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ORIGINAL

Universal access to sexual and reproductive health services among women affected by HIV in Morocco: What reality?

Acceso universal a los servicios de salud sexual y reproductiva entre las mujeres afectadas por el VIH en Marruecos: ¿Qué realidad?

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Abstract

Background: HIV remains a major global public health problem, resulting in 40.1 million deaths since the beginning of the epidemic. In 2021, 38.4 million people were living with HIV, 54% of who are women and girls. In Morocco, the number of people living with HIV (PLHIV) is 23,000 of which 63% of cases have been reported in three regions (Souss Massa, Casablanca and Marrakech). The objective of this study describe the barriers to access sexual and reproductive health for women living with HIV in Marrakech, Morocco.
Methods: This study is a mixed quantitative and qualitative descriptive study. The study population is composed of women living with HIV receiving health services in the prefecture of Marrakech. A questionnaire survey and interviews were conducted to gather descriptive data on this population, as well as to collect information on the accessibility of sexual and reproductive health care for this category of women.
Results: The average age of the women interviewed was 38.64 ± 8.58 (20 to 58 years). The majority of the women (89%) were from Marrakech with a clear predominance of urban areas (72%). The difficulties in accessing reproductive health services were reported by women surveyed, particularly for gynecological examinations (66.70%), family planning (33.30%) and psychosocial support (66.70%). The results of this study showed that HIV-positive women's access to reproductive health services depends on several barriers at different levels. Stigma and discrimination are still the main concerns of HIV-positive women in our context in addition to economic barriers.
Conclusion: Measures to improve access to and utilization of reproductive health services for women living with HIV must integrate all the biological, psychological and social (attributes) of these women with a change in provider behavior and a reorganization of services to ensure more integration and coordination of care between different levels of care.

Keywords: Women living with HIV, sexual and reproductive health, accessibility to care.

Resumen

Antecedentes: El VIH sigue siendo un grave problema de salud pública mundial, que ha causado 40,1 millones de muertes desde el inicio de la epidemia. En 2021, 38,4 millones de personas vivían con el VIH, de las cuales el 54% eran mujeres y niñas. En Marruecos, el número de personas que viven con el VIH (PVVS) es de 23.000, de las cuales el 63% de los casos se han registrado en tres regiones (Souss Massa, Casablanca y Marrakech). El objetivo de este estudio es describir las barreras de acceso a la salud sexual y reproductiva de las mujeres que viven con el VIH en Marrakech, Marruecos.
Métodos: Se realiza un estudio descriptivo mixto cuantitativo y cualitativo. La población de estudio está compuesta por mujeres que viven con el VIH y reciben servicios sanitarios en la prefectura de Marrakech. Se realizó una encuesta por cuestionario y entrevistas para recopilar datos descriptivos sobre esta población, así como para recoger información sobre la accesibilidad de la atención sanitaria sexual y reproductiva para esta categoría de mujeres.
Resultados: La edad media de las mujeres entrevistadas era de 38,64 ± 8,58 (20 a 58 años). La mayoría de las mujeres (89%) procedían de Marrakech, con un claro predominio de las zonas urbanas (72%). Las mujeres encuestadas señalaron las dificultades de acceso a los servicios de salud reproductiva, en particular para los exámenes ginecológicos (66,70%), la planificación familiar (33,30%) y el apoyo psicosocial (66,70%). Los resultados de este estudio mostraron que el acceso de las mujeres seropositivas a los servicios de salud reproductiva depende de varias barreras a distintos niveles. El estigma y la discriminación siguen siendo las principales preocupaciones de las mujeres seropositivas en nuestro contexto, además de las barreras económicas.
Conclusión: Las medidas para mejorar el acceso y la utilización de los servicios de salud reproductiva para las mujeres que viven con el VIH deben integrar todos los atributos biológicos, psicológicos y sociales de estas mujeres con un cambio en el comportamiento de los proveedores y una reorganización de los servicios para garantizar una mayor integración y coordinación de la atención entre los diferentes niveles de atención.

Palabras clave: Mujeres que viven con el VIH, salud sexual y reproductiva, accesibilidad a la atención.

Introduction

The number of people living with HIV worldwide at the end of 2021 is estimated to be 38.4 million, 54% of whom are women and girls aged 15 years and older, with approximately 4,900 young women aged 15-24 infected with HIV each week (UNAIDS, WHO 2022). In 2021, 650,000 people died of HIV-related causes and 1.5 million people were infected with HIV compared to three million in 1997 (WHO, 2022). The WHO African Region is the most affected region with more than 25.6 million people living with HIV in 2021 and nearly two-thirds of new HIV infections worldwide. In 2021, the percentage of new HIV infections in sub-Saharan Africa is 51%, women and girls accounted for 63% of all new HIV infections[1,2]. In Morocco, the number of people living with HIV (PLHIV) is 23,000 of which 63% of the cases have been notified in 3 Regions (Souss Massa, Casablanca and Marrakech). The number of AIDS-related deaths is estimated at 387 by the end of 2021. The incidence rate is 0.2 per 1000. According to the latest Spectrum estimates for 2020, women account for 43% of PLWHA (8,500), and fewer than 100 HIV infections will occur annually among children through mother-to-child transmission (PMTCT). The percentage of coverage of pregnant women with antiretroviral treatment to prevent mother-to-child transmission of HIV (PMTCT), meanwhile, has increased from 33% in 2011 to 62% in 2016[2,3].

The links between Sexual and Reproductive Health (SRH) and HIV are widely recognized, as HIV infections are most often sexually transmitted or associated with pregnancy, childbirth and breastfeeding, and the risk of HIV transmission and acquisition is increased in the existence of some Sexually Transmitted Infections (STI)[4]. In addition, sexual and reproductive health conditions have the same causes as HIV infections, including poverty, limited access to adequate information, gender inequality, cultural norms, and social marginalization of the most vulnerable populations[4]. Creating and organizing linkages between essential HIV services (prevention, treatment, care and support) and essential SRH services (family planning, maternal and newborn health, STI prevention and management, sexual health promotion, violence prevention and management, and unsafe abortion prevention) in national programs has important public health benefits[4,5].

That is the reason why several recommendations have been developed around the world to effectively link HIV and SRH actions. These include: the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children (May 2004), the New York Call to Commit to Linking HIV/AIDS and Sexual and Reproductive Health (June 2004), the World Summit Outcome (September 2005), the Consensus Statement: Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services (November 2007), the UNAIDS "Fast-Track" three-ninety strategy, and the Global AIDS Strategy 2021-2026. Around 17.8 million women worldwide are living with HIV (UNAIDS, WHO 2016)[1,2]. These women require special treatment and care to meet their own health needs. However, violations of women's social, economic, and legal rights limit their ability to access treatment and protect their sexual and reproductive health rights6. Indeed, women face a "triple jeopardy" in the face of AIDS: as HIV-infected individuals, as mothers of infected children, and in their responsibility to care for their partners, family members, or orphans with AIDS[5,7,8]. In addition, HIV-positive women face stigma and judgmental attitudes from health care providers, economic barriers, and lack of decision-making power, which limit their access to information and choice of contraceptive methods[5,7,8]. Socially marginalized women, such as sex workers, immigrants, intravenous drug users and prisoners, face particular difficulties in accessing services because of the double discrimination they face due to their personal circumstances and their HIV status[7,9,10]. Women living with HIV infection therefore need particularly tailored access to HIV prevention services, access to accurate information, to reduce the risk of re-infection with another strain of HIV, to protect them from unwanted pregnancy, to monitor their pregnancies (ANC, PNC, etc.), and to have access to emergency obstetric care services to manage the mother and her newborn at the time of birth[11]. Several studies have explored the individual sexual and reproductive health needs of HIV-positive people and analyzed healthcare in relation to family planning, sexually transmitted infections, breast and uterine cancer, maternal protective services, and prevention of mother-to-child transmission[9,12]. So, organizing and strengthening existing linkages between SRH and HIV programs can provide important public health, socioeconomic and individual benefits[4], including: increased access to and utilization of SRH and HIV services, access to sexual and reproductive health services adapted to the needs of person living with HIV, reduced HIV-related stigma and discrimination, expanded care for key underserved and vulnerable populations, increased support for dual protection, improved quality of care, better understanding and protection of people's rights, and increased program effectiveness and efficiency.

In Morocco, we don't have enough information on the degree of integration of SRH and HIV/AIDS care and prevention services, and we have never explored HIV-positive women's perceptions of barriers to access and their needs and expectations regarding these SRH services (family planning, maternal and neonatal health, and breast and cervical cancer screening). Target 7 of the MDGs states that by 2030, there must be universal access to sexual and reproductive health services, including family planning, information and education, and the integration of reproductive health into national strategies and programs. To this end, we proposed to

conduct this study to identify barriers to accessing sexual and reproductive health services for HIV-positive women in areas of high HIV prevalence in Morocco.

Objective

The objectives of this study are to:

- Explore the needs and expectations of sexual and reproductive health services for women living with HIV regarding
- Describe the barriers and facilitators to accessing SRH services for women living with HIV

Method

Type of study

In order to achieve our objectives, we conducted a mixed qualitative and quantitative exploratory study. The proposed design is a single case study with multiple levels of analysis. The single case in our study is represented by the prefecture of Marrakech/Marrakech-Safi Region. Our study was conducted at the referral center of the city of Marrakech and the department of infectious diseases at the Mohammed VI University Hospital in Marrakech. The region of Marrakech is the second region most affected by HIV-AIDS in Morocco.

Study Population

The population of our study is composed of HIV-positive women attending the two services and health providers involved in the care of people affected by HIV and AIDS and SRH services (general practitioners, maternal and child health nurses, midwives, referral center staff, provincial, regional and central officials). We opted for a non-random accidental sampling for information on HIV-positive women during the nine-month data collection period. We recruited women who presented themselves at the referral center and at the infectious diseases department of the Marrakech University Hospital during the data collection period. The total number of women surveyed was 114. We conducted semi-structured interviews with health professionals, operational managers, key informants from non-governmental organizations, and managers from UN agencies involved in programs for the care of HIV-positive women of reproductive age until the information was saturated.

Data collection and analysis

The dimensions to be investigated in our study related to reproductive health services are institutional and organizational factors (accessibility, continuity of care, comprehensiveness, women-centered care, and coordination between levels), inter-relational factors (support from family and friends/community and peer support), individual factors (knowledge of the benefits and importance of accessing reproductive health services), and ethical factors (right to health and dignity of women affected by HIV/AIDS). A questionnaire administered to these 114 women provided us with information on their socio-demographic characteristics and their clinical follow-up related to a problem with reproductive health at the level of the health care services. The quantitative data were analyzed using SPSS 22.0 with a risk of error of less than 5%. First, a descriptive analysis of the socio-demographic characteristics and other variables to be studied of our population was performed.

Ethical Considerations

The research was carried out while respecting and ensuring all ethical considerations, namely, the acquisition of the agreement of the ethics committee, the authorization for data collection which was established by the supervising institution and presented to the persons concerned, the respect of anonymity and confidentiality concerning the information collected through the different data collection tools, as well as the obtaining of the free and informed written consents of the participants.

Results

We conducted 114 questionnaires face to face and 59 interviews with HIV-positive women at the study sites; the average duration of these interviews was 24.62 min. The average age of the women interviewed was 38.64 ± 8.58 (20 to 58 years). The majority of the women (89%) were from Marrakech with a clear predominance of urban areas (72%).

Socio-demographic characteristics

The majority of HIV positive women surveyed in our study are Moroccan (99.1%), and 0.9% are sub-Saharan. Women living in Marrakech represent 89% of our sample size followed by those from Safi (8%) while the cities of Essaouira, Youssoufia and El Kalaa represent only 1% each of our sample size. The urban area is the most represented with 72% of women. We found that 55% of PSF are married, 21% are divorced, 16% are widowed and 8% are single. Approximately 85% of the HPWs in our study have between one and three children. Women with primary and secondary education represent 64% of the women surveyed, while 29% of the latter have never attended school and 7% have a higher level of education. Housewives represent 75% of our sample size, while 25% of the HPWs in our series have different jobs. As for the average monthly income, it does not exceed 1500dh for 65% of the women in our study, and is between 1500 and 3000dh for 28% of them, while only 7% have a monthly income higher than 3000dh. About one third of the HPWs in our study have no medical coverage (27%) and 63% are beneficiaries of the medical assistance scheme offered to impoverished populations.

Medical characteristics

In our study, 58% of the women surveyed reported a medical history, while 10% reported having toxic habits. Women's HIV status has been increasingly discovered since 2000 until 2018, however 42% of this discovery is made incidentally or following screening campaigns organized by the Ministry of Health. In our study, 93% of the HPW are managed in a public institution and 7% in a private sector structure while 42% of the HPW are diagnosed with at least one symptom. The existence of another person affected by the virus in the family was reported by 54% of the women surveyed in our study, mainly the spouse (74% of cases) followed by the children (19% of cases).

Access to reproductive health services for HIV-positive women

The service needs reported by the women interviewed were psychosocial support (14.30%), the prevention of mother-to-child transmission (21.4%) and pregnancy and delivery follow-up (3.60% for ANC and 3.60% for PNC). The main services that the HPWs received were related to pregnancy and childbirth follow-up (14.9% in ANC and 15.80% in PNC) and family planning (14.90%). A difference between the services received and those needed by the HPWs in sexual and reproductive health. The difficulties in accessing reproductive health services were reported by women surveyed, particularly for gynecological examinations (66.70%), family planning (33.30%) and psychosocial support (66.70%). These difficulties were related to the non-availability or unawareness of the existence of the service or to inappropriate behavior of the health care personnel.

Table I: Services received versus services that HIV-positive women have difficulty accessing.

	Services received	Services that HIV-positive women have difficulty accessing
ANC	14.9% (17)	66.70% (76)
PNC	15.8% (18)	33.30% (38)
PMTCT	2.60% (3)	33.30% (38)
Gynecological problem	4.4% (5)	66.70% (76)
Family planning	14.90% (17)	33.30% (38)
Psycho-social support	15.80% (18)	66.70% (76)
Gender based violence	0.90% (1)	33.30% (38)

ANC: Ante-natal care
PNC, Post-natal care

Following the interviews conducted with the HPWs in our study, they expressed three types of needs that stem from the difficulties they have encountered and their previous experiences with the use of reproductive health services. The need most reported by these women is the need for a change in the behavior of health care providers in reproductive health facilities to ensure a good reception, a good listening ear, psychological support and respect for professional secrecy while fighting against stigmatization and discrimination.

Barriers and facilitators to accessing reproductive health services

Of the women surveyed, 27 responded that the quality of the reception, referral and listening services in reproductive health facilities was good to excellent. While six others were able to express their dissatisfaction with these services: «I have suffered at the level of health centers and for me the services they have are mediocre» Married 31 years old.

Regarding reproductive health services, 39 women surveyed expressed satisfaction with the health care provided by these services: «I am happy with my doctor's performance» Married 32 years old. While six others were dissatisfied with the lack of drugs and equipment as well as the inhumane behavior of the providers at these facilities «the health care offered by the reproductive health services is poor, they don't have enough drugs and equipment to take care of us» Married 43 years old. All 24 women in our series did not report their HIV status to the reproductive health service provider, of these women, nine did not know their HIV status at the time of using SRH «I was not aware of my illness» Married 31 years old. While 13 other women chose not to declare their seropositivity for fear of the reaction of those around them «for me it is a dangerous disease that society does not tolerate» Single, 38 years old. «...I was afraid of the reactions». Married 40 years old. The difficulties most reported by women who have already used a reproductive health service are related to expenses and the use of transportation (six women) «The difficulties I encounter are the distance from the center and the transportation expenses, especially with my son's illness». Married in rural areas 20 years old.

In addition to the high-waiting time (four women) and the fear of stigma and discrimination (four women) «I avoid going to the health center for fear of stigma» Married 27 years old. Exposure to stigma, discrimination and exclusion was reported by 13 women in different forms, either by delay or refusal to provide necessary care even when it is a therapeutic emergency «...The doctor let me wait two days before operating on me for appendicitis...» Married 32 years old, «...she refused to consult me on the grounds that she has no experience» Married 29 years old, «the nurse at the health center refused to treat me» Married 20 years old, or even by a behavior that does not respect the dignity of these women «...I am questioned in front of the patients without respect for professional secrecy» 31 years old married, «the doctor who consulted me sent me to another doctor and then she changed the blankets on which I was lying» 33 years old married, «...I was insulted and isolated I am depressed». Married 27 years old.

Discussion

Access to health care for HIV-positive women is a moral imperative, directly linked to human rights. The ultimate

goal is to ensure universal access to care for all patients. This study has shown that access to care can be affected by several factors, including HIV status. Perceived stigma in clinical settings discourages these women from accessing needed health care services. Good access to care is imperative to maintain the health, well-being and quality of life of people living with HIV/AIDS (PLWHA). The objective of this study was to explore the needs and expectations expressed by HIV-positive women regarding SRH and their experiences in accessing these services, including barriers and facilitating factors to access in the Marrakech Region Safi prefecture. We found that access to care was low among this population, with more than half of the women surveyed reporting difficulties accessing reproductive health care.

The services for which the women in our study report having the most difficulty in accessing are those related to reproductive health, in particular pregnancy monitoring, childbirth and vaccination, in addition to other surgical and stomatological services, even in the case of therapeutic emergencies, as well as the non-availability of several complementary check-ups in hospitals. These results are of particular importance because the lack of access or late access to care can lead to an alteration in the health of these women[13,14]. Social and financial conditions are not a major obstacle to accessing SRH as reported by our population, and it is mainly the stress and fear that precede their consultation that were most cited. Professional status and proximity to health facilities did not influence their access to reproductive health services. On the contrary, for some women, they prefer the hospital to be far away to limit the risk of disclosing their HIV status to their neighbours and relatives. About half of the sample reported perceived stigma from a health care provider. Few studies showed the factors and barriers that impede HIV-positive women's access to reproductive health care. In contrast, the majority of studies reviewed raised the relationship between access to care for HIV-positive women and stigma. According to these studies, it may be easier to reduce stigmatizing behaviours such as refusal to provide services than it is to reduce prejudicial attitudes such as those that reflect discomfort with HIV patients. The results of a systematic review that included 18 studies in 13 countries in Latin America and the Caribbean for a population of 5672 PLHIV, showed that the reproductive health needs of these women are not being met with greater exposure to institutional violence among PLHIV compared to non-HIV women. Stigma can be a significant barrier to health maintenance[14].

Interventions are needed to reduce perceived stigma in health care settings. Educational programs and modelling of non-stigmatizing behaviour can teach health care providers to provide humanistic care. Also, research is needed to improve our understanding of how health care providers' behaviours can negatively impact patients' experiences. The issues that emerged highlight the importance for Morocco to implement the good practice recommendations provided by the new guideline developed by WHO. These guidelines aim to create supportive environments for PLHIV with user-friendly health services that integrate SRH, providing sexual health counselling and support by trained and respectful health care providers.

Conclusion

Through this research, it seems obvious that the access of HIV positive women to reproductive health services depends on several factors at different levels; stigmatization and discrimination still constitute in our context the main concerns of HIV positive women in addition to the economic barriers with the expenses generated by HIV infection (additional check-ups, medication, travel expenses, absenteeism from work) and the social cost of the illness. Measures to improve access to and use of reproductive health services by these women must integrate all the biological, psychological and social features relating to these women with a change in the behavior of health care providers and a reorganization of services ensuring more integration and coordination of care between levels (PHC and hospital) and between specialties (infectious diseases, gynecology, pediatrics, biology).

Our study was conducted in the province of Marrakech, which is one of the regions most affected by HIV infection. However, our results cannot reflect the situation of the use of reproductive health services by HIV-positive women in other regions of the kingdom, so it would be relevant to conduct other studies in other regions, particularly those most affected by the HIV endemic.

Abréviations

HIV/AIDS (Human immunodeficiency virus infection and acquired immunodeficiency syndrome), PNC (Post-natal care), ANC (Ante-natal care), WHO (Word Health Organization), STI (Sexually transmissible disease), PMTCT (prevention of mother-to-child transmission), UNAIDS (United Nations Programme on HIV/AIDS), SRH (Sexual and reproductive health), SDGs (Sustainable Development Goals), UHC (University hospital center), NGO (non-governmental organization), SPSS (Statistical Package for the Social Sciences), HPW (HIV positive woman), MAD (Moroccan dirham).

Declarations

Ethics approval and consent to participate.
The research protocol was approved by the Ethics Committee for Biomedical Research. All study participants signed a consent form before the start of the study.

Competing interests

All authors declare no competing interest.

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Authors' contributions

Bouchra Assarag searched the literature, extracted data, and synthesized data and developed the first draft of the manuscript; Hanane HABABA carefully checked the manuscript, to provided essential methodological advice. The authors have read and approved the final manuscript.

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