

Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes

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Abstract This paper synthesizes the rates, barriers, and outcomes of HIV serostatus disclosure among women in developing countries. We identified 17 studies from peer-reviewed journals and international conference abstracts — 15 from sub-Saharan Africa and 2 from south-east Asia — that included information on either the rates, barriers or outcomes of HIV serostatus disclosure among women in developing countries. The rates of disclosure reported in these studies ranged from 16.7% to 86%, with women attending free-standing voluntary HIV testing and counselling clinics more likely to disclose their HIV status to their sexual partners than women who were tested in the context of their antenatal care. Barriers to disclosure identified by the women included fear of accusations of infidelity, abandonment, discrimination and violence. Between 3.5% and 14.6% of women reported experiencing a violent reaction from a partner following disclosure. The low rates of HIV serostatus disclosure reported among women in antenatal settings have several implications for prevention of mother-to-child transmission of HIV (pMTCT) programmes as the optimal uptake and adherence to such programmes is difficult for women whose partners are either unaware or not supportive of their participation. This article discusses these implications and offers some strategies for safely increasing the rates of HIV status disclosure among women.

Keywords HIV seropositivity; Truth disclosure; Women; Sexual partners; Psychology, Social; HIV infections/transmission; Disease transmission, Vertical/prevention and control; Counseling; Review literature; Meta-analysis; Africa South of the Sahara; Thailand; Developing countries (*source: MeSH, NLM*).

Mots clés Séropositivité HIV; Divulgation vérité; Femmes; Partenaire sexuel; Psychologie sociale; HIV, Infection/transmission; Transmission verticale maladie/prévention et contrôle; Conseil; Revue de la littérature; Méta-analyse; Afrique subsaharienne; Thaïlande; Pays en développement (*source: MeSH, INSERM*).

Palabras clave Seropositividad para VIH; Revelación de la verdad; Mujeres; Parejas sexuales; Psicología social; Infecciones por VIH/transmisión; Transmisión vertical de enfermedad/prevencción y control; Consejo; Literatura de revisión; Meta-análisis; África del Sur del Sahara; Tailandia; Países en desarrollo (*fuente: DeCS, BIREME*).

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Voir page 305 le résumé en français. En la página 306 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 306.

Introduction

The prevention and control of human immunodeficiency virus (HIV) infection depends on the success of strategies to prevent new infections and to treat currently infected individuals. Voluntary HIV testing and counselling serve both goals. HIV testing and counselling provide essential knowledge and support to individuals at risk for contracting HIV, enabling uninfected individuals to remain uninfected and those infected to plan for the future and prevent HIV transmission to others (1, 2). Knowing their HIV status may also enable HIV-infected individuals to access early and appropriate treatment, care and support programmes. Furthermore, HIV-infected women who know their serostatus are in a better position to make informed

choices about their reproductive lives and, if pregnant, to access specific interventions, such as antiretroviral prophylaxis and infant feeding counselling and support, which can significantly reduce the risk of mother-to-child transmission of HIV (3–5). At present, the majority of HIV-infected individuals are unaware or receive the services they need.

Disclosure of HIV status to sexual partners is an important prevention goal emphasized by the WHO (6) and the Centers for Disease Control and Prevention (CDC) (7) in their protocols for HIV testing and counselling. Disclosure offers a number of important benefits to the infected individual and to the general public. Disclosure of HIV test results to sexual partners is associated with less anxiety and increased social sup-

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port among many women (8). In addition, HIV status disclosure may lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future. Disclosure of HIV status also expands the awareness of HIV risk to untested partners, which can lead to greater uptake of voluntary HIV testing and counselling and changes in HIV risk behaviours (1, 2, 9). It is clear from the literature that risk behaviours change most dramatically among couples where both partners are aware of their HIV serostatus (1, 2, 9). In addition, disclosure of HIV status to sexual partners enables couples to make informed reproductive health choices that may ultimately lower the number of unintended pregnancies among HIV-positive women (2).

Along with these benefits, however, there are a number of potential risks from disclosure for HIV-infected women, including loss of economic support, blame, abandonment, physical and emotional abuse, discrimination and disruption of family relationships. These risks may lead women to choose not to share their HIV test results with their friends, family and sexual partners. This, in turn, leads to lost opportunities for the prevention of new infections and for the ability of these women to access appropriate treatment, care and support services where they are available.

This paper reviews the current information available on HIV status disclosure among women in developing countries. The implications of non-disclosure are considered in the context of prevention of mother-to-child transmission (pMTCT) programmes. Programmatic and policy strategies that have been used to increase disclosure rates and minimize negative outcomes among women are also discussed.

Methods

We reviewed all published abstracts and journal articles from January 1990 to December 2001 identified through a comprehensive search of four medical and social science electronic databases including: PubMed, the National Library of Medicine's (NLM) Gateway database, Psych INFO, and Sociologic Abstracts. We also searched four HIV-related journals by hand: *AIDS Care*, *AIDS*, *AIDS and Behavior*, and *AIDS Education and Prevention*. Any article that qualified during these searches was then retrieved from the library and the bibliography searched for any additional references. The terms used during the computer-based searches include HIV counselling and testing and disclosure, HIV voluntary counselling and testing and disclosure, HIV serostatus disclosure and women, and pMTCT and disclosure. To be eligible for this review, the article must have included data on the rates, barriers or outcomes of HIV serostatus disclosure; the study must have been conducted in a developing country and have included only women. We also contacted several of the authors personally to clarify some of the findings and to bring ourselves up to date on current research. The 17 articles reviewed in this paper include 15 articles from sub-Saharan Africa and two articles from south-east Asia. The studies reported vary greatly in terms of their sample size, study design, and methods of data collection (see Table 1 and Table 2).

Results

Disclosure rates

Fifteen studies were identified reporting rates of disclosure to sexual partners among women in developing countries (Table 1). Fourteen of the published studies were conducted in sub-Saharan

Africa (3 in the United Republic of Tanzania, 3 in Rwanda, 3 in Kenya, 2 in Burkina Faso, 1 in Uganda, 1 in South Africa and 1 in the Democratic Republic of the Congo). The remaining study was conducted in Thailand. The assessment period for disclosure in these studies ranged from two weeks to almost four years, and the rates of disclosure ranged from 16.7% to 86%.

Few studies assessed the length of time from diagnosis to disclosure. Among studies that did look at this correlation, it was found that as the length of time since diagnosis increases, the rate of disclosure also increases. For example, Antelman et al. found that disclosure to sexual partners among women attending an antenatal clinic increased from 22% within two months of diagnosis to 41% after nearly four years (10).

Data from these articles indicate that there is a core group of women who do not share their HIV test results with their sexual partners even after several months of follow-up. Kilewo et al. found that 77.8% of HIV-positive pregnant women participating in a perinatal transmission trial had not shared their HIV test results with their sexual partners 18 months after diagnosis (11). Working in Kenya, Galliard and colleagues found that 76.1% of the HIV-positive pregnant women who had not disclosed their results two months after diagnosis said that they never intended to disclose to their partners (12).

Barriers to disclosure

Table 1 includes a summary of the barriers to disclosure that women in developing countries identified. Either the study participants were asked directly about the perceived barriers to disclosure or the investigators identified the correlates associated with disclosure and non-disclosure of HIV test results through multivariate analysis.

The most common barriers to disclosure mentioned by participants included fear of abandonment, rejection and discrimination, violence, upsetting family members, and accusations of infidelity. Women's fear of abandonment was closely tied to fear of loss of economic support from a partner. In these settings where resources are extremely scarce and women's access to resources independent of their partner is uncommon, it is not surprising that fear of losing this instrumental support from a partner is a major consideration when deciding whether to share HIV test results or not.

Four of the studies reviewed used multivariate analysis to determine predictors of disclosure. Both Farquhar et al. and Galliard et al. found that younger women (under the age of 24 years) were more likely to disclose to sexual partners than older women (12, 13). Additionally, Farquhar found women of lower socioeconomic status had a higher disclosure rate than women of higher socioeconomic status (13). Antelman et al. also found that women who had been in relationships for a longer period of time (defined as more than two years) were more likely to disclose than women who had been in relationships for a shorter duration (10). Women who reported fewer sexual partners and who personally knew someone with HIV/AIDS were also more likely to disclose (10). Issiaka and colleagues found that women with a higher level of education were more likely to share their results with their partners than women who were illiterate (14).

Outcomes of HIV status disclosure

Ten studies reported on the outcomes of HIV status disclosure, summarized in Table 2. The majority of the studies reported positive outcomes related to disclosure. Women reported receiving kindness, understanding or acceptance following disclosure in three of the studies. An important finding is that

Table 1. HIV serostatus disclosure: rates and barriers

Setting	Study	Population	Study design	Rate of disclosure	Barriers to disclosure
Burkina Faso	Issiaka et al., 2001 (14)	79 HIV-positive pregnant women tested as part of antenatal care	Cross-sectional	31.6% of women had shared their status with their partner an average of 8 months after HIV testing and counselling (range 1–20 months)	Fear of being rejected or abandoned (71.4%) Fear of being considered unfaithful (24%) Educated women shared results with their partners more often than illiterate women
Burkina Faso	Nebie et al., 2001 (15)	306 HIV-positive pregnant women enrolled in a perinatal trial	Time series design with no comparison arm	17.6% disclosed to sexual partner during 13.9 months of follow-up	Fear of domestic violence
Kenya (Mombasa)	Gaillard et al., 2000 (12)	331 HIV-positive pregnant women tested as part of antenatal care	Cross-sectional	32% had disclosed their results 2 months after diagnosis 76.1% of those women who had not disclosed said they never intended to disclose to partner	Fear of partner's reaction (94.1%) <22 years of age was associated with higher disclosure rate
Kenya (Nairobi)	Farquhar et al., 2000 (13)	104 HIV-positive pregnant women tested as part of antenatal care	Cross-sectional	65% had disclosed their results to their partners. The time frame for disclosure is unclear	Fear of blame (54%) Fear of physical assault and abandonment (19%) Disclosure was associated with age <24 years and low socioeconomic status
Kenya (Nairobi)	Rakwar et al., 1999 (25)	520 randomly selected women from an STD clinic who were interviewed about their HIV knowledge and beliefs but not tested for HIV	Cross-sectional	10% of women said they did not intend to disclose their HIV status to their partners if they tested positive. Actual disclosure rates not reported	Fear of accusations of infidelity (63%) Fear of abandonment from partner (55%) Fear of violence from partner (51%)
Rwanda (Kigali)	Keogh et al., 1994 (28)	47 women enrolled in prospective study and given HIV testing and counselling as part of the study	Before-and-after study design with no comparison arm	79% of women disclosed to their sexual partner 3 years after diagnosis	Fear of rejection and blame Did not want to frighten partner Partner was sick
Rwanda (Kigali)	Ladner et al., 1996 (26)	1233 pregnant women tested as part of antenatal care	Before-and-after study design with no comparison arm	Among women who had received their test results, 50.9% of HIV-infected women and 94.6% of HIV-negative women planned to inform their partner of their HIV status. Actual disclosure rates not reported	Fear of family conflicts or expulsion from the marital home
Rwanda (Kigali)	Van der Straten et al., 1995 (27)		Cross-sectional	77% reported discussing their HIV results with partner in past year; 79% disclosed within 2 years. Of the 47 HIV-positive women who were asked about disclosure 2 years after diagnosis, 21% had not disclosed to their partner	Not reported

(Table 1, cont.)

Setting	Study	Population	Study design	Rate of disclosure	Barriers to disclosure
South Africa	Sigxaxhe & Matthews, 2000 (24)	28 HIV-positive pregnant women tested as part of antenatal care	Qualitative study design using in-depth interviews	Not reported	Fear of rejection Fear of discrimination Fear of verbal abuse Concerns about public ignorance of the disease.
Thailand (Bangkok)	Bennetts et al., 1999 (16)	129 HIV-positive pregnant women tested as part of antenatal care	Cross-sectional	44% of women disclosed their status only to their partner, 34% had disclosed to another person. Time frame for disclosure is the 18–24 months postpartum	Fear of shaming family
Uganda	Pool et al., 2001 (23)	208 women attending maternity clinics in 3 rural sites	Qualitative study design using focus group discussions	Not reported	Fear of being accused as the source of infection Fear of accusation of infidelity Fear of separation
United Republic of Tanzania (Dar es Salaam)	Antelman et al., 2001 (10)	1078 HIV-positive pregnant women tested as part of antenatal care	Time series design with no comparison arm	22% disclosed to partner within 2 months, 40% disclosed to partner after 46 months	Fear of losing confidentiality (32%) Fear of social isolation (14%) Not wanting to worry others (17%) Fear of conflict with partners (15%) Just being afraid (11%)
United Republic of Tanzania (Dar es Salaam)	Kilewo et al., 2001 (11)	1050 HIV-positive pregnant women tested as part of antenatal care	Time series design with multiple study arms	16.7% disclosed to their sexual partner 18 months after diagnosis	Fear of stigma (46.4%) Fear of divorce (46.4%) Fear of violence (16.1%)
United Republic of Tanzania (Dar es Salaam)	Maman et al., 2002 (22)	245 women from voluntary HIV testing and counselling clinic	Cross-sectional	69% of HIV-positive and 83% of HIV-negative women disclosed to sexual partner 3 months after HIV testing	Fear of abandonment Fear of violence Fear of accusations of infidelity
Zaire (Kinshasha)	Heyward et al., 1993 (17)	364 women (187 HIV-positive, 177 HIV-negative) tested as part of antenatal care	Before-and-after study design with no comparison arm	At post-test counselling, 70% of women intended to disclose their HIV test results to their partners. Actual disclosure rates not reported. Only 2.2% of women brought their partners in for free HIV testing and counselling during the 12-months of follow-up	Fear of divorce (63%) Fear of accusations of infidelity (86%)

disclosure was not associated with the break-up of marriages. In fact, four of the studies reported that most marriages survived disclosure (12, 15–17).

Of concern is the proportion of women reporting negative outcomes following status disclosure (ranging from 4% to 28% of respondents). Negative outcomes included blame, abandonment, violence, anger, stigma and depression. The proportion of women reporting violence as a reaction to disclosure

ranged from 3.5% to 14.6%. The true incidence of violence related to HIV status disclosure was hard to determine from these studies, as there were no base rates of violence obtained at the beginning of the studies. Furthermore, most studies did not define violence or describe its severity, therefore making direct comparisons across studies difficult.

Interestingly, several studies mentioned that fear of consequences such as abandonment, violence and discrimination

Table 2. HIV serostatus disclosure: reported outcomes

Setting	Study	Population	Study design	Positive outcomes of disclosure	Negative outcomes of disclosure
Burkina Faso	Issiaka et al., 2001 (14)	79 HIV-positive women tested as part of antenatal care	Cross-sectional	Informed partners were either indifferent (72%) or had an encouraging attitude (24%)	4% reported a case of dispute without violence
Burkina Faso	Nebie et al., 2001 (15)	306 HIV-positive pregnant women enrolled in a perinatal trial	Time series design with no comparison arm	Most women remained with their partners	Among 54 women who disclosed to their partners, only 2 actually separated from that partner
India (Mumbai and Sumerpur)	Shah & Shah, 2000 (29)	52 HIV-positive pregnant women	Cross-sectional	Not discussed	12 women were beaten or abused by their in-laws, and 18 women were no longer allowed to do household activities
Kenya (Mombasa)	Gaillard et al., 2000 (12)	331 HIV-positive pregnant women interviewed 2 months after testing positive	Cross-sectional	73% of partners were understanding 9.3% had no comment	10.5% of partners did not believe the results, 3.5% chased the woman out of the house, and 3.5% physically assaulted the woman
Rwanda (Kigali)	Keogh et al., 1994 (28)	47 HIV-positive women who were part of a prospective study	Before-and-after study design with no comparison arm	62% reported a positive reaction (such as acceptance) from their partners	17% reported a negative reaction (blame or anger) from their partners. 21% reported reactions of fear, disbelief or shock. Slightly over a quarter of women reported their marriage deteriorated.
South Africa (Cape Town)	Matthews et al., 1999 (8)	88 HIV-positive mothers attending an outpatient clinic	Cross-sectional	19% of women who disclosed said their disclosure resulted in more kindness	27% of women reported at least one problem. 13% experienced violence from partners, 9% reported that their partner left them, and 3% were forced to move away from home
Thailand (Bangkok)	Bennetts et al., 1999 (16)	129 HIV-positive women enrolled in a perinatal transmission trial	Cross-sectional	72% of women were still in a relationship with their partners	28% separated from their partner or their partner died
United Republic of Tanzania (Dar es Salaam)	Kilewo et al., 2001 (11)	1050 HIV-positive pregnant women enrolled in the PETRA study	Time series design with multiple study arms	91.7% of women reported that their relationship continued	14.6% of partners reacted violently
Zaire (Kinshasa)	Heyward et al., 1993 (17)	187 HIV-positive 177 HIV-negative childbearing women at a public hospital	Before-and-after study design no comparison arm	At 12 months no women reported divorce or separation	Not discussed.

were major barriers to disclosure. When the study participants were asked the outcomes of disclosure, however, these fears were seldom realized among women who chose to disclose their status. In Kilewo's study from the United Republic of Tanzania, 46.4% of women who did not disclose their HIV status to their partners reported that fear of divorce was a major barrier to disclosure, but 91.7% of women who did disclose their results reported that their relationship continued afterwards (11). Heyward found a similar trend in Kinshasa: 63%

of women who did not disclose their HIV status reported fear of divorce as the major barrier, yet, 12 months after disclosure, no woman in the study reported divorce or separation (17). This finding can mean one of two things. It may mean that only women who are confident in the safety and strength of their relationship actually disclose their results, and women who are less confident choose not to. It could also mean that women perceive the risk of a negative outcome to be more likely than it is in fact.

Discussion

A review of the rates of disclosure found that between 16.7% and 86% of women choose not to disclose their HIV status to their partners. The majority of women who disclosed HIV test results to their partners reported supportive reactions from partners. Negative outcomes were less common and included shock, disbelief, abandonment and violence. Fear of negative outcomes was nonetheless the barrier to HIV status disclosure most often mentioned by women.

Disclosure rates of HIV status reported in these studies are impossible to compare directly because the studies differed in how they measured rates of disclosure and in the time frames used. It is nevertheless possible to identify trends for rates of HIV status disclosure. It is clear from these studies that the lowest rates of HIV status disclosure were reported among women in antenatal care. This article has therefore chosen to focus on women attending antenatal clinics, as the low rates of disclosure seen there have several implications for pMTCT.

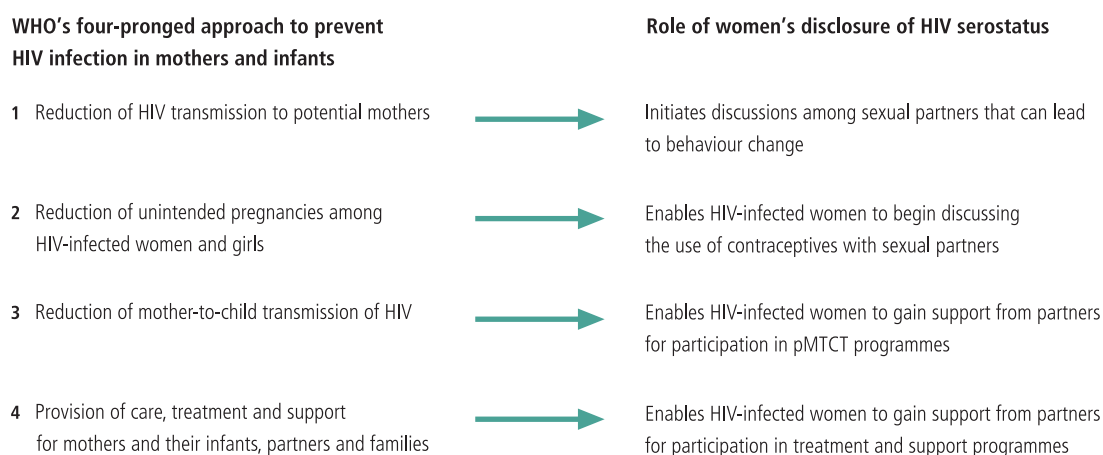
WHO has outlined a four-pronged approach to prevent HIV infection in mothers and their infants. The four elements are: the reduction of HIV transmission to potential mothers; the reduction of unintended pregnancies among women and girls living with HIV; the reduction of mother-to-child transmission of HIV; and the provision of care, treatment and support for mothers and their infants, partners and families.

The low rates of disclosure seen in many of these studies have implications for each component of the strategy, as outlined in Fig. 1. First, disclosure of HIV status between HIV-uninfected women and their sexual partners is necessary to initiate discussions about HIV/AIDS that raise both partners' awareness of the risk of infection and may ultimately lead to behaviour change to reduce HIV risk. Secondly, disclosure can be an important starting point for HIV-infected women to begin discussing the use of contraception with their partners and reduce the number of unintended pregnancies among HIV-infected women. Thirdly, disclosure plays an important role in women's uptake of pMTCT programmes and in their participation in treatment and care and support programmes. In order to benefit from interventions that can reduce HIV perinatal transmission, women must be

willing to be tested for HIV, and if they are HIV-positive they must be willing to accept and adhere to pMTCT prophylaxis. The optimal uptake and adherence to pMTCT programmes is difficult for women whose partners are either unaware or not supportive of their participation. Finally, it has been well documented in Africa that women often lack the power to make independent decisions with regard to their own health care and that of their children (18–20). It is therefore difficult for HIV-infected women to seek social and medical support from care and treatment programmes for themselves and their infants without first disclosing their HIV status to their partners.

Voluntary testing and counselling protocols were originally designed for clients seeking HIV testing and counselling services at specialized clinics or in the context of consultations for sexually transmitted infections. They need to be tailored for use in antenatal care services to focus specifically on the decisions that women have to make in the context of their antenatal care and, more importantly, to reflect the fact that women in these settings are not voluntarily seeking HIV testing and are likely not to have considered being tested for HIV prior to attending antenatal clinics. There is, at present, considerable interest in adapting the standard HIV testing and counselling protocols for use in different service settings. In a recent WHO technical consultation report, participants concluded that there is a need to re-evaluate the testing and counselling approaches used in health care settings such as antenatal clinics (21). Furthermore, the report suggests that there is a need to streamline counselling for women in antenatal care by tailoring it to the individuals, based on their HIV test results (21). One approach to streamlining is to provide HIV-negative women with the option either to opt out of counselling altogether or to receive a shorter counselling session focused primarily on prevention of future infections. This would enable counsellors to have more time for discussions with HIV-positive women or HIV-negative women at high risk of infection. Post-test counselling for HIV-positive women would be more comprehensive, including pMTCT, a discussion of partner notification and disclosure, options for family planning, and strategies for increased partner involvement in pMTCT programmes. This recommendation arises from the fact that, in most developing countries, antenatal clinics are

Fig. 1. Role of HIV status disclosure in the prevention of HIV infection in mothers and infants



WHO 04.26

short-staffed and counsellors are overburdened. Requiring counsellors to extend post-test counselling to discuss the importance of disclosure for all women would put intolerable strains on an already overstretched system. Therefore, it is necessary to focus limited resources on the women who stand to benefit the most from extended counselling.

There are several strategies to consider when modifying current voluntary HIV testing and counselling protocols in order to increase the rates of safe HIV status disclosure among HIV-positive women who are tested during antenatal care. The standard protocols for HIV testing and counselling offered by WHO (6) and CDC (7) do not dedicate sufficient time to considering the challenges of HIV status disclosure that are faced by many clients, particularly women. In the CDC protocol, the total counselling time allotted to discussing partner notification and disclosure in pre-test and post-test counselling sessions is between five and seven minutes. Standard counselling protocols need to be enhanced for HIV-infected women, concentrating on barriers to partner notification, and additional counselling needs to focus on helping women identify the pros and cons of disclosure. If women mention fear of violence as a barrier to disclosure during counselling, counsellors should be prepared to refer women to domestic violence services in areas where they are available.

One way of targeting the best use of resources for counselling support would be to identify the women most at risk for negative outcomes following disclosure through the use of screening tools. Such screening tools would ask women about prior communication with their partners regarding HIV and HIV testing, prior experience with violence, and anticipated reactions of partners to HIV status disclosure. Based on results of the screening, counsellors may present women with alternative options; these would include opting not to disclose, or deferring disclosure until a time when the woman feels it is safe to do it.

Counselling tools such as role-play scenarios may also be useful to help women develop the self-confidence and communication skills they need to share HIV test results safely with their partners. In addition, post-test clubs initiated by the AIDS Information Centre in Uganda have been shown to be highly effective in encouraging individuals to share their HIV test results with others and in reducing the stigma associated with HIV counselling and testing. These

results suggest that implementing post-test clubs as part of voluntary counselling and testing may help women gain the support they need to disclose their test results to their sexual partners (30, 31).

Broader community-based initiatives to deal with underlying gender norms and social attitudes about HIV/AIDS and violence against women must accompany individually focused initiatives in order to create safer and more comfortable environments for women to share their HIV test results. For example, fear of stigma was one of the barriers to disclosing HIV test results most often mentioned by women. It is therefore important to initiate community-based programmes that would normalize HIV testing in the community and reduce the amount of stigma women perceive towards people infected with HIV. This, in turn, would allow women to feel more comfortable disclosing their own HIV status to others.

As the HIV epidemic continues to grow, there is an urgent need to identify innovative strategies to prevent new infections and to improve the quality of life for individuals who are already infected. In addition, there is a dearth of information on women's experiences with HIV status disclosure from areas other than sub-Saharan Africa. Studies need to be conducted in other regions of the world, such as Latin America and central and south Asia, to describe the variability in rates, barriers and outcomes of HIV status disclosure to sexual partners.

Access to voluntary HIV testing and counselling is crucial in order to allow individuals to discover their status and take advantage of important prevention and care interventions. It is clear from the literature that women, in particular, face a number of significant barriers to disclosure and that some women face negative outcomes as a result of disclosure. Strategies are now needed to support women who want to disclose their HIV test results safely to their sexual partners, and to enable these women to avail themselves of prevention and treatment programmes where they exist. ■

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Résumé

Taux, limites et conséquences de la révélation de leur statut sérologique VIH par les femmes dans les pays en développement : répercussions sur les programmes de prévention de la transmission du VIH de la mère à l'enfant

Le présent article fait le point sur les taux, les limites et les conséquences de la révélation de leur statut sérologique VIH par les femmes dans les pays en développement. Nous avons relevé dans des revues dotées d'un comité de lecture et les comptes rendus de conférences internationales 17 études menées dans des pays en développement – 15 en Afrique subsaharienne et 2 en Asie du Sud-Est – dans lesquelles étaient mentionnés les taux, les limites ou les conséquences de la révélation de leur statut sérologique VIH par les femmes. Ces études rapportaient des taux de révélation allant de 16,7 % à 86 %, les femmes fréquentant les dispensaires spécialisés dans le test et le conseil volontaires pour le VIH étant plus enclines à révéler leur statut VIH à leur partenaire sexuel que celles testées dans le cadre des soins anténatals. Parmi

les obstacles mentionnés par les femmes figuraient la peur d'être accusées d'infidélité, d'être abandonnées ou d'être victimes de discrimination ou de violence. Entre 3,5 % et 14,6 % des femmes ont déclaré avoir subi une réaction violente de la part de leur partenaire après lui avoir révélé leur statut VIH. Les faibles taux de révélation du statut VIH associés aux soins anténatals ont des répercussions sur les programmes de prévention de la transmission du VIH de la mère à l'enfant, puisqu'il est difficile pour les femmes dont le partenaire n'est pas au courant de la situation ou ne les encourage pas à participer à ces programmes d'en tirer le meilleur profit. Le présent article examine ces répercussions et propose des stratégies pour que les femmes puissent davantage et sans danger révéler leur statut VIH.

Resumen

Revelación de la serología VIH por mujeres de los países en desarrollo: tasas, obstáculos, resultados y repercusiones en los programas de prevención de la transmisión materno-infantil

En este artículo se hace una síntesis de las tasas de revelación de la serología VIH por mujeres de los países en desarrollo, de los obstáculos a dicha revelación y de los resultados de esta. Se identificaron 17 estudios publicados en revistas con revisión editorial por pares y en resúmenes de conferencias internacionales — 15 del África subsahariana y dos de Asia sudoriental — que contenían información sobre las tasas, los obstáculos o los resultados de la revelación de la serología VIH por mujeres de los países en desarrollo. Las tasas de revelación registradas en esos estudios oscilaron entre el 16,7% y el 86%; la probabilidad de revelación de su estado serológico a la pareja fue más elevada en las mujeres que acudieron voluntariamente a clínicas independientes de asesoramiento y diagnóstico del VIH que en aquellas cuyas pruebas se realizaron en el contexto de la atención prenatal. Los

obstáculos a la revelación manifestados por las propias mujeres incluyeron el temor a las acusaciones de infidelidad, el abandono, la discriminación y la violencia. Entre un 3,5% y un 14,6% de las mujeres refirieron haber sufrido una reacción violenta por parte de su pareja. Las bajas tasas de revelación de la serología VIH registradas en el entorno de la atención prenatal tienen varias consecuencias para los programas de prevención de la transmisión materno-infantil del VIH, pues es difícil que la captación por esos programas y la adherencia a ellos sean óptimas si la pareja de la mujer desconoce o no apoya su participación. Este artículo analiza esas consecuencias y propone algunas estrategias para incrementar de forma segura las tasas de revelación de la serología VIH por parte de las mujeres.

ملخص

الإعلان عن الحالة السيرولوجية لفيروس العوز المناعي البشري بين النساء في البلدان النامية، ومعدلاته والعوائق التي تعترضه والخصائص المترتبة عليه: التأثيرات على برامج الوقاية من انتقال فيروس العوز المناعي البشري من الأمهات لأطفالهن

في سياق إثبات الرعاية السابقة للولادة لهن، وكانت العوائق التي تحول دون الإعلان عن الحالة السيرولوجية لفيروس العوز المناعي البشري وفق ما حددها النساء تتضمن الخوف من الاتهام بعدم الإخلاص والتجرد من الفضيلة، ومن العزل والنبذ والتمييز والعنف. وقد أبلغ ٣,٥% - ١٤,٦% عن معاناتهن من ارتكاس عنيف من أزواجهن تلو الإعلان عن حالتهن السيرولوجية. وقد كان للمعدلات المنخفضة للإعلان عن الحالة السيرولوجية لفيروس العوز المناعي البشري التي أبلغت عنها النساء في مواقع الرعاية السابقة للولادة العديد من التأثيرات على الوقاية من انتقال فيروس العوز المناعي البشري من الأم إلى الطفل، إذ إن الالتزام المثالي بهذه البرامج وتطبيقها صعب على النساء اللاتي يجهل أزواجهن أدوارهم في ذلك أو لا يقدمن الدعم لتلك الأدوار. ويتناول هذا المقال هذه التأثيرات ويستعرض بعض الاستراتيجيات لزيادة معدلات الإعلان عن الحالة السيرولوجية لفيروس العوز المناعي البشري بين النساء.

الخلاصة: تستعرض هذه المقالة الإعلان عن الحالة السيرولوجية لفيروس العوز المناعي البشري بين النساء في البلدان النامية، ومعدلاته، والعوائق التي تعترضه والخصائص المترتبة عليه. وقد حدّدنا (١٧) دراسة من المجالات التي تخضع لمراجعة الزملاء والمنحصات التي عرضت في مؤتمر دولي، وكان ١٥ منها من البلدان الواقعة في جنوب الصحراء الأفريقية فيما كانت دراسات منها من جنوب شرق آسيا. وقد تضمنت تلك الدراسات معلومات حول معدلات الحالة السيرولوجية لفيروس العوز المناعي البشري بين النساء في البلدان النامية والعوائق التي تعترض الإعلان عنها والخصائص المترتبة على ذلك. وقد تراوحت المعدلات للإعلان عن ذلك في تلك الدراسات بين ١٦,٧% و ٨٦,٠%، واتضح أن النساء اللاتي يحضرن لإجراء اختبار طوعي بمحض إرادتهن للكشف عن فيروس العوز المناعي البشري ولزيارة عيادات التوعية والنصح أكثر ميلاً للإعلان عن الحالة السيرولوجية لفيروس العوز المناعي البشري لديهن لأزواجهن من النسوة اللاتي أحررت لهن الاختبارات

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