A woman-centered approach to infant feeding and HIV

US & Canadian providers in discussion

(part 1 of 2)

Judy Levison, MD MPH
Shannon Weber, MSW
Deb Cohan, MD MPH
Whitney Waldron, RN
Mona Loutfy, MD, FRCPC, MPH
Wangari Tharao

Welcome!

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CENTER FOR LEARNING & INNOVATION

Mehroz Baig, MIA, MS

Communications Specialist

SFDPH, Center for Learning and Innovation

Contact Gary, our CBA Program Manager:

25 Van Ness Ave, Suite 500

San Francisco, CA 94102

T: (415) 437-6226

E: gary.najarian@sfdph.org

W: www.getSFcba.org

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Poll Question: What type of organization do you work for?

Housekeeping

Have questions during the webinar?

- Type them in the chat box!

Did you have a chance to complete the HPAT?

- If not, please do so via link in chat box!
- If yes, great! Sit back and enjoy the webinar!

Please be sure to complete the evaluation at the end of the webinar! We love all feedback.

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Webinar Tips

- Please do not put the phone line on HOLD during the webinar
- Please be sure your audio preference is selected – PC/Phone
- Please feel free to type comments/questions into the chat box
- Q&A – Raise your hand and we will call on folks individual

Twitter handles:

- @getSFcba
- @LoveYou2org
- @missmonaloutfy
- @DeborahCohan
- @Wangari_Tharao

Social Media Hashtag:
#SFHarmReduc

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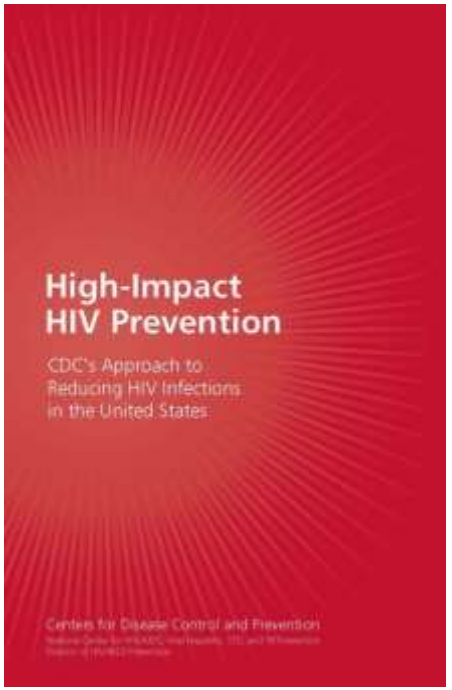
What is Capacity Building Assistance (CBA)?

CBA attempts to provide information, training, and technical assistance to the HIV prevention workforce in order to increase the adoption and implementation of high impact prevention strategies.



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HIV testing

- **Community-based testing** – Thomas Knoble
- **Testing in clinical settings** – Oliver Bacon, Stephanie Cohen
- **Home testing-** Hyman Scott, Oliver Bacon
- **Novel HIV testing technologies** – Severin Gose
- **Linkage/partner services-** Charles Fann
- **Internet Partner Services**– Frank Strona, Charles Fann
- **Perinatal HIV and testing** – Shannon Weber, Deb Cohan
- **Billing-** Denise Smith, Athina Kinsley

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Prevention for High Risk Negative Persons

- **PrEP/PEP-** Oliver Bacon, Stephanie Cohen, Jonathan Fuchs, Albert Liu, Shannon Weber, Deb Cohan, Judy Auerbach

- **Personalized Cognitive Counseling-** Tim Matheson/Ed Wolf

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Policy/Planning

- **Use of data to support HIV continuum efforts-** Data to Care: Susan Scheer, Charles Fann, Erin Antunez, Darpun Sachdev
- **Support of National HIV Behavioral Surveillance** – Henry Raymond Fisher
- **Social media to support outreach**– Frank Strona, Megan Canon (SFAF), Sapna Mysoor (AP&I WC)
- **Working with cross-sector partners** – Eileen Loughran
- **Harm Reduction Strategies with IDU** – Eileen Loughran
- **Jurisdictional Planning** – Dara Geckeler, Eileen Loughran

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A woman-centered approach to infant feeding and HIV

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Dr. Mona Loutfy

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Objectives for webinar #1 (today)

- Review current data on breastfeeding & HIV transmission
- Identify reasons why a woman living with HIV might consider breastfeeding
- Discuss a woman centered approach to infant feeding counseling in the setting of HIV

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Objectives for webinar #2 (Coming: Fall 2015)

- Describe co-management formats for pediatricians and ob/gyns
- Discuss approaches to multidisciplinary care for women living with HIV who are considering breastfeeding
- Explore risk management and legal implications

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Today's Overview

- Shannon introduction to topic (5 minutes)
- Dr. Levison reviews the data (15 minutes)
- Dr. Mona Loutfy on the Canadian story (5 minutes)
- Panelists introduce themselves: Wangari Tharao, Dr. Deb Cohan, & Whitney Waldron (2 mins each)
- Facilitated discussion with panelists (30 minutes)
- Questions from the audience (30 minutes)

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Where did this begin?

CROI Perinatal HIV Hotline lunch discussion 2/2012

- Informed choice model proposed
- Dynamic discussion between ob/gyns & pediatricians followed
- White paper discussion notes

http://nccc.ucsf.edu/wp-content/uploads/2014/05/CROI-2012-Informed_Choice_Breastfeeding_Discussion.pdf

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November 2012

Facilitated discussion at CDC's Elimination of Mother to Child Transmission (EMCT) Stakeholders group:

- Online information confusing for women
- Sense of loss expressed by women
- Concerns about bonding

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Publication of a risk reduction model, the response

Breastfeeding and HIV-Infected Women in the Uni
Stra

Judy Levi
[1]Department
[3]Department

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Issues in Applying a Harm Reduction Approach to Breastfeeding in the Context of Maternal HIV

To the Editor—A harm reduction approach to breastfeeding in the context of maternal human immunodeficiency virus (HIV) was a refreshing perspective to consider and we congratulate Levinson et al [1] on this provocative suggestion. Harm reduction as a counseling philosophy is in consonance with the World Health Organization guidelines, as both focus on informed parental decision making [2]. Choices regarding infant feeding are highly personalized for parents, and we must not negate that these choices

672 • CID 2015:60 (15 February) • CORRESPONDENCE

remain personal for women with HIV despite the limitations imposed by transmission risks and national guidelines.

discussion using a harm reduction approach [6].

There is also an ethical difference be-

Our group is finalizing a systematic review exploring risk of perinatal HIV transmission through breastfeeding among

Patient Pamphlets

Woman-centered printables about HIV and infant feeding:

- Bonding with your baby without breastfeeding
- Infant Feeding & Women Living with HIV

http://www.hiveonline.org/for-you/hiv-women/

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International Women & HIV Conference

February 2015 Dr. Mona Loutfy presents an oral abstract on infant feeding & HIV

- http://regist2.virology-education.com/2015/5thHIVwomen/08_Loutfy.pdf

We make a video for you: http://www.hiveonline.org/dr-mona-loufty-on-the-canadian-experience-listening-to-women-living-with-hiv-talk-about-breastfeeding

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Review of the data

Judy Levison, MD, MPH

Associate Professor, Department of Obstetrics and Gynecology

Baylor College of Medicine

United States Perinatal Guidelines March 2014

- Breastfeeding is not recommended for HIV-infected women in the United States, including those receiving cART

- Women who test positive on rapid HIV antibody assay should not breastfeed unless a confirmatory HIV test is negative

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Perinatal Guidelines: www.aidsinfo.nih.gov

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What is the thinking behind the guidelines?

- Prior to the availability of antiretroviral therapy, the risk of HIV transmission from breastfeeding mother to baby was 16%.

- If formula is available, feasible, affordable, safe, sustainable (AFASS)—such as the U.S., then not breastfeeding usually makes sense.

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Nduati et al. JAMA 2000; 283(9):1167-1174
Shapiro et al. International AIDS Society Conference 2006
Thior et al. JAMA. 2006;296(7):794-805

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What are the risks of formula feeding?

- In low resource areas of the world, formula feeding has been associated with higher rates of infant death than death from HIV.

- Mixed feeding (alternating breast and formula feeding) has a higher risk of HIV transmission than exclusive breastfeeding.

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Coutsoudis A et al. Lancet 1999. 354:471-6.
Coutsoudis A et al. AIDS 2001.15:379:-387.

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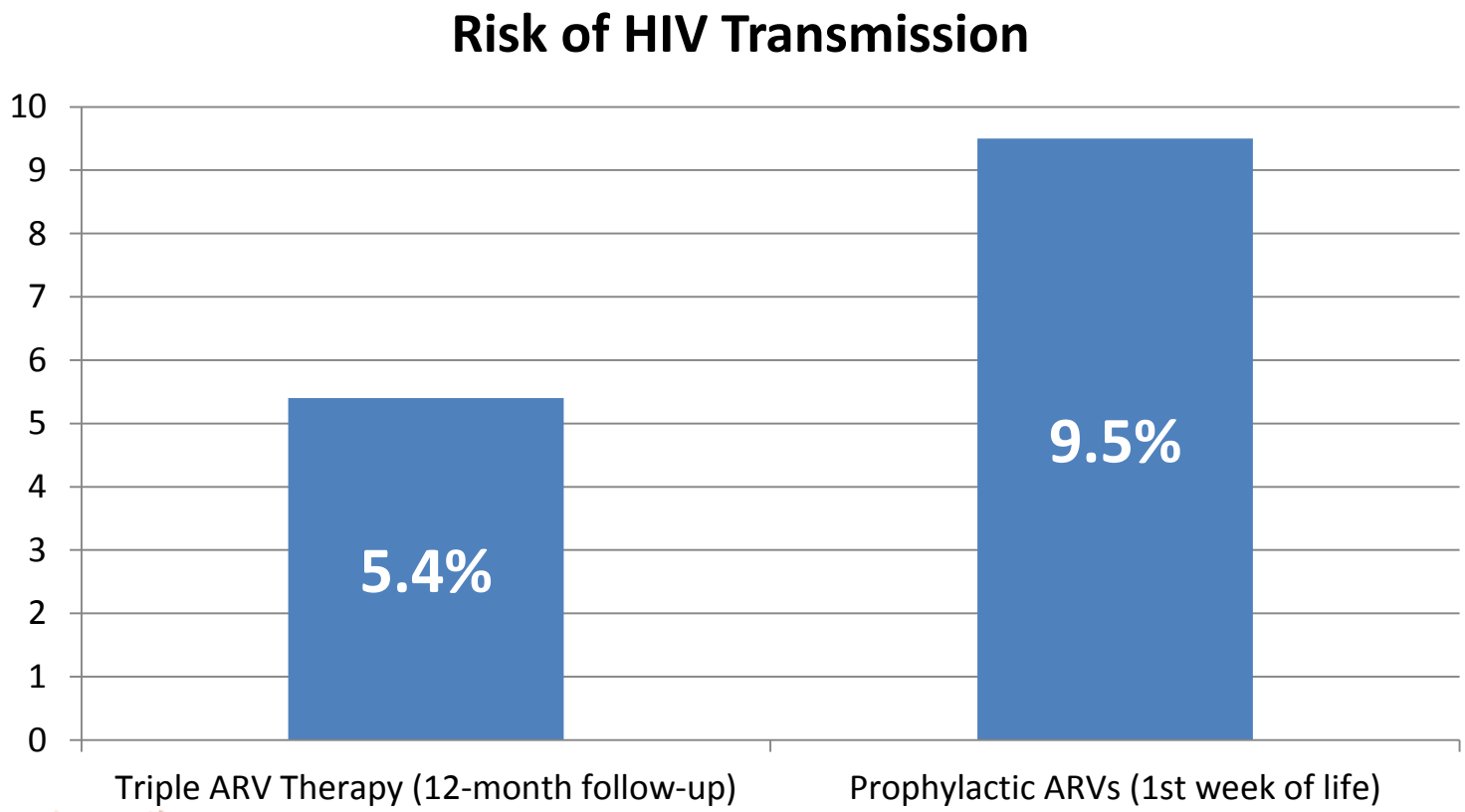
What is the HIV transmission rate associated **WITH** antiretroviral therapy? What is the evidence?

- Kesho Bora study
- Mma Bana study
- Breastfeeding, Antiretrovirals, and Nutrition (BAN) trial


Breast Milk/
Serology
Haematology

Kesho Bora study: maternal treatment while breastfeeding



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Kesho Bora Study Group. Lancet Infect Dis 2011;11:171–80.

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Mma Bana study (Botswana): maternal treatment while breastfeeding

1.1%

- Maternal ARV use among 560 women (zidovudine/lamivudine BID with a) abacavir OR b) lopinavir/ritonavir OR c) nevirapine) during pregnancy, and up to 6 months of breastfeeding was associated with a 1.1% cumulative risk of transmission

- 95% of all women had VL<400

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Shapiro R et al. N Engl J Med 2010; 362:2282–94

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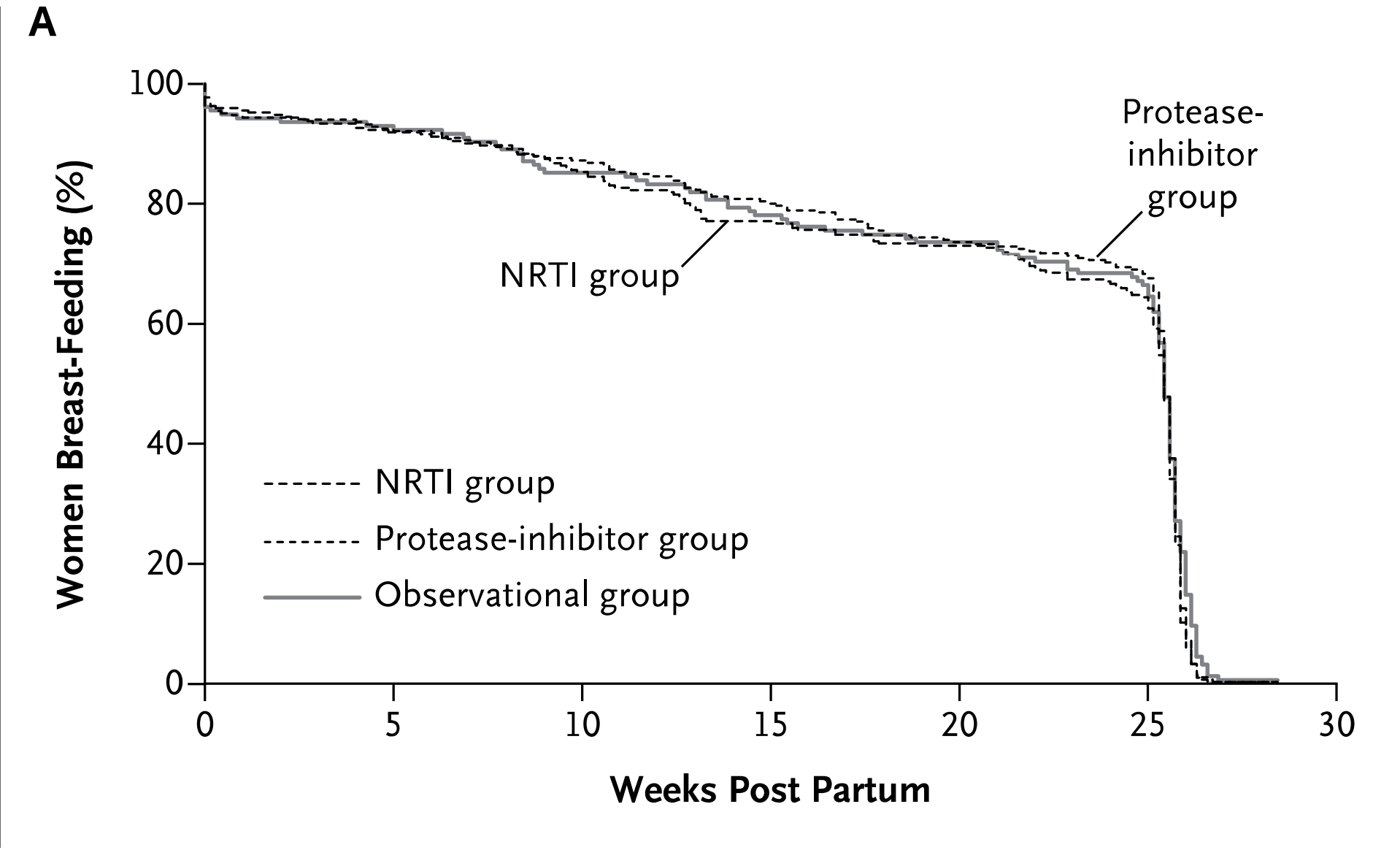
Shapiro p. 2288 Figure 2 A

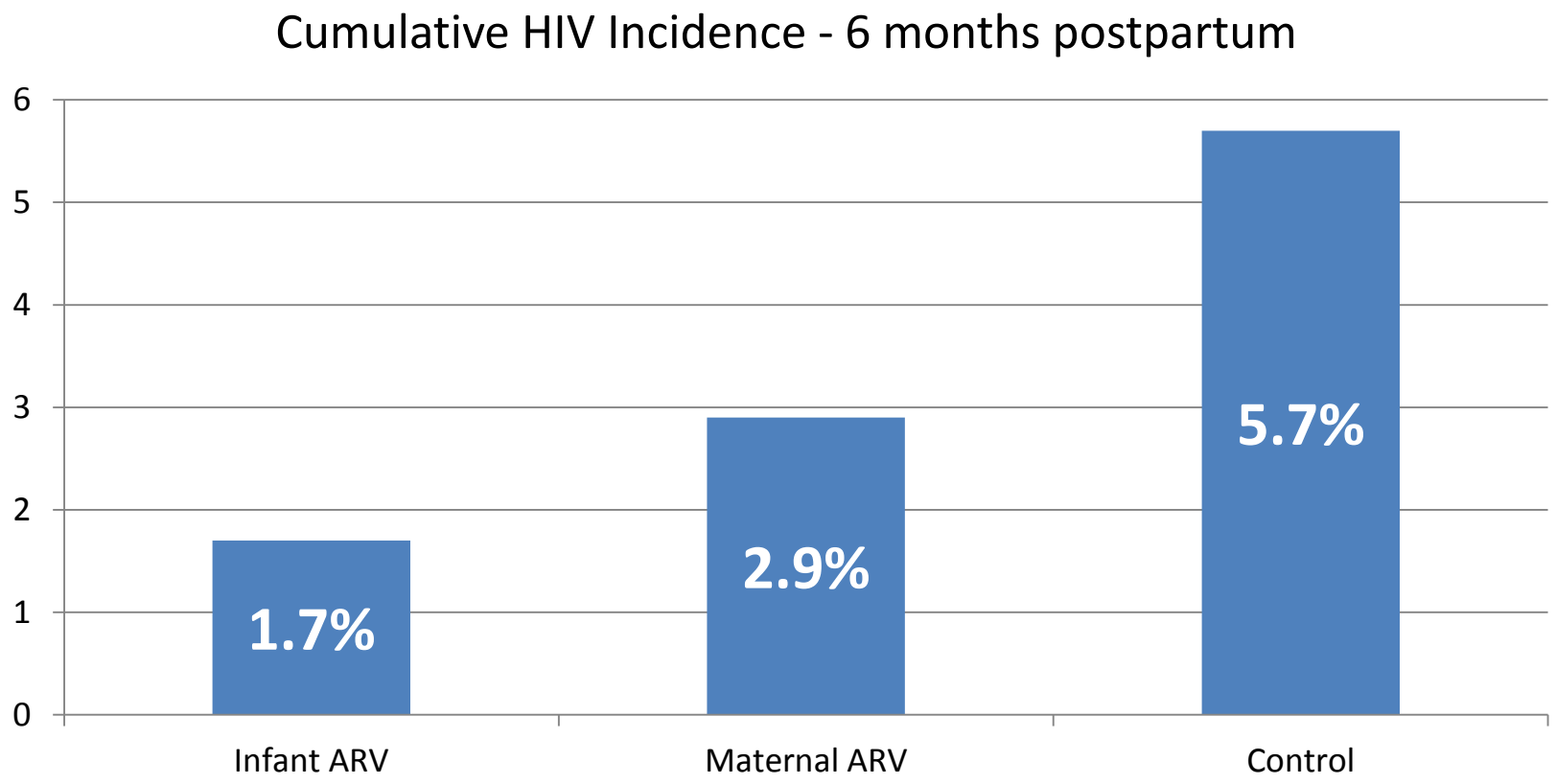


BAN Trial: Infant prophylaxis vs. maternal treatment while breastfeeding

- Compared infant ARV prophylaxis (daily nevirapine in increasing doses according to infant weight) vs. maternal ARV therapy (the majority received zidovudine/lamivudine with lopinavir/ritonavir BID) for the duration of breastfeeding vs. a control group of 1 week of neonatal ARV prophylaxis.

Chasela C et al.N Engl J Med 2010; 362:2271-81.

BAN Trial: Infant prophylaxis vs. maternal treatment while breastfeeding cont.



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Chasela C et al.N Engl J Med 2010; 362:2271-81.

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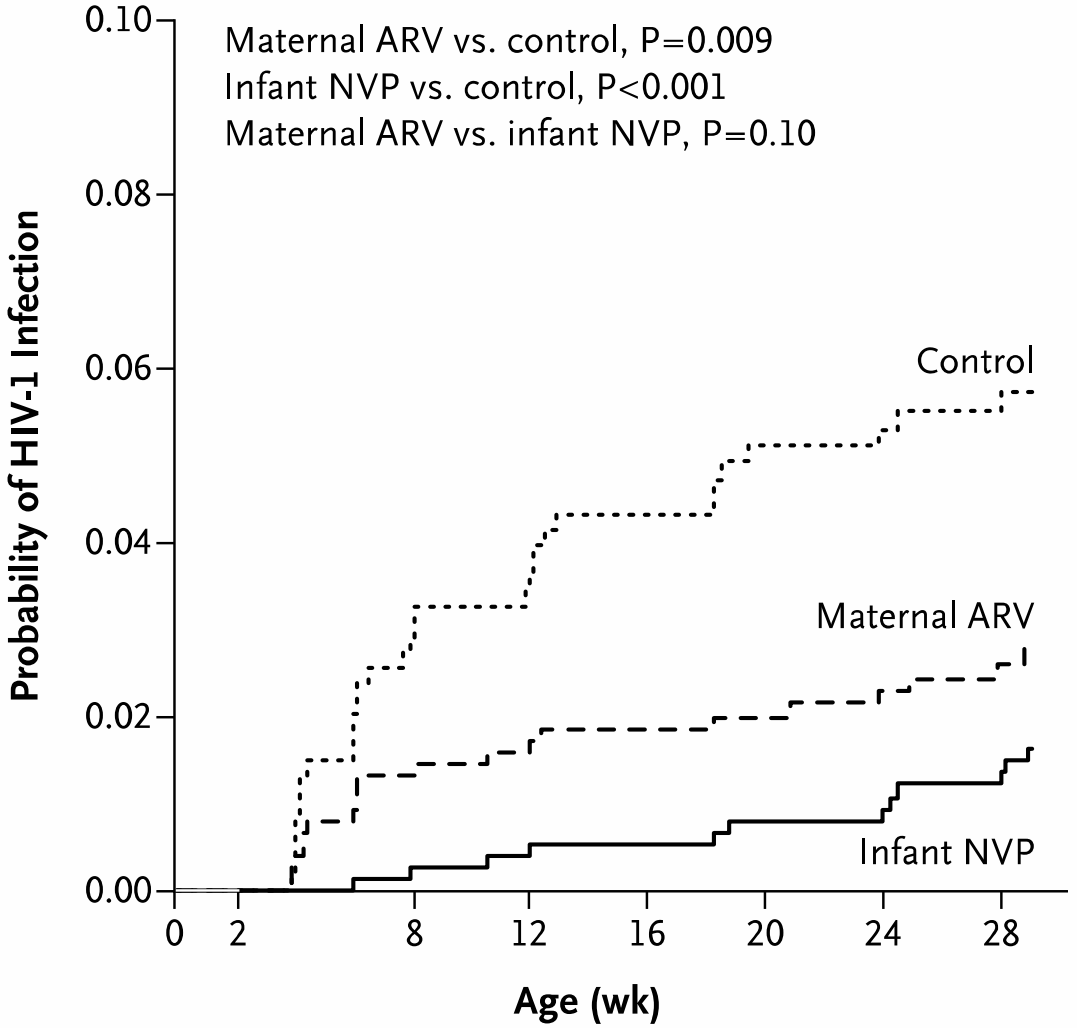
Chasela P. 2278
Figure 2 A

A HIV-1 Infection in HIV-1–Negative Infants at 2 Weeks



No. at Risk

Control	600	558	539	514	480	476	471
Maternal ARV	767	731	715	699	683	679	662
Infant NVP	785	752	741	727	710	706	687

WHO guidelines (2010)

- Treat mother with ARVs until baby fully weaned

OR

- Treat baby with ARVs until fully weaned

ARV-prophylaxis options for HIV-infected pregnant women who do not need ART for their own health

Option A: Maternal AZT	Option B: Maternal triple ARV prophylaxis
MOTHER	**MOTHER**
• Antepartum AZT (from as early as 14 weeks gestation) • sd-NVP at onset of labour* • AZT+3TC during labour and delivery* • AZT+3TC for 7 days postpartum* * sd-NVP and AZT+3TC can be omitted if mother receives >4 weeks of AZT antepartum	Triple ARV from 14 weeks until one week after all exposure to breast milk has ended • AZT + 3TC + LPV/r • AZT + 3TC + ABC • AZT + 3TC + EFV • AZT + 3TC (or FTC) + EFV
INFANT	**INFANT**
Breastfeeding infant Daily NVP from birth until one week after all exposure to breast milk has ended *Non-breastfeeding infant* AZT or NVP for 6 weeks	*Breastfeeding infant* Daily NVP from birth to 6 weeks *Non-breastfeeding infant* AZT or NVP for 6 weeks

WHO Guidelines

Who wants to breastfeed in the U.S.?

- Case 1: A 32-year-old woman, originally from Nigeria, was diagnosed with HIV during her current pregnancy. During prenatal care, she communicated to her obstetrician her desire to breastfeed.

- She feared that not breastfeeding would raise suspicion in her community about her HIV status.

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Case 1 (continued)

- The patient was referred to the local pediatric HIV specialist, who explained the risks of HIV transmission via breastfeeding. The patient expressed relief to discuss her concerns with a provider. Knowing she had options provided a space for her to contemplate the best decision for her situation.

- She opted to breastfeed for 6 weeks, both to "prove" to her community that she does not have HIV and in response to public messages that "breast is best." Both she and her baby remained on ARVs while she breastfed.

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Who wants to breastfeed in the U.S.?

- Case 2: A 35 year old woman recently diagnosed with HIV, known HIV+ partner discloses not breastfeeding is the hardest part of adjusting to her diagnosis
- She'd breastfeed her first child for 2 years and planned to do the same with this infant, feels breastfeeding provides the best nutrition, immune support and optimal bonding
- After discussing all the options including the risks of HIV transmission, unknown safety of infant exposure to ARVs through breast milk and other alternatives for infant feeding, she ultimately decides to bottle feed with banked breast milk.

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Our approach to infant feeding discussion

- Ask: "In the U.S. it is recommended not breastfeeding if a woman has HIV. Is that an issue/problem for you?"

- If, after hearing the risks, the woman still wants to breastfeed, then what?

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Harm reduction strategy: theory behind our practice

- "People will make more health-positive choices if they have access to adequate support, empowerment, and education."

- An example of harm reduction is needle exchange programs (better not to use IV drugs but if you are going to, then use clean needles to reduce your risk of HIV, hepatitis, and bacterial infections)

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Marlatt GA et al. Harm reduction: pragmatic strategies for managing high risk behaviors. 2nd ed. New York: Guilford Press, 2012.

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Risk Reduction Framework

- **Validate** her desire to breastfeed
- **Seek** to understand her motivation to breastfeed
- **Explore** alternatives
- **Offer** harm reduction

Harm Reduction Approach

1. **Discuss** timing of and methods of weaning with options
2. **Discuss** what is known and not known about reduction in lactational HIV transmission
3. **Explain** that exclusive breastfeeding appears safer than mixed formula/breastfeeding
4. **Ensure** the woman is receiving a suppressive ARV regimen
5. **Discuss** the option of infant ARV prophylaxis beyond the standard 6 weeks of zidovudine syrup

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Harm Reduction Approach Cont.

6. **Monitor** maternal viral load monthly
7. **Conduct** HIV polymerase chain reaction testing for the infant monthly while breastfeeding and at 1, 3, and 6 months after weaning
8. **Monitor** the infant for evidence of hematologic toxicity depending on ARV regimen and pediatric recommendations
9. **Educate** the woman about presenting for care immediately for signs of mastitis

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IHPREG

INTERDISCIPLINARY
HIV PREGNANCY
RESEARCH GROUP

Dr. Mona Loutfy

Ms. Wangari Tharao

AN INTERDISCIPLINARY APPROACH TO UNDERSTANDING INFANT FEEDING IN THE ERA OF HIV

HIV & Infant Feeding Forum

A Collaboration Between

Community forum

HIV & Infant Feeding in Ontario

A day to talk about the issues related to infant feeding

Saturday, September 21st, 2013

Specific location in Toronto to be announced

Participants Will:

- Exchange information about infant feeding guidelines in Ontario
- Learn more about the risk of transmission with breastfeeding
- Hear from experts about clinical issues, research, and the law
- Help guide future research in Ontario on this topic

THE COMMUNITY FORUM IS FREE BUT REQUIRES ADVANCED REGISTRATION

Registration begins on Monday, July 29th 2013 and ends Monday, September 16th 2013

Please Register by email to marvelous@whiwh.com OR logan.kennedy@wchospital.ca

Lunch will be provided. Space is limited.

For more information you can contact *Logan* Kennedy at logan.kennedy@wchospital.ca Or 416-351-3732 ext. 2784

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WHAT ARE THE CONTROVERSIES?

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Outlining the main issues for HIV and Infant feeding

Controversy 1: Contradicting Guidelines

Controversy 2: In the era of ART, how much of a risk is there?

Controversy 3: Misunderstanding of the science

Controversy 4: Psycho-social, stigma, fear issues

Controversy 5: Legal implications

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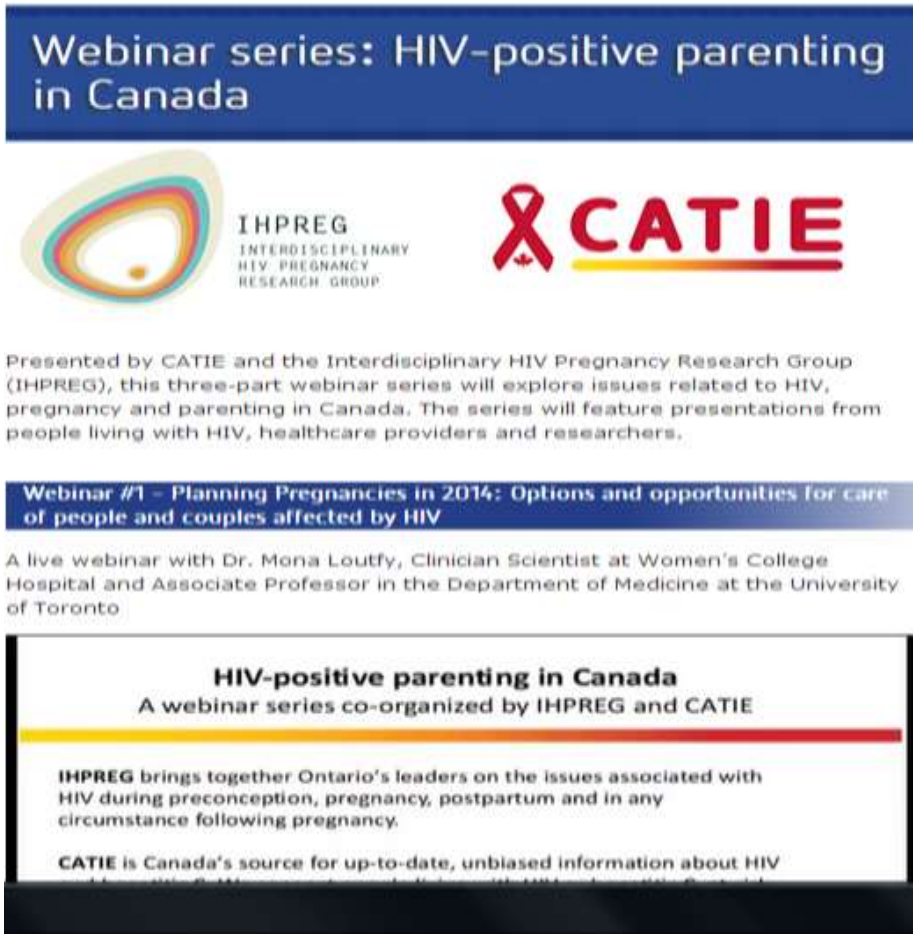
People listened & asked questions

Community wanted to know

Activities

1. Webinar with CATIE



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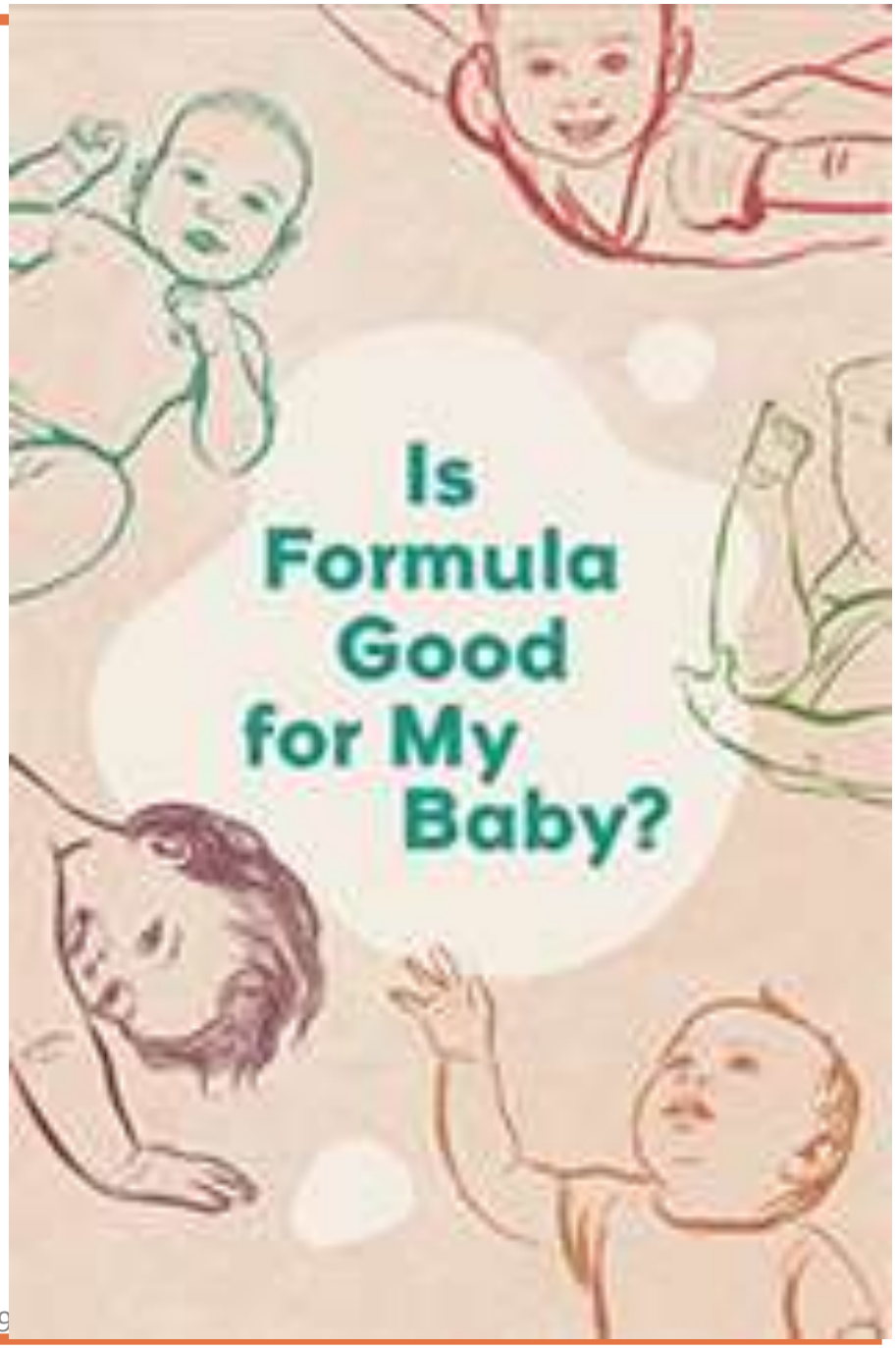
Activities

2. Patient resource with CATIE

CATIE

Canada's source for HIV and hepatitis C information



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Activities

3. HIV Infant Feeding Working Group

Agenda

When: Thursday, February 7th, 2013
Where: The Ontario HIV Treatment Network, 1300 Yonge Street, Suite 600, Toronto, Ontario
Schedule of Events

Time	Item	Presenter(s)
8:00 – 8:30 am	ARRIVAL AND BREAKFAST	
8:30 am	WELCOME	Dr. Mona Loutfy and Maureen Ringlein
8:35 – 8:50 am	RESULTS OF SCOPING REVIEW	Logan Kennedy and Dr. Mona Loutfy
8:50 – 9:00 am	UPDATE ON BASIC SCIENCE LITERATURE	Dr. Lena Serghides
9:00 – 10:00 am	ONTARIO PILOT DATA	Dr. Lydia Kapiriri and Wangari Tharao
10:00 – 10:30 am	COFFEE BREAK	
10:30 – 11:00 am	RESULTS FROM THE MOTHERING STUDY	Dr. Saara Greene
11:00 – 11:15 am	MATERNAL CLINCAL CONSIDERATIONS	Dr. Mark Yudin and Jay MacGillivray RM
11:15 – 11:30 am	DISCUSSION OF DATA FROM ONTARIO	ALL
11:30 – 12:00 pm	LUNCH BREAK	
12:00 – 12:45 pm	BASIC SCIENCE RESEARCH CONSIDERATIONS	Dr. Kenneth Rosenthal
12:45 – 1:15 pm	NETWORKING BREAK	
1:15 – 1:45 pm	PEDIATRIC/FAMILY CONSIDERATIONS	The Teresa Group
1:45 – 2:15 pm	PEDIATRIC CLINICAL CONSIDERATIONS	Dr. Ari Bitnun and Georgina MacDougall RN
2:15 -2:45 pm	DISCUSSION OF PEDIATRIC CONSIDERATIONS	
2:45 – 3:00 pm	BREAK	
3:00 – 3:45 pm	OPEN DISCUSSION	
3:45 – 4:30 pm	NEXT STEPS AND SETTING PRIORITIES	

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IHPREG

The Teresa Group

The IHPREG and Teresa Group Infant Feeding Working Group

One Day Meeting Report

Hosted by The Ontario HIV Treatment Network

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Acknowledgements

This research was made possible through the generous support of the following:

Ontario HIV Treatment Network

CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada

Special thanks to our research teams:

IHPREG
INTERDISCIPLINARY HIV PREGNANCY RESEARCH GROUP

McMaster University

The Teresa Group

WCHRI
WOMEN'S COLLEGE RESEARCH INSTITUTE
Health care for women REVOLUTIONIZED

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CENTER FOR LEARNING & INNOVATION

CPN
BUILDING THE CAPACITY OF THE NATION'S HIV PREVENTION WORKFORCE
Funded by Centers for Disease Control and Prevention

Panel Discussion

Dr. Mona Loutfy

Whitney Waldron

Dr. Judy Levison

Dr. Deb Cohan

Wangari Tharao

Moderator: Shannon Weber

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CLINICIAN CONSULTATION CENTER

National rapid response for HIV management and bloodborne pathogen exposures.

Perinatal HIV Advice
(888) 448-8765, 24/7
nccc.ucsf.edu

The **Perinatal HIV Hotline** provides clinicians of all experience levels with cost-free, round-the-clock, expert advice on:

- Managing HIV in pregnant mothers and their infants
- HIV testing in pregnancy
- Preventing transmission in labor, delivery and post-partum period

The **ReproID HIV Listserv** is a forum to connect with providers, discuss perinatal HIV cases, and share resources. Contact Brenda Goldhammer, Program Manager, at goldhammerb@ucsf.edu to join.

Our mission is to improve patient health outcomes by building the capacity of healthcare providers through expert clinical consultation and education.

Poll Question: My organization would be interested in further customized training or technical assistance on perinatal HIV.

Questions from Participants

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Office Hours! 7.23 Starting at 10 am PST

- You can chat with Shannon about:
  - Talk in detail about the crossroads of infant feeding decisions and disclosure: what are options?
  - Practice the conversation: bringing up infant feeding options with a women living with HIV
  - Brainstorm about creating collaborative efforts in your area to support women with their infant feeding choices (milk banks, bottle feeding and bonding sessions, etc.)
  - Discuss adapting the patient brochures to your local area

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www.getSFcba.org/events

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