Preconception, Contraception and Conception for Women Living With HIV (WLWH): How Health Home Care Managers Can Provide Support to Facilitate Improved Health Outcomes
Webinar Series for Health Home Care Managers

• **Part 1**: Preconception, Contraception, Conception/Pregnancy Counseling and Care for Women Living With HIV (WLWH) & the Prevention of Mother-to-Child Transmission (PMTCT) of HIV

• **Part 2**: Postpartum Care for WLWH, Care of HIV-Exposed but Uninfected Newborns & Breastfeeding Recommendations to PMTCT for both WLWH and Women at High Risk for Acquiring HIV

• **Part 3**: Post Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP) & Care of Women at Risk for HIV
Objectives for Health Home Care Managers

• Recognize preconception, contraception and conception recommendations and needs specific to women living with HIV (WLWH)

• Identify actions to optimize health and minimize risk in WLWH and their partners throughout the stages of family planning

• Understand strategies to reduce the risk of mother-to-child transmission (MTCT) of HIV
HIV Prevalence and Number of HIV Positive Childbearing Women in New York State by Year of Delivery, 1988-2016

- Number HIV Positive:
  - 1,898 in 1988 (0.65%)
  - 830 in 1990 (0.33%)
  - 416 in 2016 (0.18%)

- Percent Positive:
  - Approximately 400 HIV positive women give birth each year in New York State

78% decline in number and 72% decline in rate from 1990 to 2016
Race/Ethnicity Distribution of Childbearing Age Women*, Childbearing Age Women Living with HIV*, and Women Living with HIV Giving Birth, NYS, 2016

Childbearing Age Women: 15-45 years old

- Non-Hispanic White: 57%
- Non-Hispanic Black: 17%
- Hispanic: 16%
- Asian: 1%
- Other: 1%

Childbearing Age Women with HIV: 9%
- Non-Hispanic White: 9%
- Non-Hispanic Black: 54%
- Hispanic: 1%
- Asian: 1%
- Other: 6%

Women with HIV Giving Birth: 3%
- Non-Hispanic White: 7%
- Non-Hispanic Black: 59%
- Hispanic: 30%
- Asian: 1%
- Other: 1%

*Childbearing Age: 15-45 years old
Number and Rate of Mother-to-Child HIV Transmissions by Year of Delivery, New York State, 1997-2016

* 1990 - estimate based on 1,898 exposures and an estimated 25% transmission rate
**1997 data include February-December births.
Preconception:

Preconception Counseling and Care for Women of Childbearing Age Living with HIV
General Principles of the Importance of Preconception Care

• Provides opportunities to improve outcomes for mothers and babies

• Requires active participation of women and individualized management plans

• Facilitates discussion on diet, weight, exercise, smoking, use of alcohol and/or drugs, environmental risks, vaccination status

• Encourages management of medical conditions, such as HIV
Goals of Preconception Care Specific to WLWH

• Prevent unintended pregnancy
• Prevent HIV transmission to partner
• Optimize maternal and paternal health
• Improve maternal and fetal outcomes
• Prevent perinatal HIV transmission through multiple interventions, including rapid, sustained maternal viral load suppression (VLS)

ACOG Practice Bulletin No.167; Oct, 2016
Preconception Counseling for WLWH (1)

- Non-judgmental and respectful of woman’s autonomy in reproductive decision-making
- Non-stigmatizing and reassuring that she can have a safe, healthy pregnancy with very low risk of MTCT

❖ Important:
  - Require multiple interventions to reduce MTCT to the lowest possible level
  - Acknowledge maternal anxiety, if present, and provide support
  - Prioritize and focus on HIV management, but not to overshadow the pregnancy → Pregnancy should not be defined by HIV.
Preconception Counseling for WLWH (2)

- Active, ongoing assessment of a woman’s pregnancy intention
- Discussion of contraceptive options
  - prevention of unintended pregnancies, and
  - spacing and timing of intended pregnancies
- Emphasize health promotion, risk reduction and behavioral change, as indicated
Preconception Counseling for WLWH (3)

• All WLWH of childbearing potential should be counseled regarding dual-protection contraception/safer sex practices (e.g., condom and another form of contraception)
  – Prevent HIV transmission to sexual partners
  – Protect WLWH from sexually transmitted infections (STIs)
  – Decrease risk of acquisition of resistant strains of HIV

Preconception Counseling for WLWH (4)

• Plan to initiate, continue, or modify antiretroviral therapy (ART) to optimize the woman’s health, regardless of pregnancy intention, and to reduce MTCT risk
  – Assess teratogenicity
• Assess potential barriers to ART adherence and strategize/implement ways to reduce/eliminate
• Achieve and maintain a sustained, undetectable viral load (viral load suppression – VLS) through ART adherence and regular, ongoing HIV care
Preconception Counseling for WLWH (5)

• What does Undetectable mean?
  – Undetectable describes the lowest limit that different lab tests use to measure the amount of virus (viral load) in a person’s bloodstream (plasma); usually reported as copies of virus per millimeter (mL) of blood
  – Undetectable = 200 copies/mL or less (more commonly 20 copies/mL or less)

• What does Viral Load Suppression (VLS) mean?
  – VLS is the continuous, long-term suppression of a person’s viral load (generally to undetectable levels) as the result of treatment with antiretroviral (ARV) medications

https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/876/undetectable-viral-load
https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/1650/viral-suppression
# Unintended Pregnancy

<table>
<thead>
<tr>
<th>Mistimed</th>
<th>Unwanted</th>
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</table>
| • Woman did not want to become pregnant at the time pregnancy occurred but **did want to become pregnant at some point in the future** | • Woman **did not want to become pregnant then or at any time in the future**  
• 18% of pregnancies |
| • 27% of all pregnancies                      |                                                            |

Potential Health Impacts of Chronic Disease
UNINTENDED PREGNANCY RATES

Between 1981 and 2011, unintended pregnancy has become increasingly concentrated among poor and low-income women.

Rate (per 1,000 women aged 15–44)

- <100% of poverty
- 100-199% of poverty
- All women
- ≥200% of poverty

Unintended pregnancy rates varied widely in 2010.

No. of unintended pregnancies per 1,000 women aged 15–44

- 32–40
- 41–47
- 48–54
- 55–62


Source: Guttmacher Inst. "Unintended Pregnancy in the United States"
Preconception/Prepregnancy Counseling

• **Desires pregnancy:**
  - Discuss with primary/HIV health care provider
  - May refer to maternal-fetal medicine specialist
  - Focus on improving/stabilizing health
  - Determine medication safety for use with pregnancy

• **Does not desire pregnancy:**
  - Refer to primary or women’s health care provider for contraceptive counseling
  - Discuss availability of effective and highly effective contraception
  - Remove barriers to access contraception

*May refer to Ryan White Funded Programs & Services*
Preconception - Bottom Line: What Health Home Care Managers Need to Know

• Prevention is paramount
• Open communication about family planning needs and desires is necessary
• Access to reproductive health services and autonomous decision-making should be supported
• Ongoing HIV care, ART adherence and VLS are key
Contraception Counseling and Care for Women of Childbearing Age Living with HIV
US Medical Eligibility Criteria for Contraceptive Use

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf
## US Medical Eligibility Criteria: Categories

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>No restriction for the use of the contraceptive method for a woman with that medical condition</td>
</tr>
<tr>
<td>2</td>
<td>Advantages of using the method generally outweigh the theoretical or proven risks</td>
</tr>
<tr>
<td>3</td>
<td>Theoretical or proven risks of the method usually outweigh the advantages – or that there are no other methods that are available or acceptable to the women with that medical condition</td>
</tr>
<tr>
<td>4</td>
<td>Unacceptable health risk if the contraceptive method is used by a woman with that medical condition</td>
</tr>
</tbody>
</table>
Most Effective

Less than 1 pregnancy per 100 women in a year

- Implant: 0.05%
- Reversible Intrauterine Device (IUD): LNG - 0.3% Copper T - 0.8%
- Male Sterilization (Vasectomy): 0.15%
- Permanent Female Sterilization (Abdominal, Laparoscopic, Hysteroscopics): 0.5%

Injectable: Get repeat injections on time.
- Pills: Take a pill each day.
- Patch, Ring: Keep in place, change on time.
- Diaphragm: Use correctly every time you have sex.

Least Effective

18 or more pregnancies per 100 women in a year

- Male Condom: 18%
- Female Condom: 21%
- Withdrawal: 22%
- Sponge: 24% parous women, 12% nulliparous women

Fertility-Awareness Based Methods

- Fertility-Awareness Based Methods

Spermicide

Other Methods of Contraception

Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

Condoms should always be used to reduce the risk of sexually transmitted infections.
Contraception Counseling for WLWH (1)

- HIV infection does not preclude the use of any contraceptive method; however, drug-drug interactions between hormonal contraceptives (e.g., pill, patch, ring, injection, implant) and ARV medications should be considered
  - Drug-drug interactions may include lower contraceptive efficacy

- Resources are provided at the end of the presentation to assist with contraceptive counseling

## Contraception Counseling for WLWH (2)

<table>
<thead>
<tr>
<th>ARV Drug</th>
<th>Effect on Contraceptive Drug Levels and Contraceptive's Effects on ART and HIV</th>
<th>Clinical Studies</th>
<th>Dosing Recommendation/Clinical Comment for COC/P/R</th>
<th>Dosing Recommendation/Clinical Comment POPs</th>
</tr>
</thead>
</table>

- More reported contraceptive failures but no concern for decreased therapeutic efficacy of the woman’s ART
- Efficacy of different hormonal contraception likely similar to oral contraceptive pills (combined/progestin-only) with “typical use”
  - Failure rate of 6 to 12 pregnancies per 100 women in a year

Intrauterine Devices (IUD) and HIV

• No evidence of increased HIV transmission or acquisition with IUDs (both LNG-levonorgestrel releasing and copper)

• No evidence of increased infections even in WLWH with low CD4

https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6503.pdf
Contraception Decision-Making

- What method does she want to use?
- What is important to her in choosing a contraceptive method?
- What has she heard from her friends, advertisements, others?

❖ The most effective form of contraception is the one she will use!
Contraception - Bottom Line: What Health Home Care Managers Need to Know

- HIV does not prevent the use of any birth control method, but
  - Some ARVs may make hormonal contraceptives less effective
  - WLWH should speak with their provider about best options
- Dual protection/safer sex practices should be promoted, including the use of condoms, to prevent HIV/STI acquisition/transmission
- Access to reproductive health services is vital
- Ongoing HIV care, ART adherence and VLS are key
Optimizing Health/Reducing Risk in the Context of HIV (1)

- Establish/maintain routine, ongoing HIV primary and gynecologic care
- Achieve and sustain clinical and immunologic stability
  - Including rapid, sustained VLS
- Provide prophylaxis for opportunistic infections, when indicated
- Manage comorbidities (diabetes, HTN, etc.)
- Implement lifestyle changes: engage in regular physical activity, lose weight if overweight/obese
Optimizing Health/Reducing Risk in the Context of HIV (2)

• Administration of varicella, rubella, hepatitis A, hepatitis B and influenza vaccines before pregnancy
• Avoidance of medications known to be harmful to the fetus
• Maintenance of good oral health
• Supplementation with folic acid
Optimizing Health/Reducing Risk in the Context of HIV (3)

• Smoking, alcohol and drug cessation; alcohol and drug rehabilitation/treatment, when necessary
• Treatment of opioid use disorder (e.g., medication-assisted treatment/MAT with Buprenorphine or Methadone, access to syringe exchange programs)
• STI testing and treatment of woman and partner(s), including HIV, HCV, syphilis, Chlamydia and gonorrhea
Optimizing Health/Reducing Risk: WLWH and Their Partners (1)

- Inquire if partner(s) is/are aware of woman’s HIV status
- If not, explore with woman barriers to disclosure
- Complete a domestic violence screen
- Develop a disclosure plan
- Offer resources to assist with disclosure
  - NYSDOH PartNer Assistance Program (PNAP)
  - NYCDOHMH Contact Notification Assistance Program (CNAP)
    - staff can notify potentially exposed partners anonymously and help those who want to tell their partners on their own
Optimizing Health/Reducing Risk: WLWH and Their Partners (2)

- Inquire about her partner’s HIV status
- Offer HIV and STI testing sites for the partner
- For partners who are HIV-negative
  - Provide information on Post Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP)
- For partners who are identified as HIV-positive
  - Provide rapid linkage to HIV care with ART initiation
HIV-negative Partners of WLWH: Post Exposure Prophylaxis (PEP) for Prevention of HIV Infection

- Involves taking ART very soon after a possible exposure to HIV to prevent acquiring HIV infection
- Intended for emergency situations
  - Not meant for regular use by people who may be exposed to HIV frequently
- Must be started as soon as possible to be effective and always within 72 hours (3 days) after a possible exposure to HIV
- Involves taking ART every day for 28 days
- Immediately notify health care provider or go to ER for PEP

https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/20/87/post-exposure-prophylaxis--pep-
HIV-negative Partners of WLWH: Pre-Exposure Prophylaxis (PrEP) for Prevention of HIV Infection

- Involves taking daily ART by HIV-negative individuals to reduce their risk of acquiring HIV
- Is a biomedical intervention
- Can dramatically lower the risk of getting HIV from sex; can also reduce the risk from injection drug use
  - Adding other strategies, such as condom use with PrEP, can reduce the risk even further
- Is not a pill, but rather, a “Program”
  - Regular health care, HIV/STI testing, risk reduction

https://www.hivguidelines.org/prep-for-prevention/prep-to-prevent-hiv/#tab_2
https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/20/85/pre-exposure-prophylaxis--prep-
Why Take PrEP?

- Significantly reduces the risk of acquiring HIV infection
- PrEP is controlled by the HIV-negative partner
  - May promote self-efficacy, sense of empowerment
- Not all people living with HIV (PLWH) are willing to take ART
- Not all PLWH are adherent to ART
- Sometimes ART regimens fail, so PLWH may have detectable viral loads in the blood
Optimizing Health/Reducing Risk - Bottom Line: What Health Home Care Managers Need to Know

- WLWH and their partners need access to ongoing preventive services and medical care
- Disclosure is very important, referrals for assistance are available
  - Don’t assume one’s status has been shared
- Emergency and long-term ARV medications are available for HIV-negative individuals to take to prevent HIV acquisition
- Ongoing HIV care, ART adherence and VLS are key
Conception:

Conception Counseling and Care for Women of Childbearing Age Living with HIV
Conception Counseling for Serodiscordant HIV Couples

- Expert consultation is recommended so approaches can be tailored to couples’ specific needs
- Partners should be screened and treated for genital tract infections before attempting to conceive
- Partners living with HIV infection should attain maximum viral load suppression before attempting conception
  - prevent HIV sexual transmission
  - minimize the risk of HIV transmission to the newborn
Conception Options for Serodiscordant HIV Couples

- Assisted insemination at home or in a provider’s office with a partner’s semen during the peri-ovulatory period — peak fertility: 2 to 3 days before and day of ovulation
- Donor sperm
- Peri-ovulatory intercourse
- PrEP for the partner without HIV
- ART and VLS for the partner living with HIV

**U=U:** Undetectable equals Untransmittable
Couples of Differing Status and Conception Strategies (1)

- **Woman HIV-positive & Man HIV-negative**
  - assisted insemination at home or provider’s office with man’s semen during the peri-ovulatory time
  - eliminates risk of HIV transmission to the partner without HIV

- **Woman HIV-negative & Man HIV-positive**
  - use of donor sperm from a man who does not have HIV
  - eliminates the risk of HIV transmission to the partner without HIV

Other Options:
- ART and VLS for HIV(+) partner & PrEP for HIV(-) partner; U=U
  *see next slides

Couples of Differing Status and Conception Strategies (2)

• Partner living with HIV unable to achieve VLS or VLS status unknown
  – Administration of PrEP to the partner without HIV is recommended (includes regular assessment for acute HIV infection, HIV/STI testing, lab monitoring, risk reduction education, etc.)
  – Limit sexual intercourse (without condoms) to the period of peak fertility

Undetectable equals Untransmittable (U=U)

- Scientific advances have shown ART:
  - preserves the health of people living with HIV
  - effective means of prevention (“Treatment as Prevention”)
    - reduces community viral load
    - prevents sexual HIV transmission, even in the absence of condoms and PrEP

This means people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner

- U=U does not extend to breastfeeding, blood transfusions, transplants, and the sharing of syringes or drug preparatory paraphernalia/items

Couples of Differing Status and Conception Strategies (3)

- Partner living with HIV on ART and achieved sustained VLS
- Given U=U data, both members of a serodiscordant partnership should be active participants in the decision to initiate or discontinue PrEP
  - Couples may decide ART treatment for the HIV-positive partner provides sufficient protection against HIV transmission
  - HIV-negative partners may choose to take PrEP, particularly if they have other sexual partners; are unsure of their partner’s viral load or their partner’s ability to stay consistently suppressed; or feel more secure in their sex lives with the added protection of PrEP

Conception and PrEP

• Efficacy of PrEP during attempts to conceive has not been formally studied
  – it is still an option for partners who do not have HIV infection

• Evidence suggests that PrEP in this setting does not affect male fertility and is safe for women during the periconception period
  – more definitive research is still needed

https://www.hivguidelines.org/
Conception: Promoting Best Outcomes

- Early identification of pregnancy
- Early collaboration with experienced HIV provider
- Early prenatal care
Prevention of Mother-to-Child Transmission

• What WLWH need to know:
  – current HIV treatment recommendations
  – use of ART to both optimize maternal health and prevent MTCT
  – factors influencing transmission
    □ mode of delivery; duration of membrane rupture; maternal plasma viral load and CD4 count; maternal co-infections; invasive obstetrical procedures; breastfeeding
  – Newborn management and ARV prophylaxis for HIV-exposed infants
WLWH and Pregnancy (1)

• Assessment of HIV disease status

• Plan to initiate, continue, or modify ART
  – All pregnant WLWH should receive ART, initiated as early in pregnancy as possible, to prevent perinatal transmission regardless of plasma viral load or CD4 T lymphocyte count
  – Assess teratogenicity

• Maintain viral load below the limit of detection (=VLS) throughout pregnancy and lifetime
WLWH and Pregnancy (2)

• Minimize risk of perinatal transmission through use of ARV medications
  – Antepartum (initiate during prenatal period, if not already on prior to conception)
  – Intrapartum (initiate during labor and delivery, when indicated)
  – Postnatal (initiate ARV prophylaxis for the newborn)
    • Several diagnostic HIV tests are needed between birth and 4 to 6 months of age to definitively determine newborn’s HIV status

• Breastfeeding contraindicated; formula only
• No maternal premastication of food for child
WLWH in the U.S. and Breastfeeding

- WLWH in the United States (U.S.) should be advised not to breastfeed
  - Maternal ART reduces, but does not eliminate, the risk of HIV transmission via breast milk
  - Safe and affordable infant feeding alternatives are accessible in the U.S.
  - Lack of safety data on most modern ART regimens during breastfeeding

Prenatal Care

More frequent viral load monitoring is recommended in pregnant WLWH than non-pregnant WLWH because of the importance of rapid and sustained viral suppression in preventing perinatal HIV transmission.
Stigma, HIV and Pregnancy

• Stigma and discrimination occur when knowledge about HIV and pregnancy is limited
• Some WLWH experience stigma and discrimination about their desire for children
• Stigma can limit services and support for WLWH
  – A support network, including Health Home Care Managers, can be protective against stigma, reduce barriers to care and promote access to needed services to support improved health outcomes for women, their partners and their children
Conception, Pregnancy/PMTCT - Bottom Line: What Health Home Care Managers Need to Know

- Some WLWH and their partners experience stigma throughout the stages of family planning
- Many options are available to safely conceive for WLWH and serodiscordant couples
- U=U for sexual transmission
- Risk of MTCT of HIV can be dramatically lowered with specific strategies
- Early identification of pregnancy, entry into prenatal care and collaboration with an experienced HIV provider are critical
- Ongoing HIV care, ART adherence and VLS are key
Role of Health Home Care Managers to Support WLWH from Preconception to Pregnancy
Role of Health Home Care Managers (1)

• Facilitate referrals with **active navigation** and **linkage** to identified supportive services needs, including Ryan White programs:
  – Insurance enrollment/recertification
  – Housing assistance
  – Transportation assistance
  – Food/nutrition support for WLWH and their families
    • Special Supplemental Nutrition Program - Women, Infants and Children (WIC)
    • Ensure access to formula (no breastfeeding)
Role of Health Home Care Managers (2)

- Facilitate **navigation**, **linkage** plus **engagement** and **retention** in care
  - Primary care/HIV care
  - OB/GYN care
  - Mental health treatment
  - Substance use treatment
  - Other specialties as needed
Role of Health Home Care Managers (3)

- Care coordination, care coordination, care coordination!
- Assess for barriers to medical and/or supportive services, ART adherence and VLS; implement strategies to reduce/eliminate barriers
- Have awareness and sensitivity regarding stigma experienced by some WLWH and their partners; perform actions to mitigate
- Ensure postpartum follow-up, including resuming contraception
Role of Health Home Care Managers (4)

- Ensure newborn engaged in general pediatric care and pediatric infectious diseases care, if needed
  - several HIV diagnostic tests required birth through 4 to 6 months of age to definitively determine HIV status
- Ensure mother has ready access to ARV prophylaxis for newborn so no interruption in therapy after hospital discharge
  - Coordinate discharge planning with birth facility, pharmacy and insurance
- Continue to provide emotional support
Contact Information

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National Perinatal HIV Hotline Resource

#(888) 448-8765

- 24 hours a day, 7 days a week, 365 days a year
- Clinician Consultation Center (CCC) provides free, confidential, and timely expert perinatal HIV and HIV-exposed infant consultation to clinicians of all experience levels and training backgrounds
- Advice is based on Federal treatment guidelines, current medical literature, and clinical best practices
Resources on Preconception, Contraception and Conception for WLWH

New York State Department of Health AIDS Institute

* HIV    * HCV    * STIs    * SUBSTANCE USE    * LGBT

- HIV Testing and Acute HIV
- ART
- Primary HIV Care
- Perinatal HIV Care
- PrEP
- PEP
- Hepatitis Care
- STIs
- Substance Use

https://www.hivguidelines.org/
Introduction
Maternal HIV Testing and Identification of Perinatal HIV Exposure
Counseling and Management of Women Living with HIV Who Breastfeed
Preconception Counseling and Care for Women of Childbearing Age Living with HIV
Antepartum Care
Intrapartum Care
Postpartum Follow-Up of Women Living with HIV Infection
Management of Infants Born to Women with HIV Infection
Appendix A: Review of Clinical Trials of Antiretroviral Interventions to Prevent Perinatal HIV Transmission
Appendix B: Supplement: Safety and Toxicity of Individual Antiretroviral Agents in Pregnancy

Resources on Preconception, Contraception and Conception for WLWH

Contraceptive Counseling and Resources:

- [https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm](https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm)

HIV Among Pregnant Women:

- [https://www.acog.org/About-ACOG/ACOG-Departments/HIV](https://www.acog.org/About-ACOG/ACOG-Departments/HIV)
Additional Resources

https://www.health.ny.gov/diseases/aids/general/about/hlthcare.htm
Additional Resources

https://www.health.ny.gov/diseases/aids/general/about/comm_support_services.htm
Additional Resources

Partner Services & Retention in Care:

• PNAP
  – https://www.health.ny.gov/diseases/aids/general/about/field_services.htm
  – https://www.health.ny.gov/diseases/communicable/std/partner_services/
  – https://www.health.ny.gov/diseases/aids/providers/regulations/partner_services/
  – https://www.health.ny.gov/diseases/aids/providers/regulations/reporting_and_notification/question_answer.htm

• CNAP
  – https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-partner-notification-law.page
  – https://www1.nyc.gov/site/doh/health/health-topics/aids-hiv-contact-notification-assistance-program.page

• Retention in Care
Additional Resources

HIV/AIDS Warmline 800-933-3413
HIV treatment, ARV decisions, complications, and co-morbidities

Perinatal HIV Hotline 888-448-8765
Pregnant women with HIV or at-risk for HIV & their infants

Hepatitis C Warmline 844-HEP-INFO 844-437-4636
HCV testing, staging, monitoring, treatment

PrEPline 855-HIV-PrEP
Pre-exposure prophylaxis for persons at risk for HIV

Substance Use Warmline 855-300-3595
Substance use evaluation and management

PEPline 888-448-4911
Occupational & non-occupational exposure management
Additional Resources

New York State Clinical Education Initiative:
Tele-mentoring with Project ECHO™
HIV/STD/HCV/PrEP/PEP Inquiries
(technical assistance, and additional clinical tools available)

Resource Center of Excellence
# 1-866-637-2342 (toll free) or # 585-612-1343
support@ceitraining.org
Additional Resources

NYC Mental Health and Substance Use Services:
NYC WELL Hotline (24 hours a day/ 7 days a week by phone, text and online chat)
# 1-888-NYC-WELL (# 1-888-692-9355)

NYS Office of Alcohol and Substance Use Services:
Agency Main Number and General Information
# 518-473-3460
Referrals can be obtained by calling OASAS HOPEline
# 1-877-846-7369

NYS Office of Mental Health:
# 1-800-597-848
Patient Educational Resources

- Birth Control: https://www.bedsider.org/

- Planning for Pregnancy: https://www.cdc.gov/preconception/planning.html

- HIV and Pregnancy: https://www.acog.org/Patients/FAQs/HIV-and-Pregnancy