

HIV/AIDS and Women's Health in Uganda: LingerinG Gender Inequity

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Abstract

The issue of HIV/AIDS and women's health can be viewed in the context of (1) the unravelling epidemic, (2) the screening of women for HIV and the provision of ongoing surveillance, and (3) hope for the future, even though the battle against HIV has not been won. Ugandan society is patriarchal, and men control many aspects of women's lives including sexual matters and use of money in the household. The population growth in Uganda is among the highest in the world: 3.4% per annum, and in 2002, the country had a population of 24.4 million. One person in five (22.4%) is a woman of reproductive age.

Résumé

La question du VIH-sida et de la santé des femmes peut être envisagée dans le contexte de (1) l'épidémie émergente, (2) du dépistage du VIH chez les femmes et de l'offre d'une surveillance continue, et (3) de l'espoir envers l'avenir, même si le combat contre le VIH n'a pas encore été gagné. La société ougandaise est patriarcale; les hommes régissent de nombreux aspects de la vie des femmes, dont les questions sexuelles et l'utilisation de l'argent au sein du ménage. La croissance démographique de l'Ouganda fait partie des plus élevées du monde : 3,4 % par année. En 2002, le pays comptait une population de 24,4 millions de personnes. Une personne sur cinq (22,4 %) est une femme en âge de procréer.

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THE FACE OF THE HIV EPIDEMIC

HIV-1 infection, initially described as "slim disease," was first recognized in Uganda in 1982. By the end of the 1980s, diseases associated with severe immune suppression, such as oral candidiasis, tuberculosis, epidemic Kaposi's sarcoma, cryptococcal meningitis, pneumocystis carinii pneumonia, toxoplasmosis, and skin infections, were seen with increasing frequency.¹

Sexually transmitted diseases (STDs) have always been closely linked to HIV/AIDS transmission. Two

randomized controlled trials of STD treatment for the prevention of HIV-1 infection, in Mwanza, Tanzania, and Rakai, Uganda,² unexpectedly produced contrasting results.³ A decrease in the incidence of HIV-1 in the population was associated with improved STD case management in Mwanza but was not associated with STD mass treatment in Rakai, dashing any hope that this strategy would help in the fight against HIV/AIDS in areas where the cost of antiretroviral therapy (ART) was out of reach.

In pregnancy and the postpartum period, the percentage of CD4+ cells declines steadily in women infected with HIV-1,⁴ but pregnancy does not seem to accelerate HIV progression.⁵ Evidence from Zambia suggested that HIV/AIDS was increasingly contributing to maternal mortality in the region,⁶ possibly because of the lack of effective ART. It is unclear if breastfeeding by HIV-positive women is a risk factor for maternal death.⁷ Observations in Uganda also seemed to suggest an increase in maternal deaths indirectly caused by HIV, but no epidemiological studies have confirmed an association between HIV and an increase in maternal deaths. Malaria has also been reported to be more severe among people who are HIV-positive.⁸

WOMEN: A CONVENIENT GROUP FOR SCREENING

National HIV surveillance was launched in Uganda in 1989 at four sites with testing of pregnant women attending antenatal clinics. This surveillance increased to seven sites in 1991 and 19 sites in 2002. The seroprevalence rates in 1990 (4.1% and 25% in rural and urban areas, respectively) were alarming. Urban sites have continued to have higher prevalence rates than rural sites to date.⁹ Whereas patients with fever and antenatal clinic attendees may reflect trends, data from patients with fever markedly overestimate population HIV-1 prevalence and data from antenatal clinic attendees underestimate it.¹⁰

Infertility or subfertility has also been reported to be a consequence of HIV infection. A study in Uganda's Rakai district indicated that the prevalence of pregnancy is

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substantially reduced in women infected with HIV.¹¹ The prevalence of HIV-1 infection was significantly lower in pregnant than non-pregnant women (13.9% and 21.3%, respectively). The authors of this study conclude that if HIV surveillance is confined to pregnant women, the prevalence of HIV-1 among women of reproductive age will be seriously underestimated.¹¹

DO WOMEN BENEFIT FROM PARTICIPATING IN SCREENING PROGRAMS?

The HIV testing at the sentinel surveillance sites in antenatal clinics initiated in 1989 was anonymous, and women were not given their results. Testing for syphilis was also offered free of charge to pregnant women, and those who tested positive were treated free of charge, which was the only benefit of participating in the program.

In the early 1990s, research for prevention of mother to child transmission (PMTCT) of HIV saw a breakthrough with use of zidovudine.¹² Providing voluntary HIV screening programs for pregnant women and offering zidovudine treatment to those who are HIV-positive have been shown to decrease the number of cases of pediatric HIV infection.¹³ This intervention was not affordable in Uganda.

This led to concerted efforts to find solutions for PMTCT in low-resource settings, resulting in short course antiretroviral prophylaxis in the perinatal period. At the end of the 1990s came a breakthrough: short course antiretroviral prophylaxis was shown to reduce vertical transmission by as much as 50%.^{14,15} However, the euphoria generated by these successes could not be translated to meaningful care of HIV-infected women, even with the launch of the PMTCT program in 2001. In 1998, UNAIDS, the Uganda Ministry of Health, and other partners launched the first public health antiretroviral drug access initiative, but only for clients who could purchase the medications. Although the drugs were subsidized and more women than men were being tested for HIV, the majority of women could not afford ART. Therefore women did not generally benefit from this ART program.¹⁶

SOME HOPE BUT CONSTRAINED BY GENDER

A significant development over the past decade is that HIV seroprevalence among pregnant women has steadily declined from 28% in 1992 to 6.2% in 2002,⁹ close to the rate of 7.1% observed in both men and women in the seroprevalence survey of 2004–2005.¹⁷ A rapid scaling-up and comprehensive continuum of care, including access to antiretroviral treatment,¹⁸ has been advocated for all members of affected families and the MTCT Plus initiative.¹⁹ This approach, focusing on PMTCT and offering women prophylaxis for opportunistic infections and highly active

antiretroviral treatment (HAART) for their own health offers real hope. The World Health Organization estimates that approximately 20% to 35% of HIV-infected pregnant women need HAART for their health.²⁰ Between 2003 and 2006, despite the scaling-up of ART programs in the country, fewer than 20% of pregnant HIV-positive women had disease staging, and fewer than 30% of those eligible received HAART.²¹ In contrast to no antiretroviral therapy or monotherapy, HAART for HIV-1 infection in pregnant women has been shown to be safe and is not associated with increased rates of premature delivery or with low birth weight, low Apgar scores, or stillbirth. However, the use of protease inhibitors might be unsafe.²²

The situation for non-pregnant women in Uganda is still unclear, because their medical care including ART has been scaled-up only since 2005. The good news is that the proportion of women aged 15 to 19 who have never had sexual intercourse has shown a steady increase over time, from 38% in 1995 to 48% in 2000–2001 and to 54% in 2004–2005. The proportion of men aged 15 to 19 who have not had intercourse has not shown a sustained increase: 52% in 1995 to, 61% in 2000–2001, and 58% in 2004–2005.¹⁷

The sad news is that women remain less knowledgeable than men about the relevance of condoms in HIV prevention. Only two thirds of women (compared with three quarters of men) said that using condoms every time they have sex can reduce the chance of getting AIDS.¹⁷ Although fewer women than men aged 15 to 29 years have multiple sexual partners (3.3–7.6% vs. 21.3–29.2% had 2 or fewer partners in the preceding 12 months), HIV seroprevalence among women was more than double that of men (3.2–9.1% and 1.2–6.8%, respectively).¹⁷

Adolescent girls are particularly vulnerable: the ratio of girls to boys infected with HIV was 4:1 in 1992 and 3:1 in 2004.¹⁷ This might be because of early sexual debut, early marriage, and having sex with older men. Young women therefore experience the health effects of immune suppression much sooner after HIV infection than men of the same age. The vulnerability of women has persisted from the 1980s to the present day, (HIV Sero survey in 2004–2005) despite declining HIV prevalence in the population. This may be explained by gender inequity and persistent poverty.^{23,24}

CONCLUSIONS

HIV seroprevalence has declined among pregnant women in Uganda, consistent with the decline in the general population. Women do undergo testing for HIV during pregnancy, but they have not significantly benefited from HAART. Women report fewer sexual partners than men, but the prevalence of HIV is two to three times higher for

women than for men, and girls seem to be more vulnerable than boys.

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