Exchange
ON HIV AND AIDS, SEXUALITY AND GENDER

Lina risked her life to enable her husband become a father

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Lina Tembe.

Lina Tembe, aged 28, is a mother living with HIV who resides in the outskirts of Maputo, the Mozambican capital city. Lina decided to become pregnant to demonstrate her love for her husband, who was sero-negative, and who had a great desire to be a father of a daughter.

They have since divorced. "I knew that I was HIV positive before I met my ex-husband. While we were dating, he did not believe that I was HIV positive. Together we decided to be tested and it was confirmed that I was positive and my ex-husband, negative", she says.

Their decision to live as husband and wife did not go down well with family members, she says, adding, they had no peace.

Lina did not have much information about safe ways to get pregnant while avoiding the risk of infecting the baby with HIV. But she says she took the risk for a noble cause. "I was discouraged to have a baby twice during my prenatal visits. On one occasion, the doctor told me that I had TB and advised me to have an abortion," she said.

It was only after contacting Doctors Without Borders (MSF) that it became clear to Lina and her husband how important it was to consult specialists before a discordant couple decides to have a child. Women living with HIV and AIDS should be aware of these risks when considering whether to have children and planning a family. Special counselling and support should therefore be provided to HIV-positive women planning a pregnancy, whether their partner is HIV-positive (seroconcordant) or HIV-negative (serodiscordant) .

"A woman living with HIV must seek medical consultation every six months to check the CD4 count to be able to establish whether it is safe for her to have a baby or not," says MSF nurse Colette Denis, who advised Lina. She added that the ideal time to get pregnant is when the CD4 count is high because the viral load is low.

Pregnancy may carry additional risks for an HIV-positive woman, both for her health and the infant's. Women living with HIV and AIDS should be aware of these risks when considering whether to have children and planning a family. Special counselling and support should therefore be provided to HIV-positive women planning a pregnancy, whether their partner is HIV-positive or HIV-negative.

Seroconcordant couples should be counselled to use condoms to prevent re-infection with another strain of HIV. When planning a pregnancy, they should be advised to attempt conception at fertile times of the menstrual cycle to limit exposure.

Couples in which a sexually-active woman living with HIV and AIDS has an HIV-negative male partner must engage in protected sex using a condom to ensure that the male partner remains uninfected. For those desiring children, various options should be discussed, including the possibility of adoption.

Artificial reproduction techniques can significantly reduce HIV transmission among discordant couples. To prevent female-to-male infection, artificial insemination can be used. Simple techniques to introduce sperm into the woman's vagina using a syringe or other clean receptacle during the fertile time of the menstrual cycle can provide a means to conceive without infecting the male sexual partner.

Lina did not accept the doctor's advice to abort. She explains: "I did this because this was our only opportunity to have a daughter; my husband and I decided to keep the pregnancy. I then stopped the treatment of TB so as not to harm the foetus."

Lina appreciates the role played by her ex-husband, his family and hospital staff until delivery through caesarean section. "I was very happy when I was informed that my daughter was born healthy, "she said.

Lina is getting TB treatment and is also on ARVs

The risk of mother-to-child transmission of HIV is low for HIV-infected mothers, who take anti-HIV medications during pregnancy and have a viral load less than 1,000 copies/mL near the time of delivery. For some HIV-infected mothers, a scheduled caesarean delivery at 38 weeks of pregnancy can reduce the risk of mother-to-child transmission of HIV.

If a woman's birth waters break or she goes into labour, it is unclear if a caesarean delivery will still reduce the risk of mother-to-child transmission of HIV. Depending on an individual woman's situation, a vaginal delivery may be an alternative to a planned caesarean delivery. Regardless of type of delivery, healthcare providers should ensure that the baby is not exposed to the HIV-

infected mother's blood. This reduces the risk of mother-to-child transmission of HIV.

A week after birth, the mother is encouraged to come for consultation, Colette says. It is then that counselling on prevention of vertical transmission and maintaining exclusive artificial feeding or breastfeeding is given.

Lina being HIV positive and nursing TB opted for exclusive formula feeding to avoid HIV transmission to the child. Often, decisions to breastfeed are influenced by the HIV-related stigma associated with women who do not breastfeed and cultural ideas concerning what behaviour constitutes 'proper motherhood'. For example, even when women know the potential risks associated with breastfeeding, they may fear that not to do so will provoke comments among neighbours.

The wide use of modern ARVs has extended the lifespan of HIV patients, and modern techniques have radically reduced the risk of transmission from father- to- mother, or mother- to- child. Research published in the journal, *Human Reproduction*, was carried out by Dr Jeanine Ohl at the Centre d'AMP de Strasbourg about assisted reproduction techniques on 57 couples in which at least one partner had HIV. Sperm from the HIV positive men was "washed" to virtually eliminate the chance of the virus being transmitted. A third of the 39 couples in which the man was HIV positive managed to conceive a baby this way.

However, only one of the HIV positive women became pregnant, although standard and normally highly successful in vitro fertilisation (IVF) techniques were used. IVF is a process by which egg cells are fertilised by sperm outside the body. Some research has found evidence of premature ovarian failure in infected women although this would need confirming in a larger study. Dr Simon Gregson from Imperial College London has studied the fertility of HIV positive women and says there is now firm evidence that they find it harder to conceive. He said: "Some studies have suggested that fertility is reduced by as much as 30 to 40 per cent. He added: "It is possible that the

virus is more easily transmitted to a woman who has had an STD which has already damaged her fertility. But the virus itself may be causing an extra effect. "

After 18 months, Lina's baby was tested for HIV at the Children's Consultation on Risk (CCR) and the result was negative. "It was not easy to get the baby tested for HIV. The 18 months we waited for the test results were very stressful," she says.

A major challenge in the prevention of vertical transmission is that HIV-positive mothers find it hard to accept their condition and share their results with their husbands and relatives. Many women are afraid of creating problems at home, she says.

Evidence gathered by International Community of Women Living with HIV/AIDS (ICW) indicates that exclusive breastfeeding or exclusive feeding with milk-alternatives, rather than mixed feeding, is effective in reducing mother-to-child transmission of HIV.

Researchers at the Africa Centre, University of KwaZulu-Natal, found that there was a four per cent risk of postnatal transmission to infants solely fed on breast milk between the age of six weeks and six months. The 2007 research, published in The *Lancet*, found that infants who received formula milk or animal milk in addition to breast milk were nearly twice as likely to be infected as infants who received breast milk only. The mucous membrane within the intestine is thought to act as an effective barrier to HIV infection. Breast milk ordinarily strengthens and protects this lining.

ICW adds that HIV positive women rarely receive correct information about feeding options and alternatives to breast milk, or advice about complications such as sores in the baby's mouth or breast inflammation. According to this evidence, the cost of alternative sources of milk often also puts this choice out of the reach of many women.

According to WHO, pregnancy may carry additional risks for an HIV-positive woman, both for her own health and the infant's health and therefore such women should be aware of these risks when considering whether or not to have children. Those planning a pregnancy, whether their partner is HIV-positive or not, need special counselling and support.

The UN agency adds that seroconcordant couples should be counselled to use condoms to prevent re-infection with another strain of the virus. When planning a pregnancy, they should be advised to attempt conception at fertile times of the menstrual cycle to limit exposure. Where a sexually active woman living with HIV and AIDS has an HIV-negative male partner, they must use a condom to ensure that the male partner remains uninfected. For those desiring children, various options should be discussed, including the possibility of adoption.

Guidelines from the Office of the United Nations High Commissioner on Human Rights and UNAIDS state that "The HIV status of a parent or child should not be treated any differently from any other analogous medical condition in making decisions regarding custody, fostering or adoption"

Above all, HIV positive women have the right to make informed voluntary decisions about having children or not and the right to healthy motherhood. But to be able to do this, they need non-judgemental, confidential support, services and advice on contraceptives, conceiving, child bearing and rearing that will enable them to make informed decisions about whether or not to have children and how to rear them. ■

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