Stigma and Discrimination as Barriers to PMTCT and HIV Care

Introduction

• Global goals have been set for virtual elimination of vertical transmission of HIV and 50% reduction in HIV-related maternal mortality by the year 2015.

• Scale-up of interventions for mothers and babies is essential for achieving these targets.

• Approaches to scale-up must take into account that vertical transmission is not only a biologic problem but also a complex set of social, economic, political, and cultural factors.

• Key among these barriers are stigma and discrimination (S&D) that affect HIV transmission and transmission-related stigma and discrimination (T-RS&D) in women’s lives.

Figure 1: A Framework for the Effects of Stigma on Maternal, Neonatal, and Child Health

Methods

• Systematic review of the existing academic and programmatic literature to examine the current evidence on stigma, discrimination, and their impacts on PMTCT and family health to identify

• How stigma and discrimination act as barriers at each step in the complex series of interventions that women and infants must complete for successful PMTCT (characterized as “the PMTCT cascade”)

• How and whether the integration of PMTCT and maternal care (ANC) and maternal, neonatal, and child health (MNCH) services may mitigate the negative effects of stigma and discrimination

• Search engines: PubMed, Scopus, and Google Scholar. Focusing on the three key areas of stigma and discrimination as a barrier to PMTCT, integration of PMTCT with ANC/MNCH services and stigma and discrimination; and interventions to reduce these barriers

• Data was used to develop recommendations for programmatic actions to integrate the reduction of stigma and discrimination into PMTCT services

Results

A. Stigma, Discrimination, and the PMTCT Cascade: Substantial evidence from research conducted in a variety of country settings indicates that stigma and discrimination from the community, family, and health care workers are significant factors in complicating the PMTCT cascade. We found that stigma and discrimination affect every step of the cascade (Table 1).

Table 1: Effects of HIV-related Stigma at Every Step of the PMTCT Cascade

<table>
<thead>
<tr>
<th>Step in the Cascade</th>
<th>New HIV-related Stigma</th>
<th>New HIV-related S&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screening</td>
<td>Stigma and discrimination may limit access to testing services.</td>
<td>Women may feel anxious or distressed about being tested.</td>
</tr>
<tr>
<td>2. Diagnosis</td>
<td>Women may feel anxious or distressed about being tested.</td>
<td>Women may feel anxious or distressed about being tested.</td>
</tr>
<tr>
<td>3. Treatment</td>
<td>Women may feel anxious or distressed about being tested.</td>
<td>Women may feel anxious or distressed about being tested.</td>
</tr>
<tr>
<td>4. Care</td>
<td>Women may feel anxious or distressed about being tested.</td>
<td>Women may feel anxious or distressed about being tested.</td>
</tr>
</tbody>
</table>

Figure 2: The PMTCT Cascade

B. Integration of ANC/MNCH and HIV Services: Will it remove S&D as a barrier to PMTCT and cause of loss to follow-up?

Figure 3: Potential Relationships of HIV-related S&D and Service Integration

Conclusions

It will be impossible to reach global goals to virtually eliminate vertical transmissions and reduce HIV-related maternal mortality without addressing the real costs of women’s lives. In particular, it is necessary to lessen the barriers of stigma and discrimination. Integrating maternal health and HIV care may not only overcome social barriers that limit women, parents, and infants from fully accessing health services. It may also affect social policies to make clinical services into effective systems, and accelerate the growth of women and families. PMTCT, maternal, neonatal, and child health services for women living with HIV/AIDS must address the social and economic barriers that currently prevent them from accessing services.

For more information, please see


Literature Cited


