

what are women's HIV prevention needs?

are women at risk?

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Yes. In 1997, women comprised 22% of all AIDS cases in the US. Heterosexual contact is the leading risk exposure category for all women (38%), and 29% of those are due to sex with an injection drug user (IDU). Injection drug use accounts for 32% of all cases.¹ The majority of women who have sex with women (WSW) acquired HIV via drug use or sex with a man, although a few women have been identified infected via same-sex contact.

*Women are one of the fastest growing populations being infected with HIV, and the number of AIDS cases among women increases steadily each year. Women under 30 made up 22% of AIDS cases among women in 1996. Because the time from HIV infection to developing AIDS can be long, many of these women acquired HIV in their teens.*²

African American and Hispanic women have been disproportionately affected by AIDS. AIDS rates for African American and Hispanic women are 17 and 6 times higher than for white women. In 1997, African American women made up 60% of all female AIDS cases, Hispanics 20% and Whites 19%.¹

what places women at risk?

Male-to-female transmission is estimated to be eight times more likely than female-to-male;³ in 1997, 38% of women contracted HIV through heterosexual contact, as opposed to 7% of men. Reasons for this are twofold: there are more men than women in the US infected with HIV, which increases the likelihood that women would have an infected sex partner; and HIV is more easily transmitted from men to women due to the greater exposed surface area in the female genital tract.¹

Sexually transmitted diseases (STDs) other than HIV can increase the risk of new HIV infections at least two to five times. Genital ulcers and immune response associated with STDs make it easier for HIV to enter the body. There are an estimated 12 million new cases of STDs every year, and populations at highest risk for HIV infection also have disproportionately high rates of other STDs.⁴ Treatment of STDs can be an effective HIV prevention strategy.

Injection and non-injection drug use puts women at increased risk for HIV infection and is strongly linked to unsafe sex. In one study, female IDUs reported sharing needles 32% of the time, and obtained used needles from their regular sex partner 71% of the time.⁵ Women who smoke crack cocaine, particularly women who have sex in exchange for money or drugs, are at high risk for HIV infection via sexual transmission.⁶

Sexual abuse and coercion places many women at risk. In one study, physical and sexual abuse were "disturbingly common" throughout life among women at high risk for HIV infection. Childhood sexual abuse (42%) and physical abuse (42%) was also common. Women who have been abused are more likely to use crack cocaine and have multiple sex partners.⁷ Public health agencies need to raise public awareness about sexual abuse and coercion and help women and men develop the skills needed to prevent it.

what are barriers to prevention?

Women do not wear the condom. For women to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviors regarding condom use, but also on their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making.⁸

Women are disproportionately represented among the poor. Because of this, women are less likely to have health insurance and access to health care services. Many minority women living in poverty are also disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years.⁹

Like many people in committed relationships, women may find intimacy in their relationship to be more important than protection against HIV. Unsafe sex may be linked to emotional and social (not necessarily financial) dependence on men. The ideal of monogamy, including assuming their partner's fidelity, may increase AIDS risk denial.¹⁰

Says who?

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what are the methods for protection?

Women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives. However, oral contraceptives like the pill do not protect against STDs and HIV. Female-controlled methods to prevent HIV transmission are needed. Traditionally, abstinence, condoms and dental dams have been the main methods of protection. In 1993, Reality®, a female condom, was introduced on the market but to date, results have been mixed as to its efficacy, affordability and interest in use.

Vaginal microbicides that would prevent STD transmission but allow for pregnancy have been developed and piloted in some prevention programs. Further efforts need to include large-scale efficacy trials and to increase scientific interest and support from pharmaceutical companies to develop microbicides that prevent HIV infection.¹¹

what is being done?

Recruiting women as community leaders was the basis for an effective HIV prevention program among low-income urban women living in housing developments. Women opinion leaders were trained to lead risk reduction workshops, provide HIV educational materials and condoms, and conduct HIV education through community events. The women effectively mobilized their residential community through tailored prevention messages and activities.¹²

Because women at risk are not always visible as a specific population or community, programs must strive to be where women are. A program provided HIV prevention services for women visiting their incarcerated male partners at San Quentin State Prison. The program, based at the visitor's center, trains women visitors as HIV educators, and the educators provide group and individual peer education. The program is low cost and has been well-accepted by visitors and by the prison.¹³

Interventions that promote HIV counseling and testing for both members of a couple should be considered. The California Partner Study provided couple counseling in combination with social support to serodiscordant heterosexual couples (where one partner is HIV positive and the other HIV negative). As a result, condom use increased and no new HIV infections were reported among the couples.¹⁴

Most drug treatment programs are staffed by men and oriented towards male clients. Allowing pregnant women to enroll in drug treatment, and allowing women to bring children with them would be helpful. In San Francisco, CA, a women-only needle exchange program was well accepted and used by female drug users. The number of needles exchanged and number of visits was similar between women who attended the women-only exchange versus mixed gender exchanges. However, women who visited the women-only exchange were more likely to receive health care and to receive additional health promotion services such as food, vitamins, coupons and clothing.¹⁵

what needs to be done?

Because women are more likely to be infected by men, and AIDS cases due to heterosexual contact are increasing, programs that specifically target men (especially IDUs) will have a beneficial impact on women. Needle exchange and drug treatment are important strategies, since almost half of all infections in women are due to injection drug use. Encouraging women to seek STD diagnosis and treatment should also be a part of effective HIV prevention strategies.

More research needs to be done on modes of HIV transmission and risks for women, including woman-to-woman transmission. Innovative, women-specific interventions need to be evaluated. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Interventions that address sexuality, family, culture, empowerment, self-esteem and negotiating skills, as well as interventions located in varying community settings are especially important.

PREPARED BY KATHLEEN QUIRK, MA* AND PAMELA DeCARLO*
*CAPS

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