***Sexual and reproductive health needs and experiences of (recently) pregnant women living with HIV in Mexico***

## Introduction

Globally, women represent almost half of the 40 million people who are currently living with HIV. Given the higher economic, socio-cultural, and psychological vulnerability of women to HIV infection it is likely that the proportion of woman living with HIV/AIDS (WLHA) will continue to rise in many regions of the world, as has been observed in Sub-Saharan Africa and the Caribbean (EngenderHealth/UNFPA 2006; UNAIDS 2006). The epidemiology of HIV/AIDS is closely related with sexual and reproductive health (SRH), particularly given increased rates of mother to child transmission and the increased occurrence of heterosexual transmission of the epidemic in Mexico over the past decade (CONASIDA 2006; WGNRR 2007). Furthermore, many factors that increase susceptibility of contracting HIV disproportionately impact women (Hirsch, Menses, Thompson, Negroni, Pelcastre, del Rio, 2007) and are the same those that result in deficient reproductive health outcomes including inequity, gender-based violence, poverty and social marginalization (Population Council 2007).

Prior studies indicate that the sexual and reproductive health (SRH) needs of people living with HIV in developing countries, particularly HIV infected pregnant women, are not adequately met for a variety of reasons: stigma and discrimination, bias and prejudice of health providers, lack of integration of services, and overall poor quality of SRH services (Population Council 2007, Ipas 2005, Kendall 2004). A recent multi-country assessment of SRH for WHLHA concluded that access to family planning services, contraceptives, post-exposure prophylaxis (PEP) and emergency contraception (EC) was still limited for WLHA; availability of assisted conception methods or options for legal adoption by HIV infected people were often unaddressed; stigma and discrimination against WLHA still existed in the healthcare sector; and that WLHA were largely uninvolved in local or national policy and program formulation, design and evaluation (Ipas 2005).

The objective of this study is to investigate the experience of pregnant and recently pregnant HIV infected women in Mexico with the range of SRH services including, gynecologic, family planning, and obstetric services, and to identify sexual and reproductive health needs of these Mexican WLHA.

## Data and Research Methods

The qualitative investigation was comprised of semi-structured in-depth interviews with a total of 31 WLHA, 27 of which had been pregnant in the past five years and 4 who were currently pregnant. Women in the study were included regardless of result of the pregnancy: carried to term, spontaneous abortion, or induced abortion. The study population was comprised of women from different geographic sites across Mexico including Mexico City, the rural central region (Guanajuato state), the border region (Baja California state) and the southeast region (states of Chiapas and Veracruz). These regions were selected because they represent differing levels of HIV prevalence as they range from the highest in Mexico City (236.9 per 100,000 inhabitants) and Baja California (166.4 per 100,000 inhabitants), to relatively low in Guanajuato (53.1 per 100,000 inhabitants) (CONASIDA, 2008). Furthermore, the Guanajuato site, with traditionally high rates of migration to the United States, provides a case in which to

explore the demonstrated association between the HIV and migration (Magis-Rodriguez, 2009). Participants were recruited at health centers and through non-governmental organizations (NGOs) that which provide health services for women living with HIV. All participants provided written informed consent for the interview. Participants could use pseudonyms during the interviews. To maintain the participants' confidentiality, the collected information was identified by numbers. The interviews were audio-recorded; the recorded files were deleted after analysis was completed. Simultaneously, basic socio-demographic and HIV characteristics were measured using a quantitative instrument. The study instrument was piloted with prior to administration and altered when necessary to ensure internal validity. The field work was completed in the period between September 2008 and April 2009.

Four researchers analyzed the transcripts and field notes of the interviews using content analysis, according to a set of pre-defined themes and categories as well as new categories that emerged from the interviews. We were confident that saturation had indeed been reached with the sample size we had recruited initially, and therefore did not extend our sample.

The protocol of this comprehensive study was approved by the Internal Review Board (IRB) of the Population Council and the Ethical Review Committee of CENSIDA (*Centro Nacional para la Prevención y Control del SIDA* - National Center for AIDS Prevention and Control) in Mexico.

**Findings**

The findings of this qualitative study both confirm the findings of research in other developing country contexts of the SRH situation of WLHA and highlight new issues and barriers faced by Mexican WLHA. This study corroborates that access to non-coercive family planning services, contraceptives and emergency contraception is limited for WLHA and stigma and discrimination against these women is extremely prevalent in the Mexican healthcare sector.

Regarding family planning and contraception, women reported having knowledge of condom use as a HIV/AIDS prevention method (both for discordant couples and to prevent re-infection) and method of family planning; however many reported inconsistent usage, partners who refused to use condoms, and failure of method. Contraceptive knowledge and dispensation depended on provider in that HIV specialty physicians promoted condom use only without offering other options; whereas OB/GYNs promoted tubal ligation for pregnancy prevention, and in some cases pressured and coerced women to agree to the procedure, including cases of consent obtained in unethical manner. Methods of contraception other than tubal ligation and condoms were rarely presented as options to participants and information regarding emergency contraception was also absent from the discussion on other methods of family planning.

Discrimination among health providers, both physicians and other health workers, on the basis of participant's HIV positive status was reported by women in all regions where the study was conducted. Some discrimination included derogatory comments about participant's sexuality, negligence of physicians and nurses, isolation in maternity sections of hospital, and blatant disregard of patient's questions about HIV. Personnel in three different sites breached confidentiality, including divulging patient's status to other members of the community. This pervasive reporting of discrimination within the health

sector extended to nurses and non-primary providers as well. As a result of the prejudice from health providers, some HIV infected women reported that fear of future discrimination proved to be a reason to not disclose HIV status to health providers with whom participants did not have an established relationship.

Furthermore, this study examined pregnancy management decisions and fertility desires of WLHA in Mexico. Nearly of WLHA who participated in this study decided to carry pregnancy, after HIV positive diagnosis, to term. Some of the principal reasons for this decision were a planned pregnancy, influence of faith, fear of abortion procedure, and in some cases provider influence. Intentions behind most recent pregnancies were varied. Some pregnancies were planned and women consulted assistance from doctors who managed their HIV care, others were planned prior to diagnosis, and some were unplanned but abortion was not considered as an option. Those who influenced the pregnancy management decision included partners and health providers, in which multiple forms of coercion were reported and included direct coercion not to abort, intentional misinformation and misrepresentation about risks of birth and resulted in an undesired abortion and a threat to deny care if WLHA did not abort.

Overall, women reported good quality of information and care by HIV specialists, except one particular physician in one study site. However at local health centers and non-specialty personnel who WLHA have encountered after diagnosis, prior to being referred to specialty centers were the most discriminatory, insensitive and uninformative. The perceived level of provider knowledge and quality of patient counseling varied considerably between study sites. In some sites participants remarked that their current provider was knowledgeable about HIV and responsive to their concerns, while in other sites women noted that their doctors were neither knowledgeable nor attentive to their needs, particularly in the Tijuana site.

Fear, stigma and discrimination are pervasive throughout the lives of WLHA in Mexico and impact the economic and psychological well-being of this population. Women report facing discrimination in the workplace, community, and from sexual partners which result in a decreased quality of life. Participants report an ever-present fear that others will discriminate against them and their children because of their HIV status. Women in multiple research sites reported that since being diagnosed with HIV they had abstained from sex for fear of re-infection among concordant couples or transmission among discordant couples. Fear, stigma, and discrimination impacted the fertility desires of HIV positive women particularly in the respect that many (women, health providers, and society as a whole) still firmly believed that the woman was irresponsible and certainly going to transmit the virus to the unborn child.

This study also highlighted complicating factors such as intimate partner violence (IPV). There was an increased prevalence of IPV among study sample of WLHA in all regions in which the study was conducted and included physical, sexual, and emotional violence. Approximately 40.9% of women in this sample reported ever having forced sexual contact 22.7% reported ever having forced sexual intercourse. Over 40% of women reported that sharing their HIV status resulted in emotional or psychological violence and for 9.1% the disclosure resulted in physical violence.

## Conclusion

Mexican WLHA cope with a series of problems when seeking sexual and reproductive health services. The majority of women had received limited or no counseling on contraceptive use (except for condoms and tubal ligation). Providers generally reacted negatively towards WLHA with fertility desire, sometimes pressuring women to have an abortion. Women were given very basic information on prevention of mother-to-child transmission. There is a strong need for better information and counseling to WLHA, sensitivity training for providers and improved HIV/SRH service integration.

## Table 1—Background Characteristics

| | n | % | Mean | Standard Deviation |
|---|---|---|---|---|
| ***Age (n=31)*** | | | 30.55 | 6.021 |
| *19-24* | 4 | 12.8 | | |
| *25-29* | 9 | 29.1 | | |
| *30-34* | 11 | 35.4 | | |
| *35-39* | 5 | 16.1 | | |
| *40-43* | 2 | 6.5 | | |
| ***State of Residence (n=31)*** | | | | |
| *Guanajuato* | 12 | 38.7 | | |
| *Mexico City* | 9 | 29.0 | | |
| *Chiapas* | 4 | 12.9 | | |
| *Estado de Mexico* | 3 | 9.7 | | |
| *Baja California* | 2 | 6.5 | | |
| *Veracruz* | 1 | 3.2 | | |
| ***Civil Status (n=30)*** | | | | |
| *Married* | 6 | 19.4 | | |
| *Unmarried cohabiting* | 15 | 48.4 | | |
| *Single* | 3 | 3.2 | | |
| *Divorced* | 1 | 3.2 | | |
| *Widowed* | 4 | 12.9 | | |
| *Separated* | 3 | 9.7 | | |
| ***Age at first Marriage/ Entry into Sexual Union (n=30)*** | | | 18.03 | 3.222 |
| *13-14* | 3 | 9.7 | | |
| *15-19* | 21 | 80.6 | | |
| *20-24* | 4 | 13.0 | | |
| *25-29* | 2 | 6.4 | | |
| ***Number of Children (n=30)*** | | | 2.37 | 1.066 |
| *1* | 6 | 20.0 | | |
| *2* | 12 | 40.0 | | |
| *3* | 9 | 30.0 | | |
| *4* | 1 | 3.3 | | |
| *5* | 2 | 6.7 | | |

**References:**


Bautista-Arredondo, S. Et al. Economic impact of antiretroviral therapy prescription decisions in the context of rapad scaling-up of access to treatment: lessons from Mexico. *AIDS* 2006, 20:101-109

Bruyn de, M. Reproductive choice and women living with VIH/SIDA Ipas 2002

CONASIDA; Casos nuevos y acumulados de SIDA por año de diagnóstico, por entidad federativa [New and accumulated cases of AIDS by year of diagnosis and state]. http://www.salud.gob.mx/conasida/estadis/2007/entidadfederanoviembre.pdf (accessed Jan 2008)

de Bruyn, M. (2002) Reproductive choice and women living with HIV/AIDS. Chapel Hill, North Carolina; Ipas

EngenderHealth/UNFPA; *Sexual and Reproductive Health Needs of Women and Adolescent Girls living with VIH. Research report on Qualitative Findings from Brazil, Ethiopia and the Ukraine.* July 2006

Hirsch, J.S., Meneses, S., Thompson, B., Negroni, M., Pelcastre, B. & del Rio, C. (2007). The Inevitability of Infidelity: Sexual Reputation, Social Geographies, and Marital HIV Risk in Rural Mexico. American Journal of Public Health. 2007 97(67) 986–996.

Infante, C. et al. HIV/AIDS related stigma and discrimination: the case of health care providers in Mexico. Salud Publica de México, 2006 Mar-Apr;48(2):141-50

Ipas; *Reproductive rights for women affected by VIH/SIDA? A project to monitor Millennium Development Goals 5 and 6.* Ipas USA, 2005

Kendall T and Pérez-Vázquez H. Hablan las mujeres mexicanas VIH-positivas : Necesidades y apoyos en el ámbito médico, familiar y comunitario [Mexican HIV postive Women Speak: Needs and support in a medical, family and community enviornment]. Mexico City, Mexico: Colectivo Sol, 2004: 92-108.

Magis-Rodríguez, C., Lemp, G., Hernandez, M.T., Sanchez, M.A., Estrada, F.& Bravo-García, E. Going North: Mexican Migrants and their Vulnerability to HIV/AIDS. *Journal of Acquired Immune Deficiency Syndrome* 2009 51 21–S25

Population Council Reproductive Health and Rights of HIV-positive Individuals: Establishing a Global Program. New York: Population Council 2007