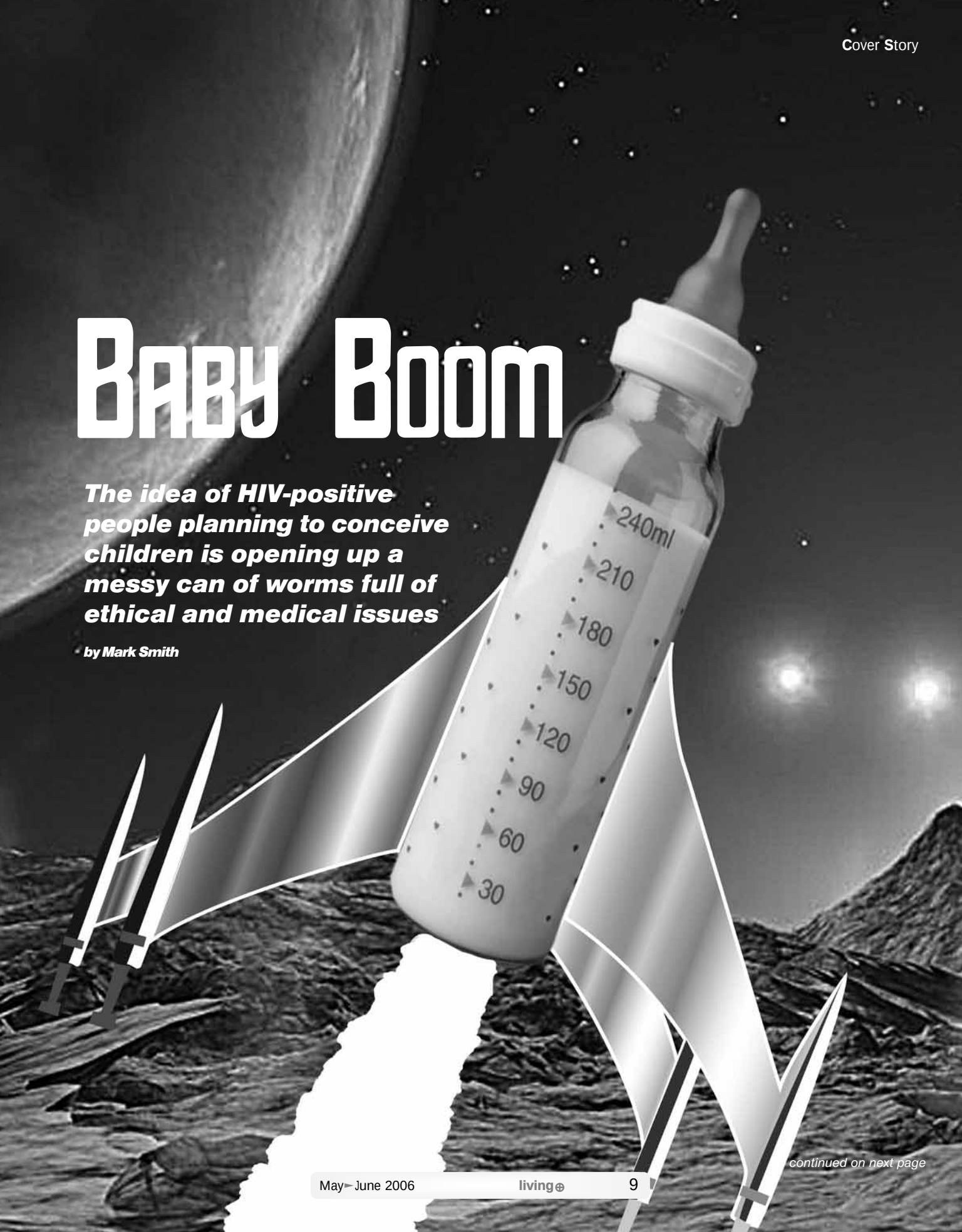
Baby Boom

The idea of HIV-positive people planning to conceive children is opening up a messy can of worms full of ethical and medical issues

by Mark Smith



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One of the major taboos that polite society is uncomfortable talking about is people living with HIV/AIDS who deliberately conceived or are planning to conceive children. The mainstream population probably assumes that letting HIV-positive people have children is akin to attempted murder, because the child will be born with the virus or more mildly, that it's like conceiving an orphan, because the parent will die. It doesn't matter whether we're gay, bisexual, or straight, HIV-positive or -negative, celibate or sexually active—we just don't talk about it. Can you recall the number of times over the past year that you and your friends met for lunch or coffee and discussed HIV-positive people making babies?

Anecdotal evidence indicates that even casual mention of this taboo subject can cause an increased occurrence of sudden projectile spewing of beverage or food by unsuspecting tablemates!

Today, the life expectancy for people living with HIV is decades, and with the prospect of living a long life comes the desire to put your life goals back on track. For a many of us, having children has been a life-long desire. But the issue does raise a number of medical and, for many, ethical issues. Approaching this subject with an open mind and sifting through the variables can help you best view this complicated can of worms.

Reducing the chances of transmission

Current HIV pregnancy research by the World Health Organization shows that mother-to-child transmission, where an HIV-positive woman passes the virus to her baby, can occur during pregnancy, labour, delivery, or breastfeeding. Without treatment, around 15 to 30 percent of babies born to HIV-positive women will become infected with HIV during pregnancy and delivery. A further 10 to 20 percent will become infected through breastfeeding.

Antiretroviral drugs are highly effective at preventing HIV transmission during pregnancy, labour, and delivery. When combined with other interventions, including formula feeding, a complete course of treatment can cut the risk of transmission to below two percent. Even where resources are limited, a single dose of medicine given to mother and baby can cut the risk in half.

Pregnancy has not been shown to expedite the progression of HIV/AIDS in women.

When only the father-to-be has HIV, a procedure called sperm washing can be highly effective. (See the article on sperm washing on page 20.) This involves separating the sperm cells from the seminal fluid and checking them for HIV before artificial insemination or in-vitro fertilization. While sperm washing is a highly effective way to protect both the mother and her baby, it unfortunately is only available at a few clinics and can be difficult to access, even in well-resourced countries.

Special delivery

Early studies showed that elective and planned caesarean sections, or C-sections—which are performed before labour begins and before the mother's water (the membranes that surround the baby) breaks—lower transmission rates. That's because it reduces the baby's contact with the mother's blood. By contrast, emergency C-sections, which are done after the membranes break, do not reduce HIV transmission.

But today, HIV-positive women who are on effective HIV therapy and have undetectable viral loads have low transmission rates for vaginal births. Since C-sections require surgery, they carry some risks. Women who have C-sections are more likely to get infections than those who give birth vaginally.

If you're on HIV therapy with a low viral load (less than 1,000), a C-section is not likely to further reduce your already low risk of transmitting HIV. But if you have a viral load over 1,000 or you're not already receiving treatment at the time of delivery, a C-section may reduce the chances of transmission.

Antiretroviral drugs and birth defects

It still isn't clear whether antiretroviral drugs can cause birth defects in babies whose mothers took these drugs during pregnancy. It's still too early in the tracking process to tell how antiretrovirals might affect a baby as he or she grows up.

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If you're a pregnant HIV-positive woman and you haven't needed to start antiretrovirals for your own health, you have choices about when in your pregnancy you start. The current recommendation is to start antiretrovirals after your first trimester. In circumstances where you haven't had any antiretroviral treatment during your pregnancy, it is recommended that you take the drugs at the start of labour, along with a C-section, to reduce the chances of mother-to-child transmission. See "Positively Pregnant," ***living*** ⊕, Issue 36, May/June 2005 for more information.

Over the past decade, I've met numerous PWAs who have had or are planning to have children: HIV-positive women in relationship with HIV-positive men, HIV-negative women in relationships with HIV-positive men, HIV-positive women and men who were unattached, and HIV-positive women and men who were in same-

sex relationships. All of these people are determined that, come hell or high water, they are going to be the best new parent a child could want. Here are a few of their stories.

Positive and pregnant in the 1980s

Angela (not her real name) is an African American woman, in her mid-forties, whose smallish build belies a giant presence of strength, courage, and dignity. She is a mother of two and has lived with AIDS for almost 20 years. It was after a lengthy illness that Angela learned from a doctor that she had the virus. In shock, she returned home that night to inform her husband of the devastating news. Instead of displaying disbelief, he sneered at her and told her, "Now you got it too, bitch!"

With nowhere else to turn, her fundamentalist upbringing, and the times being what they were in 1985, Angela felt she had no choice but to stay in that relationship and be the best wife she could be. In 1987, she gave birth to a girl. Two years later she gave birth to another daughter.

Today, Angela feels grateful that only one of her daughters was born HIV-positive, her abusive marriage is over, and she's rebuilt her life on new terms. Her biggest regret is that in 2001 her first grandchild was born HIV-positive. In some dark corner of her mind, it's not her daughter she blames for this child, but herself. She feels that if she had been a stronger woman when her daughters were growing up, she might have taught them how to make better choices in their lives.

It's never too late

Tom (not his real name) is in his forties and has been living with the virus for 12 years. After years of trying relationships with various people, Tom met the woman of his dreams in 2000. She was an HIV-negative single mother with a young daughter. With her family's full knowledge and consent, Tom married her and adopted her daughter. He now works and lives in a small city with his wife, daughter, and their new HIV-negative infant.

Tom had always hoped to become a biological father. His wife was also very interested in giving birth to another child. They spent months researching medical journals on-line and asking doctors on how an HIV-positive man and HIV-negative woman could conceive a child safely. They looked into sperm washing, which turned out to be too cost-prohibitive for them. They instead went with the medical opinion that when a HIV-positive man's viral load is undetectable, there is very little risk of transmitting the virus in his semen.

Throughout the pregnancy, his wife was regularly tested for the virus. No complications were found and their beautiful new daughter arrived safely.

This event has brought Tom the greatest joy he has ever known. If they could afford it, they would jump at the chance to have another child together.

Wake up and start dreaming

Barbara has lived with HIV for six years. She is quickly approaching her mid-30s and plans to have at least one child before she hits forty. Barbara has always felt she was destined to be a great mother.

When she got hit with her diagnosis in 2000, Barbara went through the so-called five stages of grief: denial, anger, bargaining, depression, and acceptance. Somewhere along this journey, her dream of motherhood died along with her hopes for a real future—until something shifted.

Barbara believes it was the support she received from family, friends, counselling, and doctors that encouraged her to start dismantling many of the limitations she had imposed upon herself. She feels that she's back on track with the direction of her life. She has a new career that she really enjoys and is staying abreast of the newest findings on HIV pregnancy. All of life's possibilities are back on the table.

While Barbara currently doesn't have a man in her life to father a child with her, she isn't certain that she wants an actual husband. She just wants to have that beautiful, healthy baby she's always dreamed of. She hopes for a girl.

Should any of these people be judged by society for what they've done or are planning to do? Are they just a part of a growing trend among HIV-positive people? Should we be worried about the future repercussions for their children? And at which point does community concern cross over into just being nosy?

Break this taboo and discuss the subject with a friend over lunch or coffee. But make sure you're wearing something washable. ⊕

***Mark Smith** is a member of the BCPWA Society and a community volunteer.*

Additional reading

More details and options can be found at *www.avert.org/pregnancy.htm* or at *www.pwn-wave.ca/index.cfm?group_ID=1174.*

Read more personal stories about HIV and pregnancy at *www.thebody.com/asp/may99/pregnancy.html*.