HIV women's health neglected

At an HIV/AIDS conference earlier this year it became clear that although women are the major group living with HIV/AIDS a focus on their health has been badly neglected. **Marion Stevens** who attended the conference outlines the main areas of neglect.

Many workplaces have led treatment responses to HIV/AIDS in South Africa and this has been led by an array of services including Prevention of Mother to Child Transmission (PMTCT). Early criticism of these services warned that the emphasis appeared to be on the unborn child as opposed to the pregnant woman. It also stignmatised women as transmitters of the disease. As HIV/AIDS treatment has normalised in the form of HAART (antiretroviral cocktail) and PMTCT programmes, it has become evident that women's health and rights have not been central to HIV/AIDS treatment.

In May this year the University of the Witwatersrand held its second HIV/AIDS in the workplace conference titled, 'Prevention and next steps in responding to HIV/AIDS in the workplace and beyond.' Before the conference there were calls for papers on women's health or sexual and reproductive health. Out of two days of parallel sessions, there were three papers on reproductive health accepted for one session and then an invited round table.

The abstract session was titled, 'Women's Health, Gender & Sex Work' and over a number of papers it emerged that while workplaces have focused on men as the bulk of employees, over 60% of all those infected with HIV/AIDS are women. Women are also employees and also in partnership with men, so it is important to ensure that treatment is well focused and targeted to those most affected and at risk. Courtney Sprague noted that after doing an extensive review she found that limited work had been done in this much needed area.

The roundtable session allowed for dialogue and discussion on HIV/AIDS care concerning sexual and reproductive health and rights. There were speakers on testing, cervical cancer, lesbians and HIV care, violence against women and HIV care, and on reproductive intentions and prevention. What became clear is that there were huge gaps in the care programme for women and that this expressed itself in two layers.

SEXUAL AND REPRODUCTIVE NEEDS

The first gap is the absence of clear guidelines for HIV women of reproductive age which takes into account their sexual and reproductive intentions. Disease management schemes dealing with HIV/AIDS for workplaces do not consider any of the planning work that couples or women may explore in wanting to get pregnant. Managment schemes only deal with a woman that is pregnant and then the emphasis is still on stopping HIV transmission to the child.

There are also clear issues around medication to enable the taking of HAART (the anti retroviral mix) in pregnancy for example. What most often happens is that women are put on a HAART regimen and instructed not to get pregant. This does not make sense when the women's health is improving on treatment and that also women and couples want to have children.

At the other end of the equation is the reality that those HIV positive women who are pregnant and want to have an abortion cannot find an integrated care facility in the workplace or if they have a medical aid in the private sector. Their HIV/AIDS clinician would not be able to guide them through the process, but would have to refer them on.

One positive factor is that both surgical and medical abortions are available in the private sector. Medical abortion, where a woman takes medication to induce the abortion as opposed to a surgical procedure, is available up to 56 days of pregnancy in the private sector.

Unfortunately medical abortion is not available in the public sector. While there is provision in the

William Matlala

There are big gaps in the provision of women's health

National Strategic AIDS Plan on HIV/AIDS and STIs (sexually transmitted infections), the Department of Health still needs to approve medical abortion guidelines. It is important to be able to provide this service early in pregnancy as early terminations are always safer and less invasive.

CONTINUUM OF CARE

The other layer noted by the roundtable discussion was the limited continuum of care that is offered to women. Women's health should not just be limited to women as mothers. While pregnancy and motherhood are prized, and directly related to HIV/AIDS being associated with sex, a range of other issues are also important.

A strong driver of HIV/AIDS is the inability of women to have control over negotiating safer sex and their vulnerability to abuse. The range of abuse varies and includes emotional, financial, physical and sexual abuse and all these inhibit women's ability to negotiate how and when they have sex.

Cervical cancer is closely linked to the HP virus which is sexually transmitted and is a precursor to cervical cancer. A woman can be on HAART treatment but still get cervical cancer. It is believed that HIV postive women are ten times more at risk for HPV and cervical cancer than HIV negative women.

Early detection of cervical cancer through PAP smears can result in successful treatment. However, South Africa only has about 50% of the equipment that it needs to treat cervical cancer lesions.

A new development in 2008, has been the registration of two cervical cancer vaccines in South Africa, that of Cervarix and Gardisal. These vaccines are extremely effective and can be given to young girls. At the round table, employers were challenged to provide the vaccine to young dependants of disease management schemes and to schools surrounding their workplaces. Employers view the vaccine as expensive although it is only R2 300 for the complete package – three vaccines given once off.

The roundtable noted that lesbian health is pretty much off the agenda. This is of concern when results from a study indicated a 9% HIV positive self reported infection rate amongst lesbian women. This is an area of concern given the increased rape and murder of black lesbian women.

Because of stigma and discrimination, many lesbian women may pose as bisexual in order to feel safe in the townships. Health providers need to be much more open in conversations with clients to ensure that they address sexual and reproductive health needs more comprehensively. Lesbian women may need access to emergency contraception, or if raped HIV preventative medication and they may also want to explore wanting to have a child.

Health services also need to carefully consider HIV/AIDS testing practices, as if a woman is diagnosed HIV positive she needs to have services available to her. Women are exposed to violence by partners, their families and their communities so testing needs to be voluntary.

Issues of mental health are also often at the bottom of the agenda, but it is critical to consider. Women are known to suffer from depression more than men. Anxiety, depression and issues of addiction are areas that have received little attention by those working in the area of HIV/AIDS. Mental ill health can directly relate to people not taking their medicine regularly, or to reinfection and recovery.

Studies are emerging that start to address these concerns and show the need to include an emotional and mental health component to the HIV/AIDS treatment continuum.

In conclusion, the conference showed that there are big gaps in women's health rights that need addressing. With an epidemic that affects more women than men, women's health needs to be central to the HIV/AIDS reponse. LB

Marion Stevens works in the Treatment Monitor at the Health Systems Trust.