REVIEW ARTICLE

HIV in Women in South-East Asia and India

Laxmi Shrikhande
Chairperson-HIV/AIDS Committee, FOGSI, Shrikhande Laser and Endoscopy Center, 528, Hanuman Nagar, Manewada Road, Nagpur, Maharashtra, India

Correspondence: Laxmi Shrikhande Chairperson-HIV/AIDS Committee, FOGSI, Shrikhande Laser and Endoscopy Center, 528, Hanuman Nagar, Manewada Road, Nagpur-440009 Maharashtra, India, Phones: 0712-2740958/2740184, Mob: 09822227600, e-mail: slaxmi2002@yahoo.com

INTRODUCTION

Women are creators of new life, the caretaker of daily life and the custodians of community norms and social values. However, in developing countries, one-half of all HIV infections occur in women. How the loss, will be borne?

The worldwide feminization of HIV as reported by UNICEF and WHO, is increasingly taking place in South-East Asia. And if you think HIV is limited to those who lead promiscuous lifestyles, you might be surprised that housewives outnumbered sex workers, five times, among all the women who are infected. If the trend of HIV transmission through heterosexual sex continues its upward trajectory, the number of HIV-positive women will keep rising as well.

One of the difficult experiences an HIV positive mother faces is knowing that her own fate will be mirrored in her child and that she may not be there to help that child. Nothing else can highlight better the necessity for HIV prevention among women and to offer support services for women and their families, who are living with HIV/AIDS.

GENDER AND TUBERCULOSIS

As HIV makes people more vulnerable to tuberculosis and tuberculosis goes on to kill people with HIV, these dual epidemics have together become the most serious public health threat of the decade. Women of reproductive age are more susceptible to fall sick once infected with TB, than men of the same age. Women in this age group are also at greater risk for HIV infection.

The growing concern for the TB/HIV dual epidemic among young women requires not only implementation and access to Directly Observed Treatment, Short course (DOTS) and prevention programs, but also the incorporation of TB education and information materials into MCH and HIV/AIDS programs.

GENDER AND HEALTH TECHNOLOGY

Access to health technology is a critical concern for women in developing countries: This includes, female controlled HIV prevention technology, reproductive health services such as blood transfusions, access to family planning services, abortion services, HIV testing and counseling services, STD treatment services and diagnosis and treatments for gender specific clinical manifestations of HIV.

Female Controlled Strategies

All currently available methods to prevent sexual transmission of HIV to a woman require male cooperation, which is not always forthcoming. Therefore, developing an HIV control technology within the personal control of women is a global priority.

Women in Thailand, India, Nepal and Philippines identified fear of nonconsensual sex, domestic violence, or economic abandonment as barriers to their ability to use the male condom. The ideal female-controlled method should be easy to use, prevent other STDs, and be used discretely without her partner's consent or knowledge. The female condom has yet to attain full acceptability but has the potential to emerge as an important female-controlled contraceptive and a barrier to sexually transmitted infections. Vaginal microbicides for prevention of STDs and HIV are in various stages of research and development.

GENDER AND HEALTH FINANCING

Health financing of AIDS treatment for women is compounded by gender disparity as women go undiagnosed and untreated for longer periods of time than men. Gender disparities are also reinforced by economic inequities. Conversely, access to financial resources can positively impact women's reproductive health.

HIV Epidemic in South-East Asia Scale and Diversity of the Epidemic

A diverse range of structural factors amplify HIV vulnerability and risk in the region, including widespread poverty and socioeconomic inequality, illiteracy, low social status of women, trafficking of women into commercial sex, and a large sex work

industry. The region's borders are porous, permitting widespread rural-urban, interstate, and international migration. High rates of sexually transmitted infections and limited condom use prevail, and social stigma is an important impediment to delivering effective programs.

The overall adult HIV prevalence in South and South-East Asia (0.7%) regions is relatively much lower than that in sub-Saharan Africa (5.9%). However, due to the large population in these regions, even a low HIV prevalence means that a large number of people are infected. At the end of 2006, an estimated 7.2 million (4.7-11 million) people were living with HIV in South-East Asia Region which included 0.77 million (0.47-2.1 million) new infections in 2006. Approximately, 550 000 people died of AIDS during 2006. The majority of the HIV burden in the Region is concentrated in five countries, namely India, Indonesia, Myanmar, Nepal and Thailand. Long-standing HIV epidemics have resulted in a huge burden of people living with HIV and AIDS who need prevention, care and treatment services.

At the end of 2007, women accounted for 50% of all adults living with HIV worldwide. With 60 percent of the world's population, an exploding infection rate, and insufficient prevention efforts, South and South-East Asia have become the flashpoint for AIDS in the next decade.

Predominant Modes of Transmission

Unsafe sex and injecting drug use are the main drivers of the epidemic in South-East Asia. Of the reported AIDS cases, sexual transmission accounts for 86% in India, 82% in Thailand, 76% in Nepal and 67% in Myanmar. In Indonesia, the epidemic began among IDUs, and spread through the sexual networks of IDUs to sex workers and their clients, and then to the general population.

Unsuspecting women in monogamous and often loving relationships are startling to find themselves infected with HIV through routine ante-natal tests and voluntary testing prompted by sickness or the death of their husbands.

More than 50 to as high as 90 percent of reported HIV/AIDS cases among women show that the spread of HIV among women in South-East Asia is primarily through heterosexual transmission.[1]The rise in women's HIV infections in Malaysia is exponential, rising from zero incidence in 1986 to 696 in 2004. In Thailand, the HIV/AIDS ratio of women to men has dropped sharply from 5:1 in 2002 to 3:1 in 2003.[2] In Cambodia, the number of women (aged 15 to 49) living with HIV/AIDS is estimated at 51,000 compared to total number of adults estimated at 170,000.[3] In Lao PDR, this figure is about 1,000 compared to the national figure for adults at an estimate of 1,700;[4]and in Vietnam, the number of women with HIV/AIDS (aged 15 to 49) is 65,000 compared to a total of 200,000 adults.[5] Young women are the most affected group in the world, representing 67 percent of all new cases of HIV among people aged 15 to 24 in developing countries.[6] In Malaysia, most affected are youth (age 20 to 29) and those aged 30 to 39 years' old.[7] In 2004 in Thailand, at least 70,000 young people aged 15 to 24 years were HIV-infected, and 60 percent of these were female youths.

HIV/AIDS in South and South-East Asia

Population, 2008	586,423,000
People living with HIV/AIDS, 2007	4,200,000
Women (aged 15+) with HIV/AIDS, 2007	1,500,000
Children with HIV/AIDS, 2007	140,000
Adult HIV prevalence (%), 2007	0.3
AIDS deaths, 2007	340,000

Source: Population Reference Bureau and UNAIDS

Women are Different

Women are biologically, socially and economically more vulnerable, both to unprotected sex and to HIV infection. They are also more vulnerable to the effects of HIV infection, as cultural norms dictate that they have less negotiating power to demand for care and support, as well as to fight against discrimination. This is worrying because women are often the backbone of their families where they are the caregivers, house makers and often heads of households. When they fall sick or die, their children are often left in the lurch with meager resources to fend for themselves.

Not only are women socioeconomically and culturally disadvantaged in many segments of society, the female anatomy also puts a woman more at risk of getting HIV. Females have a larger genital mucosal surface area exposed compared to males during sexual intercourse. This soft tissue in the woman's reproductive tract is able to tear and absorb fluids easily. As fluids such as semen have a higher concentration of HIV compared to those secreted by a female during sex, the risk of a woman getting the virus from a man during unprotected sex is greater. The risk of transmission multiplies when the inner linings

of the female reproductive tract or cervix tears and bleeds during sex, especially when it is forced. In a society that places a high value on virginity, unprotected anal intercourse (to protect virginity and avoid the risk of pregnancy) also poses a risk of HIV transmission as the anal tissue can be torn during the act. Also, as having a pre-existing sexually transmitted infection (STI) could increase the risk of transmission up to 10 times, women are more likely than men to have untreated STIs as the symptoms are absent or harder to see.

Women are more likely to experience a lack of access to HIV testing, care, services and support and to pay more attention to the health needs of their loved ones than their own. Also, HIV-positive women may encounter stigma and unfounded stereotypes.

HIV Drugs and Women

Research on HIV treatment in women has been limited; all HIV drugs appear to work as well in women as in men. HIV positive women may be more likely to experience certain side effects. This may be because certain HIV medications reach higher levels in the bloodstreams of women, possibly due to their generally smaller body mass, different metabolism or hormones.

Gynecologic Manifestations

Certain gynecologic problems are more common, more serious and harder to treat in women with HIV, and some do not cause noticeable symptoms. These problems include: genital herpes, human papilloma virus (HPV, which causes warts and pre-cancerous and cancerous lesions of the cervix and anus), pelvic inflammatory disease and vaginal yeast infections. Many of these conditions are treatable.

Prevention of Mother-to-child Transmission

Pregnant women infected with HIV are likely to transmit HIV to their infants during pregnancy, birth, or while breastfeeding. Without interventions, 20-45% of infants born to HIV infected women may become infected. To reach the ultimate goal of eliminating HIV infection in infants and young children, a standard package of services are required. These include HIV primary prevention services, prevention of unintended pregnancies among HIV-infected women, antiretroviral drugs for prevention of mother-to-child transmission (PMTCT), safer delivery practices, infant feeding counseling and support, sexual and reproductive health services for HIV-infected women and linkages with ongoing care and support services. PMTCT is now a standard of care in most developed countries and has resulted in nearly eliminating HIV among children in these countries. In contrast, limited progress has been made in this regard in resource-limited countries.

The coverage of PMTCT programs in the South-East Asia Region is very low; overall, less than 5% of pregnant women are offered HIV counseling and testing. Thailand is the only country in the Region to have achieved a high coverage of PMTCT services, leading to a decrease in the number of pediatric AIDS cases. In India and Myanmar, the PMTCT program includes HIV testing and counseling, administration of a single-dose of nevirapine to the mother and the baby, safe delivery practices as well as infant feeding and counseling. By the end of 2006, PMTCT services were being offered at 2,433 health facilities in India. Every district in the six high-HIV burden states and > 90% districts in the low-HIV burden states have at least one PMTCT center. In Myanmar, the PMTCT program began in 2000 and currently covers 89 of 325 townships. Bangladesh, Bhutan, Indonesia, Nepal and Sri Lanka have started PMTCT program on a smaller scale.

The greatest maternal danger may in fact occur in pregnant women whose HIV infection is not detected or in women known to be HIV infected who receive inadequate prenatal or routine HIV care.

India

India has a population of one billion, around half of whom are adults in the sexually active age group. India has 2.5 million plus HIV patients .The spread of HIV in India has been diverse, with much of India having a low rate of infection and the epidemic being most extreme in the southern half of the country and in the far North-East. The highest HIV prevalence rates are found in Maharashtra, Andhra Pradesh and Karnataka in the South; and Manipur, Mizoram and Nagaland in the North-East.

The average HIV prevalence among women attending antenatal clinics in India is 0.60%. Much higher rates are found among people attending sexually transmitted disease clinics (3.74%), female sex workers (4.90%), injecting drug users (6.92%) and men who have sex with men (6.41%).

Adolescent Reproductive Health

That increasing adolescent pregnancy and HIV in these countries indicates the greatest need to provide accurate information to young people. All young people share this need: rich and poor, sexually active and inactive, married and unmarried, male and female. They prefer to get their information about sexuality from caring adults, but often learn about sex from their peers. Unfortunately much of this information is either inaccurate or insufficient.

Strategies should be designed to address the distinct needs of subgroups of adolescents: the first group includes those who have not yet begun sexual intercourse. These adolescents are almost invisible and their needs are usually not addressed, but there is an opportunity to sustain safe behaviors among them. The second group includes those who have engaged in sexual intercourse but with no unhealthy consequences such as unwanted pregnancy, unsafe abortion, sexually transmitted infections, Reproductive tract infections, HIV and/or abusive/ violent sex. They need information, skill building, and counseling

services to adopt safe behaviors. And a third group of adolescents, who contribute a substantial share of adverse health consequences and are also the group that those delivering services have in mind. They require different set of interventions including safe abortions, contraceptive counseling and STD/HIV services.

What can be done to Meet the Challenges?

Meeting this challenge requires involvement of men as well as women, individuals and institutions, governments and NGOs, in four broad areas of activity: (i) HIV/AIDS education and information; (ii) basic education and economic activity to reduce gender inequities; (iii) improvements in policy and social environments; and (iv) provision of health and other services.

Many forces conspire to increase the risk of infection for women in developing countries but men's responsibilities in marriage can reduce the risk of HIV infection among women. Education programs that aim to prevent HIV among women should address men as well. The ability of women to inherit and access property has a direct correlation with their ability to protect themselves from HIV, and to look after themselves and their families if they become infected. This brings us to one of the core drivers of the AIDS epidemic – and that is the "Unequal Status of Women".

In many parts of the world, the rights of women to property are, by law, unequal to those of men. Women's rights to own, inherit, manage and dispose of property are written off by customs and laws that privilege men over women, and by leaders who believe that women do not deserve property. The devastating effects of discrimination in property rights – violence, homelessness, poverty, disease – harm women, their children, and a country's overall development. It is imperative that ownership and control over economic assets should be guaranteed for women.

The challenges faced by AIDS are by no means exclusively economic ones. Even if poor women had access to health care providers, they may hesitate to obtain services if the attitudes of service providers are not encouraging.

STD Control

Most women are unlikely to access STD clinics because of social stigma. They are more likely to approach their primary physicians or the reproductive health clinics. The STD control program should provide for wide spread training of primary care physicians and physicians at the reproductive health clinics in basic STD management.

Training for Obstetrics and Gynecological Specialists

Antenatal women may face discrimination by socially stymied and indoctrinated Obstetricians and Gynecologists. It is important not only to regularly update current Obs and Gyn practice as is relevant to HIV, but also to invest in training programs that address the provider attitudes towards HIV.

Investment in Education and Opportunities for Employment

Economic cooperatives that promote economic independence among women and specific female literacy initiatives should be supported in developing countries.

Social Factors

Research must focus into the gender differences constantly faced by women in each stage of the life cycle and the coping strategies, self identity, self esteem, sexual identity, social role and family studies that evaluate intergenerational impact of male dominance and resultant violence.

Lack of access to care, minimal self-motivation, attention to the health care of their children over that of themselves, and disenfranchisement among a large proportion of women all contribute to decreased rates of early detection and intervention. Medical providers need to maintain a low threshold to counsel and test for HIV, remembering that women who have HIV through heterosexual transmission may be unaware of their partners' HIV status even if aware and therefore do not perceive themselves at risk for HIV. HIV and AIDS for women is an issue of access to health care, and the care system is not always well suited to their needs.

Women already infected must be given the right to remain a productive part of their family and community while efforts are made to reduce the vulnerability of the as-yet-uninfected women.

CONCLUSION

Women hold the fabric of our societies together. We cannot afford to fail them. Successful HIV prevention depends on changing risk behaviors, not simply knowledge of HIV and how it is transmitted. It's a difficult task but not impossible. Let's join our hands together in fighting this social evil.

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