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# 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. These guidelines are evidence- and community-based and flexible and take into account diverse and intersecting local/population needs based on the social determinants of health.

**Intended Outcomes:**

- Reduction of risk of perinatal HIV transmission (from mother to child) and horizontal HIV transmission (between partners/parents) by increasing the extent of pregnancy planning by individuals with HIV through informed discussions of safer options for conception.
- Improvement of pregnancy and infant outcomes in the context of HIV through the provision of recommendations for healthy pregnancies.
- Reduction of the stigma associated with pregnancy and HIV through education.

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- Increased access to pregnancy planning and fertility services for individuals affected by HIV through education.

**Evidence:** Literature searches were conducted by a librarian using the Medline, Cochrane Central Register of Controlled Trials (CENTRAL), and Embase databases for published articles in English and French related to HIV and pregnancy and HIV and pregnancy planning for each section of the guidelines. The full search strategy is available upon request.

**Values:** The evidence obtained was reviewed and evaluated by the Infectious Diseases Committee of the SOGC under the leadership of the principal authors, and recommendations were made according to the guidelines developed by the Canadian Task Force on Preventive Health Care and through use of the Appraisal of Guidelines Research and Evaluation instrument for the development of clinical guidelines.

**Benefits, Harms, and Costs:** Guideline implementation should assist the practitioner in developing an evidence-based approach for the prevention of unplanned pregnancy, preconception, fertility, and pregnancy planning counselling in the context of HIV infection.

**Validation:** These guidelines have been reviewed and approved by the Infectious Disease Committee and the Executive and Council of the SOGC.

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**Recommendations:**

1. 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).
2. Counselling should be provided to all people with HIV of reproductive age on strategies to reduce horizontal and perinatal HIV transmission risk (I-A).
3. Individuals should be counselled on all relevant aspects of pregnancy planning—such as maintaining a healthy diet and lifestyle; the cessation or reduction of smoking, drinking alcohol, and drug use; the risk of genetic disease occurrence, and prenatal screening—as outlined in current Canadian practice guidelines irrespective of their known HIV status (III-A).
4. Folic acid (found in the form of vitamin supplements) should be initiated 3 months prior to becoming pregnant and for at least the first 3 months of pregnancy (II-3A).
5. Prospective parents should be tested for sexually transmitted and other infections/comorbidities, even if they have conceived in the past and have no symptoms of infection (III-A).
6. 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).
7. Counselling should be performed by a knowledgeable provider in a supportive, nonjudgemental manner that takes into account factors specific to sexual diversity and ethnocultural and/or religious beliefs and practices (III-A).
8. People with HIV who intend to conceive should be aware of the potential stigma and discrimination they may face from people who are less informed about the risks of perinatal and horizontal HIV transmission. They may therefore require further counselling to cope with psychosocial issues during the pregnancy or postpartum period (II-3A).
9. The preconception period can be an important opportunity to achieve mental health stability. Assembling a care team that is appropriate to the individual's or couple's needs in the perinatal period has important implications for maternal and infant health outcomes (III-A).
10. The intersection of HIV and substance use necessitates a supportive, non-stigmatizing discussion of substance use in the preconception period with referral to appropriate services, including harm reduction strategies, for both mother and infant (III-A).
11. All people with HIV should be counselled on the possible ethical and legal aspects of pregnancy planning (III-A).
12. People and couples affected by HIV who are considering pregnancy should be counselled on the possibility of legal sanctions if they do not permit antiretroviral therapy to be given to their baby after birth (III-B).
13. People with HIV should be made aware of the possibility of criminal sanctions related to HIV non-disclosure and horizontal and/or perinatal transmission (III-C).
14. Ethical considerations, including those related to the health status of a person with HIV or couples, should be discussed during preconception counselling, if relevant (III-B).
15. Clinicians should review all medications that an individual with HIV may be using, including antidepressants, hepatitis treatment, pain medications, over-the-counter medications, and herbal and alternative medications, to ensure that they are safe during conception and pregnancy. Any changes to medications should be made prior to pregnancy (II-3A).
16. All people with HIV who are planning to conceive should already be taking or imminently started on combination antiretroviral therapy, both for their own health and to prevent horizontal HIV transmission during the preconception period. They should be counselled on maintaining a high level of antiretroviral drug adherence to maintain a suppressed viral load (I-A).
17. For women not on antiretroviral therapy, initiating combination antiretroviral therapy is recommended in the preconception period to achieve a suppressed viral load and management of drug-related side effects prior to conception (II-A).
18. Women should avoid any drugs that are potentially teratogenic or considered toxic in the preconception period and in pregnancy. The safest, most efficacious antiretroviral regimen tailored to pregnancy should be selected (II-3A).
19. 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).
20. The data on pre-exposure prophylaxis should be discussed with all patients during preconception. HIV pre-exposure prophylaxis 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).
21. In patients with hepatitis C co-infection, new highly effective direct-acting agents are commonly being used to cure hepatitis C. There is inadequate evidence regarding the potential effects of these agents in pregnant women, and they should be avoided in the immediate preconception period and during pregnancy. It is ideal to treat and cure a woman's hepatitis C prior to attempting conception. There is no evidence that newer agents affect the sperm and therefore can be used in the preconception period for men. However, ribavirin, an older drug that is still used, should not be used in individuals (i.e., women and men) for at least 6 months prior to conception (II-A).
22. All recommendations with respect to combination antiretroviral therapy during the preconception period and during pregnancy should