

Pregnancy intention and reproductive care in women living with HIV

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Abstract

It is common for women living with HIV to become pregnant following their diagnosis. Rates of unplanned pregnancy are considerably higher in this population compared to the national rate. This commentary discusses possible contributors and implications of this phenomenon with a focus on the population health of women living with HIV. The goal of this commentary is to highlight the need for improved women-centered reproductive programming within comprehensive HIV care. Ultimately, this could help improve rates of unintentional pregnancy on the population level and overall reproductive care for women living with HIV.

Introduction

There are approximately 17,000 women living with HIV in Canada, indicating that women represent close to a quarter of the persons living with HIV nationally.¹ Importantly, the highest rate of new HIV diagnoses among women is in those aged 30-39 years,² a decade which coincides with the delayed shift of women's reproductive years.³ Heterosexual contact is one of the leading modes of transmission of newly acquired HIV cases.⁴ These are important trends to consider when examining the impact of living with HIV on a woman's reproductive choices.

Data from the Canadian HIV Women's Sexual Health and Reproductive Cohort Study (CHIWOS) on "Pregnancy incidence and intention after HIV diagnoses among women living with HIV in Canada" reported that close to one quarter of women living with HIV will go on to become pregnant following their diagnosis.⁴ This is unsurprising based on the decreased morbidity and increased life expectancy of patients with HIV receiving antiretroviral therapy (ART).⁵ Publicly funded health care in Canada allowing universal accessibility to ART is a key contributing factor to such. Novel ART regimens are also better tolerated, and engagement in ART lessens the impact of untreated HIV on fertility.⁶ Although it is not entirely clear how HIV affects and ART improves fertility, it has been demonstrated that fertility improves in women living with HIV following approximately 12 months of ART, as compared to women who are not on antiretroviral regimens.⁷ It would be logical to theorize that the multi-system implications of HIV could contribute to this finding. This could be through secondary sequelae of the disease, such as hypothalamic-pituitary-ovary axis deregulation suppressing ovulation in women with wasting or cachexia,⁸ consequences of invasive cervical cancer requiring excision procedures which could affect cervical competence and anatomy,⁹ or tubal dysfunction from disseminated pelvic inflammatory disease creating physical barriers to fertilization.¹⁰

While many women living with HIV go on to have successful desired pregnancies, recognition of the high rates of unintended pregnancies in this population is important to minimize potential downstream adverse outcomes by reinforcing the need for early engagement of these women in care; it is also important to acknowledge the causes that might be contributing to this finding. The CHIWOS study reports that an estimated 27.4% of sexually active women living HIV had not used an effective method of contraception in the preceding six months.⁴ Further, a study by Kaida et al. from 2016 reveals that, of the enrolled women living with HIV in Canada who reported using contraception, nearly half relied only on the male condom.⁶ These data highlight the crucial need for enhanced

education regarding contraceptive effectiveness and use, along with increased focus on providing universal and practical contraceptive access. This point is particularly crucial for women living with HIV, as contraceptive education must be tailored to this population to whom barrier contraception use is strongly promoted for prevention of viral transmission, yet might not be adequate as the sole means of contraception. Furthermore, seroconcordant couples might opt to not use any form of contraception if they perceive no concern of viral transmission to the partner.

Interestingly, the CHIWOS study describes that 61% of all pregnancies in their study group of women living with HIV were reported as unintended.⁴ It is important to note that these results are significantly higher than the overall rates of unplanned pregnancy in women of reproductive age in Canada, which is estimated at 27%.¹¹ While these numbers draw attention to the prevalence of unintended pregnancy in women living with HIV in our country, it is imperative to consider both the individual and societal implications of such realities, along with the potential causes contributing to these data. Although it is generally understood that women who become unintentionally pregnant are at risk of suffering a psychological burden, the consequences of such news can have accentuated psychological and social implications for women living with HIV, such as concern over viral transmission to the fetus.¹² Unintended pregnancy can also lead to potential adverse outcomes, such as unsafe or uninformed termination practices, decreased engagement in care due to fear of stigmatization, fewer pregnancy-safe choices in the prenatal period, or delay in identification and subsequent treatment of obstetrical complications.¹³ While these implications can relate to all women with unintended pregnancies, if pregnant women living with HIV choose not to obtain prenatal or obstetrical care, an important opportunity to engage these women in their healthcare is being missed. Pregnancy visits can not only represent an important time to offer prenatal counseling and implement harm reduction strategies, but can also increase overall engagement in medical and HIV care while strengthening therapeutic relationships.

This commentary has touched on the importance of recognizing the high rates of unintended pregnancies in women living with HIV. While a number of potential contributing factors and implications have been suggested, there remains a vital need for improved comprehensive reproductive care in this population. A main limitation of this commentary is that it cannot isolate HIV-positive status as the only contributing factor to the reproductive trends of women living with HIV, as there are undoubtedly other social and societal implications to these findings. Nevertheless, the challenge is clear: to move towards a more comprehensive and accessible reproductive care model for women living with HIV on a population level.

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