

Disclosure as a Major Setback in the Management of Mother-to-Child Transmission of Human Immunodeficiency Virus

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Abstract:

Mother-to-child transmission (MTCT) of Human Immunodeficiency Virus (HIV) remains a critical global health challenge, particularly in sub-Saharan Africa where the prevalence of paediatric HIV is disproportionately high. Despite significant advances in prevention programmes and the availability of effective antiretroviral therapy (ART), the burden of vertical transmission persists, with Nigeria contributing one of the highest rates worldwide. A major factor undermining the success of prevention of mother-to-child transmission (PMTCT) interventions is the issue of HIV status disclosure. Disclosure is central to adherence and psychosocial support, yet fear of stigma, rejection, domestic violence, and discrimination often deters women from revealing their status to partners, family members, or healthcare providers. Non-disclosure has been consistently linked to poor adherence, limited partner involvement, and increased risk of MTCT. This study employed a narrative review approach, synthesising peer-reviewed literature, policy documents, and global health reports to examine disclosure as a major setback in PMTCT. Findings reveal that while disclosure improves treatment adherence, strengthens support systems, and enhances psychosocial wellbeing, its absence undermines intervention effectiveness and perpetuates paediatric HIV infections. Structural barriers such as weak health systems, inconsistent ART supply, and socio-cultural norms further compound these challenges. Although global strategies such as the WHO "Option B+" approach have shown success in reducing MTCT rates, their outcomes are dependent on consistent ART adherence, supportive disclosure environments, and strong healthcare infrastructure. Addressing stigma, strengthening health systems, and fostering supportive disclosure frameworks remain essential to eliminating MTCT and achieving

IJMNHS

Accepted 25 June 2025

Published 30 June 2025

DOI: 10.5281/zenodo.17116313



global paediatric HIV reduction targets.

Keywords: HIV disclosure, mother-to-child transmission, antiretroviral therapy, stigma,



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Introduction

Globally, since the inception of this infection, a total of 91.4 million and 44.1 million people have been infected and died, respectively, from AIDS-related illness (WHO, 2025). The world record of HIV and AIDS revealed that 40.8 million people were living with HIV infection, with 1.4 million being children less than 15 years old as of July 2025, and 75,000 paediatric deaths occurred in the year 2024 (WHO, 2025). The transmission of Human Immunodeficiency Virus (HIV) from an infected mother to her unborn or newborn child remains one of the greatest challenges in the fight against the epidemic. This mode of transmission is commonly referred to as mother-to-child transmission (MTCT) or perinatal transmission of HIV, as it occurs during pregnancy, labour and delivery, or after birth through breastfeeding (CDC, 2022). It is also widely described as vertical transmission of HIV, emphasising the downward transmission pathway from mother to child (World Health Organization [WHO], 2023; Ugochukwu et al., 2021). The burden of paediatric HIV infection globally is largely attributable to MTCT, with studies showing that this is the predominant means by which children under five years acquire the virus. However, significant evidence suggests that MTCT can be curtailed to the barest minimum when there is strict and consistent adherence to antiretroviral therapy (ART) during both the prenatal and postnatal periods (Borode et al., 2025; CDC, 2023; Belachew et al., 2020). With proper preventive measures, the risk of vertical transmission can be reduced to less than 5%, making adherence to ART a cornerstone in achieving global elimination targets.

Despite the availability of effective ART and preventive programmes, challenges persist in ensuring optimal adherence. One of the most significant hindrances to complete adherence to treatment regimens is the issue of disclosure of HIV status. Disclosure plays a critical role in the continuum of care, as it often determines the level of psychosocial support an individual receives from their partner or family. Lack of disclosure to partners, especially in serodiscordant relationships, has been identified as a major barrier to adherence, as fear of stigma, rejection, or domestic violence discourages women from sharing their HIV status (Okumu, 2020; Hallberg et al., 2019). In some cases, even when both partners are HIV-positive, individuals may still choose to conceal their status from each other due to fear of judgment, blame, or relationship strain (Tibebu et al., 2023). Such situations compromise ART adherence and, by extension, heighten the risk of MTCT.

Given these challenges, the study addressed critical areas that can help provide a comprehensive understanding of disclosure as a major setback in the management of MTCT. The first area of focus was to enumerate the prevalence of HIV and MTCT globally and within specific regions. Despite progress in HIV prevention, sub-Saharan Africa continues to bear the greatest burden of new infections among children, primarily through vertical transmission. Understanding prevalence data is therefore necessary to contextualise the urgency of interventions. Secondly, the study examined the challenges influencing adherence to antiretroviral regimens among expectant and breastfeeding mothers. Factors such as fear of stigma, lack of partner support, poverty, cultural beliefs, and limited access to healthcare services significantly affect adherence. Structural barriers, including weak healthcare systems and drug stock-outs, further compound the problem. A detailed assessment of these



challenges will highlight the complex interplay between individual, societal, and systemic factors that undermine ART adherence and prevention of MTCT.

The third focus evaluated the impact of disclosure on MTCT of HIV. While disclosure is associated with improved adherence, better partner support, and reduced psychological stress, its absence has been linked to poor adherence and increased risk of vertical transmission. Furthermore, the seminar assessed the effectiveness of current interventions aimed at preventing MTCT. Global strategies such as the WHO's "Option B+" approach, which provides lifelong ART for all pregnant and breastfeeding women regardless of CD4 count, have contributed significantly to reductions in MTCT rates. However, the success of such interventions depends heavily on consistent ART use, partner support, and healthcare system efficiency. Evaluating these interventions will provide insights into gaps that need to be addressed. Finally, the seminar highlighted strategies for improvement in the management of MTCT of HIV.

Methodology

The methodology adopted for this study was a narrative review approach, which enabled an in-depth synthesis of existing literature on disclosure as a major setback in the management of mother-to-child transmission (MTCT) of HIV. Relevant peer-reviewed articles, policy documents, and reports published by reputable organisations such as the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) were retrieved from electronic databases including PubMed, Google Scholar, and ResearchGate. Literature was selected based on relevance to MTCT, HIV disclosure, adherence to antiretroviral therapy, and interventions aimed at reducing paediatric HIV infections. The review incorporated studies published within the last decade, although earlier works were included where necessary to provide foundational knowledge. The analysis involved identifying recurring themes such as prevalence rates, challenges to adherence, the role of disclosure, and the effectiveness of existing interventions, which were critically discussed to provide a comprehensive understanding of the topic. This method was chosen because it allowed for flexibility in integrating diverse sources and provided a broader perspective on the barriers and strategies in preventing MTCT of HIV.

Prevalence of HIV and MTCT Transmission of HIV

The Human Immunodeficiency Virus (HIV) remains one of the most significant public health challenges globally, particularly in sub-Saharan Africa where the prevalence of infection is disproportionately high. Since the onset of the epidemic, an estimated 74.9 million people have been infected, with 32.0 million AIDS-related deaths recorded by the end of 2018 (UNAIDS, 2020a). Globally, the infection continues to affect vulnerable populations, with 6000 new cases of HIV reported weekly among women aged 15–24 years, of which nearly 80% occur among adolescent girls aged 15–19 years in sub-Saharan Africa (UNAIDS, 2020a). The disproportionate burden borne by women in this age bracket is underscored by evidence showing that they are twice as likely to be infected compared to their male counterparts (UNAIDS, 2020a). Children are not exempt from this burden. In 2018 alone, 1.7 million children under 15 years were living with HIV, and 98,000 paediatric AIDS-related deaths were reported globally (WHO, 2023; UNAIDS, 2020a). Sub-Saharan Africa accounted for



nearly four-fifths of the global paediatric HIV burden, with Nigeria contributing one-quarter of the region's total infection (Chizoba et al., 2020). Nationally, Nigeria recorded 130,000 new infections and 53,000 AIDS-related deaths in 2018 (UNAIDS, 2020c). In 2019, the country's HIV prevalence was estimated at 1.4%, with close to two million people living with the virus (UNAIDS, 2020b). Reports suggest that Nigeria has consistently contributed the highest paediatric HIV infection burden globally over the last decade (Leach-Lemens, 2019), a concern reiterated by evidence from 2020 highlighting persistent gaps in prevention of mother-to-child transmission (PMTCT) services (Chizoba et al., 2020).

In light of this burden, PMTCT has become an essential intervention for addressing paediatric HIV infections. Globally, in 2018, approximately 90% of the 1.3 million HIV-positive pregnant women lived in sub-Saharan Africa, illustrating the critical need for targeted interventions in this region. However, significant progress has been achieved since the introduction of PMTCT programmes in the year 2000. Between 2010 and 2018, global new infections among children under five declined by 41%, from 280,000 to 160,000 (UNICEF, 2019). Furthermore, it is estimated that 1.1 million deaths and 2 million new infections among children under five were averted between 2000 and 2018 as a result of these programmes (UNICEF, 2019). HIV testing among pregnant women in low- and middle-income countries also improved considerably, rising from 44% in 2010 to 82% in 2018, with nearly all identified HIV-positive women placed on lifelong antiretroviral therapy (ART) (UNICEF, 2019). Yet, disparities persist, as some regions, particularly West and Central Africa, continue to lag behind in achieving optimal coverage. An example of success within the region can be seen in Burkina Faso, which achieved zero paediatric HIV prevalence within 15 years of initiating PMTCT interventions, a success attributed largely to active male partner involvement in PMTCT programmes (Linguissi et al., 2019). These examples highlight both the potential and challenges associated with PMTCT implementation in diverse contexts.

Despite the absence of a cure for HIV, preventing mother-to-child transmission is highly feasible with effective measures. According to the National Agency for the Control of AIDS (NACA, 2023), combined preventive interventions can significantly reduce the risk of vertical transmission during pregnancy, delivery, and breastfeeding. The Centers for Disease Control and Prevention (CDC, 2022; 2023) also affirm that antiretroviral medications remain the cornerstone of PMTCT, with the capacity to drastically reduce transmission risk when adherence is maintained. The World Health Organization developed a comprehensive PMTCT package in 2000, structured around four prongs. These include preventing HIV infection among women of childbearing age, preventing unintended pregnancies among HIV-positive women, preventing HIV transmission from infected mothers to their infants during pregnancy, delivery, or breastfeeding, and ensuring treatment, care, and support for HIV-positive women, their children, and families. These four pillars represent a holistic framework for addressing vertical transmission, acknowledging the biological, reproductive, and social dimensions of HIV. Current treatment regimens involve initiating ART during pregnancy and continuing through the breastfeeding period, with infants also receiving prophylactic therapy. With full adherence, HIV-positive breastfeeding mothers can reduce the risk of transmission from 35% to less than 5%, while non-breastfeeding mothers can reduce the risk from 25% to less than 2% (WHO, 2023; World Vision International, 2020).



In Nigeria, the PMTCT programme has been shaped by global strategies and commitments. Since the United Nations General Assembly's Political Declaration on HIV and AIDS in 2006, the elimination of MTCT has remained a global priority. The 2015 "Start Free, Stay Free, AIDS Free" framework targeted 21 African countries, including Nigeria, to accelerate the elimination of new paediatric HIV infections (Ikpeazu et al., 2023). Yet, progress in Nigeria has been inconsistent. Between 2015 and 2020, the number of pregnant women ranged between 6.9 million and 7.8 million annually, yet only about 35% (2.7 million) attended antenatal clinics offering PMTCT services in 2020 (Ikpeazu et al., 2023). Evidence from 2013 to 2017 indicates that HIV testing coverage among pregnant women was between 32.8% and 42.7% (Ajayi et al., 2019). Furthermore, less than one-third of pregnant women received Provider-Initiated HIV Testing and Counselling (PITC) during antenatal visits, reflecting significant missed opportunities for prevention (Chizoba et al., 2020). This gap underscores the challenge Nigeria faces despite global prioritisation of PMTCT, as the country continues to account for the highest burden of paediatric HIV worldwide (Iwegbu et al., 2022; Dirisu et al., 2020).

The declining coverage of ART among HIV-positive pregnant women in Nigeria further complicates the situation. In 2020, Nigeria contributed 14% of all new paediatric HIV infections across the 21 African countries involved in the "Start Free, Stay Free, AIDS Free" framework (Ikpeazu et al., 2023). Localised studies have also revealed major gaps in PMTCT service provision. In Jos, North-Central Nigeria, only 38.9% of primary health care centres offered PMTCT services, and uptake among HIV-positive women stood at a moderate 60% (Dawet et al., 2024). These statistics highlight the uneven distribution of services and the limitations in accessibility, particularly in rural or underserved regions. Moreover, even where knowledge of MTCT is high and perceptions of PMTCT services are positive, transmission remains prevalent due to systemic weaknesses, including insufficient coverage, inadequate infrastructure, and persistent stigma (Danladi et al., 2020).

Scholarly evidence continues to stress the urgent need for scaling up PMTCT services in Nigeria. Studies consistently point to the importance of extending PMTCT to all levels of healthcare facilities, strengthening health systems, and addressing human resource gaps (Dawet et al., 2024; Ezeudoye, 2021; Danladi et al., 2020). A particularly important recommendation is the inclusion of traditional birth attendants (TBAs) in PMTCT training, given that a significant number of births in Nigeria still occur outside formal healthcare facilities (Chizoba et al., 2020). Integrating TBAs into the PMTCT framework could help bridge gaps in rural areas, improving HIV testing, counselling, and referral of pregnant women to appropriate services. Without such innovative and context-specific interventions, the goal of achieving zero paediatric HIV transmission in Nigeria will remain elusive.

In summary, HIV prevalence remains alarmingly high globally, with women and children in sub-Saharan Africa, particularly Nigeria, bearing the greatest burden. While PMTCT programmes have led to substantial progress globally in reducing paediatric infections and deaths, Nigeria continues to lag behind due to limited coverage, poor uptake of services, and systemic barriers. The four-pronged approach to PMTCT provides a comprehensive framework that has proven effective when properly implemented. However, for Nigeria to reduce its contribution to global paediatric HIV infections, urgent attention must be given to



scaling up services, ensuring equitable access, and addressing socio-cultural and structural barriers.

Challenges Influencing Adherence to Antiretroviral (ARV) regimen

According to Leach-Lemens (2019), challenges to the successful implementation of the prevention of mother-to-child transmission (PMTCT) programme in Nigeria can be broadly categorised into inadequate service delivery, lack of health workforce, unavailability of medical products, insufficient health financing, and weak leadership and governance. Despite notable progress over the years, such as the rapid scale-up of facilities offering PMTCT services from 690 to 6,729 between 2009 and 2016, representing an 875% increase, and a 486% increase between 2012 and 2013, the programme continues to face severe setbacks. For instance, less than one-fifth of healthcare facilities in Nigeria currently provide onsite PMTCT services. Additionally, the coverage of testing among pregnant women and their partners remains limited, while antiretroviral therapy (ART) coverage is still low, with only about 34% of pregnant women living with HIV receiving ART and just 31% of children under 15 years accessing essential medications (Leach-Lemens, 2019; WHO, 2022). These gaps are further reinforced by studies such as Chizoba et al. (2020), who reported that low uptake of PMTCT services, low antenatal clinic attendance, and a preference for non-institutionalised delivery facilities remain persistent barriers to progress.

Evidence further reveals that only three-fifths (66%) of pregnant women who enrolled in PMTCT services during the antenatal period successfully completed the cascade of care, which included antenatal attendance, institutional delivery, and at least one follow-up visit for their infants. In Anambra State, approximately 22% of women in PMTCT programmes reported non-adherence to ART, pointing to challenges in sustaining treatment compliance (Leach-Lemens, 2019). These issues are often compounded by the absence of functional counselling rooms, inadequate provision of pre- and post-testing counselling, and the inaccessibility of national PMTCT guidelines (Leach-Lemens, 2019). UNICEF (2019) further notes that poor postnatal service delivery, reflected in low maternal retention, weak health systems, fear, stigma, denial, and difficulties experienced by populations living in hard-to-reach areas, continue to undermine uptake and retention within PMTCT programmes.

The shortage of skilled healthcare providers represents another fundamental challenge to PMTCT implementation. According to Leach-Lemens (2019), inadequate knowledge among providers, coupled with discriminatory attitudes towards women living with HIV, severely limits the quality of care delivered. Compounding this issue is the irregular supply of antiretroviral drugs, often due to dependence on donor sponsorship and poor data management of commodities. The limited availability of second- and third-line ART regimens poses a particular challenge for clients requiring alternative treatment. The problem was further exacerbated when the United States suspended significant HIV funding during President Trump's administration, resulting in medication shortages and forcing some health facilities to ration drugs by reducing the usual three-month supply to two-week allocations (European AIDS Treatment Group, 2025). This reflects the overdependence of Nigeria's HIV response on donor funding. While the national health insurance scheme provides coverage for less than 10% of the eligible population, attempts have been made to develop alternative funding mechanisms. For instance, Abia and Taraba states have domestically funded HIV



programmes, despite representing 81% of the national HIV burden (Leach-Lemens, 2019). Nevertheless, the lack of strong political will, weak accountability mechanisms, and donor-driven priorities that are often misaligned with government strategies continue to limit the effectiveness of the programme.

In addition to systemic and financial barriers, socio-cultural and interpersonal dynamics also play a significant role in hindering PMTCT uptake. Ogueji and Omotoso (2021) identified poor interpersonal relationships between healthcare providers and clients, inadequate family support, financial constraints, long waiting times, fear of stigma, and conflicts between social norms and the requirements of PMTCT programmes as major obstacles faced by pregnant women. In northern Nigeria, Danladi et al. (2020) observed that ignorance of the disease, fear of involuntary disclosure due to frequent clinic attendance, stigma, adherence to traditional practices, and long travel distances contributed significantly to low utilisation of PMTCT services. Similarly, Dirisu et al. (2020) reported that in Kano State, the availability of HIV test kits was inconsistent, male partner involvement was minimal, and cultural beliefs discouraged institutional deliveries. These issues were compounded by negative attitudes of healthcare workers and the poor organisation of PMTCT services, further deterring women from accessing care.

Healthcare workers themselves have also reported unique challenges that hinder PMTCT service delivery. For instance, Kram et al. (2020), in a study conducted in Lagos, highlighted that clients often provided false contact information to avoid follow-up due to stigma, denied their HIV-positive results, or showed outright unwillingness to enrol in PMTCT services. Disclosure of HIV status emerged as a particularly sensitive challenge. As Hallberg et al. (2019) and John and Chipwaza (2022) note, many women feared disclosing their HIV status to their partners due to potential consequences such as abandonment, divorce, or violence. The lack of disclosure negatively influences ART adherence, undermining the success of the PMTCT programme and resulting in poorer health outcomes for both mothers and children (Aurpibul et al., 2023).

Conceptual Analysis of Disclosure

Disclosure in the context of HIV refers to the process whereby an HIV-positive individual makes the choice to reveal their serostatus to others, including partners, parents, relatives, friends, family members, and even employers or employees depending on the situation (Tessema et al., 2023; Okumu, 2020). It has been defined more broadly by organisations working in HIV treatment and care as the act of informing others about one's HIV status, either voluntarily or in response to specific circumstances (The WellProject, 2022). As Glaser (2018) explained, disclosure is not a single event but rather a continuous process, particularly in cases involving children or adolescents who gradually acquire cognitive, emotional, and social maturity over time. The decision to disclose is therefore multifaceted and dynamic, often influenced by individual readiness, social context, and perceived consequences. For many people, disclosure provides an opportunity to share the burden of living with HIV with trusted individuals who may offer emotional support and practical assistance, thereby helping to reduce feelings of isolation and psychological distress. Nonetheless, disclosure is often accompanied by profound challenges, as the risk of rejection, discrimination, or strained relationships can make the decision extremely difficult and



stressful (Berhe et al., 2020; Okumu, 2020; The WellProject, 2022; Ejioye & Gbenga-Epebinu 2021).

Although disclosure is generally voluntary, in certain circumstances it becomes a legal or ethical responsibility. For instance, informing one's sexual partner is not only imperative for the health and safety of that partner but also a responsibility to prevent further transmission of the virus (Samuel, 2020). This form of disclosure is crucial as it enables partners to know their HIV status, access testing, and seek treatment if necessary. However, disclosure to sexual partners is also one of the most challenging forms, as individuals may fear abandonment, divorce, loss of financial support, or even legal consequences. Okumu (2020) observed that such fears frequently hinder individuals from revealing their HIV-positive status, even when they understand the health risks of nondisclosure. Paradoxically, while disclosure may expose individuals to stigma and discrimination, it also provides a mechanism for challenging stigma and creating avenues for support, which is critical for long-term adherence to antiretroviral therapy (ART) and psychological wellbeing (Samuel, 2020).

The prevalence of HIV disclosure varies widely across regions and populations, often reflecting broader cultural, social, and structural differences. Disclosure rates are typically lower in less developed countries compared to high-income nations (McHugh et al., 2018; Whembolua et al., 2018). Within sub-Saharan Africa, disclosure among partners ranges from 33% to as high as 93%, underscoring significant variation between contexts (Hallberg et al., 2019). In Ghana, research among children and their caregivers showed that only one-third of children had been informed of their HIV status by their caregivers (Amankwah-Poku et al., 2021), reflecting the particular difficulties of disclosure within family contexts. Similarly, in Ethiopia, disclosure rates among sexual partners reached 73% in the Amhara region (Tibebu et al., 2023). In Nigeria, evidence from North-Central states showed that 81% of married rural women disclosed their HIV status to at least one person, most commonly their partners (85%) or other family members (55%) (Odiachi et al., 2018). Factors such as marriage duration and prior exposure to counselling sessions were found to increase the likelihood of disclosure, as couples married for more than five years and those who had received professional counselling were more willing to disclose compared to others (Nyongesa & Mwangi, 2023). Nonetheless, disclosure remains particularly challenging in serodiscordant relationships, where fears of blame, violence, and abandonment are more pronounced (Okumu, 2020). Parents also struggle with disclosure, not only in terms of revealing their own status to children but also in deciding whether, when, and how to disclose a child's HIV-positive diagnosis (Okumu, 2020).

Disclosure manifests in multiple forms depending on the relationships involved and the context. Studies have documented disclosure between married couples, intending couples, friends, adolescents, workplace relationships, and between parents and children (Hallberg et al., 2019; Okumu, 2020; Nsibandze, 2021; CDC, 2021; John & Chipwaza, 2022; Nyongesa & Mwangi, 2023; The WellProject, 2023). Glaser (2018) categorised disclosure into four types: full disclosure, where all relevant information is openly shared; complete non-disclosure, where no information is revealed; accidental disclosure, where status is revealed unintentionally; and deception, where individuals provide misleading or false information about their condition. Each type carries different implications for health outcomes,



relationships, and psychosocial wellbeing, highlighting the complexity of disclosure decisions in everyday life.

The advantages and disadvantages of disclosure have been widely documented in the literature. Disclosure is often described as highly stressful and fraught with challenges (Aurpibul et al., 2023; Okumu, 2020). Hallberg et al. (2019), in their study of partners in Morongo, Tanzania, found that low disclosure rates were linked to fears of divorce, cultural practices, and loss of financial support. Similarly, research among 113 clients in Nairobi identified behavioural, cultural, psychological, and socio-economic factors as reasons for nondisclosure. In this study, a little over half of participants had disclosed their status, but many experienced negative consequences including rejection and discrimination. More than two-thirds (68.6%) cited fear of abandonment, stigma, and blame as barriers to disclosure. Notably, couples married for more than five years were four times more likely to disclose, and those who had received counselling were 11 times more likely to share their status compared to individuals without counselling, emphasising the role of psychosocial support in facilitating disclosure (Nyongesa & Mwangi, 2023).

In South-eastern Tanzania, research revealed that 58% of respondents disclosed their HIV status to their partners, with disclosure more common among married individuals, though often delayed by several months. Singles were significantly less likely to disclose. Fear of stigma, shame, and relationship loss remained the most common reasons for nondisclosure (John & Chipwaza, 2022). In Ethiopia, disclosure among pregnant women was high at 73%, and associated factors included living in urban areas, knowledge of HIV status prior to pregnancy, planning for pregnancy, having disclosed to others, and possessing good knowledge of prevention methods (Tibebu et al., 2023). These findings suggest that disclosure is not only shaped by personal circumstances but also by broader socio-demographic and structural factors.

The effects of disclosure extend beyond medical adherence and transmission prevention, influencing wider social and psychological outcomes. Aurpibul et al. (2023) observed among young adults in Thailand that disclosure could lead to both positive and negative social effects, including perceived social support, strengthened or strained family relationships, educational opportunities, and child-rearing experiences. In contrast, Nsibandze et al. (2021) noted significant negative consequences of disclosure, ranging from poverty and food insecurity to psychological distress, including suicidal ideation. These findings underscore that disclosure outcomes are highly contextual: while some individuals gain support and relief after disclosure, others face stigma, isolation, and discrimination. Among young adults living with HIV since childhood in Chiang Mai, Thailand, disclosure was associated with both positive outcomes, such as perceived social acceptance and support, and negative outcomes, such as strained family relationships, difficulties in employment, and heightened fear of stigma (Aurpibul et al., 2023). Consequently, the presence of strong support systems has been highlighted as critical in mitigating the psychological burden and social risks associated with disclosure.

HIV disclosure remains a complex and multifaceted process shaped by cultural, social, psychological, and structural influences. While disclosure is vital for adherence to treatment and prevention of further transmission, it is also fraught with risks that can deter individuals



from revealing their status. The literature demonstrates that outcomes vary, with some individuals benefiting from support and acceptance, while others face rejection, stigma, and discrimination. Counselling, partner involvement, and social support networks are therefore indispensable in facilitating disclosure and alleviating its negative impacts. Ultimately, strategies that promote supportive environments for disclosure are essential in addressing the challenges of HIV management and reducing the burden of mother-to-child and partner transmission.

Impact of Disclosure on MTCT

Disclosure of HIV status has been widely acknowledged as a critical factor in the management of the condition, especially in the context of preventing mother-to-child transmission (MTCT) and improving adherence to antiretroviral therapy (ART). The benefits of disclosure cannot be overemphasised, as it enhances both medical and psychosocial outcomes for individuals and communities affected by HIV. According to Glaser (2018), disclosure facilitates improved adherence to treatment, which is essential for viral suppression and reduction of the risk of MTCT. It also reduces the likelihood of missed appointments and skipped medications, thereby strengthening treatment consistency and improving long-term health outcomes. Beyond physical health, disclosure offers positive psychological benefits, such as reduced emotional stress, enhanced self-care, and greater treatment ownership, particularly among adolescents. Adolescents who are informed of their status tend to demonstrate better treatment adherence and self-management, given their increased awareness and involvement in medical decision-making. Moreover, disclosure allows them access to vital health education, including sexual and reproductive health (SRH) education, which equips them with knowledge to make safer choices and prevent further transmission. Social support and participation in adolescent peer support groups also improve psychosocial well-being, mental health, and school performance, fostering an environment where young people can thrive despite living with HIV (Glaser, 2018).

Parents and caregivers equally benefit significantly from disclosure. The process provides relief from the psychological burden of secrecy and facilitates reconciliation or acceptance of the condition. Once disclosure occurs, parents and caregivers can talk openly about HIV, both with the affected child or adolescent and with others in their social networks, creating opportunities for enhanced support. This openness helps caregivers provide the necessary encouragement for adherence and facilitates treatment continuity during periods of change, such as holidays or when the child is under the care of relatives. It also reduces behavioural problems among adolescents, as open communication fosters trust, understanding, and cooperative behaviour. In schools, disclosure allows parents and caregivers to liaise with teachers and administrators to ensure that children or adolescents living with HIV receive appropriate support, especially in times of medical need. For healthcare workers, disclosure strengthens their capacity to engage in open conversations about HIV and treatment with children, adolescents, and their families. It allows them to provide comprehensive SRH education, with a particular focus on HIV prevention strategies such as offering pre-exposure prophylaxis (PrEP) to partners of sexually active adolescents living with HIV (ALHIV). Furthermore, disclosure enables healthcare professionals to offer more effective



psychological support and appropriate referrals, thereby enhancing the overall quality of care (Glaser, 2018).

Despite these benefits, several reasons continue to hinder disclosure among individuals living with HIV. Aurpibul et al. (2023) affirm that anticipated stigma, potential negative impacts on employment, and fear of strained relationships often discourage disclosure. Stigma and discrimination remain some of the most significant barriers, as many individuals fear rejection, abandonment, or even divorce if they reveal their status to partners or families. Studies have further highlighted that non-disclosure is influenced by a lack of knowledge on the importance of openness, as well as cultural practices that perpetuate silence and fear (Hallberg et al., 2019; Okumu, 2020; John & Chipwaza, 2022; Nyongesa & Mwangi, 2023). For instance, fear of blame, discrimination, and loss of financial support often lead individuals, particularly women, to withhold their status. Additionally, structural barriers such as negative encounters with healthcare workers exacerbate the situation. Fuente-Soro et al. (2023) reported that some individuals deliberately withheld their known HIV status from healthcare providers during provider-initiated counselling and testing (PICT) campaigns in Mozambique. The study revealed that 16.1% of individuals refused to declare their status, with reasons including prior negative experiences with healthcare staff, doubts about whether they had been cured (33.3%), past experiences of physical and verbal abuse following their diagnosis (48.1%), and the negative effect of disclosure on their daily activities (46.7%). These findings highlight the deep-seated fears and lived experiences of people living with HIV, which continue to pose major obstacles to achieving universal disclosure.

Moving forward, it is essential to implement feasible, sustainable, and culturally acceptable interventions that promote safe disclosure while addressing the underlying barriers. Interventions such as targeted education and counselling are vital to encourage openness and to combat stigma and discrimination (Benner, 2020; John & Chipwaza, 2022). Education campaigns can help reshape community perceptions of HIV and foster empathy and acceptance. Community and home-based care models are also critical, as they bring care closer to individuals and create opportunities for supportive disclosure in familiar environments. Collaborating with traditional birth attendants (TBAs), religious and traditional leaders, as well as governmental and non-governmental institutions, provides a platform for wider advocacy and acceptance of disclosure in culturally sensitive ways (Iwegbu et al., 2022; Kram et al., 2020). Scaling up prevention of mother-to-child transmission (PMTCT) services is also crucial, ensuring that every pregnant woman living with HIV has access to lifelong ART and supportive counselling. Regular training of healthcare workers, including TBAs, will improve their capacity to provide non-judgemental care and sustain trust between patients and providers. Furthermore, adequate provision of medical supplies and consistent ART delivery are indispensable for strengthening adherence and facilitating disclosure without fear of treatment interruption (Ezeudoye, 2021).

Effectiveness of Current Interventions in Prevention of MTCT of HIV

The prevention of mother-to-child transmission (PMTCT) of HIV remains one of the most significant public health achievements in global HIV response, yet challenges persist in ensuring its full effectiveness. Over the years, a range of interventions has been implemented



to curb transmission during pregnancy, delivery, and breastfeeding, with the World Health Organization (WHO) introducing the “Option B+” approach as a cornerstone strategy. Option B+ advocates for lifelong antiretroviral therapy (ART) for all pregnant and breastfeeding women living with HIV, regardless of CD4 count, thereby reducing vertical transmission rates substantially (WHO, 2023). The approach has not only simplified treatment regimens but has also enhanced maternal health outcomes and contributed to long-term HIV epidemic control. However, as various studies suggest, the effectiveness of Option B+ and other PMTCT strategies is heavily contingent on consistent ART adherence, adequate partner involvement, and strong healthcare systems that can provide continuous and accessible care (Aliyu et al., 2019; CDC, 2023).

Evidence demonstrates that the global implementation of Option B+ has led to a marked decline in new HIV infections among infants, especially in countries with high HIV prevalence. For instance, Belachew et al. (2020) found that in East Africa, interventions rooted in Option B+ significantly reduced vertical transmission rates when adherence to ART was maintained. Similarly, Ugochukwu et al. (2021) documented notable improvements in Nigeria, where infant follow-up services integrated into PMTCT programs reduced paediatric HIV infections over a decade of monitoring. These successes highlight the potential of current interventions to eliminate MTCT if coverage and adherence are optimized. Nonetheless, disparities persist across regions, often due to systemic weaknesses in healthcare infrastructure and socioeconomic barriers that limit consistent uptake of ART.

Male partner involvement is increasingly recognized as a critical determinant of intervention success. Aliyu et al. (2019) emphasize that male engagement in PMTCT services significantly improves ART adherence, clinic attendance, and emotional support for women, thereby reducing HIV transmission risks. Unfortunately, cultural and gender norms in many sub-Saharan African settings hinder male participation, often leaving women to navigate disclosure, stigma, and treatment adherence alone. This gap underscores the need for gender-sensitive strategies that normalize male participation and foster shared responsibility in PMTCT efforts. Without such support, the full potential of Option B+ cannot be realized, as women may face challenges in maintaining adherence, particularly in the absence of spousal encouragement or in contexts where HIV-related stigma remains pervasive.

The efficiency and capacity of healthcare systems also play a vital role in the effectiveness of PMTCT interventions. Studies in Nigeria and other sub-Saharan African countries reveal that gaps in healthcare delivery, including shortages of trained staff, limited access to ART, and inadequate follow-up services, undermine intervention outcomes (Chizoba et al., 2020; Ezeudoye et al., 2021). Kram et al. (2020) note that healthcare providers often struggle with structural barriers such as insufficient resources and high patient loads, which reduce the quality of PMTCT implementation. Moreover, interruptions in international funding have occasionally jeopardized service delivery in resource-limited settings, further exposing the fragility of progress (European AIDS Treatment Group, 2025). Addressing these systemic barriers is essential for sustaining the gains made under Option B+ and other PMTCT strategies.

Stigma and non-disclosure remain persistent challenges that directly affect the effectiveness of PMTCT interventions. Women who fear rejection, discrimination, or violence may avoid



disclosing their HIV status, leading to reduced adherence to ART or missed clinic appointments (Hallberg et al., 2019; Aupibul et al., 2023). Research by Odiachi et al. (2018) found that non-disclosure to male partners in rural Nigeria compromised women's engagement with the PMTCT cascade, highlighting the interplay between social dynamics and biomedical interventions. Similarly, Fuente-Soro et al. (2023) observed that negative experiences with healthcare providers discouraged some patients from fully disclosing their status, thereby undermining treatment continuity. These findings indicate that while biomedical strategies like Option B+ are effective in theory, their impact is diluted when social barriers remain unaddressed.

Despite these challenges, current interventions have shown remarkable promise. UNAIDS (2020a) reported a global decline of more than 50% in new HIV infections among children between 2010 and 2019, attributing much of this progress to the scale-up of PMTCT services under strategies like Option B+. However, sustaining this progress requires addressing the persistent bottlenecks. Interventions must be adapted to local contexts, ensuring that structural, cultural, and psychosocial barriers are tackled alongside biomedical solutions. Scaling up community-based approaches, strengthening healthcare infrastructure, and integrating PMTCT services with maternal and child health programs are practical ways forward. Furthermore, enhancing training for healthcare providers to reduce stigma and improve patient trust is vital in ensuring consistent ART use and follow-up adherence (Dirisu et al., 2020; Ogueji & Omotoso, 2021).

In conclusion, current interventions such as WHO's Option B+ approach have significantly advanced the global fight against MTCT of HIV by improving maternal ART coverage and reducing infant infections. Nonetheless, their effectiveness is influenced by factors such as adherence, partner involvement, stigma, and healthcare system capacity. While evidence from East Africa, Nigeria, and beyond demonstrates the potential of these interventions to eliminate MTCT, sustaining progress requires addressing systemic and social challenges. Strengthening healthcare infrastructure, fostering male involvement, reducing stigma, and ensuring consistent ART availability will be critical for achieving the ultimate goal of eliminating paediatric HIV.

Conclusion

This study highlighted that disclosure of HIV status plays a central role in improving adherence to antiretroviral therapy (ART), enhancing psychosocial well-being, and reducing the risk of mother-to-child transmission (MTCT). The evidence demonstrates that disclosure provides benefits not only for individuals living with HIV but also for their families, caregivers, and healthcare providers. It fosters openness, promotes treatment ownership, and strengthens social support systems while creating opportunities for more effective prevention strategies. However, disclosure is a complex and often difficult process, hindered by stigma, discrimination, cultural norms, and fear of negative consequences such as abandonment or violence. These challenges undermine the effectiveness of PMTCT programmes and contribute to persistent gaps in achieving universal HIV prevention and care.

Therefore, achieving meaningful progress in eliminating paediatric HIV infections requires sustained efforts to address the multifaceted barriers to disclosure. Strategies such as



community-based education, stigma reduction initiatives, involvement of male partners, and greater collaboration with traditional and religious leaders can help create an enabling environment for openness. Strengthening health systems, improving ART availability, and providing continuous training for healthcare workers are also essential for building trust and encouraging safe disclosure. Ultimately, tackling disclosure challenges is not only about preventing HIV transmission but also about ensuring dignity, empowerment, and holistic care for people living with HIV. Without these efforts, the goal of ending mother-to-child transmission in high-burden regions, particularly Nigeria, will remain unattainable.

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Cite this article:

Author(s), OLAFUSI, Oluwatosin Esther, OHAERI, Beatrice Mgboro (RN, Ph.D), (2025). "Disclosure as a Major Setback in the Management of Mother-to-Child Transmission of Human Immunodeficiency Virus", **Name of the Journal:** International Journal of Medicine, Nursing & Health Sciences, (IJMNHS.COM), P, 1- 20. DOI: [www.doi.org/10.5281/zenodo.17116313](https://doi.org/10.5281/zenodo.17116313) , Issue: 3, Vol.: 6, Article: 1, Month: June, Year: 2025. Retrieved from <https://www.ijmnhs.com/all-issues/>

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