Presidental Address 2010

Preventing HIV in Women

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Our Chief Guest Dr. Iyanthi Abeyewickreme.
Guest of honour Prof. Steve Green
Fellows of the college,
Members of the council
Members of the college
Distingush invitees.

It is my pleasure to address you on the occasion of the inauguration of the 15th annual academic sessions of the Sri Lanka College of venereologists.

The topic I have selected for my presidential address is ‘Preventing HIV in Women.’

Working in the STD Clinic in Colombo which is the central clinic of the National STD/AIDS Control Programme where most of the HIV positive cases in the country are detected, managed and reported, my observations over the last 10 years prompted me to talk on this topic today mainly because the number of women and children detected with HIV are increasing.

By the end of September 2010, 518 women with HIV were diagnosed and 46 children were born with HIV. Although the numbers are small, this may be only the tip of the iceberg.

To date, 26 of 46 children with HIV have survived: the availability of anti-retroviral therapy (ART) prolongs their lives and improves their physical quality of life, but the social and psychological problems they will have to face cannot be compensated for by medical management alone.

We as health care providers can play an active role in preventing HIV in children. “We need to protect women to protect children.” The need to protect women from HIV is not only to protect children but also to reduce the serious impact of HIV on women itself.

Women with HIV are:

- often stigmatized and blamed for causing HIV/AIDS and other STDs.
- dismissed from their jobs or not hired,
- evicted from their homes, abandoned by their husbands or other long-term partners, and denied the custody of their children.
- sometimes pressured not to become pregnant or to be sterilized, or if they are already pregnant, to terminate their pregnancies.
- being the caregivers of families, when their health fail the families get affected badly.

Even 28 years after the onset of the epidemic HIV infection still continues to remain a serious public health problem affecting women. For the past two decades, HIV infection has affected women worldwide, more than any other life-threatening infectious disease. Women who were at the periphery at the beginning of the epidemic in 1980s are at the centre of concern today. Currently women account for 50% of the estimated 33.4 million people living with HIV globally.

This proportion varies from 27% in the Region of the Americas, 35% in the Region of Asia, to as much as 58% in the African Region. For young women, the figures are even more alarming. Globally, 75 % of young people infected with HIV are women and girls.

Even after implementation of preventive measures for more than 28 years, in 2008 of the estimated 7400 new infections a day 97% were in low and middle-income countries. Of the 6200 new infection among adults 48 % are among women.

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What is the situation in South East Asia?

The epidemic in the South-East Asia Region has grown alarmingly. Today, HIV has been reported from 10 of 11 countries in the Region (except North Korea). Of the estimated 3.5 million people living with HIV/AIDS in the Region, women account for 33% of the total. Five countries account for the majority of HIV infections - India, Indonesia, Myanmar, Nepal and Thailand. Bangladesh, Bhutan, Maldives, Sri Lanka and Timor-Leste together represent less than 1% of the total HIV burden in the Region.

What is the situation in Sri Lanka?

At the end of September 2010, a cumulative total of 1,285 HIV cases were reported to the NSACP, of which 767 were men and 518 women; 46 were children. The main mode of transmission was due to unprotected sex between men and women (82.8%). Men who have sex with men accounted for 11.2% of transmission, while mother-to-child transmission accounted for 5.4%. Transmission through blood and blood products was only 0.4%. The available statistics showed that there was a gradual increase of women infected with HIV being reported over the last three decades.

Profile of HIV infected women in Sri Lanka

**Age group** - Most infections were seen between the ages of 30 and 44 years. This pattern has persisted for the last three decades. However during past few years the number detected in the 20-30 year group has also increased. This is a matter of grave concern. Is this an indication that young people are getting infected in spite of the many preventive activities carried out during last three decades due to programmes not being targeted at this group?

**Marital status** - Among 92% ever-married HIV infected women, 55% were currently married and living with the husband, 18% were separated, and 19% widowed; 8% were single.

**Probable source of infection** – Available data indicate that 49% of women had sexual relationships only with their marital partner, 18% with a single stable partner, 20% with a casual partner, 11% had more than one male partner and 4% had sex with their clients. Thus 67% have been in a single sexual relationship.

Similar situations have been reported in other countries. More than 40% of new infections in Cambodia and Thailand were among women whose only sexual partner was their husband. A study in India found that 90% of the HIV infected women were married and their only sexual partner was the husband. This reiterates how sexual subordination makes women vulnerable to HIV.

In many societies, there is a significant power differential between men and women, which is supported by social and cultural systems giving control to males. Males are expected to initiate relationships. Sexual assertiveness in women is unacceptable and often stigmatized.

Even in countries that promote monogamy and mutual fidelity, and discourage multiple casual partners as a societal norm only women are expected to adhere strictly. While male deviation from the norm is easily accepted. This raises the question of reliance on monogamy or mutual fidelity as a principal solution for HIV prevention, as this can be misleading to some women, because fidelity protects against HIV/AIDS only if it is completely mutual and life-long.

We also know that economic subordination is another main factor that increases the vulnerability of women.

- Women’s economic dependence on male partners in order to avoid poverty for themselves and their children makes it difficult for women to negotiate safer sex practices to protect themselves from infection.
- Existing Laws regarding marriage, divorce, and child custody can impede women’s ability to leave relationships in which they are exposed to the risk of HIV infection.
- Worldwide, many women rely on prostitution, or sex work, for economic survival.
- Migration can increase a woman’s vulnerability...
to HIV infection if she is isolated from community structures.

*The available data in Sri Lanka shows that 44% of those infected are housewives, 38% are external migrant workers, 4% sex workers, 3% factory workers.*

What do we know about these groups?

**Female sex workers**

Sex work is illegal in Sri Lanka. But the sex industry operates in the capital as well as in other parts of the country. In 2009, the estimated number of sex workers was 35,000-47,000. It is well known that sex workers have played a significant role in driving the Asian epidemic.

The behavioural surveillance survey conducted in 2007 observed that 96% knew that HIV is sexually transmitted, only 70% admitted they can get protection by correct and consistent condom use. 94% knew HIV can be transmitted from mother to child. However, their reported correct and consistent condom use during the previous 12 months was not satisfactory among casino-, brothel- and karaoke bar based sex workers.

Surprisingly, 82% of street sex workers admitted using condoms correctly and consistently. This satisfactory level of condom use among street-based sex workers can be attributed to the effectiveness of the education and condom promotion programmes conducted by the National STD/AIDS Control Programme together with those implemented by NGOs working with sex workers. Low condom use reported among women in casinos, brothels, and karaoke bars could indicate the difficulty experienced in accessing them for preventive interventions.

But we need to remember the available evidence suggest that favorable behavior changes seen following exposure to a prevention intervention can wane over time. Therefore, continued efforts have to be made to promote and maintain favorable behavior of this large group of women who are at risk of getting infected with HIV.

**External Migrant Workers**

While the available data reveals that external migrants account for a little less than a half of female infections, interpretation of data needs to be done with caution as there is an over-representation of this group in HIV testing.

An estimated 1.8 million Sri Lankans work in the Middle East, and almost 79% of them are unskilled women. Many of them are employed in low skilled, low status jobs in the domestic sector where they are highly vulnerable to harassment, violence and sexual abuse.

A survey carried out among 160 Middle East returnee’s in 2008 reports that 15-20% of them were sexually active during the course of their overseas employment, 17% were subjected to sexual harassment and 5% were raped while they were employed overseas. Some migrant women even engaged in commercial sex. None have used condoms regularly. Over 25% did not know that condoms could provide protection from HIV. These data enlighten us on the degree of vulnerability and risk to migrant Sri Lankan women outside the country.

But it is reported the participation at the existing pre-departure training programme conducted by Sri Lanka Bureau of Foreign Employment, to promote sexual and reproductive health and develop skills in safer sexual behaviours has been very low during last 15 years.

**Sri Lankan women in general**

Women accounted for 52% of the estimated midyear population of 20.4 million in 2007. Of the total population of women, 55% was in the age group 15-49 years (the sexually active and economically productive age group). There does not appear to be a significant different in age at marriage in the three groups. However, the female literacy rate is markedly low in the estate population.
It is evident that many women in the urban and rural sector are aware of the existence of HIV. A considerable number of them limit sex to a single partner. However, few appear to be aware that the condom is a useful method for the prevention of the disease. Twenty-eight years into the global AIDS epidemic, there is still no widely available technology that women can both initiate and control to protect themselves from HIV.

To enable women to protect themselves, there are three issues to be considered: They are:

i. Improving the social and economic status of women: women must be empowered to make informed choices and enabled to improve the quality of their lives.

ii. Implementation of sustainable HIV/AIDS prevention interventions that provide the necessary knowledge, develop skills, and support safer practices among both men and women, particularly in the most vulnerable sectors

iii. Providing a practical method over which women have sufficient control independent of male participation is considered desirable in the context of male domination in decision making.

Some of the possible solutions would be the use of the female condom and the use of microbicides:

**Female condoms**

Did not become popular in Sri Lanka as did the male condom because it is more expensive than the male condom, it is poorly marketed, is bulkier, and still requires some degree of male cooperation.

Although the female condom is more expensive than the male condom, female condoms could be a cost-effective prevention method to be used to prevent HIV infections in situations where the male condom cannot or would not be used.

**Vaginal microbicides**

Vaginal microbicide - is a gel or cream that could be applied to the vagina without the partner’s knowledge and which would prevent HIV infection. At the last AIDS Conference in August 2010 Vienna, the promising finding of the research on vaginal microbicides were presented.

Microbicides are expected to prevent millions of HIV infections in women, men and children. Research has shown that even a microbicide that is only 60 per cent effective would prevent at least 2.5 million infections over the course of three years.

The CAPRISA 004 trial assessed the safety and effectiveness of Tenofovir vaginal gel, a microbicide in 889 South African women participants, with a retention rate of 94.8-percent at 30 months.

It comprises the insertion of the gel up to 12 hours before sex, a second application of gel as soon as possible but within 12 hours after sex. In women with high adherence, 54-percent effectiveness was seen. Additional studies are urgently needed to confirm the findings of this trial both for safety and effectiveness.

Microbicides are intended as part of a broader package of prevention options. They would complement – not replace – options such as abstinence, faithfulness, and condom use, and yet would address a glaring gap in current prevention interventions.

*Female condoms are not widely used. Microbicides are not yet available for us. What do we have to rely on to protect women and children??*

*Getting more men to adopt safer sex - protecting women from HIV is not solely the responsibility of women. Most women with HIV were infected by unprotected sex with an infected man. Preventing transmission is the responsibility of both partners, and men must play an equal role in this effort.*
Finally till the days female condoms are freely available, acceptable and widely used, and vaginal microbicides are in the market for an affordable price it is men who have to play the vital role in protecting women and children.

Ladies and Gentlemen,

In my short address I made an attempt to highlight the need for protecting women from HIV infection and thereby preventing the birth of HIV affected children. I have drawn attention to the subservient role of women in our society and the passive acceptance of male dominance. Women in our society need to be equipped with the necessary skills to overcome this attitude.

Planning and implementing HIV prevention interventions that provide the necessary knowledge, develop skills, and support safer practices among both men and women is a daunting task. Nevertheless this challenge has to be met.

Although Venereologists have an important role in the prevention of HIV, there is a need for commitment from all stakeholders, government organisations, NGOs and the community.

It is important that we recognise the most vulnerable sectors in the populations and focus our attention on them.

The National STD/AIDS Control Programme which plays the lead role in this activity may benefit from establishing closer links with the primary health care system in the country which would provide opportunities to educate women through the existing well-organised maternal and child health programme, through its network of public health midwives and nurses. Involvement of public health inspectors in educational programmes for men will complement such a programme.

Similar linkages with NGOs and private sector organizations will strengthen our preventive actions.