Benefits and Challenges of Safer-Conception Counseling for HIV Serodiscordant Couples in Uganda

CONTEXT: *Safer-conception counseling may help people living with HIV to reduce the risk of transmission to partners and children. However, such counseling is rarely offered or evaluated in low-income countries.*

METHODS: *In 2014–2015, in-depth qualitative interviews were conducted at a Ugandan HIV clinic with 42 HIV-positive clients and 16 uninfected partners who had participated in a safer-conception counseling intervention for serodiscordant couples seeking to have a child. Participants attended up to six monthly counseling sessions in which they received instruction and ongoing support in using the safer-conception method they selected. Content analysis of interview transcripts was used to identify themes related to the benefits and challenges of safer-conception counseling.*

RESULTS: *Almost two-thirds of participants felt that safer-conception counseling was an empowering experience that enabled them to make informed choices regarding childbearing, learn how to conceive safely and understand how to stay healthy while trying to conceive. Timed unprotected intercourse was the most frequently used safer-conception method. Seven couples had successful pregnancies, and no uninfected partners seroconverted. Participants' primary concerns and challenges regarding counseling and method use were issues with manual self-insemination, difficulty with engaging partners and fear of HIV infection.*

CONCLUSIONS: *Counseling can help HIV-infected individuals make informed choices about childbearing and safer-conception methods; however, a controlled clinical trial is needed to determine whether clients use such methods correctly and to assess rates of pregnancy and transmission. Policymakers need to consider including safer-conception counseling as part of routine HIV care.*

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Researchers and clinicians have drawn attention to the reproductive rights and needs of people living with HIV,[1–3] the challenges that providers and health care systems face in trying to address these needs,[4] and the viability of different methods of facilitating safer conception for serodiscordant couples.[5,6] A great deal of work has been done to help pregnant women living with HIV prevent mother-to-child transmission[7,8] and to engage men in such efforts.[9,10] However, few providers offer safer-conception services to reduce the risk of horizontal transmission between serodiscordant partners who wish to conceive.

Providers face challenges in addressing the reproductive needs of their HIV-infected clients. They report that clients often are already pregnant when they come to them,[11] although researchers note that providers miss opportunities to discuss their clients' childbearing desires in advance of pregnancy.[5,12,13] Health care systems need to provide comprehensive reproductive health services that can help people living with HIV make family planning choices when they want to avoid pregnancy, make informed safer-conception choices when they decide to have children and facilitate pregnant women's engagement in care to prevent mother-to-child transmission.[14] Though researchers and clinicians have been working together to develop reproductive health care options for people living with HIV, we are still a long way from routine implementation of safer-conception counseling.

Researchers exploring safer-conception methods have recommended that before attempting to conceive, HIV-infected clients should take antiretroviral medication for at least six months,[15] obtain treatment for other STIs to ensure optimal health[16] and, if male, take advantage of the protective effects of circumcision.[17] Partners should be tested for HIV, and those who are uninfected could be offered pre-exposure prophylaxis in settings where this is an option. However, in most resource-constrained settings, this method is not widely available.[18] Researchers and clinicians in South Africa have developed guidelines for provision of counseling in resource-constrained settings to promote use of safer-conception methods.[19] In these settings, couples can utilize timed unprotected intercourse to reduce the risk of transmission to an HIV-negative partner,[20] or manual self-insemination to eliminate the risk of an HIV-positive female infecting an HIV-negative male

partner.*[21] Sperm washing, although effective in eliminating the risk of an HIV-positive male partner transmitting the virus to an uninfected female partner,[22] is not likely to be available in the foreseeable future in resource-constrained settings because of high costs.

Building on insights from our prior observational study with providers and clients,[25] we conducted pilot research on an intervention that provided reproductive and safer-conception counseling to people living with HIV who were considering having children. To our knowledge, safer-conception counseling is not routinely offered in any setting, and the literature contains only a few published reports of individual clinics that offer the service[26] or of pilot studies of such interventions.[27] We sought to obtain data on benefits and challenges of delivering safer-conception counseling in resource-poor settings. Our findings may provide insight into the potential benefits of comprehensive reproductive care for people living with HIV and the vital role that safer-conception counseling can play in ensuring the best health outcomes for HIV-positive individuals, their partners and their children.

METHODS

Setting and Recruitment

We conducted two pilot studies of an intervention to promote the use of safer-conception methods. Both were conducted at The AIDS Support Organization (TASO) clinic in Entebbe, Uganda. TASO is a nongovernmental organization founded in 1987 to provide care and support for people infected with or affected by HIV in Uganda. The Entebbe site is one of 11 operated by TASO and provides HIV care to more than 6,800 HIV-infected registered clients. TASO offers antiretroviral therapy, counseling, and family planning and contraceptive services, but not routine delivery of safer-conception services. The study protocol was approved by the institutional review boards at Makerere University and the Uganda National Council for Science and Technology.

The first pilot study was conducted from May to October 2014. Clinic clients were informed of the study through a presentation in the waiting room, as well as through referrals from counselors. To be eligible to participate, clients had to have been on antiretroviral therapy for at least 12 months, to increase the likelihood that they had an undetectable viral load and reduce the risk of transmitting the virus to their partner during attempts to conceive using timed unprotected intercourse (though some risk remained). Other eligibility criteria were that the partner with whom the client wanted to conceive was HIV-negative (confirmed with an HIV test at screening), the woman in the relationship was not pregnant (confirmed with a pregnancy test at screening) and the partner would attend the safer-conception counseling sessions. Clients who had not disclosed their HIV status to their partner were not eligible for the study and were referred for assisted disclosure services.

HIV counselors at the clinic were trained to conduct the intervention. Clients who expressed interest in the intervention and met the eligibility criteria were asked to provide written informed consent. This was followed by the confirmatory pregnancy and HIV tests, and then by an initial consultation geared toward helping the couple make an informed decision about whether to pursue childbearing now or to delay pregnancy. This consultation included discussion of why the couple wanted to have a child, factors that contribute to the success of a pregnancy (e.g., CD4 level, absence of active STIs, adequate nutrition, good maternal health), the risk of transmission to the partner and infant, and why use of safer-conception methods limits these risks. Couples who decided to continue pursuing childbearing after the initial consultation received three monthly counseling sessions, which took place just before the woman was expected to have the most fertile period of her ovulation cycle. During these sessions, they were instructed on the use of their preferred safer-conception method. If the woman was HIV-positive, the couple could choose to use either timed unprotected intercourse or manual self-insemination; if the man was infected, the former method was the only option. Participants were informed that manual self-insemination entailed no risk of partner infection, while timed unprotected intercourse involved an uncertain level of risk that would be greatly reduced with use of antiretroviral therapy and treatment of any STIs. Regardless of the method they chose, couples needed to know how to identify the 2–3 days of peak fertility in the woman's ovulation cycle; this information was an integral part of the counseling, and calendars were used to aid with identification. In addition, couples received needleless syringes (to facilitate manual self-insemination) and spermicide-free condoms (to contain the man's semen after ejaculation for use in self-insemination). These items were not widely available and were provided specifically for this purpose. Participants were advised to use regular condoms outside of the peak fertility days. At the conclusion of the intervention, the partner was given an HIV test and the woman a pregnancy test (if the latter had not already been performed as a result of a missed menstrual period).

Because of difficulty in recruiting participants for the first pilot study, we conducted a second pilot study from January to October 2015. The eligibility criteria used in the first study were modified such that partners were no longer required to attend the counseling sessions (although they were strongly encouraged to do so) and

* Counseling for timed unprotected intercourse entails instructing couples to calculate the period during which the female partner is most likely to be ovulating and recommending that the couple have unprotected/condomless sex only during this period, to maximize the likelihood of conception while minimizing the risk of HIV transmission. Condom use is recommended at all other times in the woman's menstrual cycle. Counseling for manual self-insemination is appropriate for couples in which the female partner is HIV-positive and the male partner is HIV-negative. Couples are taught to use a spermicide-free condom to collect a semen sample when having sex during the female partner's ovulation period. Afterward, the man removes the condom, uses a needleless syringe to collect the semen sample and then injects the sample into the supine woman's vagina.

the minimum length of time that HIV-infected participants were required to have been on antiretroviral therapy was reduced to six months (since this is an adequate period to ensure viral suppression). The intervention was adjusted as well: The number of monthly sessions was increased from three to up to six, to provide more time for couples to acquire the skills needed to accurately implement the safer-conception method. Finally, unlike the case in the first pilot study, expert clients working in the clinic were trained to educate other clients (informally and through brief presentations in the waiting room) about the availability of safer-conception counseling and safer-conception method options, and to encourage clients to communicate with their providers about childbearing desires.

Clients (and their partners) who had participated in the pilot studies and had received safer-conception counseling following the initial consultation were invited to take part in an in-depth, qualitative interview about their experiences with the counseling sessions and their use of safer-conception methods. These interviews, which took place at the end of the intervention, were conducted in English and Luganda in a private room at the clinic. Clients and partners were interviewed separately. Not all partners participated in the study. Interviews were transcribed by the investigators, and the transcripts of interviews conducted in Luganda were translated to English by a trained research assistant.

Analysis

Interview transcripts were analyzed using Atlas.ti version 7.5. Transcripts were coded with the participant's demographic characteristics (client or partner, site, age, HIV status, number of children), and content was coded according to the key themes outlined in the interview guide. We used a modified grounded theory approach to identify additional key themes, as well as subcodes within each theme.[23] Coding of the first 10% of the transcripts was performed by the lead author (an anthropologist) and a doctoral research assistant, who then compared their coding and together made decisions on adjustments to the coding scheme. The research assistant coded the remainder of the transcripts. The coded data were reviewed by the lead author, who in consultation with the research assistant made further adjustments. In this article, we focus on the dominant themes that emerged from the analysis, including the benefits of safer-conception counseling and the challenges that clients experienced during counseling and during use of their chosen safer-conception method.

RESULTS

Sample Characteristics

Of the 159 HIV-infected clients who expressed interest in participating in one of the pilot studies, 69 were ineligible because their partner was unwilling to attend sessions (pilot study 1), was unwilling to get tested for HIV or tested positive for HIV; the woman was already pregnant; the client had not disclosed his or her status to the partner; or the client was not on antiretroviral therapy. Five others were eligible but opted not to participate in the intervention. The remaining 85 clients were eligible and had a safer-conception consultation, after which 43 decided against childbearing. Some learned that their partner had never actually been interested in childbearing and was not going to change his or her mind. Some couples decided to defer childbearing, at least for a while, because they needed to address potential risks and health concerns (such as other STIs) to ensure healthy conception. These clients were referred for family planning and contraceptive services.

The remaining 42 clients (12 in the first pilot study and 30 in the second) continued to pursue childbearing. They attended the monthly safer-conception counseling sessions and were interviewed at the conclusion of the counseling. The median age of male clients was 40, and that of female clients was 34 (Table 1). Thirty-eight percent of clients already had at least one child with their current partner, while 33% did not; data on previous childbearing was not available for the remaining 29%.

In addition to the 42 enrolled clients (26 women and 16 men), 16 partners (eight men and eight women) agreed to be interviewed about their experiences. The median age of the interviewed partners was 33 for females and 40 for males (not shown).

Seven of the 12 clients who received the intervention in the first pilot study completed all three sessions, while five dropped out because of health problems or relationship difficulties, or because they decided to pursue pre-exposure prophylaxis instead of using timed unprotected intercourse or manual self-insemination. All 30 clients who received the intervention in the second pilot study

TABLE 1. Selected characteristics of HIV-positive clients who attended safer-conception counseling, Uganda, 2014–2015

Characteristic	Median or % (N=42)
MEDIANS	
Age of male clients	40
Age of female clients	34
PERCENTAGES	
Gender	
Male	38
Female	62
Had children with partner	38
Completed ≥3 counseling sessions†	88
Partner attended ≥1 counseling session	38
Safer-conception method used‡	
Timed unprotected intercourse	86
Manual self-insemination	5
Both	8
Successfully conceived during intervention‡	19

†Participants in the first pilot study received three sessions; those in the second study received up to three additional sessions, if needed. ‡Among the 37 clients who completed at least three sessions. *Note:* Percentages may not total 100.0 because of rounding.

completed at least three monthly counseling sessions; seven of the 10 male clients—but only three of the 20 female clients—attended the sessions with their partner. Of the 37 clients in the two studies who completed the counseling, 32 (86%) chose to use timed unprotected intercourse (Table 1). Two of the 23 female clients with HIV-negative partners chose to use manual self-insemination, and three others used both manual self-insemination and timed unprotected intercourse. At the conclusion of the two studies, seven couples had had a pregnancy, and none of the uninfected partners had seroconverted (not shown).

Benefits of Safer-Conception Counseling

Almost two-thirds of the 58 interviewed participants felt that safer-conception counseling was an empowering experience, and that the information they learned had helped them to make informed choices regarding childbearing and to better understand how serodiscordant couples can reduce the risk of HIV transmission and stay healthy while trying to conceive. Below, we discuss each of these subthemes and present illustrative quotes.

• *Making informed choices.* Safer-conception counseling helped participants make informed decisions regarding childbearing. Couples who opted not to pursue childbearing after the initial consultation reported that their decision had been influenced by such factors as financial concerns and by partners' no longer being interested in having children or maintaining the relationship. Among those who decided to continue pursuing childbearing, more than half said they appreciated that counselors had provided them with useful information about options for having a child safely. For example, a 45-year-old HIV-negative man explained that "the counselor helped us by giving us those two methods to use and making sure that you choose the best that will give you the safety that you want."

One important aspect of the counseling that participants valued was receiving a detailed explanation of each safer-conception method. Participants wanted to understand the advantages and disadvantages of timed unprotected intercourse and manual self-insemination, and to make a decision based on their specific situation. One client described her interaction with a counselor as follows:

"She [the counselor] taught me the disadvantages and advantages of each method, and I decided to choose manual self-insemination because I felt it was very good for my status. This was because it was very difficult to tell [my partner] that we [would otherwise have to] go body-to-body, even [though] ... we wanted a child. So that is why I chose that method."—*HIV-positive female client, age 23*

Similarly, most other participants said that they appreciated the counselors' support in tailoring the counseling to their personal context while giving them room to make their own decisions. Indeed, participants indicated that they did not feel coerced by the counselors. As one client explained:

"She [the counselor] did not force me on which method to use. She used to ask me about what was happening, and I would go try [the method] and then get back to her and we [would] discuss the progress."—*HIV-positive female client, age 37*

• *Supporting serodiscordant couples.* Counseling allowed serodiscordant couples to explore the possibility of having a baby, which helped—and in some instances, helped save—the relationship, as the following examples show:

"She [the counselor] helped us a lot, not only me. Some women were almost separating [from their partner] because of the abuse from the relatives because of not producing [a child, and some relatives suggested] that they should marry others. Families were almost breaking, but these methods have helped them."—*HIV-positive female client, age 37*

"He [the counselor] told me to counsel my husband, to not stress him, to take him out, to relax his mind. Make him feel that even when he is HIV-positive, everything will be possible. Having children will be possible, life is possible."—*HIV-negative female partner, age 39*

Similar sentiments were conveyed by other participants, who said that the counseling sessions helped them recognize that they had the ability to live a normal life despite their HIV status, and to bear children without infecting their partner. In addition, participants described the importance of disclosure of their HIV status and partner support in ensuring successful counseling.† The counseling was critical for clients to learn what they needed to do as a couple to ensure that they could conceive without infecting the child or the HIV-negative partner. Many participants found the information they received about ovulation particularly helpful for understanding when they or their partner could conceive. Learning about this as a couple created more opportunities for partner engagement, as the following quotes illustrate:

"When I came with [my partner], the counselor taught us together, and we have been moving [working] together.... Our calendar is in our bedroom, [so] that even when I have forgotten he will remind me that it is the [ovulation] date. Even when I get into my periods, for example on [day] 11, and I have not marked [it on the calendar], he will remind me to tick that date."—*HIV-negative female partner, age 40*

"We have not known how to calculate, how to count days [until] now. Because in those years we were just playing sex normally, without knowing the days. But now we know the days of conceiving so we should count on ... those [days] for conceiving, because she wants a baby from me and I want a baby from her."—*HIV-positive male client, age 48*

• *Maintaining good health.* Participants recounted that instructions provided during the safer-counseling sessions helped them understand the need to maintain good health during and after conception. This included adherence to medication regimens, timely treatment of STIs and appropriate use of condoms. A number of participants said that counseling ensured that they practiced safer sex outside of the peak fertility days. As two clients explained:

†Although clients were eligible for the study only if they had disclosed their status to their partner, some participants had not, in fact, done so; they were offered support services to facilitate disclosure.

"The greatest lesson I learned was that [the counselor] advised me to avoid having live [unprotected] sex, so I should always put on a condom [when not trying to conceive]. She gave me the time I can remove the condom so that we can be able to get what we want. I got that well in my head together with my wife. We all learned that, even if I forget, my wife will be able to remember.... I learned that, if at any time I have some wounds, or it is my wife who has [some], we should never have live sex."—*HIV-positive male client, age 33*

"[My partner] never thinks about [contracting HIV] because he says that I am on [antiretroviral therapy] so I cannot transmit to him. The counselors confirmed to him that his responsibility is to make sure that I take my medication on time, and he really does this very well, to the extent that even when he is away, he will call at 10:00 to remind me of time. He does this both morning and evening."—*HIV-positive female client, age 33*

Some participants mentioned that going to the counseling sessions together, getting tested together and learning about their status were very important aspects of maintaining good health. An HIV-negative woman found that attending counseling together minimized her anxiety:

"I feel happy because they [counselors] will have taught us together. Not like when I am alone and when I get back home and explain to him. He might say no [to the advice I have received at the clinic]. But when we are counseled, he will understand how things should be done rightly and not him using and doing things the way he wants them to be done."—*HIV-negative female partner, age 37*

Although we preferred to have partners attend safer-conception counseling sessions to help ensure the success of couples' efforts, some female clients attended the sessions alone and were still able to use safer-conception methods successfully with their partner.

Challenges of Safer-Conception Counseling and Methods

Three main themes emerged during participant's discussion of the challenges they encountered while using safer-conception methods or during safer-conception counseling: concerns related to use of manual self-insemination, difficulty with engaging partners and fear of HIV infection. An additional concern, not discussed below, was the possibility of infertility. Although the intervention did not include fertility tests, some female participants' ages suggest that for at least a portion of the sample, fertility constraints may have inhibited couples' ability to get pregnant.

• ***Concerns with manual self-insemination.*** Although 23 of the 37 clients who completed the counseling were HIV-positive females, only five tried manual self-insemination. Participants' main concerns about using the method were the challenges of using the method and the feeling that the method was "unnatural." The quotes that follow illustrate these issues:

"I didn't want [manual self-insemination] because of its complexity. Get the semen, then syringe. Why should I go through all that, yet I can do this [use timed unprotected intercourse] shortly and finish?"—*HIV-negative male partner, age 36*

"The husband has to [masturbate] in that container, that's where he collects his sperms. Then he has to put that sperm inside the woman so that it enters the uterus, where it is for the egg to be fertilized by the man's semen. There are some processes which you have to go through like sleeping facing up.... Yeah, it's hard to do and it's risky." —*HIV-positive female client, age 28*

Two of the five couples who used manual self-insemination had positive experiences and reported that they thought it was the best way for serodiscordant couples to conceive without transmitting HIV to the uninfected male partner. As one client explained:

"I personally didn't find any problem with using a syringe [for manual self-insemination].... Though at first I [assumed] it was very painful and thought it would even hurt me, I found out that [the syringe] is first of all small and very easy to use, yet [the method] is the safest for my husband. So he is more comfortable with this method than the other one [timed unprotected intercourse] which we first used."—*HIV-positive female client, age 36*

• ***Difficulty engaging partners.*** As noted earlier, because of the difficulty we had during the first pilot study in recruiting participants whose partner could attend counseling sessions, we changed the eligibility requirements so that clients in the second pilot study could participate without their partner. The primary obstacles to partner participation were conflicts between work and clinic schedules, and the long distances partners needed to travel to reach the clinic. In addition, the cost of transportation was sometimes a barrier. A female partner explained the difficulty she had getting time off from work to join her partner for counseling sessions:

"I usually have to first report at my workplace and then come. That is where time gets me and I fail to make it here early. I am at work and I fail to get [work out] how to escape."—*HIV-negative female partner, age 36*

It is unclear how frequently work schedules were a genuine barrier to inclusion; partners may have used work as an excuse to not participate in counseling. Some clients (particularly women) told us that their partner explicitly refused to participate. As two women reported:

"He told me that he will never step here if I have not conceived. He will only come when I am pregnant and he is escorting me to see the doctors."—*HIV-positive female client, age 38*

"He is [HIV-]negative, and he is only interested in me getting a child but not coming with me."—*HIV-positive female client, age 35*

Some couples decided that the male partner would forego counseling because he had the opportunity to earn money. For example, one female client explained:

"Sometimes [my partner] is at work, and most of the time he is employed by others. So for me I usually come here [alone] because I am [HIV-]positive, [and] he stays back looking for some money to support me to come to the hospital."—*HIV-positive female client, age 32*

• *Fear of HIV infection.* Although additional concerns were evident among participants who used timed unprotected intercourse, the main issue they raised regarding this method was fear of transmitting HIV to the uninfected partner. Participants—especially those who had attended counseling sessions with their partner—said that the sessions were useful in alleviating such fears. An HIV-positive client described his experience thusly:

"She [the partner] first got scared, because she thought that she was going to contract the virus in the process. I came back and told the counselor that when I told [my partner] about the methods, she got scared. The counselor invited both of us and we came. She [the counselor] explained to her. They remained in the room alone, and I don't know what they discussed, [but] my wife accepted [agreed to try to conceive using safer conception methods] at the end. Then we counted the days.... I think that her mind was always thinking about contracting the virus after removing the condom. The very first time, she was able to see the signs [of ovulation] and truthfully told me but when she did, she actually spent [those] three days observing them. But one day she refused [to try to conceive] and I did not force her. I left it at that."—*HIV-positive male client, age 33*

In addition to worrying about the risk of transmission, HIV-negative partners had concerns related to the possible premature death of the HIV-positive partner. For example, an uninfected male partner reported:

"The problem is that she did not want me to get involved in any other risk [by having unprotected sex]—however small [the risk] is, she did not want it because she said if one of us survives, he [or she] will take care of the children."—*HIV-negative male partner, age 35*

DISCUSSION

This pilot intervention to deliver safer-conception counseling to men and women living with HIV empowered participants to make informed choices regarding their childbearing desires. Counselors were able to engage clients who wanted children in a process that enabled them to consider their health status and partner-related issues (HIV disclosure, partner HIV testing) and to assess whether their partner was willing to use a recommended safer-conception option. Participants noted that the counseling helped them choose the options that were best for them and their partner. Counseling also facilitated some couples' decision to delay or forego childbearing and utilize family planning—either for health reasons or because one of the partners did not desire children at the time.[28]

Safer-conception counseling not only helped couples affected by HIV to make informed decisions regarding their options, but enabled them to face some challenging relationship issues and, in some cases, improve their relationship. Counselors helped couples develop a better mutual understanding of their desires and of safer-conception methods. Ovulation counseling was particularly important in enabling couples to work together in their attempts to conceive, and provided concrete ways for partners to support the HIV-infected client. In addition, counselors provided ongoing support as couples used their chosen safer-conception method or switched to a different method. Participants further noted that the counseling helped them better understand the importance of adhering to antiretroviral treatment, obtaining care for STIs and continuing to use condoms when pregnant or when not trying to conceive—strategies that are critical to reducing the risk of HIV transmission. Contrary to previously published reports of providers' concerns that timed unprotected intercourse encourages couples to not use protection during nonprocreative sex,[4,6] HIV-infected clients in our study noted that the information they received helped them adhere to provider recommendations rather than just do what they wanted or preferred.

However, clients faced challenges as they sought safer-conception counseling. Some clients had difficulty getting their partner to attend counseling sessions because of conflicts between work schedules and clinic hours. The need to travel long distances to reach the clinic was also an obstacle. Some partners (most of them male) simply refused to attend the counseling sessions. Partner engagement will be an ongoing challenge in safer conception counseling and is no doubt shaped by gender disparities and inequalities in reproductive care and responsibilities, which in most (if not all) cultural contexts falls to women.[9–11]

Participants generally preferred timed unprotected intercourse because it was less complicated to use than manual self-insemination, although some couples were concerned about the (minimal) risk of HIV transmission to the seronegative partner.[25] Although manual self-insemination, unlike timed unprotected intercourse, eliminates the risk of transmission to an uninfected male partner, only a few of the couples who were eligible to use the method were comfortable doing so. Mmeje and colleagues reported that this method was considered acceptable and feasible to participants in a pilot study conducted in Kenya.[29] Use of manual self-insemination may be low in part because many women likely lack the power to persuade male partners to use this method. Studies have found that men resist use of condoms for safer sex;[30,31] similar gender dynamics may be at play in the use of manual self-insemination, which requires male cooperation.

Limitations

Our findings are from small pilot studies that focused on couples who desired to have children. Unfortunately, the first study excluded clients whose partner could not take part in counseling, which made it difficult to recruit participants, although the second study addressed this limitation. Participants' reports of their experiences with safer-conception methods, particularly timed unprotected intercourse, may have been susceptible to social desirability bias. Furthermore, we did not assess whether participants used timed unprotected intercourse correctly. Accurately determining

the timing of ovulation and the duration of peak fertility is a challenge for couples who want to use this method; in future studies, a comprehensive, detailed assessment could be used to determine if the method is used correctly.

In addition, the study results apply only to people who are receiving HIV care and intend to conceive with their partner, and are not generalizable to other populations. Individuals who are not receiving HIV care may be less likely than those who are receiving care to be familiar with safer-conception methods. Future safer-conception counseling efforts should engage a larger cohort and track outcomes over an extended period to assess rates of conception, miscarriage, birth and HIV transmission to partners and children.

Conclusions

This pilot intervention demonstrated that safer-conception counseling provides clients with support they need to make informed choices as they try to conceive. Participants in our study faced challenges in getting partners to attend the counseling sessions, but were still able to use the counseling and support provided at the clinic to engage partners at home and use their safer-conception method of choice, mirroring previously reported work.[27] Given our findings that safer-conception counseling is feasible and acceptable to clients, research is needed to rigorously evaluate such an intervention in a controlled clinical trial and to further assess its ability to promote correct use of safer-conception methods, reduce horizontal and vertical transmission, and foster healthy pregnancies and births. Despite the availability of safer-conception guidelines since June 2011[19] and calls to train providers in safer-conception counseling,[5,6,12,13] we have not seen routine adoption and implementation of such counseling in any context. Policymakers need to review the research conducted to date and develop policies for the implementation of safer-conception counseling in routine care for people living with HIV.

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RESUMEN

Contexto: *La consejería sobre concepción más segura podría ayudar a que las personas que viven con VIH reduzcan el riesgo de transmisión a sus parejas e hijos. Sin embargo, dicho tipo de consejería rara vez se ofrece o se evalúa en los países de bajos ingresos.*

Métodos: *Entre 2014 y 2015, se condujo una serie de entrevistas cualitativas en profundidad en una clínica de VIH en Uganda, con 42 clientes VIH positivos y 16 parejas no infectadas que habían participado en una intervención de consejería sobre concepción más segura, dirigida a parejas serodiscordantes con intención de tener un hijo. Los participantes asistieron a hasta seis sesiones de consejería mensuales en las que recibieron instrucción y soporte continuo sobre el uso del método de concepción más segura de su elección. Se usó análisis de contenido de las transcripciones de las entrevistas para identificar los temas relacionados con los beneficios y desafíos de la consejería sobre concepción más segura.*

Resultados: *Casi dos tercios de los participantes consideraron que la consejería sobre concepción más segura fue una experiencia empoderadora que les permitió tomar decisiones informadas en relación con la procreación, aprender a concebir de manera segura y comprender la forma de permanecer saludables mientras trataban de concebir. El coito programado sin protección fue el método de concepción más seguro que se usó con mayor frecuencia. Siete parejas tuvieron embarazos exitosos sin que ningún miembro no infectado de la pareja sufriera seroconversión. Las principales preocupaciones y los principales desafíos de los participantes en relación con la consejería y el uso de método fueron algunos problemas con la autoinseminación manual, dificultad con la participación de parejas y temor a la infección por VIH.*

Conclusiones: *La consejería puede ayudar a personas infectadas con el VIH a tomar decisiones informadas sobre la procreación y los métodos de concepción más seguros; sin embargo, es necesario un ensayo clínico controlado para determinar si los clientes usan tales métodos de manera correcta y para evaluar las tasas de embarazo y de transmisión del VIH. Quienes formulan las políticas deben considerar la inclusión de consejería sobre concepción más segura como parte de la atención rutinaria del VIH.*

RÉSUMÉ

Contexte: *Le conseil pour une conception à moindre risque peut aider les personnes vivant avec le VIH à réduire le risque de transmission à leurs partenaires et à leurs enfants. Ce conseil est cependant rarement offert ou évalué dans les pays à faible revenu.*

Méthodes: *En 2014–2015, des entretiens qualitatifs en profondeur ont été menés dans une clinique VIH ougandaise avec 42 clients séropositifs et 16 partenaires non infectés qui avaient participé à une intervention de conseil pour une conception à moindre risque à l'intention des couples sérodiscordants désireux d'avoir un enfant. Les participants ont assisté à un maximum de six séances de conseil mensuelles durant lesquelles ils ont reçu des instructions et un soutien continu dans leur pratique de la méthode de conception à moindre risque de leur choix. Les thèmes émergents concernant les avantages et les difficultés du conseil pour une conception à moindre risque ont été identifiés par analyse de contenu des transcriptions des entretiens.*

Résultats: *Presque deux tiers des participants voyaient dans le conseil pour une conception à moindre risque une expérience enrichissante qui leur avait permis d'effectuer leurs choix de procréation en connaissance de cause, d'apprendre comment concevoir sans risque et de comprendre comment rester en bonne santé pendant leur période de tentative de conception. Les rapports sexuels non protégés calculés au bon moment étaient la méthode la plus fréquente. Sept couples ont eu une grossesse réussie et aucune séroconversion de partenaire non infecté n'a été observée. Les principales préoccupations et difficultés des participants concernant le conseil et la méthode avaient trait à l'insémination artisanale, la difficulté d'engagement des partenaires et la peur de contracter le VIH.*

Conclusions: *Le conseil peut aider les personnes séropositives à opérer des choix éclairés en matière de procréation et de méthodes de conception à moindre risque. Un essai clinique contrôlé est cependant nécessaire pour déterminer si les clients*

pratiquent correctement ces méthodes et évaluer les taux de grossesse et de transmission. Les décideurs politiques doivent envisager l'inclusion du conseil pour une conception à moindre risque dans le cadre des soins ordinaires du VIH.

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