HIV and Women’s Health

"Women’s Health Services, PMMH and Durban South Complex"

Dr Ray Maharaj
The female face of the HIV epidemic

“The most significant development of the AIDS epidemic is its growing feminisation”

(Exec Dir, UNAIDS, Int Women’s Summit, July 2007)
HIV in women: a global problem

A Global View of HIV Infection

Population Infected
- 5.0% - +%
- 1.0% - 5.0%
- 0.4% - 0.9%
- 0.1% - 0.4%
- 0.0% - 0.1%

60%
Impact of HIV in women

- leading cause of death 15-24 yr
- More women than ever before
- Sex: Twice as risky than men
- Only 20% young women know
- PMTCT covers a third only
- **Contributes to Maternal Deaths**
NCCEMD Report

Direct:
Hypertension, PPH, APH, Ectopic, Abortion, Pregnancy related sepsis, Anaesthetic, embolism, collapse

HIV + 401  
HIV - 359

Indirect:
Non pregnancy related infection, AIDS, Existing maternal disease

Non pregnancy related infections:
AIDS, Pneumonia, TB, etc

1414  114
What makes women susceptible than men?

- BIOLOGICAL
- SOCIOECONOMIC GENDER STEREOTYPE (Am. Int. 2008)

HIGH RISK
Factors increasing risk

Immediate determinants
- Heterosexual sex (70%)
- Drug users 28%
- Multiple partners
- Biological factors

Contributing factors
- Socioeconomic status
- Gender disparities

(NSP 2007)
Women specific manifestations of HIV infection

- Similar to HIV – but more severe, frequent
- Vaginal yeast infection, more frequent
- Vaginosis, Chlamydia, Trichomonas, gonorrhoea
- Herpes, acyclovir
- Idiopathic genital ulcers
- HPV
- PID
- Menstrual problems
Susceptibility of women to acquire HIV (Biological)

- Higher risk from single exposure
- Cervix vulnerable site
- Greater surface area of female tract
- Immature genital tract tissue
- Concomitant STI’s/ PID
- Infertility
- Ectopic pregnancy
HIV and cervical cancer

- HPV important risk factor
- Other factors still prevalent
- High risk of HPV, SIL and ca (Rabkin, 1993, Sun 1997)
- Positive association between HIV and Ca (Chigangi, Kenya, Hawes, Moodley, Stein, SA)
- 1993 – CDC includes Ca cervix
HIV and cervical cancer

“Increasing number of younger women getting HIV, hi-risk HPV, rapidly progressing, advanced disease”

- Early sex, poor screening, late presentation, hi risk behaviour, HPV
- HIV *tat* protein (Clark, Chetty, 2002)
- Correlation with degree of suppression
Susceptibility to HIV: (Gender discrimination)

- Gender roles and stereotyping
- Violence against women
- Gender related barriers in access to services
- Lack of education
- Economic shortfalls
Prevention: Biological Strategies

- Abstinence, Faithful, Condomise:
  (Little impact, powerful in its simplicity)
- Only few successful strategies last 3 decades:
  * Male medical circumcision (SA, Kenya, Uganda) – 57% effectiveness
  * STI treatment (Tanzania): 42% effective
  * HIV Vaccine combination (Thailand): 31%
  * Tenofovir vaginal gel (SA): 39%
- Contraception: protection with condoms is the goal
Prevention:
Gender/stereotyping strategies

- Address gender equalities
- Promote economic opportunities
- Remove financial barriers to health care
- Address HIV relate stigma and discrimination
- Enforce and strengthen laws that eliminate violence against women
- Gender norms and stereotypes
How are we doing?

“In 2008, only 52% of countries that report to the UN General Assembly included targeted, budgeted support for women focused HIV programmes”
Conclusion

- Women increasingly infected at younger ages
- Predisposed by physiological and gender disempowerment
- Condom is king
- Hi risk for SIL, CaCx, STI’s, PID, Infertility
- Limited successful interventions (30-50%)
- Education, Empowerment, Cultural and Spiritual values