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

Date: Wednesday, January 24th 2018

Time: 9:00-10:30 PST, 12:00 -13:30 EST, and 18:00 - 19:30PM in Geneva.

Link: https://attendee.gotowebinar.com/register/5499989554982862594

Webinar series hosted in collaboration with:

WHO HRP, CHIWOS, Canadian Positive People's Network, Oak Tree Clinic, Women's Health in Women's Hands, Canadian Aboriginal AIDS Network and the IBP Initiative

Remembering

Webinar Objectives

- **Provide an overview** of new WHO recommendations on elective C-section and safe abortion for women living with HIV as well as current research about **the reproductive health of women living with HIV** in the Canadian context using data from the Canadian HIV Women's Sexual and Reproductive Health Cohort Study (CHIWOS);
- **Introduce guidelines and a toolkit** developed by clinicians, women living with HIV and stakeholders for health and social service providers to support reproductive health and rights within a **reproductive justice framework**; including the newly updated Canadian HIV Pregnancy Planning Guidelines (2018) and the Supporting Mothers in Ways that Work: A Resource Toolkit for Service Providers Working with Mothers Living with HIV (2016);
- **Gain insights** from women living with HIV to highlight gaps in research and priority areas for further attention;
- **Develop an action plan** on to support the sexual and reproductive health and rights of women living with HIV in the Canadian context, including actions to support the reproductive health, rights, and justice of women living with HIV.

World Health Organization | CHIWOS | BC WOMEN'S HOSPITAL+ HEALTH CENTRE | CRCPP | WOMEN'S HEALTH IN WOMEN'S HANDS COMMUNITY HEALTH CENTRE | human reproduction programme hrp research for impact | IBP Initiative Scaling up what works in family planning/reproductive health

Today's Speakers

Dr. Deborah Money

Valerie Nicholson

Dr. Manjulaa Narasimhan

Krysta Williams

Brittany Cameron

Dr. Angela Kaida

Dr. Mona Loutfy

Dr. Saara Greene

Frédérique Chabot

World Health Organization

CHIWOS

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

CRCPN

WOMEN'S HEALTH IN WOMEN'S HANDS COMMUNITY HEALTH CENTRE

human reproduction programme hrp research for impact

IBP Initiative Scaling up what works in family planning/reproductive health

Overview of the Agenda

Time	Title of Presentation	Presenter	Affiliation
9:10-9:15 PST 10:10-10:15 MST 12:10-12:15 EST	Consolidated guidelines on sexual and reproductive health and rights of Women Living with HIV	Dr. Manjulaa Narasimhan	World Health Organization – Department of Reproductive Health
9:15-9:25 PST 10:15-10:25 MST 12:15-12:25 EST	Framing Reproductive Rights and Justice	Krysta Williams	Native Youth Sexual Health
9:25-9:30 PST 10:20-10:30 MST 12:20-2:30 EST	Lived Experience of Women Living with HIV: How reproductive health, rights, and justice among women living with HIV have changed in Canada	Brittany Cameron	HIV Positive Mother, Wife, and Activist
9:30-9:40 PST 10:30-10:40 MST 12:30-12:40 EST	Current overview of research: Pregnancy after HIV diagnosis	Dr. Angela Kaida	Canada Research Chair, Simon Fraser University
Implementation 9:40-10:10 PST 10:40-11:10 MST 12:40-1:10 EST	Canada's updated Pregnancy Planning Guidelines: January 11th, 2018	Dr. Mona Loutfy	Women's College Hospital
	Supporting Mothers in Ways that Work	Dr. Saara Greene	McMaster University
	Availability and Access to Reproductive Health Services	Frédérique Chabot	Action Canada for Sexual Health and Rights
10:10-10:30 PST 11:10-11:30 MST 1:10-2:30 EST	Discussion & Next Steps	Dr. Deborah Money	

Housekeeping

1. Asking questions

- During presentations, please submit any questions using the text feature of the application
- We have allotted 20 minutes at the end of the webinar for discuss and Q&A
- If you are joining us on the phone, please send any comments or questions to Project Coordinator Sarah Watt (sawatt@sfu.ca)
- If we do not get to answer or discuss all questions posed during the webinar, the organizing team will collate the questions and send responses to all webinar attendees after the webinar. Questions & answers will also be posted online with the recorded version of the webinar.
- Please type any technical difficulties into the text feature.

2. Webinar recording

- This webinar will be recorded and posted on the IBP Channel and the WHO RHR Youtube Channel. Links will be posted at the end of the webinar.

3. Handouts

- There are handouts that you can download for your own viewing and reference

Funding

This webinar series is grateful to be supported by:

The IBP Initiative, WHO, and Social Sciences and Humanities Research Council of Canada.

IBP Initiative
Scaling up what works in family planning/reproductive health

World Health Organization

Social Sciences and Humanities Research Council of Canada
Conseil de recherches en sciences humaines du Canada
Canada

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Conflict of Interest

Today's webinar presenters have no conflicts of interest to declare.

Consolidated guideline on **sexual and reproductive health and rights of women living with HIV**

NEW recommendation on caesarean section

REC B.22: WHO recommends that elective caesarean section (C-section) should not be routinely recommended to women living with HIV.

(strong recommendation, low-quality evidence)

NEW recommendations on safe abortion services

REC B.30: WHO recommends that safe abortion services should be the same for women living with HIV who want a voluntary abortion as for all women.

(strong recommendation, very low-quality evidence)

REC B.31: WHO suggests that women living with HIV who want a voluntary abortion can be offered a choice of medical or surgical abortion, as for all women.

(conditional recommendation, very low-quality evidence)

Framing Reproductive Justice

Native Youth Sexual Health Network @NYSHN

Who are WE?!

NYSHN is a by and for Indigenous youth organization working throughout the United States and Canada across issues of sexual and reproductive health, rights and justice! (Our bodies, Our spaces)

RESISTANCE

IS SEXY !!!

WWW.NATIVEYOUTHSEXUALHEALTH.COM

Resistance is sexy because reclamation & restoration are part of the process

So what is RJ?

- The reproductive justice framework – **the right to have children, not have children, and to parent the children we have in safe and healthy environments** -- is based on the human right to make personal decisions about one's life, and the obligation of government and society to ensure that the conditions are suitable for implementing those decisions

- Represents a shift from advocating for control of our bodies, from a narrower focus on legal access and individual choice (the focus of mainstream organizations) to a **broader analysis of racial, economic, cultural, and structural constraints on our power**

Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny. Our options for making choices have to be safe, affordable and accessible

What is REPRODUCTIVE JUSTICE?

SPARK defines Reproductive Justice as a social justice movement rooted in the belief that individuals and communities should have the resources and power to make sustainable and liberatory decisions about their bodies, genders, sexualities, and lives.

"I hate how the people out there are clapping their hands at the non-native pro-choice movement, and totally ignoring our long standing and well documented history of self control over reproductive choices. It's disrespectful to pretend like RJ wasn't alive in our communities. They treat it as if it's the first time it's being done, saying things like, "Look how progressive we are!" but they totally ignore the fact that before contact we were more egalitarian than them, but their indoctrination/colonization has manipulated things so that we weren't allowed to follow the way we always did things. **Our RJ was made illegal on purpose, but that's never mentioned anywhere**."

- TJ Lightfoot, *Reproductive Justice, for real, for me, for you, for now*

HIV/AIDS AFFECTS INDIGENOUS COMMUNITIES

BECAUSE STIGMA OUTSIDE OF INDIAN RESERVATIONS EXISTS

BECAUSE COLONIZATION BEGETS GOVERNMENT MISTRUST

BECAUSE HIV/AIDS AFFECTS INDIGENOUS QUEER MEN

BECAUSE HIV/AIDS AFFECTS INDIGENOUS WOMEN

BECAUSE SUBSTANCE ABUSE AFFECTS INFECTION RATES

BECAUSE PREVENTION SPEAKS MANY LANGUAGES

BECAUSE POVERTY AFFECTS ACCESS TO HEALTH CARE

BECAUSE SEX EDUCATION IS INSUFFICIENT

BECAUSE INDIGENOUS SUICIDE RATES ARE HIGH

BECAUSE RESISTANCE IS AWARENESS

BECAUSE AWARENESS IS SURVIVAL

BECAUSE WE ARE WARRIORS

BECAUSE OUR HEALTH MATTERS

BECAUSE WE HAVE A RIGHT TO SURVIVE

BECAUSE STIGMA ON INDIAN RESERVATIONS EXISTS

R.I.S.E.: *Radical Indigenous Survivance & Empowerment*

RJ History Lesson

The shift away from "pro-choice" was led by women of color and Indigenous women whose communities never had real choices because of systemic barriers like poverty, discrimination, immigration status, and incarceration.

NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH

#KnowYourHistory
#StopErasing

Please join us for a Twitterstorm using hashtags:
#KnowYourHistory
#StopErasing

Thursday, July 31, 2014
12 pm PT/ 3 pm ET

Hosted By:
@NYSHN @NLIRH
@SisterSong_WOC
@YwuWomen

Thanks! Anushiik!

www.nativeyouthsexualhealth.com

Twitter and Instagram @NYSHN

Find us on Facebook!

Contact: info@nativeyouthsexualhealth.com

BRITTANY CAMERON

HIV POSITIVE MOTHER, WIFE, ACTIVIST

no conflicts of interest to declare

- Born in 1985
- Parents were both heroin addicts.
- Started living on the streets at 12.
- Engaging in survival sex work at 13.
- Incarcerated at 16 on and off until 18, released and moved to Montreal.
- Active crack addiction from 13 until 20.

BRITTANY CAMERON THE HISTORY

- Last HIV Negative Test – 2004.
- Took HIV Test in October 2005 but was left without healthcare (card) when I moved provinces.
- When I was finally able to access healthcare I was diagnosed with HIV over the phone.
- I was 20 years old and 36 weeks pregnant.
- Transferred to Mount Sinai Hospital, Toronto because the OBGYN had no previous experience delivering an HIV Positive Women's baby.
- Connected into Positive Care Clinic the day after diagnosis and I started ARV's.

DIAGNOSIS MARCH 2006

- Birth plan instantly shifted the moment I was diagnosed.
- Unplanned scheduled caesarean section birth at 38 weeks pregnant.
- No breastfeeding. Formula only.
- Baby given ARV's orally for 6 weeks.
- Alexis was followed by Sick Kids Hospital for a period of 18 months.
- Alexis is HIV Negative.

BABY ALEXIS MARCH 2006

- Became involved with The Ontario Early Years during pregnancy and continued to stay engaged after baby was born.
- Visit from Children's Aid in hospital – involvement based on past history and my HIV Status.
- Limited Income – Food Insecurity.
- New Community - Montreal to Peterborough.
- Lost to HIV care.
- Met current partner in 2008.
- Wrote my GED and passed!
- Disclosed my HIV Status before our first date.

BEING A NEW MOM

- Late 2009 I became pregnant with my second baby by way of traditional conception methods.
- Started ARV's at 12 weeks pregnant.
- I was educated about PMTCT and planned to have as natural childbirth as possible.
- Decided to connect to more local healthcare for pregnancy and delivery.
- OBGYN didn't have much knowledge but was willing to work with Positive Care Clinic's guidance.
- Aaliyah was born vaginally in August of 2010
- ARV's given to her orally for 6 weeks.
- Aaliyah was followed by the Positive Care Clinic 18 months – HIV Negative

BABY AALIYAH AUGUST 2010

- Decided 2 months after second baby was born to try for a third - got pregnant the first try by way of traditional conception methods.
- Reinitiated ARV treatment.
- Same OBGYN as previous pregnancy .
- Amayah was born vaginally in July 2011.
- ARV's given to her orally for 6 weeks.
- Amayah was followed by the Positive Care Clinic for 18 months.
- HIV Negative

BABY AMAYAH JULY 2011

- My partner and I have been together 9 years.
- He is HIV Negative.
- Our babies were conceived by natural conception methods.
- HIV Disclosure to the in-laws was a challenge.
- Have lived experience with #UequalsU before the hashtag.
- Learned about the Swiss Study early 2009, after the babies were born I opted to remain on treatment not primarily for myself – but for my partner because of this research.

SERO COUPLES

- Returned to school in 2014 – Graduated with Honour's from Fleming College with a Diploma in Social Service Work
- Peer Engagement Worker at PARN - Your Community AIDS Resource Network
- CHIWOS Participant
- #UequalsU Canadian Steering Committee Member
- WHAI Women's Provincial Advisory Board Member
- International Community of Women Living with HIV – North American Board Member
- International Community of Women Living with HIV - International Steering Committee Member
- Seeking Help Project Board Member - Peterborough Area Representative

WHAT I'M DOING

- Breastfeeding, HIV Transmission and HIV Criminalization in the context of Mothering
- Support beyond conception for Sero-Couples
- Women Centered Research

CURRENT ISSUES

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CONTACT INFORMATION

Research overview: Pregnancy and contraceptive use among women living with HIV enrolled in the CHIWOS study

By:
Dr. Angela Kaida
on behalf of the
CHIWOS Research Team

Canadian Webinar Series on SRHR of women living with HIV

January 24, 2018

CHIWOS
Étude sur la santé sexuelle et reproductive des femmes vivant avec le VIH au Canada
Canadian HIV Women's Sexual and Reproductive Health Cohort Study

Acknowledgements

We would like to thank…

- All the women living with HIV who participate in CHIWOS;
- The national team of Peer Research Associates, Co-investigators and Collaborators;
- The Steering Committee, Community Advisory Boards, and Aboriginal Advisory Board;
- The BC Centre for Excellence in HIV/AIDS for data support and analysis;
- Our affiliated studies: CANOC, REACH, OSC;
- And all our partnering organizations who support study recruitment and operations.
- **Our funders: CIHR Institute of Gender and Health, the CIHR Canadian HIV Trials Network (CTN 262), the OHTN, and the Academic Health Science Centres Alternative Funding Plans Innovation Fund**;

•Thank you to the following organizations who have partnered with CHIWOS to provide interview space:

•In **BC**: Oak Tree Clinic at BC Women's Hospital, AIDS Vancouver Island, BC Centre for Excellence in HIV/AIDS, Cool Aid Community Health Centre, Downtown Community Health Clinic, Keys Housing and Health Solutions (Positive Haven), Living Positive Resource Centre, Positive Living Fraser Valley, Positive Women's Network (closed), Positive Living North, and Vancouver Island Persons with AIDS Society.

•In **ON**: 2-Spirited People of the 1st Nations; 519 Community Centre; ACCKWA; Africans in Partnership Against AIDS (APAA); AIDS Committee of Durham Region; AIDS Committee of Guelph and Wellington County; AIDS Committee of Simcoe County; AIDS Network Hamilton; Alliance for South Asian AIDS Prevention; Black Coalition for AIDS Prevention; Bruce House; Casey House; Centre Francophone; Elevate NOW; Fife House; Hemophilia Ontario; HIV/AIDS Regional Services (HARS); Maggie's: Toronto Sex Worker's Action Project; Peel HIV Network; Positive Living Niagara; Prisoners with AIDS Support Action Network; Réseau Access Network; Toronto PWA Foundation; Women's Health in Women's Hands; Children's Hospital of Eastern Ontario; Kingston Hotel Dieu Hospital; Health Sciences North, Sudbury Regional Hospital, HAVEN Program; Lakeridge Health; Maple Leaf Medical Clinic; McMaster Family Practice; Ottawa General Hospital; Riverside Family Health Team; SIS Clinic, Hamilton Health Sciences; St. Joseph's Healthcare London; St. Michael's Hospital; Sunnybrook Health Sciences Centre; Toronto East General Hospital; Toronto General Hospital; William Osler Health System; Windsor Regional Hospital, HIV Care Program.

•In **QC**: ACCM; L'ARCHE de l'Estrie; ASTT(e)Q; BLITS; BRAS-Outaouais; CACTUS; CASM; Centre Sida Amitié; Corporation Félix Hubert d'Hérelle; COCQ_SIDA; Fondation d'Aide Directe-SIDA Montréal; GAP-VIES; GEIPSI; M.A.I.N.S-Bas St-Laurent; Maison Plein Coeur; Maison Dominic; Maison du Parc; Maison Re-Né; MIELS-Québec; Le MIENS Chicoutimi; Portail VIH/sida du Québec; Sidaction Mauricie; Sida-Vie Laval; Stella, l'amie de Maimie.

Acknowledgments

We honour and remember the 52 women living with HIV who participated in CHIWOS from across Canada who have passed away.

- *In memory of Marisol Desbiens*
- *CHIWOS PRA and valued colleague*

Introduction

- Health and survival outcomes for people living with HIV have improved dramatically since the introduction of cART.

- HIV treatment with sustained viral suppression enables safer reproductive options for women living with HIV, including:
  - Better maternal health
  - Improved fertility
  - Dramatic reductions in perinatal HIV transmission
  - Effectively eliminates risk of HIV transmission to partners during condomless sex (U=U)

- These improvements have transformed the reproductive health landscape for women living with or affected by HIV.

CHIWOS

Introduction

- Motherhood is important for many women living with HIV in Canada.
- Earlier studies reported that 26-58% of WLWH report fertility intentions or desires, and can benefit from comprehensive services across the continuum of reproductive care, including pregnancy planning.
- A majority of women living with HIV do not want children (either now or ever) and require access to effective contraception and safe abortion services.

CHIWOS

Research questions

To inform women-centred, integrated, HIV and Reproductive Health care delivery for women living with HIV in Canada, we assessed the following using data from the CHIWOS study:

1. Fertility intentions
2. Ever discussed reproductive goals with a healthcare provider after HIV diagnosis
3. Current contraceptive use
4. Incidence of pregnancy after an HIV diagnosis
5. Pregnancy outcomes
6. Currently have a healthcare provider with whom she feels comfortable discussing reproductive goals

CHIWOS

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RESEARCH ARTICLE

Cohort profile: The Canadian HIV Women's Sexual and Reproductive Health Cohort Study (CHIWOS)

Mona Loutfy[1,2,3]*, Alexandra de Pokomandy[4,5], V. Logan Kennedy[1], Allison Carter[6,7], Nadia O'Brien[4], Karène Proulx-Boucher[5], Erin Ding[7], Johanna Lewis[1,8], Valerie Nicholson[8], Kerrigan Beaver[1], Saara Greene[9], Wangari Tharao[10], Anita Benoit[1,3], Danièle Dubuc[5], Jamie Thomas-Pavanel[1,2], Paul Sereda[7], Shahab Jabbari[7], Jayson H. Shurgold[6,11], Guillaume Colley[7], Robert S. Hogg[6,7], Angela Kaida[6], on behalf of the CHIWOS Research Team[¶]

CHIWOS

CHIWOS Cohort Profile

Characteristics	N(%)
Median Age [IQR]	43 (36-51)
Gender identity	
Woman	1359 (96%)
Transwoman/Two-Spirit/Queer/Intersex/Other	63 (4%)
Ethnicity	
Indigenous	318 (22%)
African/Caribbean/Black	418 (30%)
White	585 (41%)
Other or multiple ethnicities	103 (7%)
Injection drug use history	439 (31%)
Median years living with HIV [IQR]	11 (6-17)
Received HIV medical care in last year	1330 (94%)
Currently on cART	1175 (83%)
Undetectable VL (plasma VL<50 copies/mL)	1099 (80%)

Fertility intentions: Do you intend to become pregnant in the future?

Restricted to cis gender women aged 16-49, pre-menopausal, not currently pregnant. Total n = 907. CHIWOS Wave 1 data, *unpublished*

CHIWOS

Since knowing your HIV status, have you ever discussed your reproductive goals with a healthcare provider?

Restricted to cis gender women aged 16-49, pre-menopausal, not currently pregnant. Total n = 907. CHIWOS Wave 1 data, *unpublished*

CHIWOS

Contraceptive Choice and Use of Dual Protection Among Women Living with HIV in Canada: Priorities for Integrated Care

Perspectives on Sexual and Reproductive Health, 2017, 49(4):TK, doi:10.1363/psrh.12046

- WHO guidelines advise that women with HIV may safely use the full range of hormonal contraceptive options.
- Evidence of drug interactions between oral contraceptive pills and some ART regimens, which may increase side effects and/or contraceptive efficacy.
- For women with advanced HIV disease, caution is advised for use of IUDs.

CHIWOS

73% (95% CI, 68–77%) of sexually active cis gender women living with HIV aged 16-49 years used an effective contraceptive in the six months prior to interview.

Contraceptive method category

•Kaida et al, 2017

PLOS | ONE

RESEARCH ARTICLE

Pregnancy incidence and intention after HIV diagnosis among women living with HIV in Canada

Kate Salters[1,2], Mona Loutfy[3], Alexandra de Pokomandy[4,5], Deborah Money[6,7], Neora Pick[6,7], Lu Wang[2], Shahab Jabbari[2], Allison Carter[1,2], Kath Webster[1], Tracey Conway[3], Daniele Dubuc[4], Nadia O'Brien[4,5], Karene Proulx-Boucher[4], Angela Kaida[1]*, on behalf of the CHIWOS Research Team[¶]

- **24%** of women reported at least one pregnancy after HIV diagnosis
- **61%** of all pregnancies reported as 'unintended'

CHIWOS

Fig 4. Time to first pregnancy after HIV diagnosis by era of cART initiation.

	Cumulative Incidence by cART era (95% confidence interval)		p-value
Timepoint	<2000		
1	0.042 (0.023, 0.076)	0.881	0.881
5	0.176 (0.133, 0.231)	0.226	0.226
10	0.235 (0.185, 0.297)	0.022	0.022
20	0.267 (0.211, 0.335)	0.008	0.008

•Salters K, Loutfy M, de Pokomandy A, Money D, Pick N, et al. (2017) Pregnancy incidence and intention after HIV diagnosis among women living with HIV in Canada. PLOS ONE 12(7): e0180524. https://doi.org/10.1371/journal.pone.0180524

•http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180524

CHIWOS

Fig 2. Time to first pregnancy after HIV diagnosis by intention status.

	Cumulative Incidence by intention (95% confidence interval)		P-value
Timepoint	Intended prengnacy	Unintended pregnancy	
1	0.009 (0.005, 0.017)	0.024 (0.016, 0.034)	0.007
5	0.065 (0.051, 0.083)	0.114 (0.095, 0.136)	<0.001
10	0.117 (0.096, 0.144)	0.168 (0.143, 0.197)	0.001
20	0.146 (0.118, 0.18)	0.192 (0.162, 0.226)	0.001

CHIWOS

•Salters K, Loutfy M, de Pokomandy A, Money D, Pick N, et al. (2017) Pregnancy incidence and intention after HIV diagnosis among women living with HIV in Canada. PLOS ONE 12(7): e0180524. https://doi.org/10.1371/journal.pone.0180524
•http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180524

Table 2. GEE Poisson model to calculate pregnancy incidence rates, expressed asnumber of pregnancies per 1000 woman-years (WY) (95% confidence interval).

	Incidence Rate per 1000 pregnancies	Rate Ratio (95% CI)
Unintended pregnancy	24.6	
Intended pregnancy	16.6	1.5 (1.2-1.8)
Overall	41.6	

•Salters K, Loutfy M, de Pokomandy A, Money D, Pick N, et al. (2017) Pregnancy incidence and intention after HIV diagnosis among women living with HIV in Canada. PLOS ONE 12(7): e0180524. https://doi.org/10.1371/journal.pone.0180524

•http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180524

CHIWOS

Pregnancy outcomes

- Among 1,165 WLWH, 278 women reported a total of 492 pregnancies after being diagnosed with HIV.
  - 18.7% ended in miscarriage or stillbirth
  - 20.5% were terminated
  - 57.3% ended in a single or multiple live birth
  - 3.5% of women were pregnant at time of interview

- Women with an unintended vs intended pregnancy were most likely to report pregnancy termination (28.4% vs. 1.8%)

CHIWOS

Do you currently have a healthcare provider with whom you feel comfortable talking to about your reproductive goals?

Restricted to cis gender women aged 16-49, pre-menopausal, not currently pregnant. Total n = 907. CHIWOS Wave 1 data, *unpublished*

CHIWOS

Discussion

The power to decide if, when, and how to become pregnant with the information, means, and support to do so is central to the reproductive rights of all women

- More women are becoming pregnant in the post-cART era than ever before; 60% of pregnancies are unintended
- WLWH must be supported if they DO want to become pregnant (including access to comprehensive pregnancy planning care and support during pregnancy and parenthood)
- WLWH must be supported if they DO NOT want to become pregnant (including access to effective contraception and abortion care)
- Women who are ambivalent about pregnancy need support too!

CHIWOS

Conclusion

HIV care delivery models, such as **women-centred HIV care**, that integrate women's health and primary care may facilitate this process by prioritizing discussions of women's sexual and reproductive desires and needs.

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Improved treatment allowing more Canadian women with HIV to become pregnant

Nearly 25 per cent of women reported a pregnancy after an HIV diagnosis, a study has found. In B.C., where the study was based, there has not been a single mother-to-child HIV transmission in more than 20 years.

Lisa Partridge holds daughter Adrianna, 4. Partridge is HIV-positive, but her medication helps to suppress the virus. (LISA PARTRIDGE / THE CANADIAN PRESS)

By LAURA KANE The Canadian Press
Sun., Aug. 27, 2017

VANCOUVER—Lisa Partridge was 14 when she learned she was HIV-positive.

The teenager living in Comox, B.C., underwent a tainted blood transfusion when she was an infant in Romania. When she fell terribly ill at age one, her distraught parents searched for a cause until a doctor finally recommended HIV testing.

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CHIWOS

Thank you!

- **For more information about CHIWOS, please contact:**

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CHIWOS

Women and HIV Research Program Presents:

2018 Updated

Canadian HIV Pregnancy Planning Guidelines

By: Mona Loutfy, MD,MPH

Thursday January 24th 2018

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We started the Canadian HIV Fertility Program in 2007 & published the 2012 Canadian HIV Pregnancy Planning Guidelines (CHPPG) [1]

J Obstet Gynaecol Can. 2012 Jun;34(6):575-590. doi: 10.1016/S1701-2163(16)35274-4.

Canadian HIV pregnancy planning guidelines.

Loutfy MR[1], Margolese S[1], Money DM[2], Gysler M[3], Hamilton S[3], Yudin MH[1].

Major clinical & scientific advances→ 2018 Updated CHPPG[2]

SOGC CLINICAL PRACTICE GUIDELINE

No. 354, January 2018 (Replaces No. 278, June 2012)

No. 354-Canadian HIV Pregnancy Planning Guidelines

This Clinical Practice Guideline has been written and reviewed by the Canadian HIV Pregnancy Planning Guideline Development Team Core Working Group and The Society of Obstetricians and Gynaecologists of Canada Infectious Disease Committee*, reviewed by the Guideline Management and Oversight Committee, and approved by the Board of the SOGC.

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Key Words: HIV, pregnancy, infectious disease, fertility, prenatal

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Abstract

Objective: The objective of the Canadian HIV Pregnancy Planning Guidelines is to provide clinical information and recommendations for health care providers to assist Canadians affected by HIV with their fertility, preconception, and pregnancy planning decisions.

Loutfy M, Kennedy VL, Poliquin V, Dzineku F, Dean NL, Margolese S, Symington A, Money DM, Hamilton S, Conway T, Khan S, Yudin M. **No. 354-Canadian HIV pregnancy planning guidelines**. Journal of Obstetrics and Gynaecology Canada. 2018 Jan 1;40(1):94-114.

Email mona.loutfy@wchospital.ca for full guidelines

2018 Updated Guidelines - Methods

- **Team:** **1** CHPPG Development Team **Core Group**; **7** CHPPG Section **Subgroup Teams w/ leads** (Sections 7&8 combined)
- **Methods:** 1) Used Appraisal of Guidelines Research & Evaluation (**AGREE**); 2) Started with 2012 and refined and built on from there; 3) **Scoping literature review** to end of 2016 done by Librarian; title & abstracts provided to Subgroup leads for assessment; and 4) Used **Evaluation of Evidence** criteria by the **Canadian Task Force on Preventive Health Care**[3]
- **Meetings**: Core Group Teleconferences; Subgroup teleconferences; One in-person meeting (funded by CIHR); more Subgroup teleconferences; communication, edits & approvals by email

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2018 Updated Guidelines – What's NEW & OLD?

- **8 Sections:** 1) Ensuring a healthy pregnancy, child and family; 2) Psychosocial/mental health related to HIV pregnancy planning and fertility; 3) Legal and ethical Issues; 4) cART and other drugs in pregnancy planning; 5) Options for reducing risk of horizontal transmission during conception; 6) Scenario-based recommendation for the prevention of horizontal HIV transmission; 7) Infertility investigations and treatment; 8) (**NEW**) HIV Infection Control in Fertility Clinics
- **36 Recommendations**
- **Frameworks:**
  - Community-based & evidence-based (OLD)
  - **NEW**: Use of a Human Rights Framework

Adopted WHO's human rights[4] premise that "all couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to do so," including people with HIV.

Highlights from Updated 2018 Guidelines

1. Ensuring a healthy pregnancy, child and family

- Reproductive health counselling, **including contraception and pregnancy planning**, should be offered to all people with HIV of reproductive age soon after HIV diagnosis and on an ongoing basis (II-3A).
- Folic acid should be taken 3 months prior to becoming pregnant and for at least the first 3 months of pregnancy (II-3A).

2. Psychosocial/Mental Health – lots NEW

- Counselling should include a discussion of the potential risk for both horizontal and perinatal HIV transmission, including perinatal transmission via breastfeeding and how transmission (or risk of transmission) might affect the mental health of 1 or both parents and other family members (III-A).
- Emphasis on encouraging non-stigmatizing discussion of substance use (III-A).

3. Legal and ethical Issues – lots NEW

•All people with HIV should be counselled on the possible ethical and legal aspects of pregnancy planning (III-A).

Highlights of Updated 2018 Guidelines

4. cART and other drugs in pregnancy planning

- Many changes related to the worldwide recommendation that all people living with HIV should be on cART.
- Also timing of insemination in relation to starting cART, PrEP & HCV treatment discussed.

5. Options for reducing risk of horizontal transmission during conception

- Couples and individuals should be counselled thoroughly about **all** horizontal HIV transmission risk reduction methods before attempting conception and supported to make an informed choice about which of the many options for conception method is most appropriate and acceptable to them (III-C).

6. Scenario-based recommendations for the prevention of horizontal HIV transmission

- Intended to guide health care providers through the specific preconception options recommended for each scenario.

cART and other drugs in pregnancy planning

- All people with HIV who are planning to conceive should already be taking or imminently started on cART, both for their own health and to prevent horizontal HIV transmission during the preconception period. They should be counseled on maintaining a high level of antiretroviral drug adherence to maintain a suppressed viral load (I-A).
- Condomless sex or sperm washing should be avoided as the conception method until the partner with HIV has been on combination antiretroviral therapy for at least 3 months with at least 2 viral load measurements below the level of detection at least 1 month apart. Preferably the partner with HIV should have been on combination antiretroviral therapy with a suppressed viral load for 6 months. When rapid viral suppression is achieved through the use of new antiretroviral agents, 2 undetectable viral load measurements at least 1 month apart should still be achieved before initiating condomless sex or sperm washing (II-A).

Pre-exposure prophylaxis (PreP) in pregnancy planning

- The data on PrEP should be discussed with all patients during preconception. HIV PrEP is not routinely recommended in the context of HIV and preconception. In the situation in which adherence and viral suppression in the infected partner cannot be confirmed, but conception attempts are still intended by the serodiscordant couple, pre-exposure prophylaxis should be recommended to the HIV-negative partner (II-A).
  - Based on HPTN052 & PARTNER studies[5,6] and
  - Two cost-effectiveness analyses[7,8]

Scenario-based recommendations for the prevention of horizontal HIV transmission

- **Different clinical scenarios:**
  - Woman living with HIV and HIV-negative Man
  - Single woman living with HIV or woman living with HIV in a same sex relationship
  - Man living with HIV and HIV-negative woman
  - Single man living with HIV or man living with HIV in a same-sex relationship
  - Man and woman living with HIV
- **Recommended that all conception options be discussed and to review pros and cons of each option**
  - More than 1 option is often acceptable and recommended per scenario, and the chosen strategy is based on patient preference. Some options may not always be the most practical based on availability of services, cost, cultural beliefs, personal risk evaluation, or clinical circumstance. In these cases, physicians and other health care providers should provide non-judgmental support of the decision of the patient(s) involved.

Options for reducing risk of horizontal transmission during conception

These are the insemination/conception options typically included:

1. Condomless sex (with a partner living with HIV who is on cART with full viral suppression) – based on HPTN052 & PARTNER[5,6]
2. **Condomless sex timed with peak fertility (with a partner living with HIV who is on cART with full viral suppression)** – HPTN052 & PARTNER[5,6]
3. The above 2 with PrEP to HIV-negative partner (not recommended in Canada, UK & Switzerland) – based on HPTN052 & PARTNER and cost-effectiveness analyses[5,6,7,8]
4. Home insemination at the time of peak fertility using a syringe
5. Sperm washing in a fertility clinic followed by IUI
6. In-vitro fertilization or ICSI
7. Egg and/or sperm donation (with gestational carrier) when applicable
8. Adoption

Highlights of Updated 2018 Guidelines

7. Infertility investigations and treatment

•People with HIV should be counselled about fertility issues that also occur in the general population, including genetic disorders and advanced maternal age, and offered infertility investigations and treatment if required (III-A).

8. HIV infection control in fertility clinics

•Fertility laboratories should follow Canadian Standards Association guidelines for infection control when handling HIV-positive materials and use additional procedures available for the processing of HIV-positive sperm to ensure the preparation of a virus-free sample (III-A).

•Some more detailed recommendations (**NEW**).

Next Steps

1. Disseminate

2. Implement

- *Assess barriers…such as stigma, access, ethocultural differences*

3. Monitor & Evaluate

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Thank you !!!

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Supporting Mothers in Ways that Work

A Resource Toolkit for Service Providers Working with Mothers Living with HIV

Saara Greene, MSW, PhD. Associate Professor McMaster University School of Social Work
on behalf of the HIV Mothering Study Team

Mothers Living with HIV in Canada

Across Canada, women living with HIV (WLWH) are increasingly becoming pregnant and having children.

The HIV Mothering Study

Goal: to understand the psychosocial needs and experiences of WLWH across Ontario in pregnancy and the first year of motherhood

Data collection: 3rd trimester, 3, 6 and 12 months postpartum

Methods: Narrative interviews + Surveys (stress, symptoms of depression, HIV stigma, etc.) + Information from medical records

Participants: 77 pregnant WLWH 18yrs+ enrolled at HIV and obstetrical care centers in Ontario from March 2011 to December 2012

Peer Research Associate Model: Aligning with the tenets of community-based research, leadership by mothers living with HIV was essential to the development and conduct of this study. Mothers living with HIV advised all aspects of the research and were integral to the data collection, analysis and dissemination activities as research team members and Peer Research Associates.

Our Social Justice Approach

This toolkit reflects our team's commitment to addressing issues of social justice and care for mothers living with HIV, and is underpinned by the following values:

HIV & pregnancy is a success story

- WLWH can have positive experiences of pregnancy and successfully prevent HIV transmission to their babies
- WLWH have a right to become pregnant and have children

Community engagement and leadership:

- Greater Involvement of People Living with HIV/AIDS (GIPA)
- Meaningful Involvement of Women Living with HIV/AIDS (MIWA)

Centering women's voices:

- Women's voices and experiences at the center of research and dissemination activities

Focusing on narratives:

- Focus on women's stories using a narrative methodological approach

Language matters:

- Dispel myths and misconceptions about HIV that may influence health and social care practice through the conscious use of language

Supporting Mothers in Ways that Work

A Resource Toolkit for Service Providers Working with Mothers Living with HIV

Toolkit Overview

Purpose: to increase health and social care providers' awareness and understanding of the psychosocial needs and experiences of WLWH during pregnancy, childbirth, and postpartum.

Target Audience: all health and social care providers who may interact with WLWH during pregnancy, childbirth and postpartum including:

- Physicians, nurses and social workers
- Service providers working in primary care, obstetrics, HIV, mental health, and community-based organizations, e.g. shelters, community health centers
- Child welfare/child protection workers
- Public Health officials

Toolkit Sections & Content

Section #1 - Mothers Living with HIV in Canada

- Background and current issues
- Epidemiological data (pregnancy, perinatal HIV transmission, etc.)
- Specific procedures recommended for WLWH and their babies during the perinatal period related to HIV prevention (e.g. medications, mode of delivery, breastfeeding avoidance, etc.)
- Unique psychosocial concerns expressed by WLWH
- Resources and implications for service providers

Section #2 - The HIV Mothering Study: An Overview

- Purpose and focus of the study
- Methodology including involvement of Peer Research Associates
- Participant demographics

Section #3 - Perinatal Care: What Works and What Needs to Change

- Range of experiences that WLWH have when interacting with HIV and non-HIV care providers from pregnancy to postpartum
- Highlights what positive and negative care experiences actually look and feel like
- What Women Need & Key Practice Implications

Section #4 – Why Aren't You Breastfeeding?: Infant Feeding and HIV

- Global practice guidelines related to infant feeding and HIV (e.g. breastfeeding avoidance in Canada where its assumed women have access to safe drinking water & infant feeding alternatives)
- Social standards and cultural pressures that assert "breast is best"
- The complexities related to infant feeding for WLWH related to guilt and loss, feeling like a "good mother" and fear of HIV-related stigma
- What Women Need & Key Practice Implications

Section #5 – Mothers Under the Gaze: Health & Social Surveillance

- The criminalization of HIV non-disclosure in Canada
- Surveillance and monitoring of WLWH within health and social care systems, e.g. childbirth, child welfare system, infant feeding practices
- How WLWH experience health and social surveillance
- What Women Need & Key Practice Implications

Section #6 – Experiences of Stigma and Discrimination

- What is HIV-related stigma?
- Thinking about HIV-related stigma and other forms of oppression
- What does HIV-related stigma look and feel like for WLWH?
- What Women Need & Key Practice Implications

Section #7 – Taking Action

- What is needed to optimize health and social care for WLWH
- What you can do as an individual, and as a collective and system

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Do you want copies of the toolkit?

The toolkit is available in English and French:

Google "Supporting Mothers in Ways that Work" to download the PDF
or send hard copy requests to:
Allyson Ion
iona@mcmaster.ca

Action Canada for Sexual Health & Rights Action Canada pour la santé & les droits sexuels

Action Canada for Sexual Health and Rights is a national organization committed to advancing and upholding sexual and reproductive health and rights in Canada and globally.

We run a national toll-free 24-hour access line that provides information on sexual and reproductive health and referrals for pregnancy options. We also provide financial and logistical support to those who need it through our Norma Scarborough Emergency Fund.

Access Line: 1-888-642-2725 or access@actioncanadashr.org

We cannot talk of reproductive health care, including abortion, without the following context:

- Human rights for all people
- Freedom from violence or fear of violence
- Access to justice
- Non-discrimination,
- Access to resources
- Real access to services that are safe and affirming
- The safeguarding of personal autonomy

Guaranteeing access to abortion as one part of achieving reproductive justice

While abortion has been decriminalized in 1988, access to this service is still compromised in Canada. Only 1 in 6 hospitals provide abortion services in Canada, the majority of which, like free standing sexual health clinics, are disproportionately dispersed across Canada, with most located in urban areas, less than 150km from the US border.

The overall limited availability of abortion services through clinics and hospitals is compounded by other barriers related to wait times, unnecessary strict rules and regulations, and health care providers refusing to offer the services on moral and religious grounds. In effect, despite our health care system's supposed 'universality', we still have a two-tiered system of access to abortion services.

What we know about barriers to abortion services

- The majority of people who do not have access to services in their own communities, and therefore have to travel long distances, live in rural and/or remote areas.
- Barriers disproportionately affect young people and marginalized people, especially those who are low-income, Black, Indigenous and racialized, migrants or refugees, and those who do not speak English or French.

- Not having access to abortion care in your own community makes it more likely that you will exceed gestational limits of services in your region or in Canada.

Thank you!

Contact information: Frederique@actioncanadashr.org

More information: www.actioncanadashr.org

www.mifegymiso.com

Discussion

Reminder:

Please type your questions into the text box at the bottom of your screen.

If your question does not get answered, please check back on the uploaded link (provided below). We will review and answer any remaining questions, and post alongside the recorded webinar.

The Webinar will be posted in the HRP Video Library:

https://www.youtube.com/channel/UCFNsy8viIjdvy9gB8M30M3A

IBP video library:

https://www.gotostage.com/channel/965084607443925509

Next Steps

- Developing a **Canadian Action Plan** to address the Sexual and Reproductive Health and Rights for Women Living with HIV, including priorities highlighted from this webinar on HIV disclosure and related issues for women.

Webinar 4: Save the Date!

Self-Efficacy, Resiliency, and Peer Support:

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

Friday, March 9th 2018, 9-10:30am PST / 10-11:30am MST /12-1:30pm EST / 6-7:30pm Geneva

Save the Date!

Canadian Association for HIV Research conference (CAHR) in Vancouver:

Developing a national action plan to advance the sexual and reproductive rights of women living with HIV

Thursday, April 26th: 1PM-4PM PST

Objectives:

- Present overview of Canadian Webinar Series and discuss key policy, programming, and research considerations
- Engage in inter-sectoral small group discussions regarding key action items to inform national action plan to advance the SRHR of WLWH

Thank you!

For more information about the Canadian Webinar Series, please contact:

Sarah Watt (Webinar Coordinator)

Email: sawatt@sfu.ca

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Closing words

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