Skills Building: Guidelines

Guidelines to support HIV-affected individuals and couples to achieve pregnancy safely: Update 2018

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Background

- ≥ 50% of people living with HIV (PLHIV) desire children
  - PLHIV have reproductive rights
  - Sexual and reproductive health services should be available to all
  - Transmissions in serodifferent couples remain SSA epidemic driver
  - Unplanned pregnancy remains common amongst women on ART

- Dolutegravir safety concerns highlight need for integrated fertility intentions screening for all women of childbearing potential accessing ART

- Safer conception supports 90/90/90, EMTCT and HIV prevention efforts
What is Safer Conception?

- Using risk reduction strategies to minimise
  - Horizontal
  - Vertical
  } HIV transmission risks during pregnancy attempts

- Opportunity to optimise male and female prepregnancy health
Scope

• This guideline supports
  • Routine fertility intentions screening
  • Safer conception service provision for presumed fertile HIV-affected couples
  • Prepregnancy counselling and basic prepregnancy assessment
  • Delivery of low cost, low tech services in low resource settings
  • Effective contraception provision for those not currently desiring a child

• Covers all HIV-affected individuals and couples:
Key Game Changers since 2011

• UTT/TasP
  • U=U
  • Reduced need for other safer conception strategies
  • Assisted reproductive technologies no longer required for fertile couples

• PrEP

• ART safety information (EFV/DTG)
• Expanded contraceptive method mix
Terminology

Serodiscordant \rightarrow Serodifferent

Unprotected sex \rightarrow Condomless sex

Heterosexual Couples \rightarrow Inclusive of all individuals and couples

HIV affected = seroconcordant, serodifferent or serounknown
Establishing Fertility Intentions

Are you (and your partner) thinking about having a baby any time soon?

Ask everyone: women and men
Ask routinely
Ask again....and again....and again

Normalise
Working with Couples

• Ideally engage both partners
  • Not always possible
  • Never exclude an individual if partner won’t/can’t come
    • individuals can benefit from comprehensive care too

• Undisclosed individuals:
  • Support but never force disclosure
  • Be alert if only partially disclosed
When an individual or couple wants a child

Strategy choice depends on:
- HIV dynamic
- Context
- Resource availability
- Clinical factors
- Client preferences
U=U: foundation stone

Start ART ASAP

On ART ≥ 6 months

If available:
Confirm lab VL < 200 6 monthly

Sustained optimal adherence

Intervene if VL NOT <200
Defer pregnancy attempts

Add other strategies if low level viraemia and/or couple can’t wait for U=U
Where U=U is not attainable

Why not U=U?
- Laboratory viral load unavailable
- Drug supply issues
- Adherence gaps
- Not everyone knows their status or engages in ART care

If you cannot apply U=U with confidence offer other safer conception strategies as adjuncts to minimise HIV risks
Dolutegravir Safety and Conception

- **Woman have the right to choose:** Check fertility intentions then inform and advise
- **Current pregnancy desire:** avoid DTG
- **No current desire** (on reliable contraception or not of child-bearing potential): use DTG
- **Already on DTG and wants child:** VL <200, switch to EFV
- **Already pregnant on DTG:** only switch if <8 weeks gestation

Keep up to date with new information

Pharmacovigilance: report any adverse outcomes
PrEP

**Recommended if**
- Requested by HIV- partner
- HIV+ partner not on ART
- Bridging (HIV+ partner on ART for < 6 months)
- Adherence concerns
- Unknown status partner
- Anxiety causing sexual dysfunction
- HIV- woman pregnant and remains at substantial HIV risk

**Consider if**
- Viral load unavailable
- Drug supply or healthcare access issues

**Not necessary:** HIV+ partner VL < 200, on ART > 6m, adherent

**Caution:** HIV+ partner not virally suppressed and possible 1st line resistance

**Provide PrEP** according to existing guidelines, minimum 20 day lead in period
STIs

Screen all partners who engage
- Syndromic screening questionnaire
- Clinical examination (at least once)
- Laboratory/point of care tests where available e.g. syphilis, hepatitis, torch

Contact tracing essential
- Both partners must complete treatment before attempting pregnancy

Remember syndromic screening misses asymptomatic cases

New STIs during pregnancy common
- Encourage return to consistent condom use once pregnancy confirmed, even if U=U

Negative impacts:
- HIV transmission risks
- Fertility/infertility
- Pregnancy outcomes
Other Pre-pregnancy Screening

- Cervical cancer screening
- Obstetric history
- General health review
  - Manage comorbidities
  - Medication review
- Folic acid supplementation
- Advanced maternal age counselling
- Baseline antenatal care bloods
- CD4 < 200 and not improving: appropriate OI prophylaxis
Timed Condomless Sex

• If U=U: avoid ‘meddlesome’ advice
• If not U=U (and cannot wait): timing recommended
  • Limiting attempts to peak fertility reduces HIV risk exposures

• Timing methods:
  • Cell phone apps (Cyclebeads™, Dot™)
  • Paper calendar
  • Cervical mucus monitoring
  • Ovulation predictor test kits

Correct timing is not easy
Self-insemination

1. Male ejaculates into condom or specimen jar (check condom does not contain spermicide)
2. Ejaculate (semen) drawn up into 5ml needleless syringe
3. Place syringe 4 - 6 cm into woman's vagina when she is lying down, push semen slowly out of needleless syringe
4. Woman should remain lying down with hips slightly tilted for +/- 30 minutes

- If male HIV- = optional strategy
- Not necessary if
  - HIV+ partner is U=U
  - HIV- male is on PrEP
- Useful for highly anxious couples
- Always discuss as an option
- Easily taught by providers
- Done at home
- Combine with peak fertility timing
No current desire for a child

• **No child desired: provided reliable contraception**
  • if already on contraception check fertility desires routinely: plans change
  • consider method choice: return to fertility relevant if wants children later (long acting hormonal injections)

• **Offer wide method choice**
  • women should be able to choose preferred method
  • Address myths about contraception as cause of infertility

• **Male partner involvement**
  • not required but can be beneficial

• **Short term contraception**
  • important option where clinical situation indicates need to defer pregnancy until circumstances optimised
Additional Considerations

• Pregnancy confirmed
  • Link both partners to appropriate care
  • Early linkage to antenatal care for ongoing PMTCT interventions

• Miscarriage
  • 25% of pregnancies
  • Manage/counsel appropriately

• Infertility
  • Access to assessment and management limited
  • Prolonged trying for pregnancy associated with risks
  • Discuss options
    • Adoption/fostering
    • Surrogacy
    • Assisted reproductive techniques
Thank you