Alaska ID ECHO: HCV-HIV-PrEP-STIs

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

NPAIHB
Indian Leadership for Indian Health

People Living with HIV and Breastfeeding

June 13, 2023

This program is supported by a grant from the Northwest Portland Area Indian Health Board and funding is provided from the HHS Secretary's Minority HIV/AIDS Fund.

Welcome to Alaska Infectious Disease ECHO: HCV, HIV, PrEP, STIs

Approved Provider Statements:

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Contact Hours:

ANMC designates this activity for a maximum of 12 contact hours, including 3 total pharmacotherapeutics contact hours, commensurate with participation.

Financial Disclosures:

Youssef Barbour, MD & Lisa Townshend-Bulson, APRN / faculty for this educational event, are primary investigators in an ANTHC sponsored hepatitis C study funded in part by Gilead Sciences. All of the relevant financial relationships listed have been mitigated.

Requirements for Successful Completion:

To receive CE credit please make sure you have actively engaged in the entire activity, your attendance is recorded by the facilitator, and complete the course evaluation form found here: https://forms.gle/18t4EgvN2WdnM4P77

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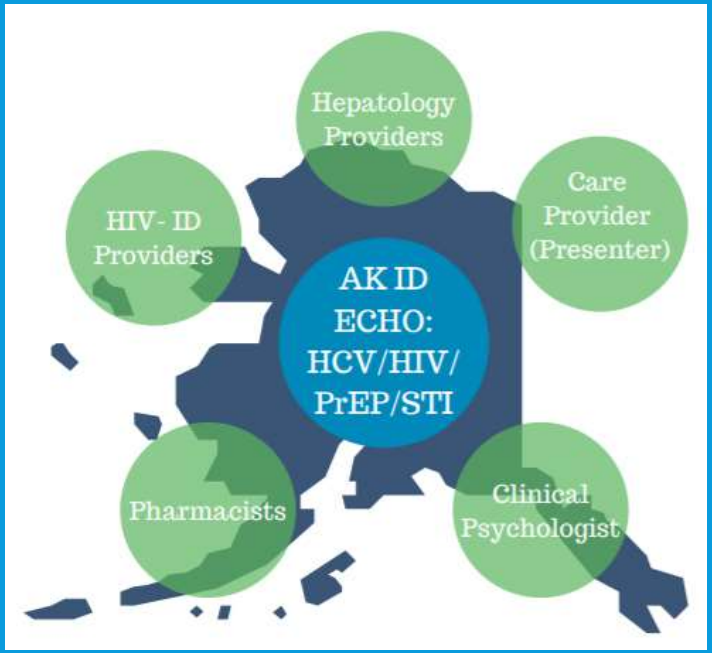
ALASKA NATIVE MEDICAL CENTER

AK ID ECHO: CONSULTANT TEAM



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ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Mountain West AIDS Education and Training Center

HIV and Infant Feeding

Breast/chestfeeding Updates

ANTHC AK ID ECHO
6/13/2023

Leah Besh, PA-C Early Intervention Services/HIV Program

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This presentation is intended for educational use only, and does not in any way constitute medical consultation or advice related to any specific patient.

AETC AIDS Education & Training Center Program Mountain West

Agenda

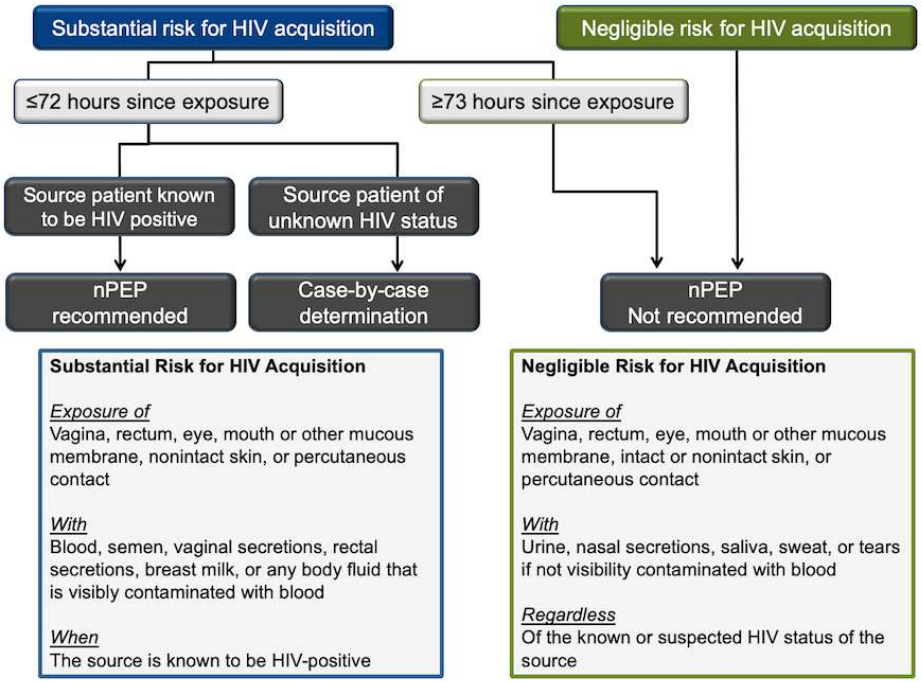
- Increase your knowledge of PEP/PrEP, and how it is safe in Pregnancy
- New perinatal stance on breast/chest feeding
- How to best counsel patients on feeding recommendations
- Pediatric lab monitoring
- Pediatric prophylaxis if breastfed
- ANMC procedure
- Pediatric ID consult at 32 weeks

What is nPEP:
nonoccupational Post Exposure Prophylaxis

- TDF/FTC 200/300mg 1qd (Truvada) **plus**

  Raltegravir 400mg BID or Dolutegravir 50mg 1qd x 28 days
- Determine if PEP is necessary
- Start within 72 hours of exposure
- Determine if client should transition from PEP→PrEP
- Ensure follow-up labs occur

Dolutegravir (DTG) became a preferred medication in pregnancy in 2022 after additional research was obtained to demonstrate no significant increased NTD risk for patients taking DTG vs other ART medications.

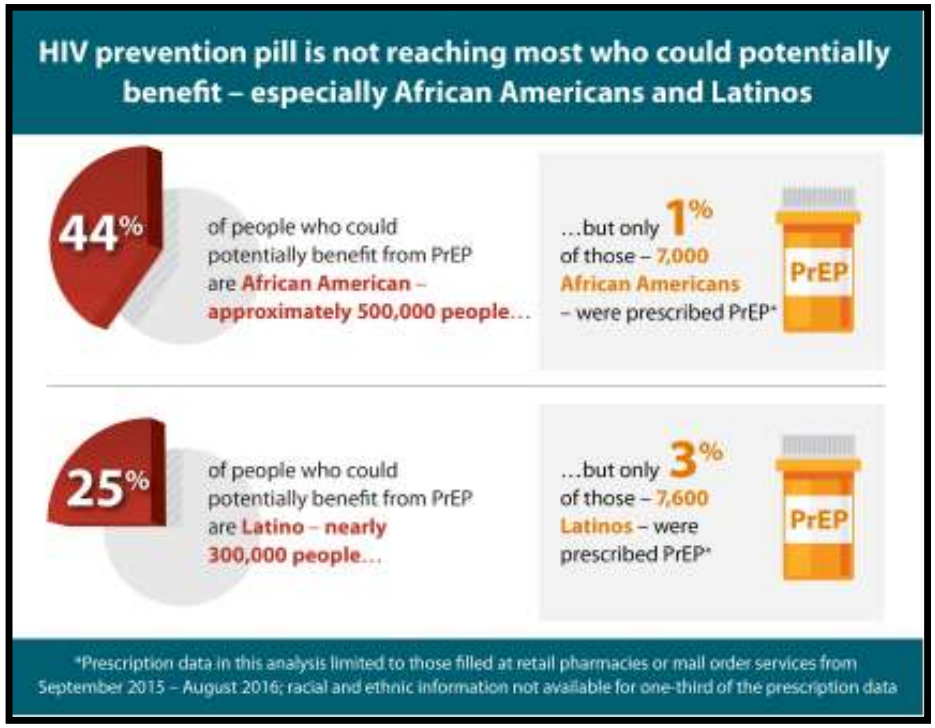


www.hiv.uw.edu/go/prevention/nonoccupational-postexposure-prophylaxis/core-concept/all

What is PrEP?

- A prevention strategy in which an individual takes a medication **regularly** (along with continued behavioral **risk-reduction** strategies) to prevent HIV infection

  - Medication first became available in 2012
  - United States PrEP guidelines first published in 2014
  - U.S. Preventative Task Force classified PrEP as a
  - grade A recommendation in June 2019
    - Insurance coverage improved
  - First injectable Medication approved January 2022



https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

Who May Benefit from PrEP

- Anyone who self-identifies a need for PrEP
- People with partners living with or at-risk for HIV
- People with any of the following risk factors in the past 6 months
  - Bacterial STI (gonorrhea, syphilis, any rectal STI)
  - Condomless anal sex
  - Transactional sex
  - Injection drug use with shared needles and/or shared equipment
- Some populations are at higher risk based on epidemiology and sexual networks
  - MSM
  - Trans women

Additional risk factor
if the patient's partners would benefit from PrEP

www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

PrEP in Pregnancy

- Centers for Disease Control and Prevention (CDC) guidance recommends health care providers should discussPrEP with all sexually active people without HIV—including individuals who are trying to conceive, pregnant, postpartum, or breastfeeding—to prevent HIV acquisition **(AII);** counseling should include the benefits of PrEP to prevent HIV acquisition and perinatal transmission **(AI)** and potential adverse effects of PrEP during periconception, pregnancy, postpartum, and breastfeeding periods **(AII).** Health care providers should offer PrEP to those who desire PrEP or have specific indications for PrEP use (e.g., injection drug use).

- **Tenofovir disoproxil fumarate/emtricitabine *(Truvada)* 1 pill daily is the recommended PrEP medication in pregnancy**
  - These two antiviral medications are part of the preferred HIV regimen in pregnancy=**SAFE**

https://clinicalinfo.hiv.gov/en/guidelines/perinatal/whats-new

PrEP Summary of Recommendations: Oral Meds

- TDF not recommended for CrCl<60
- TAF not recommended for CrCl <30

Table 1a: Summary of Clinician Guidance for Daily Oral PrEP Use

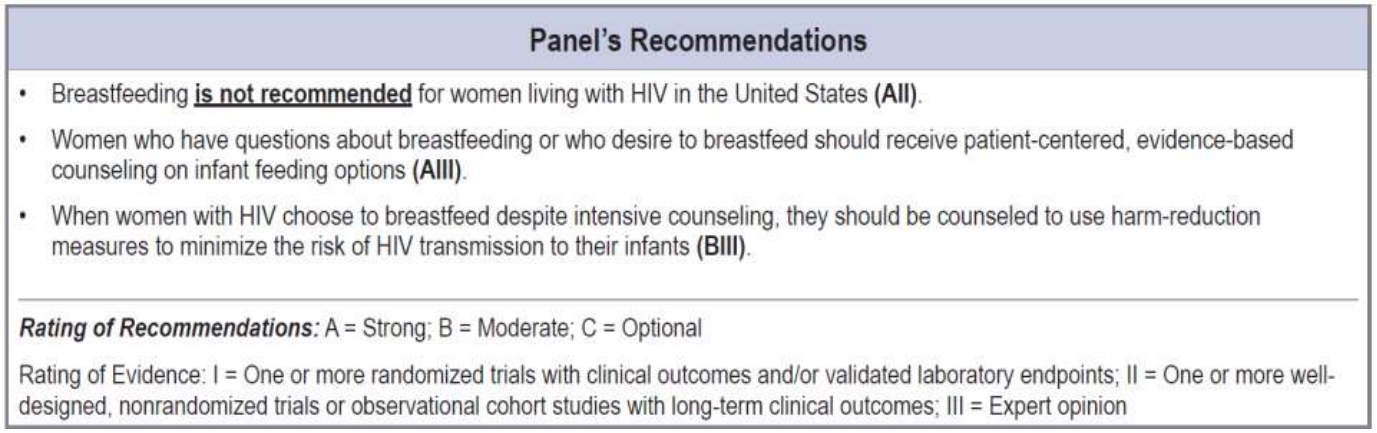
	Sexually-Active Adults and Adolescents[1]	Persons Who Inject Drug[2]
Identifying substantial risk of acquiring HIV infection	Anal or vaginal sex in past 6 months AND any of the following: • HIV-positive sexual partner (especially if partner has an unknown or detectable viral load) • Bacterial STI in past 6 months[3] • History of inconsistent or no condom use with sexual partner(s)	HIV-positive injecting partner OR Sharing injection equipment
Clinically eligible	**ALL OF THE FOLLOWING CONDITIONS ARE MET:** • Documented negative HIV Ag/Ab test result within 1 week before initially prescribing PrEP • No signs/symptoms of acute HIV infection • Estimated creatinine clearance ≥30 ml/min[4] • No contraindicated medications	
Dosage	• Daily, continuing, oral doses of F/TDF (Truvada®), ≤90-day supply OR • For men and transgender women at risk for sexual acquisition of HIV; daily, continuing, oral doses of F/TAF (Descovy®), ≤90-day supply	
Follow-up care	**Follow-up visits at least every 3 months to provide the following:** • HIV Ag/Ab test and HIV-1 RNA assay, medication adherence and behavioral risk reduction support • Bacterial STI screening for MSM and transgender women who have sex with men[3] – oral, rectal, urine, blood • Access to clean needles/syringes and drug treatment services for PWID **Follow-up visits every 6 months to provide the following:** • Assess renal function for patients aged ≥50 years or who have an eCrCl <90 ml/min at PrEP initiation • Bacterial STI screening for all sexually-active patients[3] – [vaginal, oral, rectal, urine- as indicated], blood **Follow-up visits every 12 months to provide the following:** • Assess renal function for all patients • Chlamydia screening for heterosexually active women and men – vaginal, urine • For patients on F/TAF, assess weight, triglyceride and cholesterol levels	

[1] adolescents weighing at least 35 kg (77 lb)
[2] Because most PWID are also sexually active, they should be assessed for sexual risk and provided the option of CAB for PrEP when indicated
[3] Sexually transmitted infection (STI): Gonorrhea, chlamydia, and syphilis for MSM and transgender women who have sex with men including those who inject drugs; Gonorrhea and syphilis for heterosexual women and men including persons who inject drugs
[4] estimated creatine clearance (eCrCl) by Cockcroft Gault formula ≥60 ml/min for F/TDF use, ≥30 ml/min for F/TAF use

https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf

Breast/Chest feeding guidance over the years

- 1985: *HIV infected women should be advised against breastfeeding to avoid postnatal transmission to a child that may not yet be infected-CDC* -Public Health Service
- 2015: *In discussing the avoidance of breastfeeding as the strong, standard recommendation of HIV-infected women in the United States, the panel notes that women may face social, familial, and personal pressures to breastfeed despite this recommendation (not to breastfeed) and it is important to begin addressing possible barriers to formula feeding*.-Health and Human Service panel
- 2018



Panel's Recommendations

- Breastfeeding **is not recommended** for women living with HIV in the United States **(AII)**.
- Women who have questions about breastfeeding or who desire to breastfeed should receive patient-centered, evidence-based counseling on infant feeding options **(AIII)**.
- When women with HIV choose to breastfeed despite intensive counseling, they should be counseled to use harm-reduction measures to minimize the risk of HIV transmission to their infants **(BIII)**.

Rating of Recommendations: A = Strong; B = Moderate; C = Optional

Rating of Evidence: I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion

https://clinicalinfo.hiv.gov/en/guidelines/archived-guidelines/perinatal-guidelines

New*
As of 1/31/2023

What is the major change?

The primary recommendation is now to support parental choice through shared decision making, no a specific feeding mode

Infant Feeding for Individuals With HIV in the United States

- The former section, Counseling and Managing Individuals With HIV in the United States Who Desire to Breastfeed, was revised and retitled to provide more comprehensive guidance on feeding infants born to individuals with HIV. Content about breastfeeding in other sections was revised to align with and refer to updated recommendations in this section.
- The Panel recommends that people with HIV receive evidence-based, patient-centered counseling to support shared decision-making about infant feeding. Counseling about infant feeding should begin prior to conception or as early as possible in pregnancy; information about and plans for infant feeding should be reviewed throughout pregnancy and again after delivery **(AIII).** During counseling, people should be informed that—
  - Replacement feeding with properly prepared formula or pasteurized donor human milk from a milk bank eliminates the risk of postnatal HIV transmission to the infant **(AI).**
  - Achieving and maintaining viral suppression through ART during pregnancy and postpartum decreases breastfeeding transmission risk to less than 1%, but not zero **(AI).**
- Replacement feeding with formula or banked pasteurized donor human milk is recommended to eliminate the risk of HIV transmission through breastfeeding when people with HIV are not on ART and/or do not have a suppressed viral load during pregnancy (at a minimum throughout the third trimester), as well as at delivery **(AI).**
- Individuals with HIV who are on ART with a sustained undetectable viral load and who choose to breastfeed should be supported in this decision **(AIII).**
- Individuals with HIV who choose to formula feed should be supported in this decision; potential barriers to formula feeding should be identified and addressed **(AIII).**
- Content about counseling and management of individuals who choose to breastfeed was updated, with added content on situations in which to consider stopping or modifying breastfeeding.

https://clinicalinfo.hiv.gov/en/guidelines/perinatal/whats-new

HIV Transmission risk via breastfeeding

Without maternal antiretroviral therapy	**Infant risk of acquiring HIV through breastfeeding: 15-20% over 2 years**
With a maternal sustained viral suppression during pregnancy and throughout postpartum	**Infant risk of acquiring HIV through breastfeeding: decreased to <1%, but not zero**

https://clinicalinfo.hiv.gov/en/guidelines/perinatal/infant-feeding-individuals-hiv-united-states

LOW RISK for HIV transmission to infants

- Are at low risk for transmitting HIV to their newborns born at ≥37 weeks gestation, including mothers who –
  - Received at least 10 consecutive weeks of antepartum ARV drugs, *and*
  - Achieved and maintained *or* maintained effective viral suppression (defined as at least two HIV RNA level <50 copies/mL obtained at least 4 weeks apart) for the remainder of the pregnancy, *and*
  - Had a HIV RNA <50 copies/mL at or after 36 weeks, *and*
  - Did not have acute HIV infection during pregnancy, *and*
  - Have reported good ART adherence and adherence concerns have not been identified.

Individuals with HIV on ART at "low risk" for infant HIV transmission should be counseled on the options of formula feeding, banked donor milk, or breastfeeding

- The infant feeding options that eliminate the risk of HIV transmission are formula and pasteurized donor human milk.
- Fully suppressive ART during pregnancy and breastfeeding decreases breastfeeding transmission risk to less than 1%, but not zero.
- If breastfeeding is chosen, exclusive breastfeeding up to 6 months of age is recommended over mixed feeding (i.e., breast milk and formula), acknowledging that there may be intermittent need to give formula (e.g., infant weight loss, milk supply not yet established, mother not having enough stored milk). Solids should be introduced as recommended at 6 months of age, but not before.
- The postpartum period, which can be difficult for all parents, can present several challenges to medication adherence and engagement in care. Ensuring that parents have access to both a supportive clinical team and peer support in the postpartum period is beneficial in promoting medication adherence and viral load monitoring.
- Access to a lactation consultant or lactation support provider with expertise in supporting breastfeeding by individuals with HIV is beneficial.
- As most studies of breastfeeding in mothers with HIV were conducted in resource-limited settings, more information is needed about the risk of HIV transmission through breastfeeding in high-resource settings and when individuals are adherent to ART with sustained viral suppression starting early in pregnancy.
- Breastfeeding provides numerous health benefits to both the infant (e.g., reduction in asthma, gastroenteritis, and otitis media) and the parent (e.g., reduction in hypertension; type 2 diabetes; and breast and ovarian cancers).

https://clinicalinfo.hiv.gov/en/guidelines/perinatal/infant-feeding-individuals-hiv-united-states?view=full

Table 13. Infant Antiretroviral Prophylaxis for Newborns of Mothers With Sustained Viral Suppression Who Breastfeed

Newborns at Low Risk of HIV Acquisition During Breastfeeding	
Recommended Regimen	**Recommended Duration**
ZDV	ZDV administered for 2 weeks (see Table 12 for dosing)
Optional Extended Postnatal Prophylaxis for Newborns at Low Risk of HIV Transmission During Breastfeeding	
Optional Regimen	**Optional Recommended Duration**
ZDV	ZDV administered for 4 to 6 weeks (see Table 12 for dosing)
NVP	**Simplified Age-Based Dosing for Newborns ≥32 Weeks Gestation Receiving Extended NVP Prophylaxis During Breastfeeding[a]**

Age	Volume of NVP 10 mg/mL Oral Syrup Daily
Birth to 6 weeks	1.5 mL
6 weeks to 6 months	2.0 mL
6 months to 9 months	3.0 mL
9 months to 1 to 4 weeks post-weaning	4.0 mL

https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/antiretroviral-management-newborns-perinatal-hiv-exposure-or-hiv-infection?view=full

Pediatric HIV Laboratory Follow-up

Infants at Low Risk	
Criteria for Infants at Low Risk	**Age at HIV NAT[b] Testing for Infants at Low Risk**
Infants born to mothers who— • Received ART during pregnancy; • Had sustained viral suppression (usually defined as <50 copies/mL); *and* • Were adherent to their ARV regimens	14–21 days 1–2 months[d] 4–6 months
Infants With Perinatal HIV Exposure Who Are Being Breastfed	
Age at HIV NAT[b] Testing for Infants With Perinatal HIV Exposure Who Are Being Breastfed	
Birth 14–21 days 1–2 months 2–4 months[e] 4–6 months	
If breastfeeding continues beyond 6 months of age, NAT testing should be performed every 3 months during breastfeeding. In addition to the standard time points after birth, NAT testing also should be performed at 4 to 6 weeks, 3 months, and 6 months after cessation of breastfeeding, regardless of the age at when breastfeeding ends.	

https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/pediatric-arv/tables-pediatric-arv.pdf

Additional Considerations

- When to stop breastfeeding:
  - Temporarily if HIV viral load is detected >50
    - Immediately repeat HIV viral load
    - Provide previously stored breastmilk, or other replacement feeding,
    - Ensure good antiretroviral compliance
  - Complete cessation if repeat viral load is detectable >50
  - Engaging child protective services or similar agencies is not an appropriate to a patient who wishes to breastfeed.

Patients in the USA have struggled to navigate infant feeding in the absence of more guidance

"It is very important that we are given a choice. Not given a choice - like I just need you to support what my decision is. It's not my provider's place to tell me what to do with my life or my babies. I just need you to leave the space open for discussion and choice."
- Ciarra (Ci Ci) Covin

2022 Annual National Perinatal HIV Hotline Roundtable: Breast/Chestfeeding https://www.youtube.com/watch?v=erWXE5pl5Xo
https://www.thewellproject.org/a-girl-like-me/aglm-blogs/gold-ish-liquid

MWAETC

ANMC HIV Perinatal and Pediatric Considerations

- We should increase the use of PEP and PrEP-they are safe in pregnancy.
  - PEP preferred regimen: Tenofovir (TDF)-Emtricitabine *(Truvada)* plus Dolutegravir *(Tivicay)* both once a day together x 28d
  - PrEP preferred regimen: Tenofovir (TDF)-emtricitabine (*Truvada)* once a day
- Support your patients in their feeding choice if they are at LOW RISK for HIV transmission to their infant.
  - Ensure patients are aware the risk of HIV transmission to their infant via breast feeding when they are virally suppressed is <1% but NOT Zero.
- In most circumstances if the patient chooses to breastfeed and meets low risk criteria for HIV transmission, antiviral therapy for infant does not need to be extended past 2 weeks post delivery.
- For breastfed infants, additional laboratory HIV testing is recommended until 6 months post cessation of breast feeding.
  - Ensure parents are aware of potential difficulty of receiving blood samples on infants
- All pregnant persons living with HIV are recommended to schedule a Pediatric ID Consult at 32 weeks GA for post delivery care management planning.

AK ID ECHO

AK Infectious Disease ECHO

- Second Tuesday of every month from noon-1:00 PM
- To join, https://echo.zoom.us/meeting/register/tZ0qc--qqj0qH9cw7gRs1d7K98I3AIvQJjHa
- www.anthc.org/ak-id-echo

- Upcoming session
  - July 11: Overview of HIV Injectable Medications

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

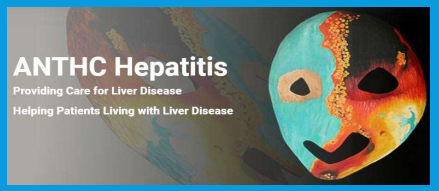
ADDITIONAL LEARNING OPPORTUNITIES

Alaska Liver Disease ECHO

- Third Thursday of every month from noon-1:00 PM
  - https://echo.zoom.us/meeting/register/tZUrcOqgqTwjHt2OI6vWpnJ9v1v3pG0BqjBc
  - www.anthc.org/ak-id-echo
- 2023 theme ~ *Ways You Can Help Reduce Morbidity of Mortality From Liver Disease*
- June 15: Effective Strategies for Alcohol Use Disorder Screening – When, Where, and How to Implement

LiverConnect

- Second Tuesday of every month 8:00-9:00 AM
  - https://echo.zoom.us/meeting/register/tJUvdeytqT4vGtzmN4TyvItMlNRlZW7U38EU#/registration
  - www.anthc.org/hep/liverconnect
- July 11: When to Refer and Preparing a Patient for Liver Transplant



ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ADDITIONAL LEARNING OPPORTUNITIES

Addiction Medicine ECHO

- Second and fourth Thursday of each month from noon-1 p.m.
  - https://zoom.us/meeting/register/tJIvf-itrTsqHdZDfE3IZ_KuUZeD3lOkQiSR.
  - www.anthc.org/project-echo/addiction-medicine-echo
- June 22: LGBTQIA+ and Substance Use
- Email: behavioralhealth@anthc.org

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

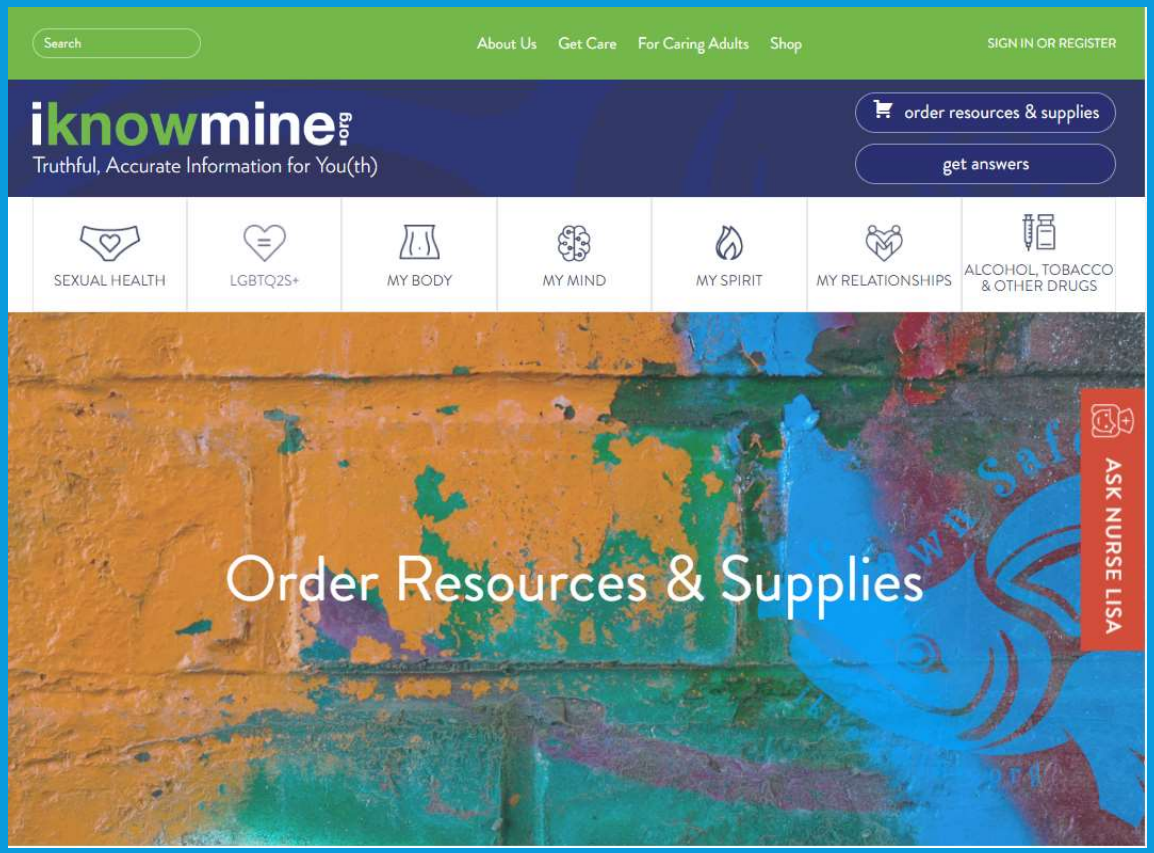
Indian Country ECHO Programs

- Harm Reduction, Infectious Disease, and more!

www.indiancountryecho.org/teleecho-programs

NPAIHB
Indian Leadership for Indian Health

Free prevention resources available at iknowmine.org/shop



HARM REDUCTION KIT

CONDOMS FOR ORGANIZATIONS

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

iknowmine.org

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Indian Leadership for Indian Health

Thank you!

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