INHIMAGE: INFEZIONE DI HIV NELLA MEDICINA DI GENERE

Napoli, 29 Maggio 2019

La gestione della sieropositività nelle dinamiche relazionali

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Ancora oggi la donna è considerabile una categoria soggetta a iniquità sociale?

Theory of gender and power (Connel R. 1996)

Secondo Robert Connell la disuguaglianza sessuale tra uomini e donne si declina attraverso le tre seguenti principali strutture social:

- **la divisione sessuale del lavoro** (per es. lavori di cura non retribuiti, lavori apicali istituzionali)
- **la divisione sessuale del potere** (empowerment etero o autodeterminato/disempowerment culturale)
- **la struttura della catessi:** modalità dell'investimento affettivo e cognitivo nelle relazioni interpersonali (per esempio sessualità correlata e limitata dall'idea di immoralità e di pregiudizi sociali)

Theory of gender and power & HIV
Wingood e Di Clemente (2000)

Le differenze presenti in ambito lavorativo, nelle dinamiche di potere e nelle dinamiche relazionali tra uomini e donne,

possono **incrementare la vulnerabilità delle donne al virus dell'HIV?**

Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risk Factors, and Effective Interventions for Women

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Developed by Robert Connell, the theory of gender and power is a social structural theory based on existing philosophical writings of sexual inequality and gender and power imbalance. According to the theory of gender and power, there are three major social structures that characterize the gendered relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis. The aim of this article is to apply an extended version of the theory of gender and power to examine the exposures, social/behavioral risk factors, and biological properties that increase women's vulnerability for acquiring HIV. Subsequently, the authors review several public health level HIV interventions aimed at reducing women's HIV risk. Employing the theory of gender and power among women marshals new kinds of data, asks new and broader questions with regard to women and their risk of HIV, and, most important, creates new options for prevention.

The concept of power imbalances in the subordination of women was first articulated in the early 20th century by Charlotte Perkins Gilman, who wrote in 1911 that

> all our human scheme of things rests on the same tacit assumption; man being held the human type; woman a sort of accompaniment and subordinate assistant, merely essential to the making of people. She has held always the place of a preposition in relation to man. She has always been considered above him or below him, before him, behind him, beside him, *a wholly relative existence—"Sydney's sister," "Pembrokes's mother"—but, never by any chance Sydney or Pembroke herself.*[1]

Gilman emphasized that in our androcentric culture, man defines woman not in relation to herself but in relation to him. Simone de Beauvoir's groundbreaking book *The Second Sex*, first published in 1949, also expounded upon gender and power imbalances without using the term androcentric.[2] de Beauvoir eloquently stated that in our culture, males are perceived as "real" and everything else, including women, is perceived as "other." One consequence of "otherizing" women is that they become defined in terms of

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APPENDIX A
Proposed Model Conceptualizing the Influence of the Theory of Gender and Power on Women's Health

Societal Level	Institutional Level	Social Mechanisms	Exposures	Risk Factors	Biological Factors	Disease
Sexual division of labor	Work site, school, family	Manifested as unequal pay produces economic inequities for women	Economic exposures	Socioeconomic risk factors		
Sexual division of power	Relationships, medical system, media	Manifested as imbalances in control produce inequities in power for women	Physical exposures	Behavioral risk factors	Anatomical features Genetic determination Hormones	HIV
Cathexis: social norms and affective attachments	Relationships, family, church	Manifested as constraints in expectations produce disparities in norms for women	Social exposures	Personal risk factors		

NOTE: The public health level includes exposures, risk factors, biological factors, and disease. The social/behavioral sciences level includes risk factors, biological factors, and disease. The medical level includes biological factors and disease.

APPENDIX B
Theory of Gender and Power: Exposures, Risk Factors, and Biomedical Properties

Sexual division of labor Economic exposures Women who live at the poverty level have less than a high school educational have no employment or are underemployed have a high-demand/low-control work environment have limited or no health insurance have no permanent home (i.e., are homeless)	Socioeconomic risk factors Women who are ethnic minorities are younger (i.e., less than 18 years of age)
Sexual division of power Physical exposures Women who have a history of sexual or physical abuse a partner who disapproves of practicing safer sex a high-risk steady partner a greater exposure to sexually explicit media limited access to HIV prevention (i.e., drug treatment, female-controlled methods, school-based HIV prevention education)	Behavioral risk factors Women who have a history of alcohol and drug abuse poor assertive communication skills poor condom-use skills lower self-efficacy to avoid HIV limited perceived control over condom use
Cathexis: social norms and affective attachments Social exposures Women who have a partner that is older a desire or whose partner desires to conceive conservative cultural and gender norms a religious affiliation that forbids the use of contraception a strong mistrust of the medical system family influences not supportive of HIV prevention	Personal risk factors Women who have limited knowledge of HIV prevention negative beliefs not supportive of safer sex perceived invulnerability to HIV/AIDS a history of depression/psychological distress
Biological properties Anatomical and biomedical properties HIV is transmitted more efficiently from men to women than from women to men, as women are the receptive partner during sexual intercourse STDs aside from HIV are also transmitted more efficiently from men to women than from women to men, and they can increase women's vulnerability to HIV STDs are more asymptomatic in women; thus, women may be less likely to seek treatment for STDs more likely to develop STD-related complications (i.e., HIV) Biological characteristics such as having sex while menstruating, using oral contraceptives, a history of cervical ectopy, and having an immature cervix	

Correlates of Consistent Condom Use Among HIV-Positive African American Women

Jerris L. Raiford, PhD
Gina M. Wingood, ScD, MPH
Ralph J. DiClemente, PhD

ABSTRACT. *Introduction:* African American women are the fastest growing group at risk of contracting HIV, as over 68% of women diagnosed with HIV are African American. The present study used social-cognitive theory and the theory of gender and power to identify correlates of consistent condom use among African American women living with HIV.

Methods: We recruited 366 women, 18-50 years of age and living with HIV from several HIV/AIDS clinics in the southeastern United States. The majority of women, 84.2% (N = 308), were African American. Women completed a baseline interview assessing sociodemographic, psychosocial, and partner-related factors potentially associated with consistent condom use, defined as reported use of condoms during every vaginal sex episode with a male sexual partner in the past 30 days.

TABLE 1. Sociodemographic and Condom Use Characteristics of HIV+ African American Women (N = 308)

	n	(%)
Age (years)		
18-35	156	(50.6)
36-51	151	(49.0)
Missing	1	(0.3)
Education (years)		
< 12	110	(35.7)
≥ 12	198	(64.3)
Annual household income (US$)		
< $5,000	170	(55.2)
> $5,000	134	(43.5)
Missing	4	(1.3)
Marital status		
Married	38	(12.3)
Unmarried	269	(87.3)
Main partner		
No	243	(78.9)
Yes	65	(21.1)
Male sexual partner (past 30 days)		
No	74	(24.0)
Yes	234	(76.0)
Relationship length (main partner)		
≤ 30 months	109	(35.4)
> 30 months	134	(43.5)
Missing	243	(21.1)
Disclosed to partner		
No	55	(17.9)
Yes	253	(82.1)
Sexual partner serostatus[1]		
HIV negative	170	(72.6)
HIV positive	64	(27.4)

[1]Among those reporting male sexual partners in past 30 days (n = 234).

TABLE 2. Multiple Logistic Regression Model of Factors Associated with Consistent Condom Use (N = 234)

	Adjusted† Odds Ratio	95% Confidence Interval
Partner communication self-efficacy		
High self-efficacy	7.77**	(3.3-18.6)
Low self-efficacy	1.00	
Partner serostatus		
Seronegative	4.62**	(1.9-11.5)
Seropositive	1.00	
Perceived partner-related barriers to condom use		
Low partner-related barriers	4.68**	(1.8-12.2)
High partner-related barriers	1.00	
Perceived peer norms		
Peer norms supportive of consistent condom use	2.38*	(1.0-5.7)
Peer norms non-supportive of consistent condom use	1.00	

*$p \leq .05$; **$p \leq .001$.
†Covariates age ($p = .03$) and income ($p = .002$) are not shown.

Risultati

Results: Among those HIV-positive African American women reporting use of a condom in the past 30 days (n = 234, 70%), consistent condom use was reported by 67.1% of women. This rate was lower (51.6%) among women having an HIV-positive male sexual partner; the rate was higher (74.1%) among women having an HIV-negative male sexual partner. Compared to women who were inconsistent condom users, women with HIV were more likely to use condoms if they: had high partner communication self-efficacy ($OR = 7.77$, 95% $CI = 3.3\text{-}18.6$, $p = .001$), had a HIV-negative male sex partner ($OR = 4.62$, 95% $CI = 1.9\text{-}11.5$, $p = 0.001$), had low partner-related barriers to condom use ($OR = 4.68$, 95% $CI = 1.8\text{-}12.2$, $p = 0.001$), and had perceived peer norms supportive of condom use ($OR = 2.38$, 95% $CI = 1.0\text{-}5.7$, $p = 0.03$).

Conclusion: These findings suggest that HIV interventions may enhance consistent condom use among African American women living with HIV by targeting women's self-efficacy to communicate with their partners and women's perception of personal and partner-related barriers to condom use. doi:10.1300/J013v46n02_04 *[Article copies available for a*

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Condom use among young women: Modeling the Theory of Gender and Power

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Abstract

Objective—This study sought to articulate pathways between constructs from the Theory of Gender and Power (TGP) and their associations with sexual behavior.

Design—The data were collected pre-intervention during a randomized controlled HIV prevention trial. Participants were 701 sexually active, unmarried African-American females, aged 14–20, who were not pregnant, and were recruited from three health clinics in a southeastern U.S. city. Structural equation modeling was used for the analyses.

Main Outcome Measure—Self-reported condom use.

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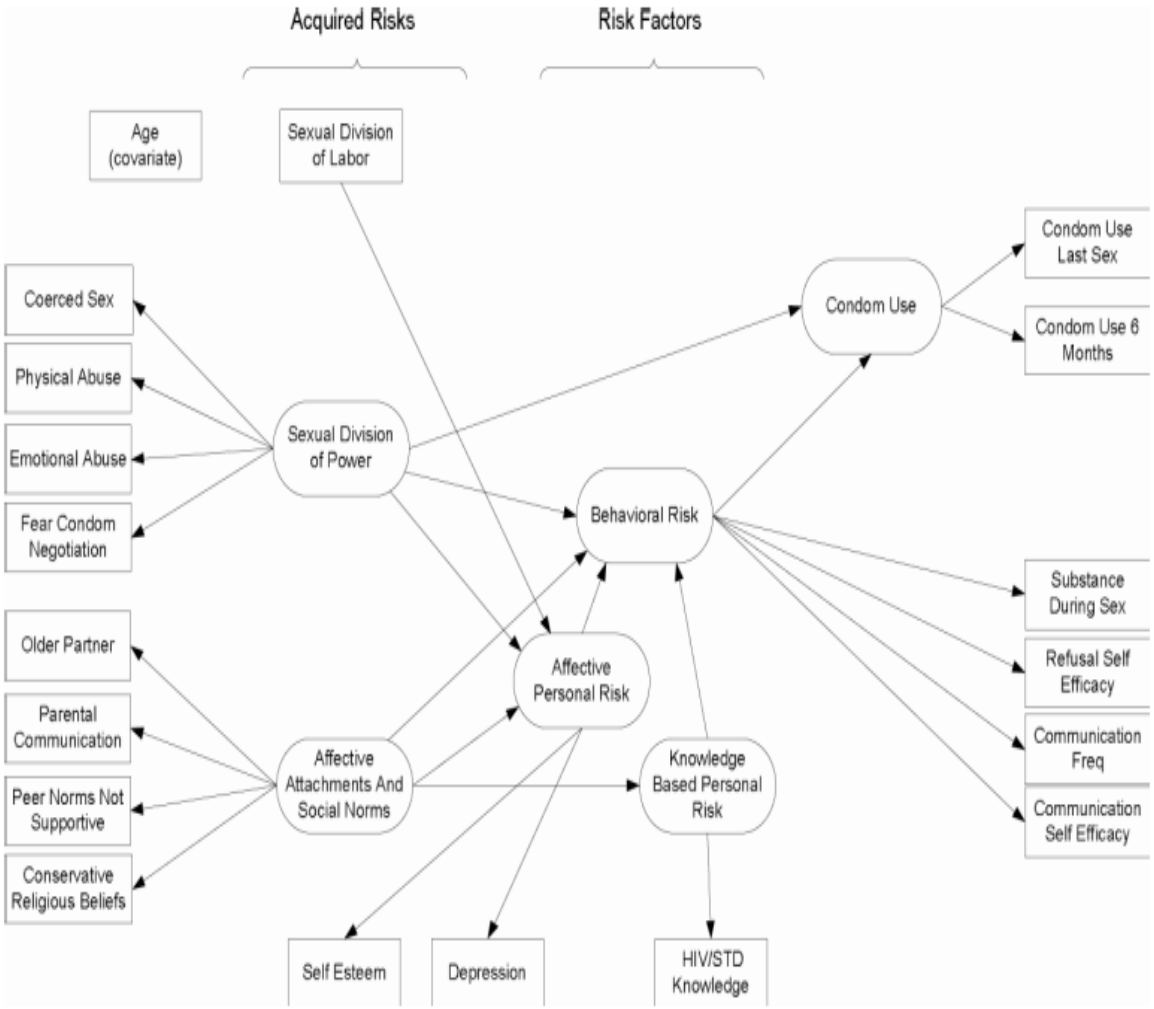
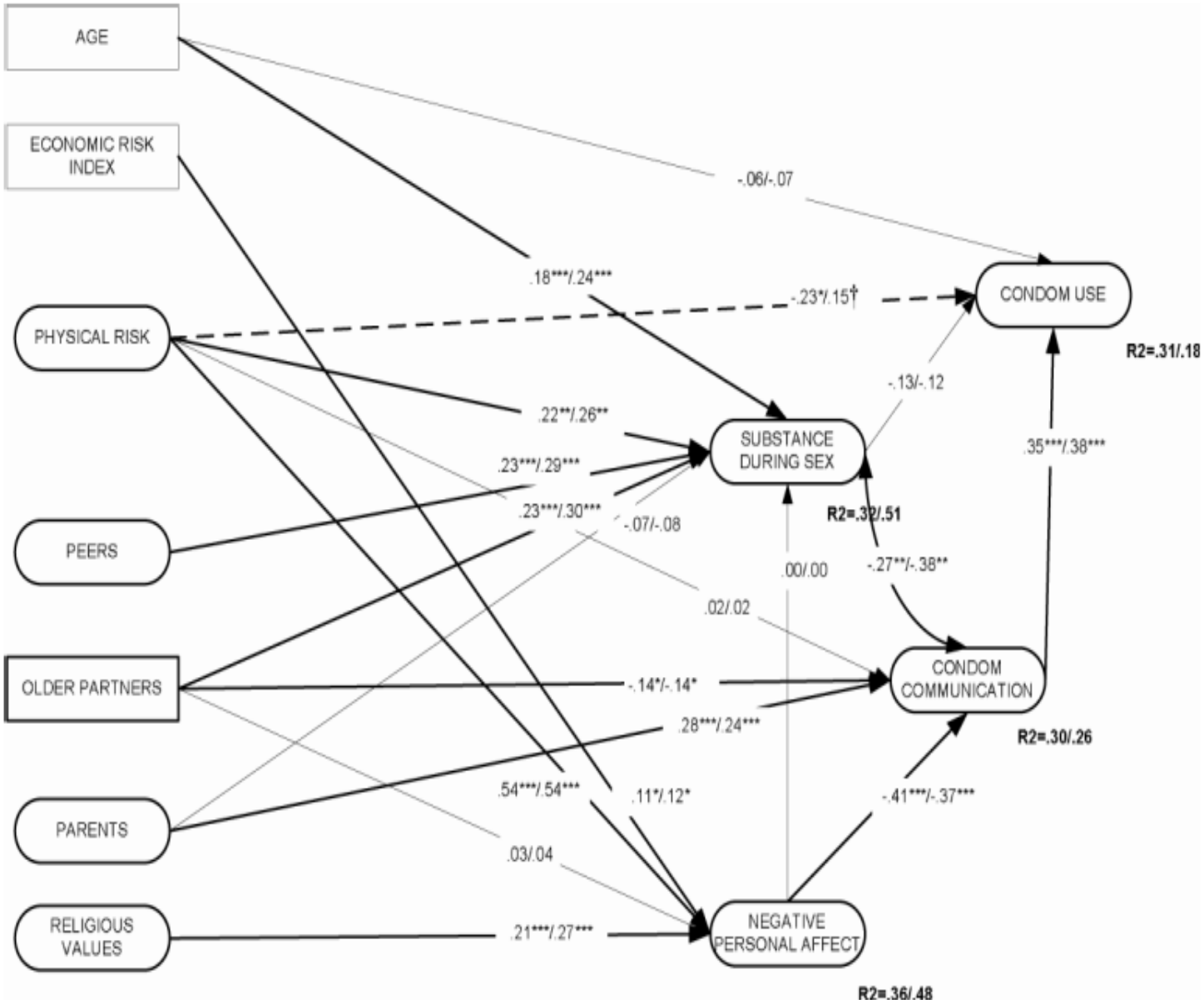

Acquired Risks
Risk Factors
Age (covariate)
Sexual Division of Labor
Coerced Sex
Physical Abuse
Emotional Abuse
Fear Condom Negotiation
Sexual Division of Power
Condom Use
Condom Use Last Sex
Condom Use 6 Months
Behavioral Risk
Substance During Sex
Refusal Self Efficacy
Communication Freq
Communication Self Efficacy
Older Partner
Parental Communication
Peer Norms Not Supportive
Conservative Religious Beliefs
Affective Attachments And Social Norms
Affective Personal Risk
Knowledge Based Personal Risk
Self Esteem
Depression
HIV/STD Knowledge


AGE
ECONOMIC RISK INDEX
PHYSICAL RISK
PEERS
OLDER PARTNERS
PARENTS
RELIGIOUS VALUES
SUBSTANCE DURING SEX
CONDOM COMMUNICATION
NEGATIVE PERSONAL AFFECT
CONDOM USE
-.06/-.07
.18***/.24***
-.23*/.15†
R2=.31/.18
-.13/-.12
.22**/.26**
.23***/.29***
.23***/.30***
-.07/-.08
R2=.32/.51
.35***/.38***
.00/.00
-.27**/-.38**
.02/.02
-.14*/-.14*
.28***/.24***
R2=.30/.26
.54***/.54***
.11*/.12*
-.41***/-.37***
.03/.04
.21***/.27***
R2=.36/.48

Risultati

Results—Theoretical associations yielded a well-fitting structural model across initial and cross-validation samples. A significant amount of variance was explained for the variables of condom use (R2=.31, .18), partner communication (R2=.30, .26), substance use during sex (R2=.32, .51), and negative personal affect (R2=.36, .48). Partner communication (.35, .38) was the strongest predictor of condom use, negative personal affect (−.41, −.37) was the strongest predictor of partner communication, and physical risk (.54, .54) was the strongest predictor of negative personal affect.

Conclusion—This model provides evidence to support both direct and indirect associations between social and behavioral risk factors and condom use. Associations between TGP constructs and condom use can facilitate future development and analyses of interventions based on this theory.

Sexual Relationship Power, Safer Sexual Communication, and Condom Use: A Comparison of Heterosexual Young Men and Women

Yachao Li & Jennifer A. Samp

Communication is essential to negotiating safer sex, yet power dynamics make condom use difficult to manage. Guided by Dyadic Power Theory and the chilling effect, we predicted that men's sexual relationship power is negatively curvilinearly associated with safer sexual communication, such that men will report more communication when they are relatively equal in power to their partners, whereas women's power is positively associated with safer sexual communication. Moreover, because women have to communicate condom use desire, communication should mediate the relationship between power and condom use for women. Results supported the hypotheses and provided implications for gender-based power imbalance in sexual domains.

Keywords: Condom Use; Gender Differences; Safer Sexual Communication; Sexual Relationship Power

College-aged individuals are at high risk of sexually transmitted infections (STIs), including HIV (CDC, 2013). One reason for these sexual health risks is that people do not consistently use condoms, especially with close or committed partners (Ellen et al., 2002). Thus, theoretical models have identified various individual factors, such as safer sex knowledge, perceived social norms, or self-efficacy, to predict people's condom use

Yachao Li is a doctoral student in the Department of Communication Studies at the University of Georgia. Jennifer A. Samp is a Professor in the Department of Communication Studies at the University of Georgia. A version of this paper was presented at the 2017 International Communication Association Annual Conference in San Diego, CA, USA. The authors would like to thank Dr. Jiyeon So for her support in the initial phases of this project. Correspondence to: Yachao Li, Department of Communication Studies, University of Georgia, 513 Caldwell Hall, Athens, GA 30605, USA. E-mail: yachao.li@uga.edu

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Table 1 Summary of Regression Analyses on Gender Moderating the Linear Relationships between Sexual Relational Power and Safer Sexual Communication

	All (N = 352)			Men (n = 179)			Women (n = 173)		
Variables	b	*SE*	ΔR^2	b	*SE*	ΔR^2	b	*SE*	ΔR^2
Step 1			.374***			.269***			.527***
Condom Use Intention	.512***	.035		.427***	.053		.622***	.045	
Step 2			.016*			.008			.015*
Condom Use Intention	.521***	.035		.432***	.053		.605***	.045	
Sexual Relational Power	.010	.023		−.047	.034		.070*	.030	
Gender	−.104**	.035							
Step 3			.014**						
Condom Use Intention	.516***	.035							
Sexual Relational Power	−.051	.031							
Gender	−.100**	.035							
Power × Gender	.130**	.046							

Note. Standard coefficients were reported in text. Power × Gender = the interaction between sexual relationship power and gender.
***$p < .001$. **$p < .01$. *$p < .05$.

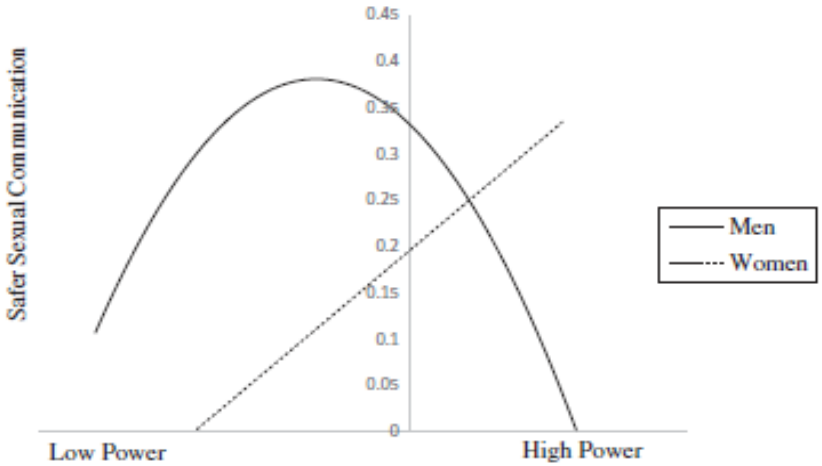

Figure 1 Two-Way Interaction Effect between Sexual Relationship Power and Gender on Safer Sexual Communication.

Figure 2 Indirect Effect from Sexual Relationship Power to Condom Use through Safer Sexual Communication for Women. *Note.* Values not in the parentheses are standardized parameter estimates for each path. Values in the parentheses are standardized errors for each path. ***$p < .001$, *$p < .05$.

[a] The standardized regression coefficient between power and condom use, without controlling for safer sexual communication.

[b] The standardized regression coefficient between power and condom use, after controlling for safer sexual communication.

Risultati

H1a. For men, sexual relationship power is negatively curvilinearly associated with safer sexual communication, such that men will engage in greater safer sexual communication when they perceive themselves and their partners as relatively equal in sexual relationship power, than when they perceive themselves to be substantially more or less powerful than their partners.

H1b. For women, sexual relationship power is positively associated with safer sexual communication.

H2. For women, safer sexual communication mediates the positive relationship between sexual relationship power and condom use, such that sexual relationship power is positively associated with safer sexual communication, which in turn is positively associated with condom use.

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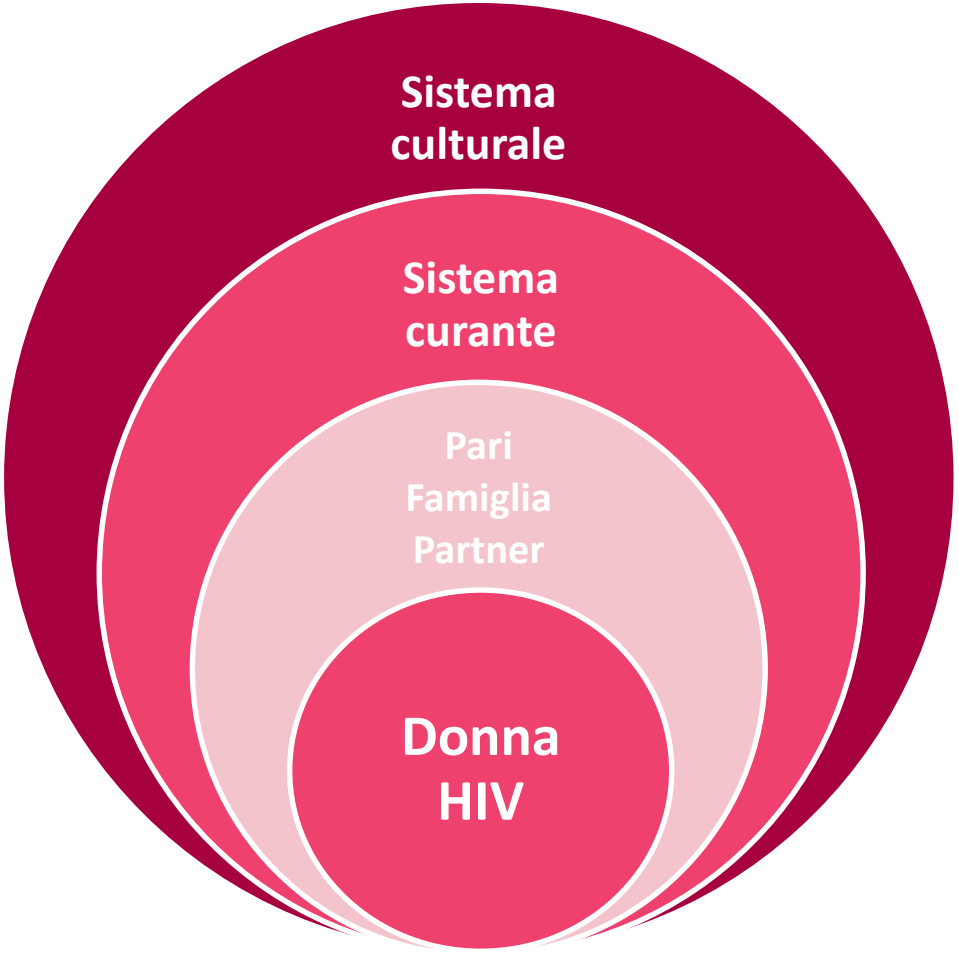

Il percorso di cura della donna in HIV

Prevenzione HIV e STI nella Donna: criticità

- Ridotto accesso alle cure
- Ridotto accesso ai programmi di screening
- Pregiudizi degli operatori

Prevenzione: Caso clinico (1)

Età: 32

Nazionalità: italiana

Scolarità: 13

Occupata

Nubile

E è la partner sieronegativa di F, paziente sieropositivo in trattamento presso la Terza divisione di questo ospedale in regime ambulatoriale. Da circa 3 anni ha una relazione con il nostro paziente che però gli ha nascosto la sieropositività, assumendo anche comportamenti a rischio (rapporti sessuali senza *condom*). Scoperta per caso la sieropositività del compagno, giunge presso il ns reparto e richiede consulenza di coppia infettivologica e psicologica che gli vengono accordate.

Prevenzione: Caso clinico (2)

Colloquio di coppia

Nel corso del colloquio di coppia la donna riferisce di essere venuta a conoscenza della sieropositività di F in maniera casuale e a seguito della scoperta di un recente tradimento .La donna appare visibilmente provata e riferisce di aver richiesto di parlare con noi per avere nozioni in merito all'HIV e all'esposizione al rischio di contagio subita.

Dopo aver effettuato sia la consulenza infettivologica sia la consulenza psicologica di coppia, la paziente torna alla nostra osservazione per ricevere nuova seduta di counselling psicologico individuale.

Prevenzione: Caso clinico (3)

Colloquio di individuale

Nel corso del colloquio individuale, la donna riferisce di aver deciso di restare con F nonostante il tradimento subito e la scoperta della sua sieropositività. Racconta di non avere mai usato il preservativo con F poiché si fidava di lui, più grande e più "*esperto*" di lei. Inoltre mi spiega che, pure temendo di restare incinta, avrebbe sempre preferito il coito interrotto invece del condom per pudore di andarlo a comprare o peggio per "timore di ingelosire" F. La donna appare ancora molto scossa e, indagato il motivo della sua preoccupazione,emerge non tanto la paura del contagio *("quando si ama si accetta tutto dell'altro")* quanto la paura di essere nuovamente tradita e lasciata. Risulta necessario dunque indagare la dimensione della percezione del rischio e la dimensione del potere relazionale tra i partner che risulta squilibrato ai danni della donna.

Identificazione della diagnosi di HIV nella donna

- L'atto successivo del counselling pre test è quello di mettere la persona a conoscenza del risultato per poi, nel caso di esito positivo del test HIV, farla accedere alla terapia (linkage to care)

- La modalità di comunicazione della diagnosi, soprattutto nel caso di positività al test HIV, incide in modo significativo sulla modalità in cui la persona gestirà la sua condizione di malattia e i suoi comportamenti di salute

- Tema principale del counselling post test è la Disclosure

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Change in Patterns of HIV Status Disclosure in the HAART Era and Association of HIV Status Disclosure with Depression Level among Women

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Abstract

Whether widespread use of HAART changed patterns of HIV status disclosure among women living with HIV is largely unknown. In addition, the association between time to first HIV disclosure and depression has not been fully explored among women. A retrospective cross-sectional survey was conducted among HIV-infected women from the Washington, DC site of the Women's Interagency HIV Study to collect detailed information about their HIV status disclosure behavior. A sample of 202 HIV-positive women, 102 diagnosed prior to and 100 post-HAART era participated in this study. Relationships between treatment era when diagnosed (pre-HAART or HAART era) and patterns of HIV status disclosure, and associations between HIV status disclosure and depression level were examined using generalized linear regression models with generalized estimating equation to adjust for repeated measurements from the same individuals. Our analyses showed that treatment era was not associated with either comfort level of HIV status disclosure or time to first HIV disclosure to either family members or friends. However, women were less likely to disclose HIV status to their family members in the HAART era ($P = 0.006$) after adjusting for social network type, comfort level of disclosure, time to first disclosure and

Table 2

HIV Status Disclosure Patterns in Pre-HAART and HAART Groups

HIV Status Disclosure Patterns	Overall (N=202)	Pre- HAART Group (n1=102)	HAART Group (n2=100)	P- value
Comfort level of disclosure				
A family member or relative, %				0.368
Very comfortable	34.5	39.2	30.0	
Comfortable	18.8	14.4	23.0	
Somewhat comfortable	17.3	17.5	17.0	
Not comfortable	29.4	28.9	30.0	
A friend, %				0.067
Very comfortable	17.2	20.9	13.7	
Comfortable	18.3	19.8	16.8	
Somewhat comfortable	25.3	29.7	21.0	
Not comfortable	39.3	29.7	48.4	
First person to disclose				
A family member or relative, %				0.170
Female	60.0	63.8	56.9	
Male	40.0	36.2	43.1	
A friend, %				0.103
Female	62.5	75	50.0	
Male	37.5	25	50.0	
Time to first disclosure				
A family member or relative, %				0.564
Within a few days	72.7	75	70.0	
A few weeks after	6.3	4.2	8.5	
A few months after	21.0	20.8	21.1	
A friend, %				
Within a few days	81.1	66.7	94.7	0.089
A few weeks after	2.7	100	0	
A few months after	16.2	27.8	5.3	
Extent of HIV Status Disclosure to Social Network Groups				
Family member or relative %				
All or nearly all	43.2	52.0	34.0	0.010
Most of them	17.8	17.0	18.6	
About half	7.6	2.0	13.4	
Some of them	6.1	8.0	4.1	
Very few	14.7	13.0	16.5	
None	10.7	8.0	13.4	
Current Friends, %				0.139
All or nearly all	18.1	21.0	15.0	

1. Comfort level with disclosure of STD status: comparing comfort levels of disclosing STD such as HIV between the pre-HAART and HAART groups, no significant difference was observed for disclosure to either family members or friends groups (see Table 2).

2. Time to first HIV status disclosure: After diagnosis, 77% of the participants chose a family member or relative as their very first person to disclose HIV status. Among family members, mother, sisters, and husband/boyfriend/main partner were the most frequent persons to whom participants first disclosed. About 60% of the women first disclosed their HIV status to females. No difference was found in the distributions of first HIV disclosure to different genders between the treatment eras (see Table 2). The majority of participants disclosed their status within a few days (see Table 2). For both family and friend groups, no significant difference was observed in comparing time to first HIV status disclosure between the treatment eras (see Table 2).

3. Disclosure level to social networks: The overall disclosure levels to family members and friends can be found in Table 2. About 61% and 30% of participants reported disclosure of their HIV status to all/most family members or friends respectively. Comparing disclosure level between the treatment eras, a significant difference was observed for family members, with women disclosing more in the pre-HAART era ($P = 0.010$, see Table 2); this difference was not observed for the friend group. To further examine whether the association between treatment era at enrollment and extent of HIV status disclosure is independent from other risk factors, a multivariate analysis was carried out, with social network type (family vs friend), comfort level of disclosure, time to first disclosure and length of follow up time being the covariates. Our results showed that treatment era at enrollment remained significantly associated with extent of HIV status disclosure to family members ($P = 0.006$) even after adjusting for these covariates.

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Reproductive Health

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HIV status disclosure to male partners among rural Nigerian women along the prevention of mother-to-child transmission of HIV cascade: a mixed methods study

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Abstract

Background: HIV status disclosure to male partners is important for optimal outcomes in the prevention of mother-to-child transmission of HIV (PMTCT). Depending on timing of HIV diagnosis or pregnancy status, readiness to disclose and disclosure rates may differ among HIV-positive women. We sought to determine rates, patterns, and experiences of disclosure among Nigerian women along the PMTCT cascade.

Methods: HIV-positive women in rural North-Central Nigeria were purposively recruited according to their PMTCT cascade status: pregnant-newly HIV-diagnosed, pregnant-in care, postpartum, and lost-to-follow-up (LTFU). Participants were surveyed to determine rates of disclosure to male partners and others; in-depth interviews evaluated disclosure patterns and experiences. Tests of association were applied to quantitative data. Qualitative data were manually analysed by theme and content using the constant comparative method in a Grounded Theory approach.

Results: We interviewed 100 women; 69% were 21–30 years old, and 86% were married. There were 25, 26, 28 and 21 women in the newly-diagnosed, in-care, postpartum, and LTFU groups, respectively. Approximately 81% of all participants reported disclosing to anyone; however, family members were typically disclosed to first. Ultimately, more women had disclosed to male partners (85%) than to family members (55%). Rates of disclosure to anyone varied between groups: newly-diagnosed and LTFU women had the lowest (56%) and highest (100%) rates, respectively ($p = 0.001$). However, family ($p = 0.402$) and male partner ($p = 0.218$) disclosure rates were similar between cascade groups. Across all cascade groups, fear of divorce and intimate partner violence deterred women from disclosing to male partners. However, participants reported that with assistance from healthcare workers, disclosure and post-disclosure experiences were mostly positive.

(Continued on next page)

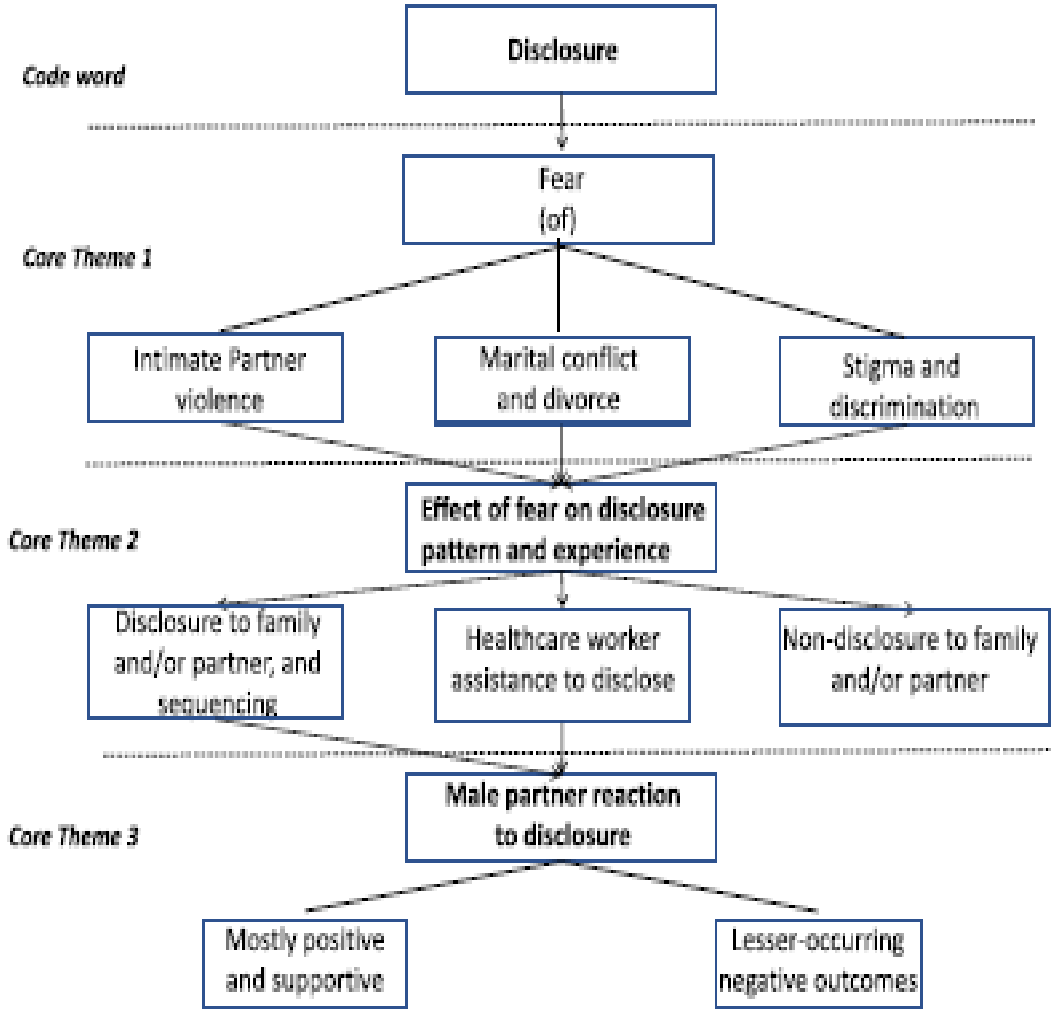

Fig. 1 Core emerging themes from qualitative data analysis

Conclusion: In our study cohort, although disclosure to male partners was overall higher, family members appeared more approachable for initial disclosure. Across cascade groups, male partners were ultimately disclosed to at rates > 75%, with no significant inter-group differences. Fear appears to be a major reason for non-disclosure or delayed disclosure by women to male partners. Augmentation of healthcare workers' skills and involvement can mediate gender power differentials, minimize fear and shorten time to male partner disclosure among women living with HIV, regardless of their PMTCT cascade status.

La disclosure: Caso clinico

Età: 40

Nazionalità: italiana

Scolarità: 8

disoccupata

separata

La paziente R ricoverata in IV divisione presso quest'ospedale con diagnosi di Polmonite da Pneumocisti Jiroveci, viene dimessa dopo più di un mese con diagnosi di HIV e prescrizione di terapia HAART. Riferisce di essersi separata dal marito circa tre anni orsono e di avere avuto una relazione con un partner con cui ha avuto ripetuti comportamenti sessuale a rischio e che ha successivamente scoperto essere sieropositivo. La paziente richiede colloquio psicologico nel corso del primo accesso di Day hospital, lamentando significativo stato ansioso e declino del tono umorale con tendenza all'isolamento sociale.

La disclosure: Caso clinico (2)

Nel corso del colloquio R racconta di avere continui incubi notturni e forte preoccupazione in merito alla possibilità che qualcuno possa scoprire la sua condizione di sieropositività (rivelata solo all'ex marito e alla madre).

R ha anche una figlia di 13 anni con cui attualmente vive presso l'abitazione della madre e che recentemente avrebbe subito bullismo dai compagni di scuola. R ha deciso di non dire alla figlia della sua sieropositività, sebbene tema che nel quartiere qualcuno possa sapere qualcosa .

Pertanto riferisce ritiro sociale e forte calo umorale .

R è davvero spaventata dalla sua condizione psicologica e non sa se è giusto tenere la figlia all'oscuro della sua patologia. Chiede pertanto un supporto nella decisione relativa alla possibilità di dire alla figlia di essere sieropositiva.

Treatment : retention in care e Aderenza

- Monitoraggio dell'aderenza terapeutica
- Individuazione precoce degli eventi sentinella
- Gestione della crisi attraverso *èquipe* multiprofessionale
- Rimodulazione del percorso terapeutico attraverso il *"tailored approach"*

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Predictors of Adult Retention in HIV Care: A Systematic Review

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Abstract

A systematic literature review was conducted to identify predictors of poor adult retention in HIV medical care in developed and developing countries. An electronic search was conducted with MEDLINE (OVID), PubMED, EBSCO, SCOPUS, and Cochrane databases, as well as manual searches. Original, quantitative, adult studies in English, published between 1995 and 2015 were included. Only those with a focus on predictors of retention in care were reported on. Of the 345 articles identified, thirty were included following an independent assessment by two raters. In developed countries, the most frequently cited predictors of poor retention were active substance use and demographic factors. In developing countries, physical health factors were most frequently associated with poor retention in care. The results from this review suggests primary concerns for poor retention include substance use and physical health factors. Other psychosocial factors, such as psychiatric illness and social/welfare factors, were also found to be relevant.

Keywords

Improving postpartum retention in care for women living with HIV in the United States

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Research findings have consistently demonstrated that women living with HIV in the United States and globally experience declines in medication adherence and retention in care after giving birth. A number of studies have identified factors associated with postpartum retention in care, but the evidence base for interventions to address the problem and close this gap in the HIV care continuum is limited. Furthermore, the majority of studies have been conducted in low-resource or moderate-resource countries and may be less applicable or require adaptation for use in high resource countries. In the United States, up to two-thirds of women drop out of care after delivery and are unable to maintain or achieve viral suppression postpartum, at a time when maternal and pediatric health are closely linked. We conducted a critical review of the literature to identify existing gaps regarding maternal retention in the United States and conceptualize the problem through the lens of the integrated and ecological models of health behavior. This review describes existing barriers and facilitators to retention in HIV care postpartum from published studies and suggests steps that can be taken, using a multilevel approach, to improve maternal retention. We propose five core action steps related to increasing awareness of the problem of poor postpartum retention, addressing needs for improved care coordination and case management, and using novel approaches to adapt and implement peer support and technology-based interventions to improve postpartum retention and clinical outcomes of women living with HIV.

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Keywords: HIV infections, medication adherence, postnatal care, postpartum

Treatment: caso clinico (1)

Età: 45

Nazionalità: italiana

Scolarità: 8

disoccupata

divorziata

M è al corrente della sua sieropositività dal 2000. Riferisce di avere contratto il virus dell'HIV dal marito, attualmente defunto. Ha assunto diverse terapie antiretrovirali manifestando una buona risposta virologica, sebbene nel corso degli anni e dopo le due gravidanze andate a buon fine (entrambi i figli negativi), non abbia sempre avuto un'aderenza terapeutica adeguata a causa del suo disturbo depressivo, che ciclicamente ritorna e incide sui suoi comportamenti di salute. Richiede nuovo colloquio psicologico in quanto recentemente manifesta difficoltà nella deglutizione della terapia (bolo isterico) con conseguente peggioramento della compliance.

Treatment: caso clinico (2)

Nel corso del colloquio psicologico M riferisce di avere da poco intensificato una relazione di coppia con un nuovo partner che, sebbene abbia accettato senza problemi la sua condizione di malattia, tuttavia manifesta comportamenti aggressivi e talvolta anche violenti verso di lei, tanto da arrivare a picchiarla.

M ha due figli ed è già nonna di tre nipoti che cura e aiuta economicamente pure essendo disoccupata.

A seguito del definitivo trasferimento del compagno presso la sua abitazione, M avrebbe nuovamente manifestato declino umorale e comparsa di bolo isterico fino alla totale sospensione dell'assunzione della HAART.

Emerge in modo significativo il problema della mancata elaborazione della propria condizione di malattia, vissuta come una colpa e come una condizione di condanna tanto da ingaggiare una relazione altamente disfunzionale col nuovo partner.

Recovery: verso il 4 90°

- La sieropositività nel ciclo di vita
- Il recupero del benessere psico fisico dopo la diagnosi
- Qualità della vita oggettivamente rilevata VS

  soggettivamente percepita

Recovery: caso clinico (1)

Età: 43

Nazionalità: italiana

Scolarità: 13 Occupata- nubile

G. è a conoscenza della sua sieropositività da quasi 15 anni. Da sempre ha manifestato un'ottima aderenza terapeutica e una viremia azzerata con condizione clinica ottimale. Riferisce di avere contratto il virus da un suo fidanzato che all'epoca del contagio non sapeva di essere HIV positivo, pertanto racconta da di non aver mai serbato per lui rancore e si ritiene responsabile di essersi esposta al contagio. Sebbene abbia avuto diverse difficoltà nella gestione della sieropositività nei primi tempi dalla diagnosi, successivamente è riuscita ad avere 3 relazioni anche stabili con partner sieronegativi con cui ha gestito in modo sereno la sua sieropositività , sempre comunicata dall'inizio del rapporto. Attualmente però è single e vive da sola nella sua abitazione che ha da poco acquistato vicino al posto di lavoro. G dopo un ciclo di sedute di counselling psicologico effettuate circa due anni fa richiesto da lei a seguito della separazione dall' ultimo partner, <u>richiede recentemente nuovo colloquio lamentando lieve declino del tono umorale.</u>

Recovery : caso clinico (2)

Nel corso del colloquio G riferisce di avere da poco ricevuto la proposta di una promozione lavorativa che la porterebbe a lavorare 6 mesi all'anno fuori Italia, comportandole anche un miglioramento dello stipendio, che però avrebbe rifiutato. Racconta di essere rimasta sorpresa positivamente da questa notizia, ma che non avrebbe accettato per varie ragioni, tra le quali quella di aver da poco una nuova relazione con un uomo per cui non sentirebbe l'esigenza di fare un cambiamento così radicale della sua vita. Relativamente alla relazione sentimentale racconta che, come suo solito ha subito parlato al partner della sua sieropositività e che per adesso la gestione della stessa sembra non dare preoccupazione.

Nonostante non ci sia nessun evento né sintomo che parli di un disagio, G però ha sentito l'esigenza di un colloquio psicologico di supporto affermando testualmente che *« dopo 15 anni a combattere per la mia salute e perché la mia patologia non inficiasse la mia vita, sento di essere riuscita in questa battaglia, tanto da avere una vita invidiabile sotto tutti i punti di vista, forchè uno : la memoria di quello che ho passato e il desiderio che un giorno finalmente convivere con l'HIV non sia più sinonimo di discriminazione»*

Conclusioni

- La gestione della sieropositività nelle dinamiche relazionali della donna viene influenzate dalla sua condizione di iniquità sociale tutt'ora presente

- La condizione di disparità di genere incide sull' accesso alle cure e sull'esposizione al rischio

- Il potere sociale e relazionale influiscono sulla capacità di negoziazione di comportamenti sessuali sicuri

- La sieropositività assume il ruolo di cassa di risonanza della condizione di iniquità sociale

Counselling per la Donna HIV

Obiettivi

- Analisi variabili psicosociali
- Individuazione delle criticità
- Creazione di un Progetto terapeutico personalizzato

Finalità

- Miglioramento dell'accesso alle cure e ai Programmi di Prevenzione Primaria
- Miglioramento dell'aderenza terapeutica
- Miglioramento della qualità di vita soggettivamente percepita
- Riduzione del peso della disparità di genere sulla gestione della sieropositività

“Chi non si muove non può rendersi conto delle proprie catene”
(Rosa Luxemberg)

Grazie per l’attenzione

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