Promoting sexual health in black African women who have HIV


There is an upwards trend of HIV infection in women and in particular women from sub-Saharan Africa. The clinical nurse specialist has a pivotal role in promoting sexual and reproductive health and must educate and discuss how transmission risks can be reduced, particularly for those in relationships where only one partner has HIV.

HIV/AIDS clinical nurse specialists based in the community are experienced in providing advice and support for people infected with or affected by HIV. They have broad and appropriate knowledge of the disease processes and treatment, as well as an understanding of psychosocial issues. The nurse is able to offer individualised care for people in their own homes by working alongside other service providers. This function straddles continuing care, palliative care and health promotion.

At least 70 per cent of global HIV cases were transmitted through heterosexual intercourse (Hewitt et al, 2001) (Fig 1). Worldwide, women have been shown to be the fastest growing category of people with HIV infection (McDonnell and Kessenich, 2000). This rapid increase among women has been noted in London where the number of cases in black African residents within a local NHS trust area has undergone a four-fold rise in recent years with women making up over half of all newly diagnosed cases (Lambeth, Southwark and Lewisham Health Authority (LSLHA), 2001).

Issues specific to black African women

Many of these women have to deal with numerous other social and cultural issues in addition to the medical demands associated with new HIV status.

Childbearing and sexuality

As most of the women who present with HIV infection are in the prime of their lives (LSLHA, 2001), childbearing concerns are prominent. The dynamics of a relationship are influenced or altered by the knowledge of the woman’s HIV diagnosis. For example, Van der Straten et al (1995) noted that managing emotional and sexual intimacy could be challenging in a sero-discordant relationship (where only one partner has HIV) due to transmission concerns.

It has been claimed women experience a loss of their sexuality when they discover they are HIV positive. This has been largely attributed to the stigma surrounding HIV.

Relationships and inequality

Van der Straten et al’s (1995) study exploring HIV management in black South African sero-discordant heterosexual couples showed that stigma hindered disclosure to others and communication about HIV and sex. Pool et al (2001) stated that the principal concern of women who have been diagnosed with HIV was the possible reaction she would receive from her husband. The women the authors interviewed were fearful that if their husbands found out they were HIV positive, they would be blamed, and separation or domestic violence might result. According to Pool et al (2001), women from sub-Saharan Africa who are HIV positive are in a particularly vulnerable state as patriarchal structures are strong in certain parts of that region, and relationships are characterised by gender inequality with men having the final say in reproductive and sexual matters such as how many children they will have and whether they use condoms. This culture of male dominance has implications for HIV management in the UK as a large number of those infected are asylum seekers who have limited access to public funds or employment.

WHO definition of sexual health

There is clearly a role for the clinical nurse specialist to promote sexual and reproductive health based on the World Health Organization definition: “Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationship” (WHO, 1986).

If fear of rejection is the reason many infected women choose to keep their HIV status secret from their male partners (Tangmunu et al, 1999), it follows that the couple may be practising unsafe sex as the woman grapples with the dilemma of how to initiate safe sex. This may lead to feelings of guilt on the woman’s part as well as fear of being blamed or rejected. Rogers-Clark and Smith (1998) add that women with HIV often feel that others see them as dirty, diseased and undeserving. Even in cases where the woman’s HIV status is disclosed to their partner, negotiation of safer sex can be problematic and may result in a poor sexual relationship.

For the majority of HIV discordant couples, reproductive decisions appear to be significant and among the most difficult to confront. According to VanDeventer et al (1998), who claim women with HIV have similar fertility rates to those without HIV, the difficulty stems from the anticipation of shortened lifespan for the infected partner and the risk to the uninfected partner or foetuses.

Bungener et al (2000) compared the psychosocial and psychopathological aspects of HIV infection in African
and European women with HIV and found the desire to have children was much greater in African women. An HIV infection appears to hinder the woman’s ability to fulfil what Pool et al (2001) said was her perceived traditional role of sexual partner and mother.

The role of the clinical nurse specialist

Sexual and reproductive health issues for women with HIV are arguably more difficult and complex to tackle because HIV still carries a stigma, which can result in discrimination. The diagnosis of HIV has a profound impact on the discordant heterosexual couple, often requiring major adjustments in sexual behaviour. It is essential that measures are taken to reduce transmission to a sexual partner. Preparing the woman to share the knowledge of her HIV diagnosis with a sexual partner is a major challenge. Although fraught with problems, this is a vital step in the process of learning to live with HIV.

Sexual intimacy and reproduction is an aspect of a couple’s life that must be approached with a high degree of sensitivity. Couples may avoid discussing sex. The nurse should tactfully seek to build a trusting relationship with the couple to facilitate open discussions.

The nurse needs to work proactively with the serodiscordant couple and, more importantly, the uninfected partner to achieve behaviour modification. Such work is particularly relevant in the light of Baker et al’s (1990) claim that maintaining a stable partnership is greatly influential to a person’s ability to successfully adapt to a chronic disease. Stability in her relationship may help the HIV positive woman keep her sense of normality and sustain her sexual integrity, as well as encouraging her to comply with any treatment regimen.

Challenges of increased survival time

As people with HIV continue to survive for longer (Klaus, 1995), the need arises to recognise that serodiscordant couples experience normal emotional and biological drives and therefore require support as they make difficult decisions about sexual and reproductive issues.

Huge advances in HIV management have made it possible for steps to be taken, before and during pregnancy and after the birth to reduce the chances of mother-to-child transmission (Fig 1), while also avoiding infection of the HIV-negative partner (Klaus, 1995). The clinical nurse specialist is in a pivotal position to provide up-to-date preconception information to enable the couple to make their own decisions. The nurse, as part of the multidisciplinary team, can help to interpret information given to clients by other professionals and help them prepare appropriate questions when referred to other agencies.

Since condom use remains the most widely recommended strategy for preventing transmission of infection, the couple appear to have limited options:

- Condom use;
- Abstinence;
- Risk-taking.

Studies have shown that it is not possible for all women to request condom use (Joffe, 1996). Instead of simply giving standard information on using condoms, the nurse needs to consider individual circumstances and encourage the client to develop a personal strategy. The nurse can help women develop communication, negotiation and assertiveness skills. Van der Straten et al (1995) proposed male partners be involved via voluntary counselling and testing, as well as emotional support during testing, even where the partner tests negative. The involvement of both partners on a continuing basis will help to:

- Ensure the acceptance of any subsequent interventions;
- Influence consistent safer sex practices;
- Aid decisions about pregnancy.

Preparing the professional

It is important to tailor the services we provide to take account of the ethnic and cultural background of the recipient. The nurse needs to have a sound understanding of sexual and reproductive issues from the client’s perspective. Care needs to be orientated to each client’s needs. The nurse needs to be adequately prepared to be involved in levels of care that are more complex than giving simple information.

Conclusion

Some of the strategies proposed in this article can easily be incorporated into the day-to-day activities of the nurse, while others will need long-term strategic planning and resourcing. What is required above every thing else, however, is the recognition from health professionals that sexual and reproductive health is an integral facet of life that should not be ignored.