

Assessing access to assisted reproductive services for serodiscordant couples with human immunodeficiency virus infection

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Objective: To understand the barriers that serodiscordant couples with human immunodeficiency virus (HIV) face in accessing services for risk reduction and infertility using assisted reproductive technology (ART).

Design: Two-arm cross-sectional telephone “secret shopper” study.

Setting: Infertility clinics designated by the Society for Assisted Reproductive Technology (SART), 140 from 15 American states with the highest prevalence of heterosexual HIV-infected men.

Patient(s): Clinical and nonclinical staff at SART-registered clinics.

Intervention(s): Standardized telephone calls to SART-registered clinics by investigators in the roles of physician and patient callers.

Main Outcome Measure(s): Availability and difference in services offered to callers and the rate of referral if the clinic did not provide these services.

Result(s): Of the 140 sampled SART clinics across 15 states, callers in both patient and physician roles spoke to a staff member at greater than 90% of targeted clinics (127 clinics total). Of the physician callers 63% were told that the clinic could offer services, as compared to 40% of patient callers. Of the 55 clinics that were unable to provide services to the patient caller, 51% referred to other clinics with confidence that they could offer these services; 67% of clinics would provide services for both prevention and infertility purposes.

Conclusion(s): Risk reduction services for HIV were more available at the sampled fertility clinics than previously reported in the literature. However, the responses depended on the person calling. The clinics demonstrated low rates of concordance with the American Society for Reproductive Medicine's guidelines, which endorse referral of patients to other facilities from sites unable to offer services. (Fertil Steril® 2017; ■: ■–■. ©2017 by American Society for Reproductive Medicine.)

Key Words: Assisted reproduction, fertility, HIV prevention, risk reduction, serodiscordant couples

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Individuals of reproductive age account for approximately 65% of new human immunodeficiency virus (HIV) infections in the United States (1). Persons living with HIV have been shown to have similar childbearing motivations or future pregnancy desires as their HIV-uninfected counterparts (2). As a result, and much like the general population, HIV-infected individuals have demonstrated an acceptance and demand for assisted reproductive technology (ART) (3–5). Sperm washing with intrauterine insemination (IUI), in vitro fertilization (IVF), and IVF with intracytoplasmic sperm injection (ICSI) are among several risk reduction strategies effective in preventing HIV transmission and in assisting pregnancy for HIV-serodiscordant couples (6–8).

In 2015, the American Society for Reproductive Medicine (ASRM) revised a committee opinion on HIV and infertility treatment where they found “no ethical reason[s] to withhold fertility services at clinics with the necessary resources to provide care to HIV-infected individuals” (7). Previous studies indicated, however, that only 3% of ART practices provide services to patients with HIV (7, 9). Poor access has been attributable to personnel transmission concerns, cross-contamination concerns, lack of expertise among clinicians in handling such specimens, and high cost of the separate laboratory facilities recommended by the ASRM (7). The ASRM strongly encourages providers to “reduce these barriers to care in order to make infertility treatment available to HIV-infected individuals” (7). Despite reports of low access and clear guidelines, no studies to date have rigorously examined this issue (9).

This study investigated the availability of assisted reproductive services for women seeking to conceive with an HIV-infected partner. The study focused on couples composed of an HIV-infected man and HIV-uninfected woman. We hypothesized that the majority of clinics would not offer services to these couples, with lower rates of availability when a patient called compared with when a physician called on behalf of a patient.

MATERIALS AND METHODS

To determine the level of access and barriers that HIV-serodiscordant couples face when accessing ART, we conducted a two-arm cross-sectional telephone secret shopper study of fertility clinics in the United States. Our population of interest prompted us to select 15 states with the highest HIV prevalence among heterosexual individuals. We selected states with the highest prevalence due to a likely higher need and demand for ART services among their populations. The 15 states included Connecticut, Delaware, the District of Columbia, Florida, Georgia, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, and South Carolina. Using the Society for Assisted Reproductive Technology (SART) database, we called all 140 clinics within the 15 highest prevalence states (10). The primary study outcomes included the availability of services to the patient caller, the differences in the services offered to the patient and physician callers, and rates of referral if the clinic was unable to offer services. The secondary outcomes included the type of fertility services offered

to the physician callers; whether the clinics agreed to accept referral for risk reduction, for fertility only, or for both; and whether clinics would also provide their patients with pre-exposure prophylaxis (PrEP) services.

The first arm of the study consisted of author A.L. (female) posing as an HIV-uninfected woman with an HIV-infected male partner. Specifically, she described herself as a 30-year-old nulliparous woman who had recently moved to the area near the clinic being contacted and was interested in attempting to conceive safely with her HIV-infected husband. In this scenario, neither the patient nor her husband had a diagnosis of infertility. The patient’s goal was to gain information about access to ART. The second arm of the study consisted of author P.B. (male), C.R. (female), or M.C. (female) posing as a new obstetrician-gynecologist in the area near the clinic. The physicians were calling to refer a 30-year-old nulliparous HIV-uninfected woman with an HIV-infected husband for ART. In this scenario, the physician stated that neither the patient nor the husband had a diagnosis of infertility but were interested in using ART for risk reduction.

To ensure uniformity of data collection, the callers used an eight-item call script, consistent of domains covering access, experience, services offered, and referral patterns (Supplemental Appendix, available online). The development of both the physician and patient call scripts was a collaborative effort among health services researchers, obstetrician-gynecologists, and infectious disease specialists. We piloted scripts in 10 clinics within the states of Virginia and Illinois, the highest HIV-prevalent states in the nation following the selected study sample.

The callers phoned clinics between January and March 2016. Physician and patient calls were separated by at least 3 weeks to minimize recall bias. The initial order in which they called each clinic was random with an attempt to vary physician and patient call order to each clinic. Calls were made during regular business hours. When unable to reach a clinic, both physician and patient callers were instructed to leave call-back numbers or voicemails. The callers aimed to mimic real situations in which physician callers sought to speak with a clinician in the clinics. The patient callers began by inquiring at the receptionist or patient coordinator level.

We recorded all call data in Google Forms for immediate data collection and analyzed the data using SAS 9.4 (SAS Institute). We powered our sample at 80% with a two-sided alpha of 0.05. The power estimation applies to our hypotheses that the majority of clinics would not offer services to HIV-positive individuals and that across all clinics and by state the patient callers would elicit dissimilar rates of availability from clinics compared with physician callers. Because we were interested in testing the discordance between the physician and patient responses among the same clinics, the data are correlated and thus cannot be analyzed as two independent samples. We used McNemar’s test for marginal homogeneity to test the discordance between responses to the physician and patient callers. The Boston University institutional review board deemed this study to be non-human subjects research.

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