

## Management of Child-bearing Attitude among HIV Cases

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### ABSTRACT

HIV is the acronym for human immuno-deficiency virus. A person infected with HIV medically known as an HIV positive person. AIDS stands for Acquired Immune Deficiency Syndrome. The reported rate of transmission of HIV from mother to child (vertical transmission) varies widely with higher rates seen in the developing world. Other factors increasing the likelihood of vertical transmission are the mother having advanced disease, having a lower CD 4 count and breastfeeding the new born. The present paper aims to Change the negative attitude for conceiving a child with the help of therapeutic counselling, to aware the client about the medicine to prevent HIV infection in child. It was hypothesized that Therapeutic Counselling will reduce the negative attitude towards the bearing/conceive the child. A sample of 50 HIV infected pregnant females (1 or 2 month's pregnancy) was selected for the present study. A Self Constructed Attitude Scale for measuring attitude towards child bearing issues was taken. Results indicated that due to counselling sessions, the subjects changed their attitude and grew more confident on issues like birth and survival of the child.

**Key words:** HIV, AIDS, Child-bearing

*James et al.* (2001) reported that HIV-positive men and women may have fertility desires and may intend to have children. The

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extent of these desires and intentions and how they may vary by individuals' social and demographic characteristics and health factors is not well understood. A sample of 2,864 HIV-infected adults who were receiving medical care was taken. The study concluded that among those desiring children, 69% of women and 59% of men actually expect to have one or more children in the future. The proportion of HIV-infected women desiring a child in the future is somewhat lower than the overall proportion of U.S. women who desire a child. The fertility desires of HIV-infected individuals do not always agree with those of their partners: As many as 20% of HIV-positive men who desire children have a partner who does not. Generally, HIV-positive individuals who desire children are younger have fewer children and report higher ratings of their physical functioning or overall health than their counterparts who do not desire children, yet desire for future childbearing is not related to measures of HIV progression. HIV-positive individuals who expect children are generally younger and less likely to be married than those who do not. Multivariate analyses indicate that black HIV-positive individuals are more likely to expect children in the future than are others. While HIV-positive women who already have children are significantly less likely than others both to desire and to expect more births, partner's HIV status has mixed effects: Women whose partner's HIV status is known are significantly less likely to desire children but are significantly more likely to expect children in the future than are women whose partner's HIV status is unknown. Moreover, personal health status significantly affects women's desire for children in the future but not men's, while health status more strongly influences men's expectations to have children.

*Zuccotti, G., (2010)* described the views and attitudes towards reproduction by couples who are HIV positive and attempts to understand their perspectives. The study concluded that most health professionals generally had a negative attitude towards

childbearing by HIV positive couples. Their views and approaches on the issue were based mainly on biomedical considerations. The main discourses on childbearing that emerged from the study were the conditional choice, the anti-childbearing, and the pro-rights. Most of the health professionals interviewed tend to take a generally negative stance towards reproduction by people with HIV/AIDS. There is a need for a clear set of guidelines for health professionals (HPs) on how to deal with HIV positive people who may desire to reproduce.

*Bankole, A. (2015)*, explained that attitudes of women and men living with HIV and their providers towards pregnancy and abortion among HIV-positive women in Nigeria and Zambia Fertility decisions among the HIV-positive are complicated by disease progression, the health of their existing children, and possible ART use, among other factors. Using a sample of HIV-positive women (n=353) and men (n=299) from Nigeria and Zambia as well as their health care providers (n=179), he examined attitudes towards childbearing and abortion among HIV-positive women on individual measures as well as an index. Support for HIV-positive women to have a child was greatest if she was nulliparous or if her desire to have a child was not conditioned on parity and lowest if she already has an HIV-positive child. Support for childbearing among the HIV-positive was found to be lower among HIV-positive women than among HIV-positive men, both of which were lower than support from providers. Support for abortion varied more depending on the measure. Half of all respondents indicated no/low support for abortion on the index measure while between 2 to 4 in 10 respondents were supportive of HIV-positive women being able to terminate a pregnancy. The overall low levels of support for abortion for HIV-positive women indicated that HIV does not seem to qualify for most respondents as a medical condition which justifies abortion. Being Nigerian and residing in an urban area

both increased support for childbearing among HIV-positive respondents. About a fifth of HIV-positive respondents reported being counselled to end childbearing after their diagnosis. In sum, respondents from both Nigeria and Zambia demonstrated tempered support of (continued) childbearing among HIV-positive women. While integrating HIV and family planning services remains challenging, increased medical and social education about childbearing while managing HIV may have the potential to reduce stigma and help HIV-positive individuals meet their reproductive goals.

According to *Sandgren et.al (2007)* aimed to study the current knowledge, risk behaviour and attitudes to voluntary counselling and testing concerning HIV/AIDS among pregnant women. A sample of 520 pregnant women was taken which concluded that most of the women in *Semey* were positive to prevention strategies for mother-to-child transmission after hearing about it.

*Fedchuk et al (2009)* found out that In Ukraine, the rate of HIV-infected dissemination among pregnant women is one of the highest in Europe. This parameter equals to 0.45% of all pregnant women in 2008, while it was only 0.002% in 1995. The increase in the number of the HIV-infected women was of additional concern because of the risk of vertical transmission from mothers to their children. In Ukraine 86% of the patients of reproductive age who are being treated are women. It is worth mentioning that daily 10 children are born to HIV-infected mothers in the south of Ukraine. Early diagnosis, treatment and behaviour counselling is crucial to avoid transmission and limit the damaging effects of the disease. The studies performed by Ukraine explorers show us that about 12%–38% HIV-infected mothers became informed on their positive status only at the birth-houses. During last 10 years HIV infected pregnant women number increased by 17% (from 28% to 45%). Permanently increases the number of children born by HIV-infected mothers. However, the level of the anti-retroviral

therapy provided to HIV-positive pregnant women was equal only to 11%. Anti-retroviral therapy applied timely allowed diminishing the newborns HIV infection from 30% to 9%. As the result, more than 1295 previously infected children were qualified as healthy.

*Kagaayi et. al (2010)* studied that WHO recommends use of extended infant prophylaxis with *nevirapine* (NVP) as one strategy for the prevention of breast milk mother-to-child (p-MTCT) HIV transmission. They evaluated the impact of extended NVP prophylaxis for p-MTCT at six weeks of age using data from the Rakai Health Sciences Program, Uganda. They compared the proportion of infant HIV acquisition at six weeks of life among breastfeeding mothers who were not on ART during pregnancy/lactation for three time periods: 2002/mid-2007 when mothers and infants only received single-dose NVP (sdNVP), mid- 2007/mid-2008 when mothers received Zidovudine (AZT) starting at 28 weeks of pregnancy and sdNVP for mother and baby, and mid-2008/2009 when mothers and infants received the mid- 2007/2008 regimen plus infant prophylaxis with NVP during lactation. Chi-square test for trend was used to compare proportion of infants with HIV-infection over the three periods. Excluding mothers who were on ART, 164 mother-infant pairs were seen in 2002/mid-2007 period, 38 in the mid-2007-2008 period, and 82 in the 2009-2010 periods. The six-week infant infection rates were 11.0% (18/164) in 2002/mid-2007, 2.63% (1/38) in mid- 2007/2008 period and 1.2% (1/82) in the mid-2008/2009 period (P- for trend=0.005). Extended infant prophylaxis with NVP reduced infant HIV acquisition. Scale-up of extended NVP prophylaxis has the potential to substantially reduce prenatal and breast milk HIV transmission.

*Adair et. al (2007)* studied that where the HIV prevalence rate for women is 26.4%, there is high risk for mother-to-child

transmission (MTCT) of HIV. Efforts to prevent MTCT focused on reducing the fertility level of HIV-positive women. Adair examined the desire for children and unmet need for contraception to limit or space births among HIV-positive women age 15-49 years. Multivariate analysis of HIV-positive women, 83% of whom have never learned their HIV status, showed that the desire for children in the future did not differ by socioeconomic status. Unmet need for contraception was highest among women in the poorest households. Although these women had lower HIV prevalence, they had higher potential for MTCT. The multivariate results were similar for both HIV-positive and HIV negative women because of low self-awareness of HIV status. Efforts to reduce the level of MTCT required improved access to family planning services for all women, especially the poorest, and an increase in HIV testing and counselling.

*Kanniappan et. al (2008)* studied that with access to prevention of parent-to-child transmission (PPTCT) and antiretroviral therapy (ARV), people living with HIV/AIDS were better able to consider childbearing and parenthood. However, there was limited understanding of the reproductive healthcare needs and the impact of infection on the fertility desires of women living with HIV/AIDS. Research on the relationship between fertility and HIV/AIDS had been largely clinical, focusing on the ability of women living with HIV/AIDS (WLHA) to conceive or their pregnancy outcomes. The findings of a qualitative study undertaken in Namakkal district, Tamil Nadu, India aimed to explore fertility desires, intentions and fertility decision-making in WLHA and the barriers they face in fulfilling these desires. In-depth interviews were held with selected 43 currently married WLHA aged 18–35 years and 10 key informants. The women were classified according to whether or not they had living children and, within that, whether they had experienced abortion, wanted more or any children or were pregnant. The main factors

distinguishing women who wanted to have a child and those who did not were their levels of anxiety about the future and available family support. Women who indicated that they did not have family support and were stigmatized by the family were reluctant to opt for a pregnancy as they were not sure of the future, including child care in event of parental death. In contrast, those women who decided to have a child did so based on family support, especially when family members offered to take care of the child in the future in the event of parental death. Awareness and access to PPTCT and ARV was another key factor guiding the final decision on child bearing. Findings highlight the need for further research on issues faced by WLHA in fulfilling their fertility desires and intentions and for programmes that both enable WLHA to exercise informed choice in meeting their fertility desires and sensitize healthcare providers about these needs.

***Objectives:***

- To know the effectiveness of therapeutic counselling to change negative attitude towards conceiving a child.
- To aware the client in the medicine to present HIV infection in child.

***Hypothesis:***

Therapeutic Counselling will reduce the negative attitude towards the bearing/conceive the child.

***Research Design:***

The present research work is not possible experimentally because of nature of investigation. The researcher adopted the quantitative descriptive research for gaining the objectives of the present study. It is the survey quantitative research in which the event has already occurred and the effects of the variables were studied by qualitative analysis.

- *Independent Variable:* Counselling and medicine
- *Dependent variable:* Attitude of mother or parents

***Controls:***

- No other medicine
- Smooth relation between husband and wife
- No child with HIV infection on first child
- 2 sessions in week of one hour

***Sample:***

Before selection of this problem, researcher first approached the authorities of Govt Hospital- PPTCT and ART centre of Jodhpur district. After some official formalities, the authorities allowed the researcher to work under certain conditions. Keeping the purpose of research work, initially 60 HIV pregnant females were approached to know their attitude towards the child in the womb. Finally 50 HIV infected pregnant females (1 or 2 month's pregnancy) were selected as a sample for the present study. It fulfils the purpose of present investigation.

***Tool:***

Self Constructed Attitude Scale for measuring attitude towards child bearing- Researcher decided to use the self-made questionnaire for this research. She then visited ART and PPTCT centre of Jodhpur district to get the details of HIV infected pregnant ladies. After few official formalities, authorities allowed her to work under certain conditions. The details of HIV infected pregnant women (name, no. & address) were taken from the centre. They were visited individually. Talking to them was a great challenge as many of them did not wanted to talk initially or the people at home were not aware about their HIV status. Stigma, denial etc. were the major issues that came the way while approaching them. Their attitude towards their child, dilemma related to the birth of baby, attitude of the family members was observed. 60 different HIV pregnant ladies were



interviewed and questions regarding the fear, social acceptance and insecurity about the child were studied. Initially there were 38 items in the scale.

**Procedure:**

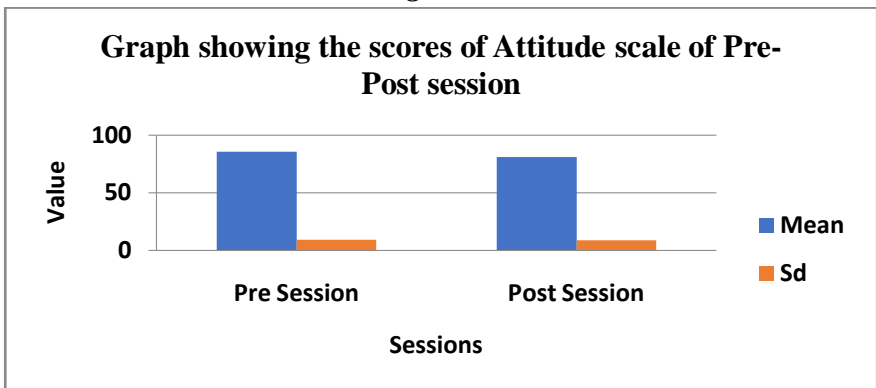
On the basis of the interview with the women, some statements were framed with the help of research literature, statements were sent to experts of field for their comment and after their suggestions, a final list was prepared for all these items. On the basis of their inter correlation, 24 items were finally selected, out of which some were related to social acceptance, insecurity and risk taking regarding the child. It had both the positive as well as negative items. It is a 5 point scale. Responses were taken on 5 categories i.e. 1, 2,3,4,5 – ‘Agree’, ‘Totally agree’, ‘Average’, Disagree, ‘Totally disagree’. The internal consistency i.e. reliability is taken out. Validity is still to be taken out.

**RESULTS AND INTERPRETATION:**

*Table 1: Showing the scores of Attitude scale of Pre-Post session-*

Session	Mean	SD	‘t’
Pre-session	85.73	9.27	2.75, $p < .01$
Post-session	80.92	8.57	

*Figure 1*



In the present investigation, an attempt is made to know the attitude of HIV positive women towards their child. Not only this, further, negative attitude towards child, due to infection, if any female was having, managed through counseling technique. Table No. 1 reveals the obtained mean scores for pre sessions by HIV infected female on attitude scale,  $M=85.73$ ,  $SD= 9.27$  which significantly differs from post session,  $M=80.92$ ,  $SD=8.57$ . The difference is significant at .01 level ( $t= 2.75$ ,  $p<.01$ ). It indicates that due to counselling sessions, these subjects changed their attitude and grew more confident on issues like birth and survival of the child. Responses of mother changed to positive on these items, "I will continue with pregnancy if my child has HIV infection. I'll over protect my baby, if he/she is infected; Even after not getting support from my husband, I'll take care of the kid, I'll not abort the child in womb, I'll try my level best to save the child from all situations, I'll give timely medicines to my child, I am confident that in the coming years there will definitely be a cure to this disease, I am confident that my child will not get HIV." These are some items in the scale on which these women were confused at but after counseling and clearing the misconceptions about the child being HIV positive, responses of these mothers changed to positive.

## **DISCUSSION:**

In the present investigation the objectives were, what is the level of insecurity among the HIV couples, what is the level of risk taking, what is the level of social acceptance of child in their view, what is the impact of counselling on the attitude of HIV pregnant mothers. On the basis of these objectives, researcher has analyzed the data which are in line with the following hypothesis, the insecurity level will be high in the HIV couples regarding the HIV transmission to their child, risk-taking behaviour will be lower among the HIV couples in respect to bearing a child, fear of social acceptance of child among the couples will be high, Therapeutic

Counselling sessions will reduce the level of insecurity, will increase the risk of conceiving the child, and the assumption regarding the social acceptance of the baby will also increase. The hypothesis conformed as the insecurity level for the following items reduced, “if my child is doubted to have HIV, then I’ll not give him birth, my HIV positive status have thrown the future of me as well as of my child in darkness, after birth my child won’t be able to live peaceful life, the thought of the birth of the child puts me in a shocking state, I’ll try my best to protect my child from all difficulties, Counsellor has told me about Nevirapin dose, still I am in great stress, there is an indefiniteness regarding the birth of the child. It reveals that cognitive counselling sessions worked to reduce the level of insecurity among the HIV pregnant.” It can be said that due to cognitive behaviour therapy, level of insecurity has reduced as the response on above items are obtained in post sessions. Counselling is effective not only for testing of pregnant women but also to convince her to carry the child. This view is supported by *Semrau et.al* (2005) who reported that nine percent (868) of 9409 women counselled antenatal were counselled with their husband. Couple-counselled women were more likely to accept HIV testing (96%) than women counselled alone (79%); however uptake of *nevirapine* was not improved.

Six months after delivery, 28% of 324 HIV-positive women reported at least one adverse social event (including physical violence, verbal abuse, divorce or separation). There were no significant differences in reported adverse social events between couple- and individual-counseled women. Similarly *Kowalczyk et.al* (2002) has reported that counseling increase the confidence level of HIV pregnant female to carry the child and fight against stigma. In present findings, apart from attitude questionnaire and life stress scale during the process of conversation, researcher felt that pregnant female is in a dilemma whether to carry a child or go

for abortion. This all is due to above mentioned facts like feeling of insecurity, social stress, economic problems etc.

The view of researcher is in collaboration with *Kirshenbaum* et al (2004) regarding the quality of PPTCT program in India which may prove the backbone for these women. He was of the view that regardless of women's pregnancy experiences or intentions, reproductive decision-making themes included the perceived risk of vertical transmission, which was often overestimated; beliefs about vertical transmission risk reduction strategies; desire for motherhood; stigma; religious values; attitudes of partners and health care providers; and the impact of the mother's health and longevity on the child. Most women who did not want children after their diagnosis cited vertical transmission risk as the reason, and most of these women already had children. Those who became pregnant or desired children after their diagnosis seemed more confident in the efficacy of risk reduction strategies and often did not already have children.

This is supported by a case-study of Rajasthan state (Prevention of Parent to Child Transmission GFATMRCC II, 2011)- Rohini (Name changed) during her sixth month of pregnancy went to the Government Hospital for her ANC testing , in her Blood Test report she was tested positive . She was referred to the ICTC and visited the counsellor who counselled her and convinced her for institutional delivery also advising her to come for retesting after a month. Rohini agreed but never visited the ICTC again even though the Counsellor tried to contact her many times. The counsellor contacted the District Coordinator who referred the case to Sana, an ORW. Sana visited Rohini's place and met her and the family members. She found out that Rohini delivered her baby a week ago in government Hospital but both the mother as well as baby was not given Nevirapine. Also, she found out that Rohini's husband had not done his HIV test and was not aware

about HIV. Sana counselled the couple on HIV, its effects and what precautions had to be taken. Rohini was very depressed on learning about the gravity of the situation. However, Sana counselled her for almost an hour and convinced her to go for HIV testing along with her husband; she also referred the baby to ICTC so that *Cotrimaxozole* could be provided to baby if required. Sana left her place after reassuring them of any other assistance and they agreed to follow precautions. Rohini's In-laws also spoke to the Project Coordinator and thanked her for sending Sana for helping and guiding them.

The above hypothesis was confirmed as our findings showed that the attitude of the HIV positive pregnant women changed and she decided to go with child. Counselling helped in reducing the social, educational, personal, family and economic stress of HIV positive pregnant women and also made her confident towards the conceiving of the child. The direction of the findings are supported by following studies- According to *MacLaren* (1998), counselling has also been considered as discussion, highlighting the need for dialogue between the counsellor and the client, focusing on the needs of the latter. Similarly, *Norton et al.* (1997), suggest counselling should be more of a two-way conversation instead of a passive transmission of information to the client. *Andrews* (1995), recommends that women be encouraged to tell their story, rather than only being given information and advice.

At last it can be said that counselling is a good intervention for the females who are carrying and at the same time under the clouds of fear of HIV transmission to their child. All over goal for present counselling by the researcher to these HIV infected females was to provide early and appropriate up to date facilities, to provide emotional care, to build up confidence against social stigma. Apart from this, counselling also assessed the support group and health services, reduced fear, ignorance and stigma surrounding HIV

concept, stimulated a community response in support of her. Counselling results for HIV pregnant lady in present investigation also acknowledges that a great relief for women to learn that there was a possibility that their babies could be HIV negative. Most of their concerns were about passing the virus to the child. This led to feelings of guilt, despair, and depression. One woman felt that her child (if born HIV positive) would be a punishment for her sins. This also led to some of the women strongly contemplating suicide or/and terminating the pregnancy, as they felt that this was the end of the world for them and that it would be unfair to bring an HIV positive child into the world. Most of them felt that if they had not been part of the support group, they would not have known about the treatment one can take before giving birth (Ribble, 1989).

## **CONCLUSION**

In a nutshell it could be elucidated that the present research work is an attempt to understand the impact of counselling on the attitude of HIV pregnant female and effectiveness of counselling, level of insecurity, risk taking and social acceptance among HIV pregnant females regarding the bearing of the child. It was hypothesized that the insecurity level will be higher in the HIV couples regarding the issue of HIV transmission to their child, risk-taking behaviour will be lower among the HIV couples in respect to hearing/conceive a child, fear of social acceptance of the child among the couples will be high and Therapeutic Counseling sessions will reduce the level of insecurity, will increase the risk of conceiving the child, and their assumption regarding the social acceptance of the baby will also increase.

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