Research Update

In the United States, women make up 30 percent of all new HIV cases; 85 percent of these women are between the ages of 13 and 44, that is, of “childbearing” age. As HIV treatments have improved, it is likely that HIV-positive women of childbearing age are more often considering parenthood. In the early stages of the epidemic, the rate of “vertical” transmission—that is, HIV transmission from HIV-positive mothers to their infants during pregnancy, during delivery, or after delivery—was at least 25 percent in the United States. By 1999, rates of vertical transmission had dropped to less than 2 percent. Researchers now estimate that vertical transmission can be prevented in 99 percent of all cases. Among children, however, vertical transmission is still responsible for 90 percent of all pediatric HIV infections in the United States, and HIV is the seventh leading cause of death among children 1 to 4 years old.

Despite the availability of successful prevention methods, the risk of vertical transmission remains. This is especially true for HIV-positive women who do not know their HIV status, are not fully informed about their options when they are considering pregnancy, or do not get prenatal care or treatment for their HIV during pregnancy. Vertical transmission is a concern not only for women who are already HIV-positive. An HIV-positive male partner may transmit HIV “horizontally” to his HIV-negative female partner and she may then pass on HIV vertically to their fetus or infant. In addition, women in same-sex couples who are considering pregnancy also face concerns about horizontal and vertical transmission via insemination.

Research on Reproductive Health

The research on this topic includes data on intentions to have children, preventing and terminating pregnancy for HIV-positive women, the mechanics of vertical transmission, and the mechanics of horizontal transmission. There is some, but not much, research on the emotional issues women and their partners face when considering and responding to pregnancy. Still, the research on technical topics related to transmission builds a foundation for counselors to address the emotional concerns of their clients, including

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issues of domestic violence, and protects counselors from making uninformed judgments that may undermine client-centered counseling.

It is also important to keep in mind that in many of these study samples, women of color, particularly Black and Hispanic women, are disproportionately represented. In fact, of the women infected with HIV in 2003, 60 percent were Black, 20 percent were Hispanic, and 20 percent were White, although together Black and Hispanic women represent fewer than 25 percent of all U.S. women. Since Black and Hispanic women are more likely than White women to be HIV-positive, it makes sense that they would be better represented in studies that focus on HIV-related concerns of women.

**Intentions to Have Children**

People with HIV, both women and men, are more likely to think about having children than they used to be. A 1996 survey of seropositive adults found that the proportion of women who wanted to have children was smaller than that found in studies of women in the general population. Another study found that prior to effective HIV antiviral treatment, HIV-positive women were more likely to report elective abortions and less likely to report an intention to get pregnant than HIV-negative women. Since the dawn of improved HIV treatment, however, studies have noted a turnaround: HIV-positive women are no more likely to become pregnant and no more likely to terminate a pregnancy than uninfected women.

Although both women and men with HIV are thinking more often about having children, many women say they do not get the information they need to make informed decisions about conception. According to a 2001 Centers for Disease Control and Prevention (CDC) study of more than 55,000 women, 40 percent of women of childbearing age and 35 percent of pregnant women did not know that vertical HIV transmission could be prevented. This broad telephone survey was designed, weighted, and aggregated to produce unbiased estimates for the U.S. population. Other studies have found that HIV-positive women do not get sufficient information about contraception.

Women who are HIV-positive are often in a double bind: while society expects women to have children, the desire of HIV-positive women for children may also violate societal beliefs about “acceptable mothering,” because the assumption is that a parent who is terminally ill will not only face grave challenges because of her illness but will eventually leave her child alone. This attitude may continue today, even in light of the dramatic treatment-related reductions in vertical transmission. This double bind is reflected in other data that suggest that women in mixed status couples have higher levels of distress than the men in these couples about “reproductive dilemmas.” Further, a New York study of 50 mixed status couples found that more than half of both female and male respondents saw HIV as “an unyielding obstacle to starting a family.”

It is crucial to note the obvious fact that not all pregnancies are planned. Consequently, some women or couples may face reproductive decisions suddenly. In addition, many women do not learn that they are HIV-infected until they become pregnant, and some, not until they are in labor. Both of these realities may undermine the planning that is ideal for approaching both HIV and pregnancy. Finally, researchers have begun to study the association among women’s power in their relationships—either with partners or with family members—HIV risk and prevention, and reproductive choices. Power differentials may result in unplanned pregnancies, limited options for contraception or disease prevention, and lack of access to prenatal care or abortion. For example, women may not insist on using condoms because they fear male partners may abuse or leave them.

**Preventing or Terminating Pregnancy**

Contraceptive approaches range from barriers such as condoms and diaphragms to hormonal methods such as the pill. These approaches vary not only in terms of their contraceptive efficacy but also in their ability to prevent disease transmission.

The diaphragm and cervical cap, unlike male condoms and even female condoms, are more easily controlled by women but leave the vagina and penis exposed to HIV. Some researchers argue that insertion of the diaphragm and cap also can cause slight trauma to the vagina, increasing the risk of HIV transmission. Studies are testing whether the addition of newly developed microbicides applied to the cervical cap or diaphragm may protect against both HIV transmission and pregnancy. Nonoxynol-9, a spermicide that was very popular for HIV prevention in the 1990s, has been shown to be ineffective in preventing HIV transmission, and some studies have suggested that its use actually increases the risk of HIV infection.

Hormonal contraception—the pill, Norplant, and patches—is effective in preventing pregnancy, but it may increase the risk of HIV acquisition in women. A 10-year cohort study in Kenya found that hormonal contraception was “significantly associated” with increased risk for HIV, although it is unclear why this is true. In addition, some HIV antiviral drugs such as efavirenz (Sustiva) and ritonavir (Norvir) may reduce the efficacy of oral contraceptives.

Intrauterine devices (IUDs), which are also very effective in pregnancy prevention, may increase the risk of sexually transmitted disease and
pelvic inflammatory disease. The IUD threads may also cause slight trauma to the penis and increase HIV transmission from men to women. Finally, sterilization, while almost 100 percent effective in preventing pregnancy, has no effect on HIV transmission.12

Once a woman is pregnant, she may decide that she does not wish to continue the pregnancy. Some studies have found that as many as 90 percent of pregnancies in HIV-positive women are unplanned.18 There has been little research about whether HIV-positive women have an increased risk of complications following abortion.19 Some researchers have suggested that vacuum abortion should be used instead of curettage to decrease the risks of excess bleeding and infection. Abortion induced by medication also has significant side effects, including nausea, vomiting, and sometimes heavy bleeding.19

**Vertical Transmission**

Vertical transmission risk occurs only from an HIV-positive mother to her baby. There have been no reported births of an HIV-infected infant from an uninfected mother and an HIV-positive father.2 Moreover, paternal HIV infection does not increase the rate of vertical transmission from an HIV-infected mother to her fetus.

There are three points at which a mother may transmit HIV to her child: in the womb, during delivery, and while breastfeeding.20 According to one researcher, breastfeeding increases the risk of vertical transmission by 14 percent,21 but in the United States, since women with HIV are advised not to breastfeed, it is rare for them to do so. In the absence of breastfeeding, labor and delivery account for 60 percent to 75 percent of vertical transmission. Vaginal delivery is especially risky, because of contact between the infant’s skin and mucous membranes and the mother’s HIV-infected blood or secretions. Intrauterine transmission, which can occur across the placenta during the gestation period or during maternal-fetal exchange of blood, accounts for 25 percent to 40 percent of cases of vertical transmission.20

Reducing maternal viral load significantly reduces the risk of transmission to a baby in all stages of pregnancy, delivery, and breastfeeding.6 Pregnant women who choose not to use prophylactic drugs continue to risk a 25 percent chance of transmitting HIV during pregnancy.22 However, there are two caveats about treatment. First, vertical transmission can occur even when viral load is below the level of detection. Second, HIV antiviral treatment during pregnancy is complicated because while zidovudine (ZDV, AZT) alone substantially reduces the risk for perinatal transmission, monotherapy is not as effective as combination therapy in treating HIV in non-pregnant adults. Thus, combination treatment, which significantly reduces maternal viral load, is recommended to protect the health of both pregnant women and their fetuses.6,22 According to some studies, however, combination treatment may be more likely than ZDV monotherapy to lead to dangers for the fetus, although more research is needed to fully understand the risk of any of these treatments.6,21,22

Finally, a single oral dose of nevirapine (Viramune) given to mothers at the onset of labor and to infants two days after delivery is effective in reducing vertical transmission. But nevirapine is rarely used in the United States because its use often leads to viral resistance and future treatment failure for both mothers and infants who do become HIV-infected despite prophylaxis.

Pregnancy can exacerbate individual reactions to HIV-related treatment, making it even more imperative to closely monitor dosage and side effects. In particular, pregnancy may increase the likelihood of drug resistance and of complications related to medication toxicity such as diabetes mellitus and liver problems.6,22

Beyond antiviral treatment, elective cesarean section has been shown to significantly reduce the risk of HIV transmission during delivery by controlling fetal exposure to maternal blood and vaginal fluids.21,23 However, non-elective cesarean sections, especially performed once a woman’s membranes have ruptured, are not associated with a significant decrease in transmission compared with vaginal delivery. Further, cesarean sections have been shown to cause complications in both HIV-positive and HIV-negative women. Since a cesarean section can be risky and does not significantly reduce transmission in women with viral loads below the level of detection, the National Institutes of Health (NIH) recommends that only those women with viral loads above 1,000 near the time of delivery undergo this procedure.5

In developed countries, there are usually viable alternatives to breastfeeding, and HIV infection is the only circumstance in which the U.S. Department of Health and Human Services has stated an absolute contraindication to breastfeeding.21 In impoverished areas, however, breast milk, even with its risks of HIV transmission, may not be more dangerous than commercial formulas. Formulas require water and water supplies may be polluted. Further, formulas are expensive, and, when over-diluted, they may lead to malnutrition and death.24

While women with HIV are able to more safely become pregnant and have children, they also have the rights to choose whether or not to be tested, and, if HIV-positive, whether or not to get pregnant and whether or not to be treated. The NIH states that care should not be denied to, and no punitive measures should be taken against women who choose minimal or no HIV antiviral therapy during pregnancy.5

**Horizontal Transmission**

Mixed status couples who want children are willing to risk unprotected sex—and HIV transmission to each other—in order to conceive, according to several studies.1 It is important to note that this population may include both opposite sex and same sex couples, for example, lesbian couples seeking to conceive...
mixed status couples seeking to conceive may consider “assisted reproductive techniques,” which some researchers describe as lowering the chance of horizontal transmission to “almost negligible rates.” Among these methods are: sperm washing, in which sperm are separated from the seminal fluid; and the “swim up” method, in which the healthy sperm swim up into a new semen-like solution and dead sperm, white blood cells, and infected semen is left behind. To further reduce transmission risk, the sperm prepared using any of these methods, alone or in combination, is used to fertilize an egg during intrauterine insemination or in-vitro fertilization. Artificial insemination and in-vitro fertilization may also be used to reduce the risk of transmission to HIV-negative male partners from HIV-positive female partners.

All of these techniques have been tested and used extensively, especially in Europe. However, researchers disagree about whether there is still an HIV transmission risk using these techniques. At this time, there are no established laboratory measures to ensure that seminal fluid treated in any of these ways is entirely free of HIV. Other risks of assisted reproductive techniques, such as the increased likelihood of having twins may also be an issue for couples pursuing these methods. Finally, assisted reproductive techniques can cost from $10,000 to $17,000 per ovulation cycle to perform, making them inaccessible to many people.

Timed ovulatory intercourse, by which couples engage in unprotected intercourse only during the female partner’s most fertile period, is riskier in terms of HIV transmission. This method has been called “relatively safe” if the HIV-positive man’s viral load is below detectable levels and his CD4+ cell count is above 400. This method does not actually reduce HIV infectivity; it limits the opportunity for transmission by limiting the number of times the couple engages in unprotected sex to the periods when intercourse would most likely result in conception.

Post-Pregnancy Counseling

In 2001, the CDC issued new guidelines for HIV counseling and testing of pregnant women. In addition to emphasizing appropriate HIV prevention counseling, these guidelines state that it is important to offer pregnant HIV-positive women specific counseling about perinatal HIV transmission and ways to reduce HIV transmission to the fetus or infant. Further, they recommend “nondirective” reproductive counseling about all available options including avoiding pregnancy, conceiving, carrying a child to term, and abortion. Finally, the CDC recommends retesting in the third trimester of pregnancy for HIV-negative women who are known to be at high risk of contracting HIV.

In 2004, the National Institutes of Health issued guidelines about the use of HIV antiviral drugs during pregnancy, and offered its own recommendations for pre-pregnancy counseling for HIV-positive women. These recommendations emphasize the importance of discussing appropriate contraception, if the woman desires; education about HIV transmission risks, prophylaxis, and treatment during pregnancy; counseling about good nutrition; screening for mental health and substance use issues; and planning for consultation about pregnancy and delivery.

Conclusion

Improved HIV treatment and evolving perinatal science have diminished a significant danger associated with reproductive decisions. As clients consider whether or not to bear children and, if so, how to conceive and deliver safely, counselors will need to approach this process with accurate information and extreme sensitivity. Despite reduced vertical transmission risk, the client’s right to make decisions about both reproduction and treatment continue to lie at the crux of the issue.
Implications for Counseling

The issue of whether to have children can be laden with emotions and judgments for people of all genders, races and cultures. It can be particularly charged for women with HIV because cultural attitudes and values about childbearing and illness are conflicted. Since HIV is a sexually transmitted disease discussions of reproductive health and childbearing are likely to arise.

Both women and men of childbearing age who test HIV-positive may have concerns about their abilities to have and raise children in the future. Clients who are HIV-negative who have HIV-positive partners may want to explore the possibility of having children. A woman may discover she is HIV-positive as a result of testing following pregnancy and suddenly find herself faced with a myriad of difficult decisions.

At a time when effective HIV antiviral treatment for both parents and fetuses is more available than ever before, HIV counselors are well-advised to learn about the information and emotional issues that may arise for clients—in both opposite-sex and same-sex couples—facing reproductive issues. At the same time, it is important not to assume that reproductive health is an issue for someone just because she or he is of childbearing age.

Since reproductive health issues can be technical, it is particularly important for counselors to be prepared to convey information at educational levels appropriate for each client, neither above nor below what a client can easily understand. To prepare for this, it is useful for counselors to feel comfortable enough with reproductive health information so that they can communicate in a variety of ways.

Raising Reproductive Issues

Listening for references to reproductive issues can provide an opening for counselors to ask more questions of clients who may have concerns about this topic. These may be overt references such as, “What would happen if I wanted to have kids?” or “My girlfriend wants to get pregnant.” Before answering such questions, it can be helpful to use them as an opportunity to find out how much a client truly knows about reproductive issues.

Counselors can raise the issue of reproductive health by asking whether the topic of having children has ever come up for a client. They can then follow the client’s lead. If a client says that she or he has not thought about reproductive issues, follow up by asking, “Would you like to know more about this topic?” Notice any emotion reflected in the client’s body language or words. For example, does the client look sad or surprised? Commenting on such observations can provide a good opening for further conversation.

Counseling HIV-Positive People

While it is important to encourage HIV-positive clients who express concerns about having children to pursue medical care, there are topics related to reproduction that counselors can address during the session. Counselors are in a position to explore the context of clients’ lives in order to understand what is motivating their concerns. For example, an HIV-positive woman may face the judgment of others regarding her decision to have children: family members and friends may ask, “How can you bring children into the world when you might not be here to see them grow up?” Simply referring a client for appropriate health care is not enough to respond to such concerns.

There are many reasons reproductive health issues may arise for a client who learns she or he is HIV-positive. Does she know or suspect that she may be pregnant, or is she concerned about future pregnancies? Is there some situation other than pregnancy that is motivating him or her? For example, is the potential for having children in the forefront of the client’s relationship? Is the client planning to tell his or her partner? How does he or she imagine the partner will react? Discuss the issues that the client believes are most likely to arise and help him or her develop potential responses. Make sure that clients have the information and referrals necessary to aid them in such discussions.

HIV-positive women may be at increased risk for domestic violence, and expectations regarding childbearing on the part of partners or other family members can also lead to violence. Be vigilant about these concerns.

Ask HIV-positive clients what having children or not having children means to them. Do not be afraid to engage in a conversation regarding their feelings about the issue. Do not assume that all clients understand how pregnancy occurs or how HIV may affect a woman or her fetus. Explore what clients know about the process of becoming pregnant, about HIV transmission to the fetus or infant, and about vertical transmission prevention strategies. Be aware that clients may be using contraceptive methods such as condoms that decrease HIV risk or methods such as the pill that have less of an impact on risk reduction. It may be helpful to discuss these methods in terms of balancing risk reduction, contraception, and pleasure.

It is important to give as much information as possible to HIV-positive clients who express an immediate concern regarding HIV transmission to their female partners who are considering pregnancy. Stress to HIV-positive clients the need for testing for other sexually transmitted disease for both themselves and their partners, since STDs can increase the likelihood of HIV transmission or acquisition.

Pregnancy and HIV Counseling

It is particularly important to ask pregnant women who are testing why they are doing so, since pregnant women may be under pressure from health care providers or family members to test. While there are
Counseling HIV-Negative Women

A woman who tests HIV-negative may express concern about pregnancy or reproductive issues if she suspects or knows she will be coming into sexual contact with an HIV-positive man or, in situations such as insemination, HIV-positive semen. Clarify what her concerns are and explore her feelings about it. Ensure that she understands the ways that HIV is transmitted and the ways that a woman can become pregnant.

Many reasons why HIV testing is important for both a mother and fetus, it is ultimately a woman’s right to decide whether and when she wants to test. Part of a counselor’s role is to ensure that all clients are testing because they want to.

It will likely be helpful to provide basic information about reproductive health to pregnant clients. For example, discuss rates of perinatal transmission, potential effects of pregnancy on HIV-positive women, and the importance of getting prenatal health care with an HIV-knowledgeable health provider. Do not assume that a pregnant client has discussed these issues with a provider or has sought prenatal care. In addition, remember that it is her right to decide whether to seek prenatal or HIV-related treatment.

Once again, it is crucial to follow the client’s lead. A client who is having significant feelings about her test result may, or may not, benefit from information. Ask the client if she thinks it will help her to hear basic information during the session or if there are other concerns that she feels are more important to add.

If the client expresses interest in terminating the pregnancy, discuss the issue with her; but keep in mind the limits of the counseling session. At the very least, refer such clients to non-judgmental resources that will allow them to explore their options.

Countertransference

HIV counselors are not immune

References


...and uninfected postpartum women in four U.S. states. Medicaid and Children's Health Insurance Program. 2002; 103(1): 166–168. The CDC estimates that approximately 25% of women of reproductive age in the United States are not using any form of contraception. For example, discuss rates of perinatal transmission, potential effects of pregnancy on HIV-positive women, and the importance of getting prenatal health care with an HIV-knowledgeable health provider. Do not assume that a pregnant client has discussed these issues with a provider or has sought prenatal care. In addition, remember that it is her right to decide whether to seek prenatal or HIV-related treatment.

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Counseling HIV-Negative Women

A woman who tests HIV-negative may express concern about pregnancy or reproductive issues if she suspects or knows she will be coming into sexual contact with an HIV-positive man or, in situations such as insemination, HIV-positive semen. Clarify what her concerns are and explore her feelings about it. Ensure that she understands the ways that HIV is transmitted and the ways that a woman can become pregnant.

Offer the client basic information, for example, about the connection between viral load and transmissibility. Assess for substance use. Encourage the client to be tested for STDs since having certain STDs can increase the risk of HIV transmission and acquisition. Make sure to have referrals available so that the client and her potential partner can discuss these issues further if they desire.

Listen for emotional concerns such as references regarding pressures from her partner or from family members. It may be appropriate to brainstorm with the client ways to communicate or help her think of how to access other support.
to societal conflicts about pregnancy options, childbearing, and childrearing. A counselor’s values and beliefs are often affected by gender, age, personal history, culture, and religious background. Take the time to explore what these issues mean to you.

If you have not already had the experience, imagine what it would be like to sit in a session with a woman who is pregnant and HIV-positive, or a man who is HIV-positive and is considering having children with an HIV-negative woman. Imagine yourself in the position of the client and think about how you would feel and what kind of support you would want.

No one expects HIV counselors not to have feelings about reproductive health or any other issue that may arise during counseling. But it is important for counselors to undertake a process to uncover their values and judgments so that they can put them aside and be with their clients.

Conclusion

The HIV counseling session may be the first time clients feel comfortable discussing reproductive issues. Their concerns may range from the need for information to the desire to talk about more emotionally laden issues. Counselors who are comfortable with information on vertical transmission and who have examined their own values, judgments, and feelings about reproductive issues will be best prepared to provide an opening for clients to explore this range of concerns.

Case Study

Lucinda is a 29-year-old woman who has been in a relationship with Sam, an HIV-positive man, for the past four years. She tests once a year “just to be on the safe side,” even though she and her partner always use condoms when they have intercourse. After her counselor, Joanne, discloses an HIV-negative test result, Lucinda says that she has decided it is time for her to have a child. She asks, “Can my baby get infected?”

Counseling Interventions

Joanne offers Lucinda positive reinforcement for raising her concern about the health of her baby and for the efforts she and Sam have taken to maintain Lucinda’s HIV-negative status. She answers Lucinda’s question, stating, “Yes, an HIV-negative woman can get HIV from her HIV-positive partner and then pass the virus on to her fetus or child.”

“Let’s start with some background,” Joanne continues. “You know, I never like to assume that people know how a woman gets pregnant or how babies develop. Would you mind telling me what you know?” Lucinda concludes a fairly accurate description by saying, “But I don’t know how to get pregnant without getting HIV.”

Joanne acknowledges the breadth of Lucinda’s knowledge and responds that there are, in fact, some ways to get pregnant, through processes like “sperm washing,” that would actually protect Lucinda. “Would you be interested in a referral for more information about reproduction and HIV?” Joanne is particularly careful during this discussion to avoid talking down or up to Lucinda.

Joanne then explores why Lucinda has decided that “it is time for her to have a child.” She also asks Lucinda about Sam’s role in this decision-making process.

“Does Sam want to have a child as much as you do?” Joanne says. Lucinda responds, “Actually, I’m not exactly sure what Sam thinks.”

Joanne asks if Lucinda believes Sam might have similar concerns about having a child and protecting it from HIV. Lucinda says she thinks he might want to have a child, remarking, “We are talking about getting married.” But she adds, “He is kind of down on the world and, you know, bringing more people into it.”

“Would Sam be willing to see someone with you, so you both can get more information about having kids?” Joanne asks. By saying this she opens the door for more discussion about Lucinda’s and Sam’s willingness to seek outside help, the strength of Sam’s feelings and Lucinda’s concerns, and the couple’s need for referrals to medical resources or emotional support.

Joanne also asks whether Lucinda or Sam have close family or friends who might have strong feelings about Lucinda’s potential pregnancy. “I’m really close to my mom and dad, and they don’t like Sam—actually, what they don’t like is that he has HIV.” She admits to Joanne that figuring out how to tell them will be a problem.

Joanne asks whether Lucinda has friends or other people she can talk to about “this kind of stuff,” acknowledging to Lucinda that these issues are often difficult to raise even with friends. Lucinda responds that she has a couple of close girlfriends and that it might be a good idea to start talking with them.

As the session closes, Joanne asks Lucinda how she is feeling about the session, and lets Lucinda know that many women with HIV or with HIV-positive partners face similar concerns, which can bring up many feelings. Finally, Joanne asks Lucinda if there are any other referrals she thinks might help her or Sam.
Test Yourself

Review Questions
1. True or False: Vertical transmission, that is, transmission of HIV from mother to fetus or infant, is again on the rise.

2. True or False: Vertical transmission is responsible for the majority of pediatric HIV infections in the United States.

3. A major concern for HIV-positive women who are thinking about their reproductive health is: a) the morality of having children if a person is HIV-positive; b) the efficacy of early treatment with HIV antiviral drugs that can lower vertical transmission rates to less than 2 percent; c) there are no major concerns, because HIV-positive women don’t usually have children; d) both a and b.

4. True or False: HIV-positive men can transmit HIV directly to a fetus.

5. Which of these methods will not enable couples with at least one HIV-positive partner to conceive children with less risk of HIV transmission to the fetus? a) sperm washing; b) sperm isolation; c) timed ovulatory intercourse; d) the swim up method.

6. Which of these contraceptive methods does not offer some protection against both pregnancy and HIV? a) diaphragms; b) condoms; c) sterilization; d) all of these offer protection.

7. A problematic aspect of hormonal contraception for HIV-negative women is: a) it is messy and hard to use; b) even when used in addition to a barrier method, it may increase the woman’s risk of contracting HIV; c) it is not effective in preventing pregnancy; d) all of the above.

8. The highest risk of vertical transmission happens during: a) pregnancy; b) labor and delivery; c) post-delivery blood-to-blood contact between mother and infant; d) breastfeeding.

Discussion Questions
1. How do you feel about HIV-positive people having children? How might an HIV-positive client’s revelation that he or she is thinking about conceiving children affect your counseling?

2. What are some considerations for HIV-positive and HIV-negative women who are exploring pregnancy prevention? What are some considerations for HIV-positive and HIV-negative women who want to get pregnant?

3. What emotional issues might arise for HIV-positive women considering pregnancy? What barriers in an HIV-positive woman’s life might make it difficult to choose to have children or not to have children?

4. How would you respond if an HIV-positive, pregnant woman told you she was not planning to get treatment during her pregnancy? How would you respond if she said this was because of the risk of transmitting toxic drugs to her fetus?

5. Consider three ways you might bring up a woman’s reproductive health during a pre-test counseling session.

Answers
1. False. Since the late 1980s, vertical transmission rates have dropped dramatically, the result of HIV antiviral treatment given to mothers during pregnancy.

2. True.

3. d.

4. False. An HIV-positive man cannot directly transmit the virus to the fetus, however, the man can transmit HIV to his female partner who in turn can transmit it to the child.

5. b.

6. c.

7. b.

8. b.
DID YOU KNOW?

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