 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 inter-professional 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

A close-up photograph of a Black man smiling warmly as he gently touches the pregnant belly of a woman. The woman is wearing a purple top. The man is wearing a dark shirt and a necklace. The background is softly blurred, suggesting an outdoor setting. The text is overlaid on the center of the image.

# 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>

**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/>

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

**ACOG Women and HIV:** HIV information for OB-GYNs and their patients  
<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/>

**HIVEonline:** Resources and support for reproductive and sexual wellness for individuals, families and communities affected by HIV <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/>



# 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







CLINICIAN CONSULTATION CENTER

Translating science into care



CLINICIAN-TO-CLINICIAN ADVICE

Thank you!

To learn more, please visit [www.nccc.ucsf.edu](http://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?