NCTCFP
NATIONAL CLINICAL TRAINING CENTER FOR FAMILY PLANNING

Virtual Coffee Break Transcript

Title: Be PrEPared: The Essential Role of Family Planning Providers in HIV Prevention
Guest Speaker: Courtney Benedict, MSN, CNM
Duration: 00:12:23

NCTCFP: Welcome to this virtual coffee break sponsored by the National Clinical Training Center for Family Planning. The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide training to enhance the knowledge of family planning staff. Our guest presenter today is Courtney Benedict from the Planned Parenthood Federation of America.

Courtney is a certified nurse midwife with over 15 years of experience in reproductive health care settings. She has served as a member of the Expert Work Group Panel for the CDC Quality Family Planning Practice Guidelines and currently works as Associate Director of Medical Standards Implementation at Planned Parenthood Federation of America. Welcome Courtney.

Courtney Benedict: Thank you, Katherine, and good afternoon to you all. And thank you for coming to this session. We will be discussing the essential role family planning providers should and must play in HIV prevention. I have no disclosures. Our objectives for this session are to discuss the disparities in HIV infection in the US, as well as the disparities in HIV prevention efforts. We will also discuss how PrEP fits in with other strategies in HIV prevention within family planning services.

So I'm wondering of you listening to this, how many of you are already providing prep? Perhaps, these slides will be a review for you. For those of you who are just starting prep services or considering it, I'm going to first set the groundwork by looking at some important statistics around HIV and prevention efforts in the United States. The overall good news is that the incidence of HIV infection in the US is declining, but there remains some very concerning data around HIV incidence.

For instance, one in seven people living with HIV in the United States are unaware of it. This should really perk your ears. As providers of

sexual and reproductive health care, we should be concentrating efforts on screening and educating on the importance of screening for HIV.

Unfortunately, black or African-American people represent a disparate number of those who are unaware of their HIV positive status. This should again perked our ears, as this is an opportunity to reduce this disparity and bring screening to patient populations who need it very much. While black and African-American people account for 12% of the US population, they account for 42% of all new HIV infections in the United States. Again, we should be on alert and thinking about how we can engage more of our patients in HIV prevention efforts, especially to address this disparity in newly diagnosed HIV infections.

Please also note that of that 42% of new infections, 60% are men who have sex with men. That means 40% are not. Of those 60% of men who are having sex with men, the majority of newly diagnosed HIV infections are in people under 35. There are also geographic disparities that exist.

Southern states only account for 38% of the country's population, but they account for about half of the new HIV infections diagnosed every year, about half of persons living with HIV, and about half of undiagnosed infection. This graph is showing new HIV infections in the United States in 2017 by gender and risk factors. Please note that blacks heterosexual women are much more likely to be newly diagnosed with HIV than black heterosexual men, and they are also more likely to be newly diagnosed than white or Hispanic women.

This is a close up of newly diagnosed women by race and ethnicity, and you can see the prevalence in which black women are being newly diagnosed with HIV. This is alarming. In this map, the darker this shade of blue, the higher the rate of HIV diagnosis, Florida, Georgia, and Louisiana are among the most vulnerable.

When you tease out the rate of diagnoses by gender, you can see that the District of Columbia and Louisiana have the highest prevalence, and many of the south east and New England states have high rates as well. Here we can see the age of diagnoses in females note that females 25 to 34 years old are the second highest age group for newly diagnosed HIV infections and probably the age of a lot of your patients. What about the type of sex or intravenous drug use and the relative risk? Your risk of acquiring HIV is highest when sharing needles and having receptive anal intercourse when you take out blood transfusions and childbirth.

This graph looks at unique individuals starting Truvada in the United States from 2012 to 2015 by quarter. We can see a 738% increase from

2012 to 2015. 2012 is when Truvada was approved in the US. But how about youth across various at risk population?

The population of prep users in the United States is significantly increasing, but it is not proportionately in line with the racial demographics of new infections. New starts of prep increased among white people in 2015 while black uptake lagged. In this last pie chart, we can see that 44 percent of African-American newly diagnosed. But in the middle pie chart, you can see African-Americans only account for 10% of all prescription.

These data points represent 43% of unique individuals who started prep from 2012 to 2015. The groupings across the x-axis are white people, Hispanic, African-American, and Asian with women noted in darker red and men in lighter red. The number of women who initiate prep is low across all ethnicities and races.

But we can see here that the rate of prep initiation among women who are African-American and Hispanic is even lower than white women. Male uptake increased while the female uptake remains flat and disproportionately lower in black women. To decrease new infections in populations with the most severe burden of HIV, we as providers need to have a clear understanding of who are candidates for prep and how to educate and message risk of HIV to specific populations. That process involves all health care providers examining their own bias or stigma around communicating HIV risk, especially specific patient populations.

Just look at all of these people with indications for prep. We have a lot of work to do considering those prep utilization pie charts we just looked at. And remember that when a person has an indication for prep, we also need to offer risk reduction counseling, which includes condom education and other behavioral risk reduction counseling strategies to reduce their risk of acquiring HIV.

This is a nice summary table available from the Centers for Disease Control on how to initiate and monitor patients with prep. So who should receive patient education on HIV prevention and prep? Really everyone, but especially those populations who are disparately at risk for being newly diagnosed with HIV. And a particular concern among many of our family planning patients is pregnancy and preconception or pre-pregnancy.

Pregnancy is associated with an increased risk of HIV acquisition. Risk is substantial for women whose partners are not taking antiretroviral treatment medication or women whose partners are treated but not virally suppressed. Women whose partners have documented sustained

viral load suppression are at effectively no risk of sexual acquisition of HIV. Clinicians providing preconception and pregnancy care to women who report that their partners have HIV but by the load status is unknown or our reported detectable should use PrEP during the preconception period in pregnancy.

Both the FDA label information and the perinatal antiretroviral treatment guidelines from the CDC permit off label use of PrEP in pregnancy. Providers should educate HIV discordant couples who wish to become pregnant about the potential risks and benefits of all available alternatives for safer conception and, if indicated, make referrals for assisted reproduction therapies. Whether or not PrEP is initiated the HIV infected partner should be prescribed effective antiretroviral therapy before attempting conception.

The safety of PrEP with Truvada versus Tenofovir alone for infants exposed during breastfeeding has not been adequately studied. However, data from studies of infants born to HIV infected mothers and exposed to Tenofovir through breast milk suggests limited drug exposure. But the WHO has recommended the use of Tenofovir for all pregnant and breastfeeding women for the prevention of perinatal and postpartum mother to child transmission of HIV in women infected.

Therefore, providers should discuss current evidence about the potential risks and benefits of beginning or continuing perhaps during breastfeeding so that an informed decision can be made. Finally, I want to leave you today with some resources for learning more about PrEP and HIV prevention. The CDC has a guide pre-exposure prophylaxis for the prevention of HIV infection in the United States that's been recently updated in 2017.

The Office of Population Affairs along with CDC, FP, and Atlas have created a wonderful decision-making guide for the provision of PrEP services entitled 10 funded family planning service sites. And the University of California San Francisco has a clinician consultation center that is available as a resource for PrEP guidelines and clinical practice. I want to thank you for joining us today for this webinar and look forward to future education on HIV prevention and family planning. Thank you.

NCTCFP: Thank you so much, Courtney.