

HIV serostatus disclosure by pregnant women and new mothers in Sub Sahara Africa - a review of the literature

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Problem statement: Serostatus disclosure is one of the key pillars for prevention of vertical transmission from mother to the infant. Frequently, pregnant women in Sub Sahara Africa (SSA) are the first in the family to test for HIV, thus, pregnancy has become an important focal point for preventive measures, not only for women. Informing others about their serostatus, has from public health perspective numerous beneficial effects, for seronegative and seropositive pregnant women alike. Due to stigma, however, seropositive women bear the risk of adverse reactions to disclosure. Studies concerning pregnant women in SSA have looked at issues around serostatus disclosure from different angles, and investigations are heterogeneous. This study is the first comprehensive review of literature concerning disclosure related issues for pregnant women and new mothers in SSA.

Methods: A systematic literature review was performed, thirty three studies were eligible for review. A framework was developed and data was synthesized for rates, positive and negative predictors, barriers and motivations, timing, disclosure targets, impacts, outcome of (i.e. reactions to) serostatus disclosure.

Results: In comparison with a previous similar review, the trend for disclosure rates has increased, e.g. the range of disclosure “to at least somebody” from 60% to 97.1%. However, still many women do not disclose to their partner. Disclosure targets are mainly the partner and the domestic circle, female relatives in particular. Most of the women disclosed early after

receiving the test result, however, the disclosure process is fluid and disclosure may also occur with substantial delay. Structural and contextual negative predictors were identified on an individual, partner relation based, behavioural and socio- cultural level. Fears and perceived risks, such as rejection, abandonment, loss of financial support, blame and violence were substantial barriers towards disclosure for women. Contextual predictors for increased disclosure were found mainly on an individual or partner relation based level. Motivations included, among many others, concern for the health of the partner and the infant, and anticipation of support and increased health- conscious behaviour of the partner, such as practise of safer sex , safe infant feeding, and partner HIV testing. Outcome, i.e. reaction to disclosure, was overwhelmingly positive in all reviewed studies. Only a minority of women had experienced dramatic adverse reactions to disclosure. This finding was in striking contrast to the high level of negative anticipations and fear towards disclosing. Impacts of disclosure, where measured, were increased partner communication about STI and HIV, support of the woman with PMTCT procedures, and sometimes increased safer sex and partner HIV testing. However, rates of condom use/safer sex were still low. Uptake of partner HIV testing remained also low, especially for partners of seronegative women. However, the information from the data provides useful information for approaches to improve support and assistance for pregnant women and new mothers towards serostatus disclosure.

Conclusion: This review shows, that many findings of individual studies are confirmed and validated through the data synthesis, suggesting that they may be extended to other SSA settings as a working basis. The review has also identified some gaps in the current knowledge that should be the concern of further research. The findings have several implications for PMTCT programs in the region, and the review provides a useful data set for further improvements of these services. The data may be used to develop, implement and evaluate strategies and interventions to increase disclosure rates, such as screening tools, couple and family centred approaches, as well as structured support group programs tailored to the needs of pregnant women.