Reproductive Health, Rights, and Justice:

Canadian Webinar Series on Implementing the WHO Guidelines on Sexual and Reproductive Health and Rights for Women Living with HIV

Wednesday, January 24, 2018

Participant Questions and Presenter Answers

Question 1:

The decision to not include PrEP as a recommendation is interesting for me. I am curious to know how Canada is doing on the 90/90/90 cascade because here, in South Africa, we are only at about 23% virally suppressed so PrEP remains a really important option, particularly where the other partner's status can't be established or viral load can be confirmed suppressed. Could the panel comment on this? Just to add to this, I understand that PrEP isn't considered necessary where the positive partner in a known, mutually disclosed HIV serodifferent couple is virally suppressed but I worry this recommendation may result in providers being less aware of the other groups where PrEP remains a really important option.

Question 1 Answer: Deborah Money

"It is important to recognize that when we write these guidelines nation-wide, it really is a generic recommendation but of course in each and every situation It's very critical to have a nuanced approach and to individualize around our knowledge with regards to the security of a partner's HIV suppression and adherence to medications and our confidence that partner is consistently suppressed. And in situations where the partner is less well known certainly PrEP is used and considered in the Canadian context.

Question 1 Answer: Mona Loutfy

In the context of guidelines, it's important to know the purpose and audience of the guidelines. The purpose of this guidelines is around pregnancy planning and HIV, and for healthcare providers to counsel

individuals and couples who are engaged in HIV care who are living in Canada. We did a thorough literature review and review of all the data related to HIV and in the Canadian context the majority of people who are planning pregnancies and preconception are engaged in care and the HIV positive individual would be on antiretroviral therapy and virally suppressed. And in that setting, PrEP is not recommended by many countries and we would be adding a medication that is not needed and that could have side effects; for those reasons we are not recommending it in such cases; again, when the HIV positive person is on effective antiretroviral therapy with a suppressed viral load. Of course, that doesn't mean that PrEP is not useful in many other settings, even in the context of pregnancy planning. And we do have a specific recommendation within the guidelines that PrEP should definitely be recommended if individuals are planning to conceive or have condomless sex if adherence isn't confirmed and if there isn't a suppressed viral load. This recommendation would extend to the important cases– i.e. if a woman is having condomless sex for the purpose of conception and doesn't know her partner's HIV status and lives in a high-risk circumstance such as in South Africa or in a situation where one individual is starting antiretroviral therapy and they're in a sero-discordant couple, the HIV negative partner is started on PrEP in those initial stages, such as done in the Partners Demonstration Study. I think that HIV Pregnancy Planning or Preconception Guidelines are best developed for each country and context. A global 'Consensus statement on Supporting Safer Conception and Pregnancy For Men And Women Living with and Affected by HIV' has been developed and was published in *AIDS and Behavior* in May 2017. [Here is a link to the Open Access article: http://rdcu.be/HlXR]. This statement covers different circumstances where PrEP will likely have a much bigger role in preconception.

Question 2:

Regarding the viral load monitoring recommendation that a person have two undetectable viral loads at least one month apart before embarking on condomless sex for conception attempts, I am curious to know what proportion of people who have a first undetectable viral load are not undetectable at that second viral load? I can understand why you would want to repeat the viral load after a month if, for example, a client has been on ART for three months and the viral load is checked and still several

thousand copies, because they may have just not had time to suppress or may be having adherence issues or even primary acquired resistance. But, where that first viral load is undetectable what is the risk that a following one will not be undetectable where adherence is maintained? I ask because, in South Africa and other resource limited settings, additional viral loads are expensive so we may struggle to implement this level of monitoring so what is the evidence of its necessity?

Just as a note, in South Africa, our public health sector laboratory has strict gate keeping which means such a request for a repeat viral load in someone who is undetectable will be rejected until 12 months have passed. It wouldn't be reasonable to ask clients to wait that long for confirmation of their viral suppression. Interested in your thoughts, although I know it is different from Canada in terms of resources.

Question 2 Answer: Mona Loutfy

I mentioned that when I was giving the presentation, what was written was for the Canadian context. In Canada, it's standard that when we start an individual living with HIV on antiretroviral therapy, we actually see them once a month and test viral load monthly until they're suppressed. That's common practice in Canada, but even without that the standard before was based on the Swiss statement that said that there was no risk of sexual transmission of HIV if the HIV-positive individual was on effective antiretroviral therapy with suppressed viral load greater than 6 months and that came out in 2008 with only observational studies at the time. We now have much more data to support that and what's been written in our guidelines comes from clinical practice, comes from myself and many others seeing couples who say, "We want to get started to use condomless sex as our method as soon as possible, so doctor what's the soonest that I can start?". So from clinical data and from clinical studies, we're recommending three months and at least must have two viral loads below the level of detection at least one month apart, which is consistent with sustained suppression. so while we still prefer six months like the Swiss statement, and in Canada 3 months is preferable, but if they really want to go ahead a minimum would be sustained suppressed viral load with testing done at least one month apart. Your question is excellent and has really made me think – if you don't have easy access to viral load testing and

cannot get a viral load approved more than once a year, what do you do? First of all, as a clinician, I would recommend using an antiretroviral therapy regimen that has a high genetic barrier, I would likely wait to do the one possible viral load that could be done per year, 6 months after starting; if their partner was HIV negative and they had the criteria of the Partners Demonstration Study, I would start their partner on PrEP. I would take the best adherence history, I could, likely using a scale and if that 6-month viral load post starting antiretroviral therapy was suppressed, I would be fine recommending condomless sex as the method of conception. All of that clinical practice would still be an ideal circumstance – it is likely common that you don't know if people are adherent, the viral load may not be done at 6 months … what if it is done earlier and not suppressed or not done at all which is likely more common; what if patients miss their appointments and they are likely to try to conceive without seeing you – all of those are the real-life situation and what clinicians have to face when counselling. So the approach is one of harm reduction and getting in as much counselling and care in, in that first or single visit with the patient(s) – starting a high-drug-resistant-barrier antiretroviral regimen, starting PrEP in an HIV negative partner, counselling on the importance of adherence and drug resistance, counselling on risk of HIV transmission and treatment as prevention and counselling that it is best to wait 6 months after the start of therapy before not using a condom and trying to conceive and coming in for that 6-month visit for a viral load testing and recommending continued engagement in care at least every 6 months. I hope that is more helpful and that I have understood the South African context.

Question 3:

Can you please talk more about the link to partner violence and abortion?

Question 3 Answer: Frédérique Chabot

When it comes to intimate partner violence, this is space where we see the overlap between what makes people more at risk of contracting HIV and what makes people more at risk of not being able to control their reproductive lives, including deciding when to be pregnant, when and how to use birth control, if or when to access abortion. There is also a link between HIV infection and intimate partner violence. Among other things,

studies are showing that people who report a history of intimate partner violence are more likely than those who do not to report behaviors known to increase the risk for HIV, including injection drug use, treatment for a sexually transmitted infection (STI), giving or receiving money or drugs for sex, and anal sex without a condom in the past year. It is also important to note that HIV-positive women in the United States experience IPV at rates that are higher than for the general population. Across a number of studies, the rate of intimate partner violence among HIV-positive women in the US (55%) was double the national rate.

One of Action Canada's frontline services is a national toll-free 24-hour access line that provides information on sexual and reproductive health and referrals for pregnancy options. Through our work on this line, we get to intimately know how barriers to abortion manifest. Supporting people through their navigation of sometimes incredibly complicated scenarios really drives home the unfairness of abortion access and how it is spotty at best. We know from research and from our own frontline work that barriers to abortion disproportionately affect young people and marginalized people, especially those who are low-income, people of color, Indigenous, migrants or refugees and those who do not speak English or French. These barriers are compounded for those living in rural or remote areas. When some people face additional barriers to accessing abortion, this only compounds the issue of access for people already vulnerable. This includes people who experience intimate partner violence.

Evidence shows that violence and poor reproductive health outcomes are strongly linked. Experiencing violence increases someone's risk of unintended pregnancies because of the likelihood of reproductive coercion. One study found that women with unintended pregnancies were four times more likely to have experience intimate partner violence than women whose pregnancies were intended. In 2007, the prevalence of IPV was nearly three times greater for women seeking an abortion compared with women who were continuing their pregnancies.

Reproductive coercion is a form of intimate partner violence, where behavior concerning reproductive health is used to maintain power, control, and domination within a relationship and over a partner. This

behavior includes explicit attempts to impregnate a partner against their will, controlling the outcomes of a pregnancy (force an abortion or prevent someone from accessing one), coerce a partner to have unprotected sex, and interfere with contraceptive methods.

Here is a more in depth breakdown of what it can look like, quoted fromhttps://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-and-Sexual-Coercion :

"Birth control sabotage is active interference with a partner's contraceptive methods in an attempt to promote pregnancy. Examples include hiding, withholding, or destroying a partner's oral contraceptives; breaking or poking holes in a condom on purpose or removing a condom during sex in an attempt to promote pregnancy; not withdrawing when that was the agreed upon method of contraception; and removing vaginal rings, contraceptive patches, or intrauterine devices (IUDs). Pregnancy pressure involves behavior intended to pressure a female partner to become pregnant when she does not wish to become pregnant. Pregnancy coercion involves coercive behavior such as threats or acts of violence if a partner does not comply with the perpetrator's wishes regarding the decision to terminate or continue a pregnancy. Examples of pregnancy pressure and coercion include threatening to hurt a partner who does not agree to become pregnant, forcing a partner to carry a pregnancy to term against her wishes through threats or acts of violence, forcing a female partner to terminate a pregnancy when she does not want to, or injuring a female partner in a way that may cause a miscarriage. Homicide is a leading cause of pregnancy-associated mortality in the United States. In one study, the majority of pregnancy-associated homicides were committed by an intimate partner."

Because of the increased likelihood of facing unintended and unwanted pregnancies, we end up speaking with people who disclose experiences of intimate partner violence. We have worked with people with whom we had to craft complex access plans for them to be able to access abortion care. When these callers are located in a community where no abortion service is available, this sometimes means that they will have to travel to access a

point of service, which can put them at more risk of violence from their partners and more likely to be unable to access that service. This, like other examples of what barriers to access looks like in real terms in Canada, tells us of the importance of considering the implications of how we make abortion available and to whom. When we do not make abortion easily accessible through primary care (which can be done by having diverse health care providers become proficient at offering medical abortion) and in every community, some people are more impacted than others. This includes people who experience intimate partner violence and people who are living with HIV.

I recommend looking at the Planned Parenthood Ottawa (PPO) Reproductive Coercion project if people are interested in becoming involved in a coordinated community response to reproductive coercion, abuse and sexual and reproductive health as through this project, PPO is seeking to increase communication and knowledge-sharing between anti-violence workers and sexual and reproductive health workers.