# ASSISTING WOMEN LIVING WITH HIV TO MEET SEXUAL AND REPRODUCTIVE NEEDS: A CHALLENGE TO HEALTH CARE PROVIDERS

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## ABSTRACT

Women living with HIV have unique sexual and reproductive health needs, because they are more vulnerable to certain sexual and reproductive problems than people who are not infected with HIV. This paper identifies the area of sexual and reproductive need of women living with HIV and the ways that the health care providers can assist them by providing needed health services. These areas include: Sexual and reproductive health counseling, advocating for condom use, child delivery care and assisted conception for positive couples. Recommendations include: Efforts to reduce stigma and discrimination from health providers as well as the general public will be important in scaling up access to the sexual and reproductive health services. Health providers should also be committed to giving complete information to HIV positive women regarding their sexual and reproductive possibilities.
**Keywords:** Women, HIV, Reproductive needs.

## INTRODUCTION

HIV (Human Immuno Deficiency Virus) is a very small germ that causes AIDS (Acquired Immune Deficiency Syndrome). It destroys the defense of the body (Immune System). Most people living with HIV can be active and productive members of the society, especially when given the necessary support (Okoh, 2006).

Yinka Jegede-Ekpe is widely recognized as the first Nigerian to speak out publicly about her HIV-Positive status. At 19 years old, she told her story to a newspaper. Her boyfriend who had promised to marry her just absconded because of the stigma. Even her best friend in the nursing school refused to eat with her, another student hid the key to the toilet, so she wouldn't be able to use it. In her words "Everybody had me isolated" (http://www.ledpa.org).

According to Abraham Maslow's theory of human needs, there are two major categories of human needs. These are the 'basic needs' and the 'meta needs'. Included in the basic human needs are the desire for love and affection, sex, security and esteems. Maslow insisted that when these needs are not met, an individual will not attainself actualization (Abanobi, 2005).

Oko (2006) defined sexual pleasure as the physical and psychological satisfaction and enjoyment one derives from any erotic interaction. In most ways, the sexual and reproductive health related needs of HIV positive women are not absolutely different from those not infected with HIV. Nevertheless, women living with HIV have important, specific sexual and reproductive health related needs. This is because, they are more vulnerable to certain sexual and reproductive problems than people who are not infected, thus demanding more health care services in that regard. According to Logie Gaballa (2008), HIV affects

women's fertility reducing it to as much as 25 – 40%. This may be fore a verity of reason from co-infection with other sexually transmitted infections to increased rates of spontaneous abortion. Another reason for the reduction of fertility in women with HIV is stigma. This has already been shown to be a problem in the case of prevention of mother to child transmission, where women have expressed fear of being tested. In the same way the use of formula feeding rather than breastfeeding can become a problem for fear of being identified as a HIV positive person (Kola and Jennifer, 2003).

Assisting women living with HIV to meet their sexual and reproductive health needs is therefore a serious need especially as regards to providing equitable care and support for those infected by HIV. This is one of the items in the overall goal of the National Policy on HIV and AIDS in Nigeria (Federal Government of Nigeria, 2004).

The objective of this paper is therefore to identify the area of sexual and reproductive needs of the HIV positive people and discuss ways the health providers can assist them to adopt safe sex methods and have access to information necessary to live healthy sexual and reproductive lives.

Sexual and Reproductive Needs of Women Living with HIV Women living with HIV are more prone to pre-cancerous cervical cell abnormalities. In addition, people with HIV have some unique sexual and reproductive health needs, including treatment and support to reduce the risk of HIV transmission in infants during childbirth and breastfeeding. Women with HIV may be under different pressures and expectations than other women as to whether or not they should have children, be sexually active or not. Researchers such as Kola, (2003) and Oko, (2006) have shown that one of the most pervasive and destructive experience for people living with HIV is the stigma and discrimination they experience within the health care setting. This takes the form of disparaging remarks and substandard service related to their HIV status (Margolese, 2004).

The attitudes of health care providers when promoting family planning and providing other sexual and reproductive health services to people with HIV, have a significant impact on how they determine their choices in relation to sexual and reproductive health (Ajuwon, 2001). This paper therefore provides ways that the health care providers can assist people living with HIV to access information necessary to live healthy sexual and reproductive lives. This include: Counseling, Condom Use, Child Delivery Care and Assisted Conception.

## SEXUAL AND REPRODUCTIVE HEALTH COUNSELING

Both men and women living with HIV need access to private space within facilities in which to discuss, with their partners, if they wish, on HIV and sexual and reproductive health issues with health service providers. Health care providers in many parts of the world are required to seek institutional guidance before offering reproductive options and services to positive people, when positive person requests access to reproductive health technology where available. Ethical guidelines should be given to help decision making in the needed services such as sperm-washing or infertility treatment to HIV positive persons.

According to Okoh (2006), Counseling is mandatory for providing reproductive health services. This is because diagnosis of HIV in an otherwise healthy individual induces a series of psychological reactions like denial, anger, anxiety, depression, to final acceptance. Counseling is very necessary to help the individual accept the infective status, carry on with life, plan for future, prevent transmission and continue to function as a useful member of the community. Counseling induces a positive attitude and high life force in the individual helping him to carry on as before in spite and irrespective of the HIV infection. The health care provider must have a sympathetic ear, be ready to give time to listen, have knowledge of accurate scientific facts about HIV and AIDS and very importantly undergo systematic and periodic training in HIV counseling.

To obtain maximum co-operation and reasonable response from people living with HIV during sexual and reproductive health counseling, the following should be considered:

- The time should be convenient and adequate for effective transfer of information and behaviour modification.
- The counselor should accept and expect a consequent emotional reaction of clients and spouses.
- The counselor should be available and easy to reach.
- Trust and confidentiality is a basic principle required in counseling and trust is necessary for the maintenance of good counselor-client relationship.

## ADVOCATING FOR CONDOM USE

The health care provider should start with a realistic attitude about why people have sex. This requires honesty and up front messaging that helps people to have better and safer sex. Many people are only aware of the male condom. The health care provider should encourage the use of the female condom. Efforts to eroticise condoms require detailed discussions about how to make condoms use feel better. Many people find the deeper penetration of the female condom's inner ring to be super-stimulating. A woman can insert the female condom while her partner watches. Female condoms can also be used vaginally and anally by removing the inner ring and placing the condom over the penis before penetrating. It is important to note that oil-based lubricants do not damage the female condom the way they do male condoms because female condoms are made of polyurethane rather than latex. So any oil or water-based lube can be used. The health care provider, in promoting condom use for HIV patients should try to keep the focus on pleasure and sex rather than disease. It is also necessary to eliminate messages and attitudes that promote shame or fear about sex, sexual preference or pleasure.

## DELIVERY CARE

Women living with HIV should not be kept separate from other women delivering their babies. The goal is to alleviate overall maternal and prenatal morbidity and mortality, including HIV testing and alternatives to breastfeeding where available. For the effectiveness of these interventions, there is an urgent need for improvements in primary health care, maternal and child health care services and skilled attendant at birth.

Lack of antenatal care, insufficient coverage of HIV testing during pregnancy and women's refusal to be tested, results in a significant number of pregnant women reaching delivery unaware of their HIV status. With the advent of rapid HIV tests, the health care provider uses the antenatal care time to diagnose HIV infection and may thus provide the necessary access to treatment. Rapid HIV testing has recently received attention as it is easier to perform and non laboratory health attendants can be trained to carry it out. According to Margolese, (2004), rapid test results can be ready in less than 30 minutes, enabling prophylactic intervention in pregnant women who test positive at delivery care. Health care providers should take special attention to provide adequate pretest counseling, and ensuring confidentiality of results.

According to the UNAIDS 2006, comprehensive HIV prevention report on the global AIDS epidemic, effective prevention of mother-to-child HIV transmission involves a combination of strategies. These include primary HIV prevention for women (including integration of HIV prevention into reproductive and sexual health services), prevention of unintended pregnancies in HIV-positive women, access to comprehensive antenatal care, promotion of voluntary HIV testing and counseling for pregnant women and their partners in antenatal and community-based settings, antiretroviral therapy for mother and newborn and counseling on strategies to reduce the risk of HIV transmission via breastfeeding. The above are serious tasks and challenges facing the health care providers.

Further report by UNAIDS has it that although pilot projects are currently delivery prevention services in antenatal setting; few countries have effectively scaled up such services. Globally, just less than 8% of pregnant women are currently offered services to prevent mother-to-child transmission of HIV (UNAIDS, 2006).

Timely administration of antiretroviral drugs to the HIV-diagnosed pregnant woman and her newborn significantly reduces the risk of mother-to-child HIV transmission. However, studies indicate that women who receive single-dose nevirapine to prevent transmission to their newborn, may develop resistance to the drug, potentially compromising the effectiveness of future antiretroviral regimen. Though the benefits of single-dose nevirapine outweigh the risk of resistance in resource-limited settings, development of affordable regimens with superior resistance profiles as an urgent global priority.

## ASSISTED CONCEPTION FOR HIV POSITIVE COUPLES

Delvaux and Nostlinger (2007) reported that the fertility of HIV positive women is lower than that of HIV-uninfected women in all but the youngest age groups. Determinants of lower fertility may be biological, demographic or behavioural. They include co-infection with other STIs, (Sexually Transmitted Infections). Example of which is Syphilis which puts women at higher risk of fetal loss and stillbirth. There is also evidence that men with more advanced HIV disease have abnormal semen and a decrease in semen volume.

Giving birth and having children play a significant role for the social and the personal identity of women in most, if not all cultures. Having this passion in mind, the health care providers gives her heart and time to help in any possibly way as to enable women living with HIV/AIDS to have their own live and healthy children. As access to antiretroviral treatment increases, and mother-to-child transmission rates decreases, having children can become a realistic option for many more HIV positive women. When people on antiretroviral treatment recover their health, their sexual activity may also increase. Assisted reproduction techniques for couples living with HIV are often successful and help to prevent HIV transmission in discordant couples. According to Delvaux Nostlinger (2007), some of the ways to assist include:

(a) If only the woman is HIV positive, insemination with the partner's semen eliminates the risk of infecting him. Insemination can be done at the home after colleting the sperm. The sperm can be inserted into the vagina or the health care provider inserting the sperm into the cervix of the woman. Antiretroviral treatment commences immediately pregnancy takes place.

(b) In occasion where only the male partner has HIV, there is no risk free method. The seminal plasma viral load can only be reduced while timing the ovulation time for prompt conception and reduced number of exposure. Insemination by donor sperm is also possible. However, several European centres and a few US groups offer sperm washing to HIV seropositive men and their HIV negative partners, followed either by intrauterine insemination or intracytoplasmic injection of sperm (ICSI) into oocytes with in vitro fertilization. Delvaux Nostlinger (2007) reports that from 1987 to 2005, more than 3,600 published attempts had been reported. A more recent report of 741 discordant couples in Italy had a 70% pregnancy rate and no infected infants.

(c) HIV positive concordant couples intending to become pregnant should target the conception time to time exposure. Health care providers should start adequate treatment for prevention of vertical transmission.

(d) Adoption is a good way of having children without running the risk of infection or the pain of carrying pregnancy. However, some cultures do not permit adoption. The health care provider should through counseling encourage the HIV couples to go for adoption. People living with HIV should have access to these existing options and be allowed to make their choices.

## RECOMMENDATIONS

Health care providers should be committed to giving complete information to HIV positive women regarding their sexual and reproductive possibilities. As much as possible desist from negative attitudes towards the sexuality of HIV positive women. Providers of sexual and reproductive health services should as much as they encourage condom use, laying emphasis on sexual pleasure and not on the disease or infection.

Efforts to reduce stigma and discrimination coming from the health providers as well as among the general public, will be important in scaling up both access to and use of antiretroviral therapy in many women. At the same time, increased access to care will serve to reduce stigma and discrimination as HIV loses its association with death and become redefined as a treatable chronic disease that most importantly, can also be coped with or managed.

Researchers should begin to research into the possibility of developing a vaccine that could be taken by HIV positive mothers and their breast milk will be free from the virus. When success is achieved in this area, HIV positive women will have a more psychologically and socially relaxed atmosphere while nursing and nurturing their children.

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