Reproductive Health and HIV: Preconception Care, Family Planning & Safer Conception

Judy Levison, MD, MPH
Associate Professor
Department of Obstetrics and Gynecology
Department of Family and Community Medicine
Baylor College of Medicine
Houston, TX
This presentation was developed in conjunction with the above medical institutions and is an adaptation of a national webinar made possible by the Cooperative Agreement #5U65PS000815-03 from the Centers for Disease Control and Prevention.

Special thanks to AIDS Education Training Centers (AETC), Title X, and CDC Elimination of Mother to Child Transmission (EMCT) partners.
Objectives

• Identify what is meant by preconception counseling for the woman with HIV
• List contraceptive options for women/couples living with HIV infection
• List safer conception methods for HIV serodiscordant couples
Northwest Health Center
Case study

• Gloria is a 32 year old HIV+ female
• Recently diagnosed HIV, acquired from a previous boyfriend
• No significant medical history/on an NRTI and PI combination
• May want children in the future
• How do you counsel her?
Do you ask women of reproductive age who are living with HIV infection about their childbearing desires?

A. No. I’ve never really thought about it
B. No. I don’t think women with HIV should have children
C. Yes, I ask at the initial visit
D. Yes, sometimes, but I don’t always think of it
E. Yes, every visit
Do you ask men who are living with HIV infection about their parenting desires?

A. Never
B. Sometimes
C. Always
In your opinion, should a woman with any of the following conditions have children?

Few Americans believe that HIV+ women should have children.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total %</th>
<th>Male %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV+</td>
<td>14%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Cancer</td>
<td>59%</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>47%</td>
<td>46%</td>
<td>47%</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>37%</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>20%</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Down's syndrome</td>
<td>19%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>17%</td>
<td>18%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Foundation for AIDS Research (2008) email survey, n=4831
Fertility desires and intentions... trends over time

• Studies of fertility desires and intentions have consistently shown that many women living with HIV want to have children.

• Survey of >1400 HIV+ adults in care in 1998:
  – 28% of bisexual/heterosexual men want to have children
  – 29% of women want children in future

• Survey of 450 HIV+ women in the UK in 2011
  – 75% stated they wanted more children

Chen JL et al. Family Planning Perspectives (2001), 33(4)
Cliffe S et al. AIDS Care (2011).23(9),1093-101
Contraceptive Use Among US Women with HIV

Women's Interagency HIV Study (WIHS):
In over 30% of these visits, HIV-infected women reported not using any form of contraception.

**FIG. 1.** Proportion of women with HIV at risk for pregnancy using various forms of contraception. Other methods included IUD, spermicide, and rhythm.

Estimated # of births to women with HIV

Live birth rates among HIV+ women before and after HAART availability

• Comparison of live birth rates 1994-1995 (pre-HAART era) and 2001-2002 (HAART era) in HIV+ and HIV- women 15-44 years:

• In HAART era, 150% increase in live birth rate among HIV+ women vs. 5% increase among HIV- women

Sharma AK et al. AJOG(2007).196,541e1-6
Preconception care

• Defined as “interventions that aim to identify and modify biomedical, behavioral and social risks to a woman’s health or pregnancy outcomes through prevention and management”

• Early prenatal care is not enough

Goals of preconception care in the context of HIV infection

• Prevent unintended pregnancy
• Prevent HIV transmission to partner
• Optimize maternal & paternal health
• Improve maternal and fetal outcomes
• Prevent perinatal HIV transmission

ACOG Practice Bulletin No 117; December, 2010
Are HIV providers discussing reproductive desires?

• Women Living Positive Survey (n=700, ARVs for 3+ years) (2011)
  – 48% previously pregnant women or those considering pregnancy were never asked about their pregnancy intentions (n=227)
  – 57% currently or previously pregnant women or those considering pregnancy had not discussed treatment options relevant to pregnancy plans (n=239)

http://www.thewellproject.org
Every interaction is an opportunity

• To discuss HIV status or testing
• To discuss reproductive health desires
  — Preconception
  — Contraception
  — Safer conception

The stories in our lives do not always coincide with the reminders in the medical health record.
Start the conversation. Stay open. Repeat.
Conduct preconception counseling

- Impact of pregnancy on HIV and impact of HIV on pregnancy
- Risk factors for MTCT and strategies to reduce those risks
  - ARV medications
  - C-section if high viral load
  - Avoidance of breastfeeding
- Risks/benefits of HIV-related medications
- Disclosure of HIV diagnosis
- Partner testing
- Safer conception options

Integrating preconception and HIV care

Challenges:

• Lack of comfort and/or knowledge

• Actual or perceived lower level of priority compared to other issues

• Time constraints

• Role of the primary care provider and the ob/gyn not entirely clear
Pregnancy and You – Making Decisions

With effective HIV treatment, women and men living with HIV infection can enjoy a long and healthy life and can look forward to a future that may include planning a family. Choosing whether or not to have a child can be very exciting but is also sometimes difficult or confusing for people with HIV. It is important to have a good relationship with a health care provider who can talk with you about issues related to your health and the health of your partner, contraception, preparing for a healthy pregnancy and preventing transmission of HIV to a partner or infant.

This survey is designed to help you and your provider talk about these issues during your visits. Giving us this information helps us to discuss topics that are most important for you each time we see you.

Name: ____________________________ Your current age: ____________________________

1. Have you ever been pregnant? □ YES □ NO

2. If YES, how many times? __________ How many children do you have? __________

3. Are you interested in getting pregnant? □ YES □ NO

4. If YES, when do you wish to conceive?
   □ Currently □ 6 months – 1 year □ 1 – 2 years □ > 2 years

5. Have you had sex with a man in the last 6 months? □ YES □ NO

6. Do you use condoms every time you have sex with a man? □ YES □ NO

7. Are you currently using birth control other than condoms? □ YES □ NO
   A. What type?
   □ None □ Birth control Pill □ IUD □ Injection (Depo-Provera)
   □ Patch □ Vaginal Ring □ Implant under the skin (Implanon)
   □ Sterilization (Tubes Tied) □ Unsure □ Other: __________________________

   B. Are you trying to get pregnant? □ YES □ NO

8. Would you or your partner like more information about planning for pregnancy?! □ YES □ NO

---

Anderson, J Preconception care and HIV tool.
Johns Hopkins Women's HIV Program, Baltimore, MD.

---

Provider Checklist

Addressing Fertility Issues in the Context of HIV

This tool is designed to help you better address both fertility issues – desire to conceive and desire to prevent pregnancy in your patients.

1. Patient is post-menopausal or S/P hysterectomy
   A. Yes – end of tool
   B. No – go to question 2

2. Patient wishes to have more children?
   A. Yes – go to question 3
   B. No – go to question 5

3. Does patient wish to conceive within the next year?
   A. Yes – go to question 4
   B. No – go to question 5

4. Patient would like to conceive within the next year.
   A. Review medication list with patient for drugs that are contraindicated in women trying to conceive (i.e. efavirenz, statins, ribavirin, tetracycline/ doxycycline). Others should be used only if no other safer effective options are available.
   AND
   B. Offer and encourage referral for preconception counseling and evaluation.

5. Patient wishes to prevent pregnancy.
   A. Patient has completed childbearing – refer to a gynecologist to discuss long term or permanent contraceptive options.
   OR
   B. Wants more children, but not within the next year – review non-permanent contraceptive options and strongly recommend referral for preconception counseling.

Key Considerations:

1. Patient has a problem with irregular menses or amenorrhea – if yes, perform a pregnancy test and refer for a gynecologic evaluation.
2. Menopause: Can be difficult to diagnose.
   ▶ If the woman is > 50 years of age with no vaginal bleeding for over one year, she is post-menopausal.
   ▶ If uncertain, refer for a gynecologic evaluation.
3. Formal preconception counseling and evaluation is strongly recommended if the patient:
   A. Is in a serodiscordant relationship
   B. Has significant medical co-morbidities
   C. Has problems with substance abuse
   D. There are concerns with the patient's current medication

The National Perinatal HIV Hotline (1-888-448-8765) provides 24/7, free, confidential expert consultation. www.nccohcf.org

Anderson, J Preconception care and HIV tool.
Johns Hopkins Women's HIV Program, Baltimore, MD.
Integrating preconception and HIV care

Guides to preconception counseling
-- for the HIV care provider
-- for clients

http://fxbcenter.org/
• Are you interested in having a child?
• When do you wish to conceive?
  – Currently 6 mos-1yr, 1-2 years; >2 years
• Are you currently using condoms?
• Are you currently using a contraceptive other than condoms?
  – If yes, what method:
  – If no, are you seeking pregnancy:
• Would you like information on planning a safe pregnancy that may reduce the risk of HIV transmission to your partner and your baby?
Case study

Second visit:

• Gloria is doing well on her antiretrovirals and has achieved viral suppression with CD4 count of 500.

• She is here to discuss contraception.
Which statement is true?

A. Injectable progestin-only contraception (DPMA) can be used by women with HIV
B. IUDs can be used in women with HIV
C. Oral contraceptives may be used in women with HIV but drug-drug interactions with ARVs should be reviewed
D. Spermicides are not recommended
E. All of the above
Benefits of Contraception for HIV-Positive Women

• Prevents unintended pregnancy
  – Half of all pregnancies in U.S. are unintended

• Allows women to plan a pregnancy that
  – Is well timed
  – Occurs when she is in optimal health
  – Minimizes risks for perinatal transmission

http://www.cdc.gov/reproductivehealth/unintendedpregnancy
http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf
Special Considerations Regarding HIV and Contraception

- Potential drug interaction with antiretrovirals (ARVs)
- Possible effects on HIV transmission
- Possible effects on HIV acquisition
- Possible effects on HIV progression
Typical Effectiveness of Contraception

HIV-positive women generally have the same options as uninfected women ... with some caveats

Oral contraceptives

• Same medical criteria as for HIV-uninfected women if woman is NOT on ART
• Drug-drug interactions are possible between ARVs and hormonal contraceptives (HCs)
  – HCs are metabolized by same pathways and cytochrome P450 enzymes as many PIs and NNRTIs
  – These interactions can cause changes in the efficacy of the ARV or contraception
# Hormonal Contraception and NNRTI Interaction Table

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect on Hormonal Contraception</th>
<th>Additional Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efavirenz (EFV)</strong></td>
<td>No effect on oral ethinyl estradiol</td>
<td>A reliable method of barrier contraception must be used in addition to HC due to decreases in progestin levels.</td>
</tr>
<tr>
<td></td>
<td>Decreased active metabolites of norgestimate (levonorgestrel AUC ↓ 83%; norelgestromin ↓64%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implant: ↓ etonogestrel</td>
<td>A reliable method of barrier contraception must be used due to reports of contraceptive failure.</td>
</tr>
<tr>
<td></td>
<td>Levonorgestrel AUC ↓58%</td>
<td>Effectiveness of emergency contraception may be diminished</td>
</tr>
<tr>
<td><strong>Etravirine (ETR)</strong></td>
<td>Ethinyl estradiol AUC ↑22%</td>
<td>No dosage adjustment necessary</td>
</tr>
<tr>
<td></td>
<td>Norethindrone: no significant effect</td>
<td></td>
</tr>
<tr>
<td><strong>Nevirapine (NVP)</strong></td>
<td>Ethinyl estradiol AUC ↓20%</td>
<td>Use alternative or additional methods</td>
</tr>
<tr>
<td></td>
<td>Norethindrone AUC ↓19%</td>
<td>No dosage adjustment needed</td>
</tr>
<tr>
<td></td>
<td>DMPA: no significant change</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: *Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States.*

[http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf](http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf)
**Hormonal Contraception and Ritonavir-boosted PI Table**

<table>
<thead>
<tr>
<th>PI Combination</th>
<th>Effect on Ethinyl Estradiol</th>
<th>Effect on Norethindrone AUC</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atazanavir/ritonavir (ATV/r)</td>
<td>↓ Ethinyl estradiol ↑ Norgestimate</td>
<td>Ethinyl estradiol ↓44% Norethindrone AUC ↓14%</td>
<td>Oral contraceptive should contain at least 35 mcg of ethinyl estradiol. OCs containing progestins other than norethindrone or norgestimate have not been studied.</td>
</tr>
<tr>
<td>Darunavir/ritonavir (DRV/r)</td>
<td>Ethinyl estradiol AUC ↓ 44% Norethindrone AUC ↓14%</td>
<td>Use alternative or additional method.</td>
<td></td>
</tr>
<tr>
<td>Fosamprenavir/ritonavir (FPV/r)</td>
<td>Ethinyl estradiol AUC ↓ 37% Norethindrone AUC ↓34%</td>
<td>Use alternative or additional method.</td>
<td></td>
</tr>
<tr>
<td>Lopinavir/ritonavir (LPV/r)</td>
<td>Ethinyl estradiol AUC ↓ 42% Norethindrone AUC ↓17%</td>
<td>Use alternative or additional method.</td>
<td></td>
</tr>
<tr>
<td>Saquinavir/ritonavir (SQV/r)</td>
<td>↓ Ethinyl estradiol</td>
<td>Use alternative or additional method.</td>
<td></td>
</tr>
<tr>
<td>Tipranavir/ritonavir (TPV/r)</td>
<td>Ethinyl estradiol AUC ↓ 48% Norethindrone: no significant change</td>
<td>Use alternative or additional method.</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: *Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States.*

[http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf](http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf)
Hormonal Contraception and PIs without Ritonavir Table

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect on Estrogen and Progestin</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atazanavir (ATV)</td>
<td>Ethinyl estradiol AUC ↑48% Norethindrone AUC ↑110%</td>
<td>Oral contraceptive should contain no more than 30 mcg of ethinyl estradiol or use alternative method. OCs containing less than 25 mcg of ethinyl estradiol or progestins other than norethindrone or norgestimate have not been studied.</td>
</tr>
<tr>
<td>Fosamprenavir (FPV)</td>
<td>With APV: Ethinyl estradiol and norethindrone; APV 20%</td>
<td>Use alternative method.</td>
</tr>
<tr>
<td>Indinavir (IDV)</td>
<td>Ethinyl estradiol AUC ↑25% Norethindrone AUC ↑26%</td>
<td>No dose adjustment.</td>
</tr>
<tr>
<td>Nelfinavir</td>
<td>Ethinyl estradiol AUC ↓47% Norethindrone ↓18%</td>
<td>Use alternative or additional method.</td>
</tr>
</tbody>
</table>

Adapted from: *Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States.*

http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf
Hormonal Contraception and CCR5 antagonist/integrase inhibitor table

<table>
<thead>
<tr>
<th>CCR5 antagonist</th>
<th>No significant effect on ethinyl estradiol of levonorgestrel</th>
<th>Safe to use in combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maraviroc (MVC)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrase inhibitor</th>
<th>No significant drug effect</th>
<th>No dose adjustment necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raltegravir</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: *Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States.*

http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf
Hormonal Contraception: Alternate Delivery Methods
Alternate Delivery Methods

• These delivery methods may also be vulnerable to drug interactions
• One small study showed a drop in estrogen and a rise in progestin with the patch and lopinavir/ritonavir
• More research needed on these delivery methods

DMPA

- Injectable (IM,SQ) progestin only contraception
- Given every 3 months
- Works by preventing ovulation
- Controversial whether it increases risk of acquisition of HIV
- Efficacy
  - 97% effective as commonly used
Contraceptive Implants

- Thin rods or tubes containing a progestin hormone
- Provide effective contraception for at least 3 yrs
- Suppresses ovulation and changes cervical mucus
- Menstrual irregularities in most users
Intrauterine devices (IUDs)

- No known drug interactions
- No increase in shedding of HIV

2 types
- Copper (Paragard) works for 10 years, may be associated with heavier menses, periods regular
- Levonorgestrel IUD (Mirena) works for 5 years, reduces menstrual blood loss (is FDA-approved as a treatment for menorrhagia), periods scant and not regular
IUD and HIV Considerations

• **No higher risk** in HIV-positive women over uninfected women for
  – Complications
  – Infections

• IUD use **not associated** with increased risk for transmission to sex partners

• Women with IUD in place who develop AIDS should be monitored for pelvic infection

CDC (2010) U.S Medical eligibility criteria for contraceptive use
Condoms

- Efficacy
  - Pregnancy prevention as commonly used
    - Male condom 85%
    - Female condom 79%
  - Pregnancy prevention when used correctly and consistently
    - Male condom 98%
    - Female condom 95%
  - Male condom is 80-95% effective at preventing HIV transmission when used correctly and consistently

WHO Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. Family planning: A global handbook for providers (2011)
Dual Contraceptive Use

• Condom use should be encouraged in HIV-positive women
  – To prevent HIV transmission
  – Prevent STI acquisition
  – As an adjuvant to contraceptives
• Condoms alone have a failure rate of 15%-21% at preventing pregnancy

American College of Obstetricians and Gynecologists (ACOG) (2010), *Obstetrics and Gynecology*, 116(6), 1492-1509
WHO Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. Family planning: A global handbook for providers. 2011
Spermicides: Not recommended

- Spermicides are not recommended by CDC
  - Disrupt cervical mucosa
  - Potentially increase viral shedding
  - Increase transmission of HIV to uninfected partners

- Diaphragms and cervical caps are not encouraged by the CDC due to concerns about their use with spermicides

Female and Male Sterilization

- Contraceptive sterilization is the most widely used method of family planning
- Clients should be advised that sterilization should be considered permanent

Male-vasectomy:
- Cutting/occluding both vas deferens
  - 1st yr failure rate 0%-0.5%

Female-sterilization
- Tubal ligation (postpartum or interval laparoscopic)
- Hysteroscopic
Bottom line on contraception

• Avoid oral contraceptives with most NNRTIs/protease inhibitors
• OCPs ok with integrase inhibitor (raltegravir) and CCR5 inhibitor (maraviroc) and rilpiberine (in newest 1 pill once a day combo Complera)
• Some controversy around DMPA risks of HIV acquisition or HIV shedding but most likely ok
• IUDs are an excellent choice
The Serodiscordant Couple
HIV discordance in couples

- Population based sample of HIV-infected persons in care
  - 58% of men and 70% of women had a primary partner
  - 50% of couples were in serodiscordant relationships
  - 20% were in relationships with partners whose HIV status was unknown

- Estimated 140,000 serodiscordant heterosexual couples in the U.S., about half of whom want children

Chen JL et al. Family Planning Perspectives (2001). 33(4), 144-152
Harris County Women’s Program
2006-2010 (n=212)

- 54 couples (26%) were seroconcordant

- 85 couples (40%) were serodiscordant

- 73 couples (34%) included HIV-positive pregnant women and FOB with unknown HIV status

Nacius L et al. AIDS Patient Care and STDs (in press)
Case presentation

Two years later:

• Gloria continues to do well on her combination regime and maintains an undetectable viral load.

• At this appointment she announces that she wants to have a child.

• How do you counsel her?
Which statement best represents your feelings about Gloria and her partner’s desire to have a baby?

A. I feel angry. How can they take the risk of her partner becoming infected with HIV and having an HIV+ child?

B. I don’t like it, but I think it is their choice

C. I really need to think about it

D. I think I should do everything I can to help them do this safely
Pregnancy

– Perinatal transmission is <1-2%
– Men and women with HIV can expect to live to see their children grow into adulthood
– Methods of conception safe for the partner exist

http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf
Preconception counseling

• If a woman is not on ARVs, consider starting them prior to attempting conception

• If a woman is on ARVs and is considering pregnancy
  – Substitute other ARVs for efavirenz because of possible risk of neural tube defects (NTDs) (B III=moderate level recommendation based on expert opinion)
  – Recommend folate or prenatal vitamins preconceptionally to reduce chance of NTDs

http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf
Serodiscordant couples

• If the woman is HIV+ and the man is HIV-, discuss the options of:
  – Ovulation predictor kits
  – Home insemination ("turkey baster method")

http://hiv.ucsf.edu/care/perinatal.html
http://hiv.ucsf.edu/care/perinatal/resources.html
Ovulation predictor kits

These test kits replace the old basal body temperature charts
When the time is right, the choices are:

• Home insemination with partner’s semen

  The “turkey baster” method

  *A needle-less syringe works fine
Home insemination

• During the 24 hours after the LH surge has occurred as documented by the ovulation predictor kit, ejaculate into a cup or into a condom without a spermicide
• Suction semen into a syringe
• Place syringe in vagina and deposit semen
• Remain lying down for 20 minutes
• Return to having protected sex with condoms
Alternatives

• Insemination in a doctor’s office with partner’s semen

• Penile/vaginal intercourse only during the 24 hours after the LH surge and using condoms the rest of the month. Placing the woman on ARVs prior to attempted conception will further protect her partner

• Post or pre-exposure prophylaxis for male (PEP or PrEP)? If yes, how many doses?

And one more word about condoms...

• If we do not broaden our discussions around reproductive health (leaving it at "use condoms"), many individuals will do what they will do at home in order to achieve pregnancy.

• It’s much better that couples conceive with support and knowledge of safe options. We don’t want clients to feel they have to hide their desire to have children.
Serodiscordance

• If the man is HIV+ and the woman is HIV-, consider:
  – Maximal viral suppression of the male
  – Ovulation predictor kit/ timed insemination with washed sperm
  – Intracytoplasmic sperm injection (ICSI)
  – Ovulation predictor kit/timed intercourse
  – Post-exposure prophylaxis (PEP) or pre-exposure prophylaxis (PrEP) for female
  – Donor insemination
Sperm washing

• Cost is in the $1500 range (when fertility consultation visits included)
  • Not widely available

http://aids.about.com/cs/womensresources/a/washing.htm

http://www.thebody.com/content/art911.html
Has the time come for natural conception in the context of full viral suppression?

- Barreiro
  - 62 serodiscordant couples
  - HIV+ partner on ART and VL < 500
  - No transmission of HIV

- HPTN 052: Treatment as prevention
  - 96% reduction in transmission of HIV among serodiscordant couples (ARVs started if CD4 350-500)

What if both partners are HIV-positive?

- When a couple is not attempting conception, we recommend condoms to avoid superinfection and sharing of antiretroviral resistant virus.

- If pregnancy desired: Ovulation predictor kit, maintaining an undetectable viral load, and once monthly unprotected sex is a reasonable approach.
Preconception counseling is not being addressed

• Data suggest that reproductive counseling does not often occur until after conception
  – Recent study of 181 HIV+ women: Only 31% reported a personalized discussion with their provider specific to their childbearing plans.
  – Of those who had a personalized discussion, most were initiated by the client rather than the provider.

Finocchiaro-Kessler S et al. AIDS Patient Care and STDS, 24(5), 317-23, 2010
Final notes on preconception counseling...

• Contraception and pregnancy desires change over time. Just because someone did not desire pregnancy in 2011 does not tell you what he or she wants in 2013.

• Don’t forget to ask the men if they and their partners are planning a pregnancy. Let them know that there are preconception counseling services available.
• THANK YOU!

• jlevison@bcm.edu