Reproductive Health

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HIV care in Finland
Total number of diagnosed HIV cases in Finland = 3638 (100-200 new cases per year)

1980 - first HIV case
1983 - first female HIV case
Before 1999 - 40-80 cases per year
From 2000 onwards
- 100 - 200 new cases per year (of which 40 – 70 are female)

1980 – 2016:
Men: 2650 – 73 %
Women: 988 – 27%
(Foreign women – 264)
Deliveries by HIV+ women 1993 - 2013

Deliveries in HUCH:
- 1993-99 – 26 deliveries
- 2000-2010 – 109 deliveries
- 2011-2013 – 53 (2016 - total in a moment over 250)

(Tampere: before 2013 -20 deliv. After 2016 22 = 42)

Type of deliveries in HUCH 2006 – 2013
- 115 Vacinal deliveries 77%
- Ceasarian deliveries 23 % - (wich 8%- emegrency)
- Others (15%) : obstrective reasons, because of HIV or HCV- big transmission risk by viruses)
Treatment of HIV+ women in fertile age - nurse’s role

1) Giving correct information

2) Helping reach realistic understanding of
   ◦ Pregnancy
   ◦ Childbirth
   ◦ Rearing a child when HIV positive

3) Encouraging women to their dreams

4) Helping to plan ahead
   ◦ Living in a relationship
   ◦ Becoming a mother
Gynecological follow-up of HIV+ women

Goals:
- effective contraception,
- Identifying abnormal pap smears
- Identifying other gynecological symptoms

Every new HIV+ woman referred to gynecologist
- Gynecological history and status
- first Pap smear, next after 6 months, then once a year.

Gynecology control visit every 1-3 years

Risk of abnormal pap smears 2.9-5% bigger among HIV + women.

Other risk factors:
- Smoking, HPV- infection, bacterial vaginosis, STD’s, low CD4- cells.
Contraception

Aim: All HIV+ women’s pregnancies are planned.

Contraception:

*First choice is hormonal intrauterine device. (HUCH gives free them to HIV patients.)

- does not change HIV medication effectiveness
- does not induce higher HI- virus counts in the genital tract

Other good options:

- Copper intrauterine device
- Subdermal contraceptive capsule
How we treat - teamwork at HUCH
(Helsinki University Central Hospital)

Infectious disease policlinic-
◦ HIV follow-up and care co-ordination during / after pregnancy

Ob & Gyn clinic
◦ antenatal follow-up, childbirth

Pediatric clinic
◦ meeting women & family before delivery
◦ information to mothers and obstetries dep. Personel about newborn medication.
◦ 2 year follow up

Co-ordination meetings every 6 weeks
HIV+ pregnant women also use same community based mother-child health centers as other women

So far, more than 300 babies to HIV+ women in Finland. (250 in Helsinki)

In Finland only one baby born with HIV
  - Mother had few contacts with healthcare during pregnancy, first early pregnancy HIV test negative, was not tested later
Planning for pregnancy

1) Both woman and man HIV+, no drug resistant virus strains
   - normal intercourse.

2a) HIV+ woman, HIV- man
   - start HIV medication to women before pregnancy
   - teach to identify ovulation time
   - Home insemination. ´Mumincup´- syringe treatment. (If sperm taken from condom, condoms without spermicide used)
Planning for pregnancy

2b) HIV- woman, HIV+ man

- HIV medication for the woman at least 6 months, (tenofovir+emtricitabine combination, coitus during ovulation time).

After pregnancy started, condom to be used.

Alternative:

-Spermwash -> insemination
  ◦ Not done routinely in Finland.
  ◦ Before treatment, fertility of both woman and man need to
  ◦ Very complicated, expensive.
HIV+ women and pregnancy

* Ensure optimal HIV medication
* Start medication as soon as possible.
* If poor medication adherence, start DOT (Directly Observed Therapy)
* HIV virus load control: 1-2 times in a 2 months, copies need to be <20.
* Glucose tolerance test recommended
* No breast feeding—big issue, need to talk

* Very important to have a control visit at week (34)-36
  ◦ planning the type of delivery
  ◦ Vaginal birth is the primary choice
HIV+ woman and delivery

* If HIV virus load > 200 elective cesarean section at week 38.

* In other cases vaginal delivery

* Zsidovudine infusion during the pregnancy (in cesarean delivery start 3 hrs before).

* Avoid invasive procedures

* If woman hasn’t been attending a prenatal clinic, and no HIV test has been done, while there is strong suspicion of HIV infection:
  start same zsidovudine protocol as above, but immediately
Follow-up of children to HIV+ women

*Before delivery:*

- Meeting with mother, medication planning
- Big blood count, check there are no contra-indications to start medication, no breast feeding.
- HI –virus load

*New born baby:*

*Big blood count (anemia, symptoms of primary infection).*

*2 days old baby:*

*Plan to stop HIV medication in week 4*
Follow-up of children to HIV+ women

* 2 months: 
  * Big blood count, HI- virus load. Symptoms?

* 4 months: 
  * HI-virus load, (big blood count).
  If HI- virus load \times 3 \text{ neg.} \text{ child is not infected. Give a BCG vaccination.}

* 18 months: 
  * HIV AgAb antibodies have disappeared stop the follow up, take a contact when is needed.
Menopause

*HIV+ women reach menopause earlier than average women

*Hormonal replacement therapy (HRT): same goals as among other women

*Because HIV medication might reduce treatment effect, possible need to increase the dose

*Sexuality should be discussed with women of all ages