SAFER CONCEPTION:

Training for health care providers
Overview of the Training

• Lecture
  – Define and provide rationale for safer conception
  – Objectives of the research and the training
  – Safer conception strategies described
    • Adjunct risk reduction strategies, fertility monitoring
  – Preconception/Safer conception counseling
    • Resources: Counseling Guide and Brochures
  – Questions & Answers

• Role Play & Case-studies

• Post-training Questionnaire & Evaluation

• Next steps: Mock counseling session and In-depth Interviews
HIV-infected women and men desire children

• 20-50% of HIV-infected men and women desire children (1-3)

• Childbearing desires can lead to unprotected sex and/or non-disclosure of HIV status (4-6)

• Contribution of intended conception to incident HIV infection is unknown, but likely represents a significant proportion given high fertility rates and the importance of having children in most HIV endemic areas (7-9)

HIV serodiscordant couples are common, and HIV transmission is high

- In sub-Saharan Africa, up to half of those living with HIV report a serodiscordant partnership (10-11)

- Up to 60% of new infections occur between stable, heterosexual, discordant couples in countries in sub-Saharan Africa, including Kenya (12-13)

- HIV transmission risk is up to 2x greater among discordant couples who conceive, compared to those who do not (14)

HIV-discordance and childbearing in Kenya

• Nyanza (15, 16):
  – HIV prevalence = 15.1%
  – Home to approximately 30% of the country’s HIV-infected population
  – Fertility average: 4.6 children per woman
  – Antenatal HIV prevalence: 16%

• Improving reproductive health is a public health priority in Kenya (17)

Reproductive rights and counseling

• With treatment, men and women with HIV are living longer, healthier lives, and can expect to see their children grow into adulthood.

• Safer conception counseling for HIV-discordant couples is a reproductive right and should be included as a public health strategy to reduce HIV incidence among men, women, and their children (18-19)

What are reproductive rights?

- The basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

- World Health Organization
Reproductive rights in Kenya

• Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

- Kenya Constitution, Article 43 (1)
Guidelines on Safer Conception

• International guidelines have shifted from recommending avoidance of pregnancy among HIV-affected populations to recognizing conception as a realistic option for HIV-affected couples.

• Evidence-based Safer Conception Guidelines developed in 2012 by the South African Clinicians Society for settings in sub-Saharan Africa (Bekker et al 2012)

• Training and materials
  – Safer Conception Guidelines, South African Clinicians Society
  – Francois-Xavier Bagnoud Center, University of New Jersey
  – University of California Bay Area Perinatal AIDS Center
Safer Conception defined

- Use of HIV prevention strategies that allow a couple to conceive while limiting the risk of HIV transmission to partner and baby

<table>
<thead>
<tr>
<th>Type of HIV transmission</th>
<th>Method</th>
<th>Estimated risk reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother + Goal: perinatal transmission)</td>
<td>Antiretroviral therapy in the mother</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Antiretroviral therapy in child after birth</td>
<td></td>
</tr>
<tr>
<td>F+ M- (goal: female to male sexual transmission)</td>
<td>Non-intercourse vaginal insemination</td>
<td>Unknown (theoretically 100%)</td>
</tr>
<tr>
<td></td>
<td>Voluntary medical male circumcision</td>
<td>66%</td>
</tr>
<tr>
<td>M+ F- (goal: male to female sexual transmission)</td>
<td>Sperm washing + IUI or IVF (+/- ICSI)</td>
<td>100%</td>
</tr>
<tr>
<td>Either partner infected Goal: sexual transmission)</td>
<td>Sex without condoms limited to peak fertility</td>
<td>Unknown 96%</td>
</tr>
<tr>
<td></td>
<td>ART for infected partner</td>
<td>63-73%</td>
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<tr>
<td></td>
<td>PrEP (oral, daily FTC/TDF)</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>Treatment of STIs</td>
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</table>
Ethical implications of providing safer conception to HIV-affected couples

- With the majority of those living with HIV infection being of reproductive age, it is critical they are given options to conceive without transmitting HIV to their partner or baby.

- The ethical dilemma in providing safer conception strategies to HIV affected couples includes the possibility of mother-to-child HIV transmission and the risk of HIV transmission to an uninfected partner.

- However, consider that HIV discordant couples who attempt to conceive currently put themselves at considerable risk of HIV transmission.

- Even though safer conception strategies may not eliminate risk, they offer a vast improvement over the status quo.

- Some have argued that it would be unethical to withhold proven HIV prevention strategies to HIV-affected couples who desire pregnancy (25).

And one more word about ethics...

• If we do not broaden our discussions around reproductive health among HIV positive people (leaving it at “use condoms”), many individuals will do what they will do at home in order to achieve pregnancy

• It is much better that they conceive with support and knowledge of safe options. We do not want clients to feel they have to hide their desire to have children
Objectives of the Research

(i) Develop a practical, concise, interactive Safer Conception Counseling Toolkit for healthcare providers (HCP)

1. HCP training session
2. Counseling guide for HCP
3. Methods brochures for patients

(ii) Evaluate the feasibility, acceptability, and comprehension of the safer conception counseling messages amongst HCPs and HIV-discordant couples
Objectives of Provider training

Upon completion of training, providers will be able to:

1. Define and explain the rationale for Safer Conception

2. Explain three safer conception strategies for M+F- couples, and three for M-F+ couples

3. Competently and confidently counsel patients on HIV prevention strategies that can be used whilst allowing pregnancy to occur

4. Competently and confidently counsel patients on preconception care

5. Understand and utilize the Counselling Guide and Brochures
HIV PREVENTION STRATEGIES FOR SAFER CONCEPTION
Overview of Safer Conception Strategies (reduction in HIV risk)

- **Baby**
  - PMTCT (95%)

- **Female**
  - ART (96%)
  - Vaginal insemination (~100%)

- **Male**
  - PrEP (63-73%)

- **Male**
  - ART (96%)
  - Sperm washing (~100%)

- **Female**
  - PrEP (63-73%)

Adjunct risk reduction strategies:
- MMC (66%), STI screening and treatment (40%),
- Unprotected sex timed to peak fertility in conjunction with ART and/or PrEP
## Prevention of mother-to-child-transmission (PMTCT)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Prevent perinatal transmission from Mother+ to baby</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>These are interventions to prevent transmission of HIV from a mother living with HIV to her infant during pregnancy, labor and delivery, or during breastfeeding.</td>
</tr>
<tr>
<td><strong>Effectiveness in HIV prevention</strong></td>
<td>with the success and increasing availability of drug regimens for prevent mother-to-child HIV transmission (PMTCT) (concurrent with safer childbirth and breastfeeding practices), the risk of mother-to-child transmission has been lowered from more than 30% to less than 1% in industrialized countries</td>
</tr>
<tr>
<td><strong>Approx. cost per pregnancy</strong></td>
<td>11,560/=</td>
</tr>
</tbody>
</table>
PMTCT: Step by step

1. Primary prevention

2. Prevention of unwanted Pregnancies in HIV+ women

3. Core PMTCT:
   - Use of ARV,
   - Safe Obstetrical practices
   - Safe infant feeding

4. Long term follow-up of mother-infant pair
# Antiretroviral treatment as prevention

<table>
<thead>
<tr>
<th>Goal</th>
<th>Prevent sexual transmission from M-F+ and M+F-</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Treating the HIV positive partner with antiretrovirals and monitoring their viral load (the amount of HIV in his blood) to make sure the HIV viral load is very low or ‘undetectable’ before attempting unprotected sex during the fertile period</td>
</tr>
</tbody>
</table>
| **Effectiveness in HIV prevention** | Barreiro: 62 serodiscordant couples (M-F+ & M+F-), Antiretroviral in HIV positive participant, and viral load<500, no HIV transmission, 68 children over 2 years of follow-up.  

HPTN 052: 96% reduction in transmission of HIV among serodiscordant couples (ARVs started if CD4 350-500). |
| **Pregnancy rate** | No measured reduction in pregnancy incidence with use of ART |
| **Approx. cost per cycle** | HAART cost=300/=  
Viral Load cost=4500/= |
Antiretroviral: Step by step

• Ensure viral load is suppressed
  – Safer Conception guidelines recommend monthly viral loads for up to 6 months
  – Counsel on adherence to ARVs
  – Counsel on 100% condom use

• Determine the fertile period
  – Counsel on identifying the fertile day
  – Unprotected intercourse during the fertile days
  – 100% condom use at all other times
## Pre-exposure Prophylaxis (PrEP)

<table>
<thead>
<tr>
<th>Goal</th>
<th>Prevent sexual transmission from M-F+ and M+F-</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Treating the HIV-negative partner with antiretrovirals called pre-exposure prophylaxis, or PrEP, during the time they are trying to get pregnant.</td>
</tr>
</tbody>
</table>
| **Effectiveness in HIV prevention** | **Switzerland study:** 46 M+F- discordant couples; ARVs in man, periconception PrEP in woman, no HIV transmission; 14 babies after 1 attempt, 25 babies after up to 5 attempts; 40 babies after up to 12 attempts.  

*Partners Prep:* 4,758 discordant couples in Kenya and Uganda, daily oral Truvada, 73% reduction in HIV transmission  

*TDF PrEP:* 1,219 men and women, daily oral Truvada, 63% reduction in HIV transmission |
| **Pregnancy rate** | No measured reduction in pregnancy incidence with use of PrEP |
| **Approx. cost per cycle** | 1650/=Per cycle. |
PrEP: Step by step

• Counsel on adherence to ARVs
  – Counsel on daily, oral use of PrEP
  – Counsel on 100% condom use

• Determine the fertile period
  – Counsel on identifying fertile period
  – Unprotected intercourse during the fertile period
  – 100% condom use at all other times

• Ideally in combination with HIV positive partner on ARVs and virally suppressed
## Vaginal insemination (VI) without intercourse

<table>
<thead>
<tr>
<th>Goal</th>
<th>Prevent sexual transmission from M-F+</th>
</tr>
</thead>
</table>
| **Description** | This is when sperm is collected from the man into a condom or a cup, and then using a needless syringe, the sperm is taken from the condom or cup and gently placed inside the woman’s vagina by the woman, or by the man. This is usually done at home, and is sometimes referred to as ‘home insemination”.
| **Effectiveness in HIV prevention** | Not yet established through research, though theoretically 100%
| **Pregnancy rate** | No measured reduction in pregnancy incidence After 6 months, 75% will attain pregnancy
| **Approx. cost per cycle** | ~100KSH per cycle for materials (non-lubricated condoms, cups, syringe) |
VI Procedure: Step by step

1. Determine the fertile period
2. Perform the procedure 3 times per cycle i.e. for a 28-day cycle on Day 11, 13, 15
3. Steps
   i. Man ejaculates into a condom or a cup
   ii. Semen is aspirated using a needleless syringe
   iii. Push out air bubbles while being careful to not spill semen
   iv. Insert syringe in vagina until the base of the syringe reaches the opening of the vagina and gently deposit the semen within one hour of collection
   v. Advise woman to lay on her back for 20 minutes with hips slightly elevated
4. Counsel to use condoms 100% during intercourse
Sperm ‘washing’ – removing HIV from sperm

<table>
<thead>
<tr>
<th>Goal</th>
<th>Prevent sexual transmission from M+F-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>This is when semen is collected from the man and then processed or ‘washed’ to remove the HIV (HIV lives in seminal fluid, not on the sperm). The washed sperm will then be placed inside the woman either through intrauterine insemination (IUI) or in vitro insemination (IVF). Sperm washing with IUI/IVF is available in Nairobi, but not yet widely available in Kenya.</td>
</tr>
<tr>
<td>Effectiveness in HIV prevention</td>
<td>CREAThe Network*: 967 discordant couples having 2840 IUI cycles and 107 IVF cycles; no HIV transmission; 463 live births</td>
</tr>
<tr>
<td>Pregnancy rate</td>
<td>CREAThe: Delivery per couple: 36% (IUI); 26% (IVF)</td>
</tr>
<tr>
<td>Approx. cost per cycle</td>
<td>Sperm washing + IUI: 5,000 - 10,000 KSH</td>
</tr>
</tbody>
</table>

*CREAThe = Centre for Reproductive Assisted Technologies for HIV in Europe, see Bujan et al 2008
Sperm washing: step by step

• Collect semen sample

• In laboratory, separate sperm from semen
  – Two methods: i) centrifuge or ii) swim up

• Test sperm to confirm absence of HIV
  – Sperm is maintained in laboratory while waiting for HIV results
What is then done with the ‘washed’ sperm?

- **Intrauterine insemination (IUI)**
  Using a thin catheter, sperm is transferred through vagina and cervix directly into the uterus where fertilization occurs.

- **In vitro insemination (IVF)**
  Eggs are removed from the woman’s ovary, fertilized outside the body using the sperm. Using a thin catheter the embryo is transferred through the vagina and cervix directly into the uterus.
## Unprotected sex limited to fertile days

<table>
<thead>
<tr>
<th>Goal</th>
<th>Prevent sexual transmission from M-F+ and M+F-</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>This is when the woman and man have sex without a condom during the woman’s fertile days. Condoms are used 100% of the time, except around the time of ovulation to allow pregnancy to occur. <em>Strongly recommended to combine this strategy with ART and PrEP as treatment as prevention.</em></td>
</tr>
<tr>
<td><strong>Effectiveness in HIV prevention</strong></td>
<td>Unknown</td>
</tr>
<tr>
<td><strong>Pregnancy rate</strong></td>
<td>Would mimic natural conception rates (20% chance per cycle)</td>
</tr>
</tbody>
</table>
| **Approx cost per cycle**         | Calendar method: negligible  
Cervical mucus monitoring: negligible  
LH testing: 85KSH per test strip  
BBT monitoring: thermometer, negligible  
Ultrasound assessment of follicles: 2500KSH per ultrasound |
Unprotected sex limited to fertile days: Step by step

1. Determine peak fertile days
   1. Calendar method (fertility beads)
   2. Monitoring cervical mucus (Billings method)
   3. Testing for Luteinizing hormone (LH) in urine
   4. Monitoring basal body temperature
   5. Ultrasound monitoring of the follicles

2. 100% condom use at all other times
Adjunct HIV risk reduction strategies

1. Voluntary Medical Male Circumcision (VMMC)
   – 66% reduction in sexual M-F+ HIV transmission

2. Screening and treatment of STIs
   – 40% reduction in HIV acquisition M-F+ & M+F-
DETERMINATION OF FERTILE DAYS

i) Calendar method (fertility beads)
ii) Cervical mucus monitoring (Billings method)
iii) Testing for LH urinary metabolite
iv) Tracking basal body temperature
v) Ultrasound monitoring for follicle development
Quick Refresher on the Menstrual Cycle

- A menstrual cycle starts on Day 1 of bleeding (first day of full blood flow) and continues until the next Day 1 of bleeding.

- The average menstrual cycle is 28 days long.

- Cycles can range anywhere from 21 to 35 days.

- Ovulation occurs midway through the menstrual cycle.
  - For a 28 day cycle, ovulation is expected around Day 14.
  - For a 32 day cycle, ovulation is expected around Day 16.
Calendar Method: Identify fertile days

- Predicts ovulation trends based on past menstrual patterns
- It is more accurate when the woman has a regular cycle
- Perceiving ovulation patterns becomes easier after a couple months of maintaining the calendar records

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
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<tbody>
<tr>
<td>CD</td>
<td>CD</td>
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<td>CD2</td>
<td>CD3</td>
<td>CD4</td>
<td>CD5</td>
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<td>CD6</td>
<td>CD7</td>
<td>CD8</td>
<td>FD12</td>
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<td>CD13</td>
<td>CD14</td>
<td>CD15</td>
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<td>CD18</td>
<td>CD19</td>
<td>CD20</td>
<td>CD21</td>
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<td>CD24</td>
<td>CD25</td>
<td>CD26</td>
<td>CD27</td>
<td>CD28</td>
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</tbody>
</table>

Key to calendar colors and symbols:
- CD = Condom day
- FD = Fertile Days (most likely to get pregnant)
Cervical mucus monitoring (Billings method): Identify fertile days

• After menses ends the external cervical os is blocked by mucus that is thick and acidic
• This mucus blocks sperm from entering the uterus
• Around the time of ovulation (Day 14) another type of mucus is produced which is:
  – higher in water content, less acidic, higher in electrolyte

• Involves estimating a woman's fertile days by observing changes in her body
  – Quality of cervical mucus
  – Elasticity (Spinbarkeit)
  – Transparency
  – Ferning pattern (under magnification)
LH testing: Identify fertile days

• Measuring the amounts of luteinizing hormone (LH) and estrogen in urine to identify the peak fertile days of a woman’s menstrual cycle

• The most fertile days are the day prior to ovulation and the day that ovulation takes place
Basal body temperature (BBT): Identify fertile days for a future cycle

- **Definition:** BBT is the lowest temperature attained by the body during rest (usually during sleep)

- **Why track:** Ovulation causes an increase of quarter to half degree Celsius in BBT; biphasic pattern: women have lower temp before ovulation and higher temp after.

- **When to track:** Measured immediately after awakening and before any physical activity

- **How to track:** The temperature is normally taken orally with a regular fever thermometer
Ultrasound Assessment for Ovulation Monitoring

**Definition:** Serial transvaginal ultrasound evaluations can demonstrate the development of a mature follicle prior to ovulation.

- Mature follicle is approximately 20-25mm before ovulation

**Ovulation:** the follicle ruptures and the egg is released

**Disadvantage:** time consuming, costly, not readily available
Fertility evaluation

• **WHO definition of infertility:** 12 cycles of unprotected sex without conception

• **HIV and Fertility:** Some evidence of decreased fertility among HIV+ men and women, and menstrual cycle abnormalities, but data are inconclusive, confounded by STIs

• **Fertility assessment prior to offering safer conception:**
  – Self-reported history of 12 months of conception attempts that result in no conception

• **Fertility evaluations:**
  – South African Guidelines suggest fertility evaluations after 6-12 months of safer conception attempts
  • Hysterosalpinogram & sperm analysis available in Kenya
Alternatives to having biological children (available in Kenya)

- Adoption
- Sperm Donation, Egg donation
- Surrogacy
Preconception counseling and resources
Pre-conception care and counseling

• **WHO Definition**: Interventions that aim to identify and modify biomedical, behavioral and social risks to a women’s health or pregnancy outcomes through prevention and management

• **Reasons for**:
  – Ensure maternal and fetal health during and after pregnancy
  – Prevent unintended pregnancies
  – Prevent HIV transmission to uninfected partner
  – Prevent perinatal HIV transmission
When to offer:

– Nonuse/inadequate use of effective contraception, or at risk for unintended pregnancy
– Expressed interest in conceiving
– Change in relationship or personal circumstances
– Woman taking medications with reproductive toxicity (examples), or interact with contraception
– There is new information about pregnancy, or HIV
What to discuss with patients considering pregnancy:

- Optimization of HIV care and treatment, CD4 count, viral load suppression, HIV counseling and testing in partner
- Safer conception strategies
- Using contraception to delay pregnancy until healthy
- Assess and manage underlying medical condition (e.g. Hypertension, Diabetes)
- Multivitamins with 400 mcg of folic acid daily
- Avoid over-the-counter medicines
What to discuss (continued):

- Healthy activity level and weight
- Ways to improve nutrition
- Resources to stop smoking and to avoid second-hand smoke
- Screening, treatment for sexually transmitted diseases
- Immunizations for Hepatitis B, Tetanus & Whooping cough, Rubella, Varicella
  - WAIT 4 WEEKS AFTER RUBELLA AND VARICELLA LIVE VACCINE TO ATTEMPT PREGNANCY
- Partner involvement AND
- Provide referrals to support services as appropriate
Emphasize importance of optimizing HIV care and treatment:

- Assessment of clinical and immunologic status e.g. CD4 count, viral load, regular HIV testing of the negative partner in a discordant relationship
  - Initiate or modify HIV treatment
  - Adjust ARV regimens to exclude efavirenz or other drugs with teratogenic potential during the preconception period

- Treat and provide prophylaxis for any opportunistic infections
Emphasize delaying pregnancy until health issues are addressed, couple in optimal health:

• Most forms of birth control are safe and effective for women living with HIV

• Encourage dual protection until pregnancy is desired and couple is healthy

•Prescribe hormonal contraception, if medically appropriate
Resources for counseling sessions

• Counseling Guide

• Brochures for men and women
Questions and Answers
## Role plays

<table>
<thead>
<tr>
<th>Client characteristic</th>
<th>Role Play scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infected female</td>
<td>27 year old on care, her husband is not HIV infected. He has stopped using condoms and we are trying to get a baby, I have told him many times that this is risky and that he can get infected but he does not want to listen, he just wants a baby</td>
</tr>
<tr>
<td>HIV infected male with an HIV infected female partner</td>
<td>33 year old man on care for the last 8 years, he recently got married to an HIV positive lady he met at the clinic during clinic follow up. She is on ART and hormonal contraception and has refused to have a baby with me because it is dangerous. She says HIV infected couples should not have babies because pregnancy is risky and we can suffer super-infection.</td>
</tr>
</tbody>
</table>

➤ Use the Patient Brochures and the Preconception Counseling guide for Providers during your role play.
Role Play De-brief

• How did you feel in your role?
• What was the most difficult part of the role?
• Which part did you enjoy most in your role?
• What additional information could have been provided to enhance your ability to counsel HIV-affected women or couples?
## Case Studies

### CASE 1:
Rebecca is 28 years old; she has been in HIV care for six years. She is currently married and living with her husband who is HIV-negative. They have one child who is seven years old. She is using condoms to prevent HIV transmission to her uninfected partner and is not on any other contraceptive method.

### CASE 2:
Jirus and Prisca have come for their clinic follow up. Jirus is HIV-infected and has been in care for two years. Jirus is on HAART and his CD4 count which was done nine months ago was 659. Prisca last tested HIV negative about 6 months ago. They are no longer using condoms because they want to have a baby.

➤ Using the *Preconception Counseling Guide for Providers* and the *Patient Brochures*, discuss within your group and write out your preconception/safer conception plan for the patient(s). You will present this plan to the rest of the participants in the training.
Case Study 1 De-brief - Rebecca

- Assessment of reproductive desires (safer conception versus contraception)
- Partner involvement
- Basic fertility evaluation through self-reported history of attempting conception
- Repeat HIV testing as indicated in the male partner
- Optimization of ART care with CD4/HIV viral load monitoring according to national or WHO guidelines
  - Adherence to ARVs
  - Switching of ARVs (no EFV in first trimester, if possible)
- Dual contraceptive protection until ready to attempt pregnancy
  - Consistent condom use
  - Reversible contraceptive
- Safer conception options (i.e. ARVs, PrEP, vaginal insemination)
  - Identifying peak fertile days/monitoring the menstrual cycle
  - Adjunct strategies: VMMC, STI Screening and Treatment
- Once pregnant
  - 100% condom use
  - ARV initiation for Rebecca, if she is not already on ARVs
Case Study 2 De-brief – Jarius & Prisca

• Assessment of reproductive desires (safer conception versus contraception)
• Basic fertility evaluation through self-reported history of attempting conception
• Repeat HIV testing as indicated in the female partner (Prisca)
• Optimization of ART care with CD4/HIV viral load monitoring according to national or WHO guidelines
  – Adherence to ARVs
  – Switching of ARVs (no EFV in first trimester, if possible)
• Dual contraceptive protection until healthy enough to attempt pregnancy
  – Consistent condom use
  – Reversible contraceptive
• Safer conception options (i.e. ARVs, PrEP, sperm washing)
  – Identifying peak fertile days/monitoring the menstrual cycle
  – Adjunct strategies: STI Screening and Treatment
• Once pregnant
  - 100% condom use
Evaluations today

• Post-training Questionnaire

• Training Evaluation
  – Content, duration, facilitation
Next steps

• Mock counseling sessions (in 1-2 weeks)
  – Each provider to counsel 1 HIV discordant couple, and 2 HIV-affected women who have agreed to participate in this research study
  – Direct observation and support by a member of the research staff

• In-depth interviews
  – Immediately following mock counseling sessions
Thank you!

• We will communicate with you the findings of this research study.

• We will inform you when Safer Conception resources have been developed and become available/approved for use in Kenya.