MCHB/DHSPS March, 2008 Webcast

Healthy Mom, Healthy Baby Routine and Rapid HIV Testing in Healthy Start

March 25, 2008

JOHANNIE ESCARNE: Good afternoon. I'm Johannie Escarne in the Maternal and Child Health Health Bureau. On behalf of the division, I would like to welcome the audience to this webcast titled "Healthy Mom, Healthy Baby Routine and Rapid HIV Testing in Healthy Start". This is the second webcast in a two-part series that began last Tuesday. The case studies and role plays for the workgroup on available on the website mchcom.com.

This is an interactive webcast that will involve approximately 30 to 35 minutes of group work. Before I introduce our presenter today, I would like to make some technical comments. Slides will appear in the central window and should advance automatically.

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On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window.

At the end of the broadcast the interface will close automatically and you'll have an opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

I would like to welcome our presenter, Elaine Gross, who is with us today she's a nursed indicator with the Francois-Xavier Bagnoud Center with the University of medicine and dentistry in New Jersey. We encourage you to submit questions via email at any time during the presentation. Without further delay I would like to welcome our presenter and the audience and begin the presentation. Elaine.

ELAINE GROSS: Good afternoon, everyone. I am really glad to be here. This program was developed several years ago by my program as part of funding from the Center for Disease Control and Prevention. And we did a very nice little workshop for the Healthy Start program in Washington, D.C. Much of what you'll see today came out of that program or was adapted from it and I hope you enjoy yourself. I'll begin the presentation.

Next slide, please. The objectives for this session are that the learner will be able to discuss factors that influence perinatal HIV transmission. Review national recommendations for HIV testing and pregnancy. This was done previously by Margaret LAMPE at the center of disease control and prevention last week. I hope many of you had

an opportunity to participate in that webcast. I'll review some of the materials that Margaret covered. We're going to describe issues regarding routine and rapid HIV testing as they apply to various Healthy Start communities, discussion HIV testing with clients served by Healthy Start programs so that you're comfortable with this. And then during the casework and role play activities, apply the information about routine and rapid HIV testing and giving the results to the use of case study discussion and role play.

Next slide, please. First I'll begin with a review of what we know about reducing perinatal transmission and what role Healthy Start program has in perinatal HIV prevention.

Next slide. Before I go any further I want to give special thanks to the following Healthy Start members for their help in developing the role plays and case discussions. The names are on the slide. They really helped me to make the case discussions and the role plays real.

Next slide. What do we know about perinatal transmission in 2008? We know that without antiretroviral ARVs. Hopefully I'll be able to use the words along with the abbreviations. Without antiretroviral drugs during pregnancy the transmission of mother to infant is one in four. We learned this early in the epidemic before we had any antiretroviral and it is still true today. If a woman has HIV infection her risk of passing the infection to her baby still is about 25% if she is not on any form of therapy and we don't have any other interventions. That's with each pregnancy. Today with all we know, the risk of perinatal transmission can be less than 2% or 1 in 50 with highly active antiretroviral therapy, with elective C-section as appropriate and with formula feeding. This is slide number six in case those of you are following along with the numbers. When does HIV transmit from mom to baby? What do we know? We know it can happen intrauterine during any time during the course of the

pregnancy in 25 to 40% of the cases. I want to stress in particular it's very risky for intrauterine infection if the mother gets exposed to HIV while she's pregnant because the chances of her being able to suppress the virus during pregnancy, as most of you have known when you have children you seem to come down with everything when you're pregnant when your immune system can be suppressed. It takes a period of time for the body's defense system to kick in to suppress the virus and so the worst case scenario may be becoming HIV infected during pregnancy. When most women don't take precautions. They think I'm pregnant already. Safer sex really isn't an issue. It can be up to 25% to 40% of cases. Intrapartum transmission right around the time of labor and delivery is the majority of the cases. It can be 60 to 75% depending on the issues. Breastfeeding we know that the HIV virus can be found in breast milk within the cells that are so protected. Breastfeeding increased the risk as much as 14 to 29%. Again, if the mother becomes exposed to HIV and infected during the breastfeeding period that increases the risk dramatically again because of the virus. Most transmission occurs close to, during labor and delivery.

Next slide, please, number 7. What are the factors that influence perinatal transmission? Well, the HIV viral load levels, what is known as HIV RNA levels, we use the abbreviations VL for viral load. The amount of virus circulating in the mother's system. The higher it is the riskier it is to transmit to her baby. That's why early in the infection before her body becomes -- her immune system kicks in is risky as well as toward the end of the disease when the immune system is really worn out. When the viral load can really get out of control because her body can't fight it anymore. There are risky times for pregnancy and for transmission. Low CD4 count, the white blood cell better known as the T-cells also when the numbers go low, that's a sign that the immune system is really stressed and under attack and that's a time that's risky for transmission of HIV from mom to baby and

co-infections, MTH folks have known about for years. Hepatitis C and B, VV, bacterial. Last week on the news I was concerned to see that CDC put out a report of a study about percentage of adolescents with STDs. That is going to increase the risk of perinatal transmission. Injection drug use, maternal injection drug use is associated -- influences perinatal transmission and then, of course, what we said before no antiretroviral therapy or prevention, prophylaxis to prevent mother to child transmission.

Next slide, please. Number 8. Obstetrical factors. The length that the membranes are ruptured or inflammation or infection of the membranes that protect the baby from infection, chorioamnionitis. The longer the labor goes on, the higher the risk of the mother transmitting to her baby. Vaginal delivery, if the viral load is high and over 1,000, invasive procedures. Anything that might introduce the virus into the baby's protected system such as fetal scalp sampling or internal monitoring. These will increase the risk. Infant factors, no surprise, prematurity, the immature skin and immature gastrointestinal system all increase the risk of transmission as well as breastfeeding.

Next slide, please. Breastfeeding in particular I wanted to spend a moment talking about because I think the message that Healthy Start folks can give to women. We've been trying -- those of us that have worked with women and children and families for years, breastfeeding, breastfeeding, breastfeeding. It's a wonderful thing we need to do but HIV and breastfeeding is problematic because the mother can transmit to her baby with breastfeeding. In the United States where we have safe water, ready access to formula women with HIV infection should not breast-feed. Even more so women who are considering breastfeeding ought to know what their HIV status is. However, there is a caveat to that. There are many cultures and the U.S. is a nation of immigrants and recent immigrants are coming from places where HIV may be very high in prevalence and

breastfeeding may be the norm. It's expected that you're going to breast-feed your baby. These women really need support if they're found to be HIV infected to help them handle that issue of not breast-feeding their babies among their families. It can be recognized if you're not breast-feeding your baby you must have HIV positive and no words are ever said, it is just a supposition that that's the case. So helping women to come up with another story per se on not breast-feeding so that the confidentiality is maintained if needed.

Next slide, please. Okay. A brief overview of antiretroviral therapy and other strategies. I want Healthy Start folks to know a little bit about this and refresh those that know a lot about this. So that you can have a conversation with women in the community about treatment if HIV is one of the issues that comes up in the pregnancy.

Next slide, please. Number 11. The goals of antiretroviral therapy are to suppress HIV below the limits of detection or as low as possible for as long as possible. This is true for everyone, not just pregnant women. To prolong life and improve the quality of life. I was thinking today coming to this webcast and I was trying to remember how long it's been since magic Johnson announced that he had HIV. But it's been a long time. So one of the things that we really need to tell people is HIV is a treatable condition. It really is a treatable condition. You can have a longer life and a quality of life with treatment. And this is something that many community members just don't know. They think it's a death sentence. The other goal of antiretroviral therapy is to preserve and restore the immune function and to reduce the risk. Today our focus is the risk of perinatal transmission.

Next slide, number 12. Margaret did a nice job with this. General care for women with HIV is to evaluate the disease. The woman's disease to see where she is. How immune

suppressed she is. Whether she needs antiretroviral therapy for her own sake. To monitor her viral load and treatment during the pregnancy because as we will hear a little bit later, the plan for the method of delivery depending on what they are viral load is, she may be an elective cesarean section rather than a vaginal delivery. Develop a strategy for long term follow-up. Healthy Start is very comfortable hooking people up to care. That's part of what you do. Women and families. And this is an important reason that we really want to get pregnant women with HIV into care.

Next slide, please. Number 13. A little bit about elective C-section. I mean planned, not emergency. Labor has not started. Membranes have not ruptured. It may reduce the risk of HIV transmission during labor and delivery for women with viral loads over 1,000. And for those women where you don't know what the viral load is, and they're not on antiretroviral therapy, it's scheduled at 38 weeks before labor and before the rupture of membranes so therefore it's really important that you tell women who have HIV infection, are pregnant, what the signs of labor are if it's a first baby so they can get into care very early. Complications of cesarean section are slightly more frequent for women with HIV infection. Again it depends on the level of their immune impairment with the disease. But they could do very nicely with a cesarean section. It is surgery so the risk is there but women need to be given the choice and make the decisions about method of delivery.

The next slide, 13. Vaginal delivery is an option if the viral load is under 1,000. The woman does not have to have a cesarean section. This is the recommendations. It's important, however, to minimize the duration of the ruptured membranes for a vaginal delivery so it is not going to be a labor going on and on and on with membranes ruptured. To educate women not to stay at home. To come in when they feel labor starting. And

then again for the providers to avoid the use of scalp electrodes and any other invasive procedures.

Next slide, please. Number 15. Now we're going to move quickly to a review of the national recommendations.

Next slide. Number 16. National recommendations for testing. HIV testing for pregnant women in the United States from the Centers for Disease Control U.S. Public Health Service as well as ACOG, the recommendation that in prenatal care HIV testing be routine and universal. Universal screening with the right to say no to the testing. Third trimester recommendations are repeat if the woman is at risk for HIV. If she lives in an area of high prevalence or she previously refused. Now, the area of high prevalence is a CDC recommendation not presently an ACOG recommendation. Let me tell you, Margaret had a very nice map of the United States last week and I kept it so I wanted to make sure I covered those regions and those states that this really pertains to for that third trimester repeat testing. Again remember there is a reason for that. If a woman becomes HIV positive, if she becomes positive during pregnancy it's very risky for transmission for her baby. The third trimester testing is meant to identify women so that the baby is not born and it's not suspected that HIV is there. The states that we're talking about with high prevalence, there are 22 jurisdictions with elevated HIV or aids case rates among women age 15 to 45 as of 2004. That's New York, Massachusetts, Connecticut, New Jersey, my state, rode island, Pennsylvania, Maryland, district of Columbia, Virginia, Tennessee, north and South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Texas and Nevada. We have -- we had a flying critter in the room who is now famous.

Next slide. Why aren't all pregnant women tested in HIV care? Well, the Institute of Medicine did a study nationwide talked to obstetricians several years ago, as well as ACOG does surveys from time to time and there are many reasons why women don't get tested. There are provider issues. Such as language barriers, no one in the office is comfortable with the language that the woman speaks. Late entry into care or no prenatal care. It is hard to do testing when that's the situation in prenatal care. The provider does not strongly recommend testing for women. I heard many stories that providers will approach it in such a way that it's hard for the woman to agree to be tested. If she's approached in such a way that well, you don't need an HIV test, do you? Who is going to say yes, of course I do. So it's how it's done really matters and then the perception on the provider's part or the office staff or clinic that HIV is not here, we don't have a problem with HIV. Our patients don't get HIV. Now, the women's reasons for not being tested, there have been studies done in both high prevalence and low prevalence states and areas. The women primarily don't think they're at risk for HIV. I'm not at risk. So therefore they don't think they need to have a test done or they've been tested recently and recently in their mind might be last pregnancy. Okay? The test wasn't offered or recommended. Adverse consequences of having a positive test was rarely mentioned by women in the study. Now, I have to tell you something that I've heard over and over again on the part of patients. They get healthcare, people draw their blood, they think they've been tested. They think they're negative because nobody comes back to them and says well you're HIV test was positive so they think everything is quiet, everything is fine because they took so much blood they must have done an HIV test. Lots of people think that's the case and they don't realize they have not been tested. So that's a piece of information that you need to take to the community. Know in most places it is an issue where you're going to be told that HIV test is routine or we need your permission, your consent for testing.

Next slide. Opt-out testing. Routine testing. What are the advantages of it? Well, it normalizes it. It is routine part of prenatal testing. When you're pregnant you go in for care there is all this blood work they do and it's a routine prenatal test. Women say they're less likely when it's a routine they're less likely to feel singled out. And they're more likely to agree because then they don't have to come up with a reason on why they should have a test. If they're asked if they should get a test. It is easier and quicker for the provider, more women are likely to be tested if it's routine, which means fewer infected infants. The disadvantages are if the patient -- if they know about HIV testing and know why it's important and that they have the right to refuse. And the provider may not be prepared to counsel if the test comes back positive. That's the only other issue, if it's routine, then the test comes back positive it's a shocker to the office and they aren't quite sure how to deal with it.

Next slide, please, number 19. Why rapid testing for pregnant women? I'm switching gears a little bit from routine to rapid. Rapid testing is a test that you can get a result from quickly. Usually between 10 and 20 minutes, under an hour. It's an opportunity to test particularly for women who are hard to reach or not in prenatal care. One of the reasons why we chose to do that, we did that workshop for the Washington Healthy Start was lots of folks, they wanted to do HIV testing out in the community as a service, as a part of Healthy Start because the incidence of HIV, the prevalence of HIV was so high in the district in women. So this is rapid testing will give someone a result right away. They don't have to worry about coming back in two weeks to get the result and then get the confirmatory test. So it's good for women who present late in pregnancy. They have not been in prenatal care, you really want to find out do they have HIV so you can start treatment for themselves as well as to prevent it for the babies. It's also good for women who are unlikely to come back for the result. They can get a result right away even though

it's a preliminary. For Healthy Start purposes it's especially important because you can up the ante by making sure that that positive woman with the preliminary positive rapid test gets to the front of the line to get into care. You'll put your focus on that, okay? , please, number 12. This is a little formula that Francois-Xavier Bagnoud Center developed years ago when we started to work with hospitals around rapid testing in labor and delivery and I call these my C3R3s. A way of thinking about rapid testing and how to handle it and it's adapted for prenatal outreach. C stands for comfort, confidentiality, consent or assent, agreement. The R stands for reason to test, results, referral and treatment.

Next slide, please, number 21. Comfort. Bringing us the rapid test. Let's really deal with Healthy Start now. Is this the best time to do this? Are you building a relationship with the woman? You're trying to get her into care so you have to kind of use your judgment on if you're just starting the relationship, do you want to bring up an HIV test right now before she gets to know you or gets to understand anything else about why she needs to be in prenatal care? What does she know about HIV? What does she know about her HIV status? She may already know she's HIV positive and not willing to tell anybody about it. How can you help the client be ready for the test? Is there anything you can do? Is the client anxious about receiving the result? How can you make that a little bit better? If you're preparations for her comfort, then the bottom line always is use your judgment about whether this is appropriate right now in this place for rapid testing in Healthy Start.

Next slide. Confidentiality. This is, you know, 2008 the stigma is still there. People really want to keep it quiet. The folks I talked to while I was developing the role plays over and over again said well, we don't have much HIV here but nobody wants to talk about it. The issue of confidentiality is very, very important. So in the community and in the environment of Healthy Start, being sensitive to all those issues. Who else is in the room? Who can

hear? Is it safe for this discussion about HIV testing or HIV prevention? How can you go about assuring confidentiality during the history taking, during the testing and for giving results?

Next slide, please, 23. Consent. Consenting process. The last bullet is missing but what is really important is do you know the jurisdiction that you're practicing in, that your program is in, is informed or written consent necessary by law? That is an important thing to know about. How much information is needed for consent or a consenting process? Does the client really understand what the test is, what the procedures are and why it's important to have it? And do you have the proper documentation if you do need consent?

Next slide. Next slide. There we go. Prenatal messages about HIV testing. What do you say? It can be as simple as this. HIV is a virus that causes aids, a woman could be at risk for HIV and not know it. She could say I'm not at risk and you can tell her she's probably right. But she's not going to know unless she has the test. HIV testing is recommended for all pregnant women. It's important. If it's a rapid test, the screening can give us results quickly. If it's a rapid test and it is a screening test, we always do a second test to confirm the positive test. We always do a confirmatory test for regular HIV tests in prenatal care as well. If the mother has HIV, medicine can reduce the risk of passing that to her baby from one chance in four to about one chance in 50. Now, that's a big, important number to remember.

Next. Next slide. The rest of the messages. Women who say no, who decline testing, won't be denied care. If a woman is negative, she can learn ways to keep from getting the virus in the future. And services are available for women with HIV. All information about

HIV testing and results are confidential, results may be reportable to your state. But there are federal and state laws that protect women with HIV from discrimination.

Next slide, 26. Why have the test? We have treatment for HIV. We have treatment for her if she needs it to keep her healthy and services for her and her family and if she is HIV positive medicines can reduce the risk of HIV transmission to her baby. If she's HIV negative we can help her learn how to reduce the risk, whether by ourselves or through special risk reduction counseling to keep her from getting HIV in the future. HIV is treatable. It is really important.

Next slide, 27. Now, Margaret last week went over in great deal the rapid tests but I'll focus on one of them in particular. There are six tests that are FDA approved. Four of them are point of care, which means they are CLIA waived. It can be done at the point of care. It doesn't mean it's not got restrictions to its use. You have to be trained and retested so you're doing it accurately but it is a simple test to do. There is one test that is available for oral fluid and that's the OraQuick advance and I'll talk about that. That's the one that many places are using in the community. All these tests are very accurate. They're specific and they're sensitive.

Next slide. This is a picture of the OraQuick advance, a test for both HIV 1 and 2. It is CLIA waived for a finger stick blood, whole blood or oral fluid. Moderate complexity for plasma. It has to be done in a lab. The kits can be stored at room temperature. It screens for HIV 1 and 2 and the results are available in about 20 minutes.

Next slide, please, 29. And this essentially is just how it works. It's a swabbing of oral fluid from the gums. It is for people that don't want to get stuck for blood and it also is good for

health workers because they're not sharps that they have to worry about in blood precautions. It's very feasible to do this in a community setting.

Next slide. The test gets inserted into the stand and it develops in 20 minutes. The timing is really important. When they do this in labor and delivery in the hospital setting they have developed beepers like a timer system so they come back -- do something else like we're always doing something else and come back in 20 minutes and read it.

The next slide, please. The accuracy of the test really depends on two things. One is that the top line is an internal control. If the test little package is okay, that you're going to always see a line where the C is. It is going to be where the C is, not someplace else but right there. Then the positive test you'll see a second line where the bottom -- where it shows on this screen where the T is. That's a positive reading. The negative is you won't see the second line.

Next slide, please. 31. The results of a rapid test are valuable because they will give you results immediately and clearly and that's what the message you need to give to your clients. But there are some other words you need to use. It's a screening test. If it's negative, that's good. That means no further testing is needed at this time with some caveats. That means it won't pick up recent infection, okay? If it's positive. The results are preliminary. We always, always do a second test to confirm the first test. Now, in pregnancy you can have false positives so it's important that women know that we always are going to do the second test.

Next slide, please. The words for counseling about the testing. If it's a negative test what does it mean? It means your test was negative. You are not infected with HIV. However,

the test might not show recent infection. In pregnancy, because it's a time frame that we really want to be sure of, we aren't going to tell her to come back six to nine months to get another test. We'll tell her to come back within a month to repeat the test. If there is a reason to suspect that she has had recent exposure. Discuss risk reduction strategies and safer sex to help her continue being negative. Refer women who need it who are at high risk for further counseling and intervention. Even though the test is negative. And then repeat the testing in the third trimester for women who are either at high risk or live in those areas that we mentioned earlier.

Next slide, please, 33. Counseling women with a positive test. This is what everybody dreads. The language you use really depends on where you are and how likely it is the woman is a positive test. If there are other things that lead you to believe that she might have positive, you might change your words a little bit but many clinicians have said your HIV screening test, the preliminary test was positive. This means you may have HIV. Sometimes people use the word you're likely to have HIV. But we won't know for sure until we get the results of your confirmatory test, the second test we're going to do. Then it is important to focus on the client's feelings and any immediate support systems she might have. It's a preliminary test, remember, so you always leave that window there that you're going to do the second test but it is important to ask, do you have somebody you can talk to about this? Because you think about it, she's pregnant. She's going to be worried about her baby, she's going to be worried about herself even though you told her it is a preliminary finding.

The next slide, please, 35. It is important to schedule a confirmatory test, to counsel her on safer sex practices, and other transmission risk if there are things, needle sharing or blood risk and to reinforce if she has HIV it's -- there is hope. There is a lot of hope. It's a

treatable disease. There is treatment for her and her reducing the risk to her baby. That message is really important. And then begin the discussion about the possibility of disclosing the diagnosis to other people, just beginning. Again, it's preliminary.

Next slide, 35. A preliminary positive rapid test must always be confirmed OraQuick. If one of the other rapid tests is being used it's important -- this is a paperwork kind of thing but --

>> Are we back on?

>> It was slide 35.

>> Just wanted to apologize for the audience. We had some technical difficulties. We're almost to the end so hang in there. Preliminary positive rapid test. This is counseling -- let me just go back a little bit in case we were not on the right place. We're talking about telling a woman her preliminary test was positive. This means you may have HIV but we won't know for sure. Sorry, I'm going to try to catch up with the slides. The preliminary positive test, it's important that you schedule and insure that the confirmatory test gets done. If it means that you can take her there to get connected to care for the preliminary confirmatory tests, counsel her on safer sex practices and other transmission risks and reinforce again that there is treatment for HIV and begin to discuss -- start the opening about the possibility of disclosing the diagnosis. Confirmatory results, preliminary test must always be confirmed. It doesn't have -- it should not -- Elisa is not necessary. The antibody is not a necessary confirmatory test, what you did with the rapid test was an antibody test so you need to confirm another way with western block or IFA. An IFA is another form of confirmatory test and to note on the form if you are filling out forms, that the rapid test was positive and therefore that's why you're requesting a confirmatory test.

Next slide. 38. Referral. Referral and follow-up are really important. If you heard this before, excuse me, but the goal -- Healthy Start is really good at this. Get the client into prenatal care and it's important it be done as soon as possible. You have a time frame or pregnancy but it's important as early as possible to get her into care and treatment both for perinatal prevention and care for yourself. Know your resources for HIV care this your community. Whenever possible, take her so that you can ensure she gets there or facilitate that process and then also recognize the need for social as well as medical follow-up services. This is just not a medical disease. There are lots of other things that come with it. Slide 38 next. This workshop and this curriculum was supported by a cooperative agreement from the Centers for Disease Control and Prevention. It's contents are the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Next slide. Now we are running a little bit behind but now is the time for the group work. What the plan is is there are six case study discussions, possible role plays that you have hopefully downloaded. They were available last week after the webcast and they were all up all week. Those of you that have groups that are observing this workshop that you can get together, choose one of those. There are six of them. There ought to be one that most closely fits your Healthy Start program. And then you're going to have some group work. We're not going to be live. You'll see us but we'll be muted but you're going to take the time to go through one of those case discussions and role plays, answer the questions. Before we do that, if there are any questions we'll take them before we go off into group work. Are there any?

>> There is one question.

>> Anyway, you're going to have 30, 35, 40 minutes. We'll give you a five-minute warning when we'll come back for a follow-up question/comment period but until we do that I'll see what the questions are before we break off and send you into your group work.

>> There is just one question. That question is, please address the cost of the oral test and how Healthy Start sites can fund this if budgets have already been approved.

>> Oh, my. The cost of the test kits are always, always, always an issue. I cannot tell you -- I'm sorry I can't address that individually. I do know that many of the hardest-hit states and jurisdictions have received support from health departments in the state have received support from the Centers for Disease Control for testing, routine testing. And I strongly urge you to get in touch with your local and your regional or your state health department folks to ask that question specifically. That will be an important one and how this can be done. I do know there are conversations going on with insurance companies and insurers on covering the cost of routine testing because this is a national recommendation now. So stay tuned and I apologize for not having a definitive answer to that.

>> Any other questions? That was the only one.

>> That was the only question. Okay. If you all are ready to go into your group work I'll go through quickly and tell you briefly what the cases are so you can have a better idea.

So the next slide, slide number 40. Role play case discussion number one is a young Latino who has very little English. Pregnant but doesn't know hit. An STD. She's at risk for

but has very little knowledge about HIV. Case number two, role play two is a young runaway who is pregnant who has very risky behavior. She's having sex for money, survival sex. She's getting -- being exposed to physical abuse. She's not in care and every time you try to get her into care she does not keep her appointments.

Next slide, 41. Role play three case study there is an urban home visit. A completely chaotic environment. The house is being sold out from under the people. This is the second pregnancy. The mom is not in prenatal care and she's got so many health problems. Case number four, role play four outreach visit in a small rural town. It is a young mom, this is her third pregnancy. Third baby in five years and she's ill. She's not feeling very well. She's had an HIV test in the past but doesn't know what the results were and it must have been negative. This is a new partner for her.

Next slide. Case discussion role play number five is an outreach visit. It is a young Native American girl who is pregnant. She is not yet in care. She has a history of risky behavior. What I like to call serial monogamy. She has one boyfriend at a time. However, there have been several boyfriends. History of STIs, STDs but the sense in the community is HIV is not here, okay? When you're making this outreach visit her mom and her auntie are in the next room. Case discussion role play number six is it's a family outreach education home visit. Very, very rural, isolated area. There are three pregnant women. It's a very involved enmeshed extended family. Everybody knows everybody else's business. The men are away for work a lot, okay? And there is also a strong religious belief against contraception and safer sex. So pick one in your groups. Have a discussion. Play the role so you feel comfortable with how you would answer the questions or have discussions about HIV testing and pregnancy and we will come back. We'll give you the warning about I would say 20 minutes after, okay? It is now -- between did it's 53 between 3:15 and 3:20 we'll

give you the five-minute warning. If you want to make comments you'll have an opportunity before we end the call. We'll be here. Put your speakers down so they will be loud enough for you to hear the warning but so that you won't get distracted from your work, okay?

>> Choose one of the case discussions and play the roles or not play the roles. We did hear. We had a lot of issues that came up, which is why these are very real as I'm sure that you all discovered. Are there any comments or questions from the audience?

>> We don't have any questions right now.

>> No questions. The purpose of including these role plays is really for project use. Feel free to use the materials that are available. If you print out the slides, I believe my email address is on them. You have our permission to use them in any way that will be useful for your projects, both the case studies as well as the slides and the content. And you are welcome to them. If there are no other comments, okay? .

>> Well, on behalf of the Division of Healthy Start and perinatal services I would like to thank our presenter and contractor the Center for Advancement of Distance Education at the University of Illinois Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website mchcom.com. We encourage you to let your colleagues know about this website. Thank you and we look forward to your participation in future webcasts.