

Treatment Issues for Women

BY VICCI TALLIS

Le défi pour les activistes du VIH/sida et contre le sexisme est de prioriser le traitement pour les femmes dans les projets des chercheurEs, des soignantEs, des organisations contre le sida, dans le but d'améliorer les connaissances et d'offrir de meilleurs services. Cet article est une version abrégée d'une recherche pour la Campagne Action Traitement en Afrique du Sud.

The gender politics of HIV/AIDS has been mainly focused on prevention, particularly on women's vulnerability to HIV infection and the prevention of mother-to-child transmission, and seldom on women's care issues of which treatment is a vital part. Gender inequality is reflected in the response to HIV/AIDS. One of the key responses to women and HIV/AIDS has been to highlight women's reproductive role and to focus on the prevention of mother-to-child transmission. Women want, and have a right to, reproductive health services that will increase the likelihood of healthy babies. However, women are often seen only as mothers and not as individuals in their own right, with their own identities and needs.

There is a vast body of literature, about the treatment and management of HIV/AIDS. The problem with much of this research is male bias—it is defined and conducted by men with most of the research participants being men (Doyal). It also pays little or no attention to the different manifestations of HIV in men and women. Whilst much of the information available is relevant for both men and women living with HIV/AIDS, the failure to address differences impacts negatively on women's health and well-being.

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A Contextual Analysis of Women and Health

A gendered approach to health does not only include biological factors but also considers the critical roles that social and cultural factors play in promoting, protecting, or impeding health (Garcia-Moreno 1999). Power relations between women and men, and between health-care provider and client, are informed by these social and cultural factors. In short, biological and social factors must be analyzed to understand how women and men experience health and illness.

The macro-political and economic factors that impact on health in general, and women's health, in particular, are located at both a national and global level. At a national level, the fiscal policies of governments mean that political choices are made which are often not in favour of the poor, particularly poor women, and one of the first areas to be impacted upon is

that of health. To an increasing extent, pressures that arise out of the global economy influence national government decision-making. The political and economic factors that impact on women's health include globalization of trade and finance and huge debt repayments that divert funds from social services.

The imposition of structural adjustment programs on indebted countries by the World Bank and International Monetary Fund (IMF) force governments to apply cutbacks to social services such as education and health. This adjustment impacts on women, men, and children in indebted countries. "Silent adjustment" is a term that has been coined to reflect the undue hardship and pressure that women experience as a result of structural adjustment.

Socio-economic factors that also impact on the health of men and women include poverty, migration and mobility, rate of urbanization, levels of violence, education, and access to healthcare amongst others.

Despite many gains made by women in the last 40 years, gender equality is not yet a reality for many women. Women still lack economic, political, and social power. Women's relationships with men are characterized by unequal power dynamics. Socially-defined roles for men and women see women's main role as reproductive, which includes child-bearing and care for children and the family. May refers to the "time poverty" of women which is the result of the long hours women spend on their reproductive roles—collecting fire-wood and water, caring for children, cooking and cleaning—to the detriment of their own well-being.

The South African Constitution entrenches women's equality, however, this does not necessarily translate to equality in women's lives, and in reality, little has changed for most women.

Women are more likely to be poor and malnourished and are less likely to have access to services—health, sanitation, clean water, education—and formal sector employment (Todaro). Female-headed households in South Africa are generally poorer than male-headed households. In 1995, the average annual income of households headed by men was \$48,000 (\$12,000 CDN) compared to only \$25,000 (\$6,250 CDN) for women-headed households. (Hurt and Budlender).

Even when women have access to income and assets (including land, equipment, employment, knowledge, and skills), these are often controlled by men and women are less able to get out of the poverty trap (May).

Gender Inequalities in Health

Gender inequality impacts on every aspect of health and illness. This includes differences in vulnerability to illness and disease, prevention, the response of the individual to their symptoms, organization and delivery of health care, the politics of diagnosis, questions asked by clinical researchers, the knowledge and understanding of disease, and the treatment required (Lorber).

Women are more vulnerable to HIV infection than men, partly due to physiology but also partly due to their limited ability to protect themselves from infection. This is heightened by a lack of women-controlled barrier mechanisms and socially constructed "rules" of heterosexual sex, where men have the power to decide when, where, and how sex takes place. We know relatively little about HIV/AIDS in women, even less so in developing countries and this obviously impacts on treatment issues (Patton; Johnson; Bass; MacNeill).

Gender Bias in Medical Research

Medical research is a profoundly gendered activity that is determined from a male perspective. Common problems experienced by women receive little attention if they are not seen as part of women's reproductive role. Gender roles influence the de-

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gree of exposure and also the access and control of resources needed to protect women and men from infection. In diseases that affect both men and women many researchers have ignored possible differences in diagnostic indicators, in symptoms, in prognosis, and in the relative effectiveness of different treatments (Garcia-Moreno; Doyal; Foster).

Women's exclusion in research is justified on the grounds that cyclical hormonal changes make it difficult to interpret results and/or the fact that women may become pregnant and put the fetus at risk. Yet, "results obtained from research on predominantly male subjects are applied with little question to (potentially) pregnant women patients" (Garcia-Moreno 19).

On a global scale, in both a developed and developing context, there is a lack of attention of health issues for women who are poor. Studies carried out on households in various countries show that less is spent on

health care for women and girls (Garcia-Moreno). Female headed-households spend more income on the nutritional needs of the household's members (Posel). According to May, if consumption patterns in male headed-households were to mirror those in women headed households, the incidence of under-nutrition in South Africa would fall by twelve per cent (cited in Posel).

Women are more likely to put the health care needs of others, such as a partner or children before their own needs (Garcia-Moreno; Koblinsky, Timyan, and Gay). The health-seeking behaviour of women is mainly based on their reproductive role—either as a pregnant woman or as a mother with a sick child—and is usually what brings women into the health care arena. Other factors that impact on women's health-seeking behaviour include time, mobility, access to funds/resources, fear of health care providers/facilities, and other social constraints which discourage women from attending healthcare facilities (Garcia-Moreno; Koblinsky *et al.*; Miles).

Gender dimensions of health can be causal factors in limiting the quality of care women receive. The quality of care received is often dependent on the power dynamic between the health care provider and patient/client. Women's subjective experiences of medical encounters include sexism of doctors, and biases inherent in the institution of medicine, which can make the experiences demeaning for women. Within reproductive health services, health care providers focus on controlling women's fertility. This is characterized by a failure to communicate information and a lack of cultural sensitivity. This often results in dehumanizing treatment that may affect women's willingness to use the services.

Strategies to improve women's health need to be grounded in a rigorous analysis of the whole range of women's productive and reproductive activities and the way these change across their life span.

Issues for Women Living with HIV/AIDS

In the final analysis the combination of unequal access to care and the gender gap in medical knowledge contributes to a situation where women in both rich and poor countries have a shorter expectancy than men after a diagnosis of AIDS. (Garcia-Moreno 14)

Only in 1993 did the Centers for Disease Control (CDC) extend the list of defining HIV related illnesses to include gynecological abnormalities and cancers. As Patton notes,

women were continually within epidemiologists line of vision, but it took a decade to achieve official recognition of the uniqueness of their clinical and social experience of the epidemic. (13)

The response to HIV/AIDS must concentrate on all aspects of the prevention/care continuum. In South Africa, the main focus of the HIV/AIDS response has been on prevention. In relation to care there has been a focus on home and community-based care as a solution to an over-burdened health care system. Treatment issues for women have largely focused on the prevention of mother-to-child transmission. While this is a vital intervention, which impacts on a women's psychologically and emotionally, it is not a treatment issue for women. It is vital for women to be seen as separate from their reproductive roles and for research and services to be extended to meet all of women's treatment needs.

A review of the literature highlights the following key problem areas to be addressed with regard to treatment issues for women:

- Are there differences in how HIV manifests in men and women? (For example, differences and similarities in opportunistic infections, meas-

urements of viral load¹ and CD+4 counts, and life span.)

- Given that initial findings suggest that differences exist in both type and severity of opportunistic infections as well as in viral load—what, then, are the implications for dosage and timing of treatment,

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clinical management and “positive living.”

Much has been written about women with HIV/AIDS dying earlier than men with HIV/AIDS (Anderson). There is nothing inherent in women that make this the case. Rather, factors such as access to health care, proactive health-seeking behaviour, and self-management of the disease impact on the life span of a person with HIV/AIDS. It has previously been mentioned that women have less access to health care than men do and are more likely to prioritize the health needs of others. This necessarily impacts on the course of the disease and their life span (Marks).

The exclusion of women from many research studies prolongs the male bias in research. Johnson states that women still comprise only about twelve per cent of the total participants in clinical trials. Key questions regarding the biological differences in female and male experiences in AIDS remains unanswered. This af-

fects women getting an accurate diagnosis and treatment.

Some Treatment Issues

There are three basic purposes for treatments available for people living with HIV:

- Treatments used to prevent opportunistic infections (prophylaxis) and drugs to treat opportunistic infections;

- Treatments used against the virus itself (anti-retrovirals);

- Treatments used to relieve or eliminate symptoms associated with HIV and the side effects of other treatments (McCullum).

Differences in Viral load, CD4 Count and Disease Progression

In the field of AIDS we still have only hints about differences in dosing, clues of metabolic differences and suggestions of what viral load levels could mean in terms of HIV progression in women. (MacNeil 14)

HIV positive women may have a higher risk of progressing to AIDS than men with the same viral load (MacNeil). This finding was based on a study of drug injecting women and men and means that women living with HIV who inject drugs can develop AIDS with less virus than positive men who inject drugs. Based on the results of the study, questions were raised about whether the initiation of anti-HIV therapy at a lower viral threshold may be justified. The study recommended that viral load should be considered to be a gender variable (Mitchell 1999).

In January 2000, a meeting of scientists and treatment activists was held in the United States to discuss and debate the issue of gender differences in treatment. The following points, based on research to date were highlighted:

- Women may have lower viral levels than men in early HIV disease (in



Rochelle Rubinstein, *untitled*, from the *Genesis series*, woodblock print, draped, photograph & heat transferred, 11" x 17", 2001.

the first five years of infection);

- Differences may not persist over time—the cause and significance of the differences remains unclear;

- No changes have been recommended for the use of anti-HIV therapy among women;

- Racial and ethnicity differences in viral load may be equally important to gender differences and should be explored (Project Inform 2000).

Combination therapies and anti-retrovirals

The decision to begin combination therapy is made on viral load, damage done to immune system (CD4+ count), and the ability to keep up the treatments on a regular basis for life. The response of women to drug therapies is the area where most information is needed. There are too

few women enrolled in clinical trials to determine whether or not there are differences between men and women.

What is known is that women metabolize the drugs at a more rapid rate (Johnson and Currier). Anastos, states “drugs are working, which is extremely important and saving lives but we may be blasting women with higher doses than we need to” (Gender-AIDS 468).

The differences in viral loads between men and women make interpreting guidelines for the onset of antiretroviral therapy difficult. For example, a woman with a CD4+ count of 475 and a viral load of 6000 copies/ml is roughly at the same risk of disease progression as a man with a similar CD4+ count but with a viral load of 10,000 copies/ml. Guidelines suggest

that the man consider anti-HIV therapy but that the woman wait until her viral load is greater, even though she is at the same risk of disease progression as the man.

Present knowledge would suggest that the drugs are equally effective in women and in men. However, drugs may be more toxic in women. Women tend to show more side effects or have more severe side effects than men do. For example, women are more likely to develop a severe rash as a side effect of Nevirapine than men are and drug levels in the blood are higher in women (Mary.Elizabeth@aegis.com).

It is obvious that more information is needed to understand both the difference in viral load in men and women and what this difference actually means (Project Inform 1999; 2000).

Differences in Opportunistic Infections, Cancers and Symptoms

More research is needed to determine the different patterns in health care and treatment issues between men and women. Gender differences have been noted in certain infections associated with HIV disease. This may include more frequent candidiasis (vaginal, esophageal and oral thrush), herpes infection and types of cytomegalovirus (CMV) disease (Johnson and Currier). It is unclear as to whether these differences are biologically based or due to psychosocial issues and treatment access.

Anderson notes that gynecological problems are common among women living with HIV/AIDS and are often present at the time of initial presentation for care and evaluation. It is known HIV impacts on hormonal levels and functioning. For example, abnormal menstrual cycles, weight loss, gynecological infections, headaches, and fatigue in women may be related to decreasing estrogen levels. Although hormone replacement therapies (HRT) are being used in both men and women living with HIV/AIDS in symptom management and weight maintenance, for women much of the focus is on the use of hormone therapy as a form birth control that may not be the central issue for women.

HIV and Menstrual Complications

Many HIV-positive women report changes in their menstrual cycle, including longer, shorter, heavier, irregular, or painful periods. Many doctors, however, view abnormal menstrual cycles as an inconvenience rather than a serious medical condition, and thus do not address them aggressively, for example with HRT, which may lead to longer survival. Problems with menstrual bleeding can cause or can be a symptom of anemia; it is thus vital to monitor menstrual cycles regularly.

A large study has revealed a significantly high prevalence of low-grade cervical dysplasia in HIV-positive women (Project Inform 1998). Cervical dysplasia is characterized by abnormal growth or alteration of cells on the cervix. In some cases this may lead to cancer of the cervix. It is also important to note that pap smears performed on HIV-positive women are more likely to give false negative results than those given to HIV-negative women. There is a strong motivation that sophisticated tests—such as the use of colposcopy—be advocated for women living with HIV. At the very least, women living with HIV should have a pap smear every six months. Women with abnormal pap smears should be tested even more frequently. In South Africa women have access to four free pap smears in their lifetime. This is not sufficient for women living with HIV.

Pelvic Inflammatory Disease (PID) represents a range of inflammatory disorders of the upper genital tract which include fallopian tubes, uterus, ovaries, and in advanced stages, abdominal lining. PID appears to be more prevalent, severe, and resistant to treatment in women living with HIV/AIDS. Furthermore, studies indicate that the relapse of PID occurs more in women with compromised immune systems (Project Inform 1998; 1999). The CDC recommends hospitalization of women with PID as intravenous antibiotics should be administered.

Conclusion

Despite women having been vulnerable to HIV infection from the onset of the epidemic and now constituting over 40 per cent of all infections globally, and over 50 per cent in sub-saharan Africa (UNAIDS), relatively little is known about gender differences in the ways in which HIV/AIDS manifests. The focus globally has been on the prevention of mother-to-child transmission, which for many is seen as a treatment issue for women, but in reality is a prevention

issue. There is a critical need for more research that focuses on women living with HIV/AIDS to improve the treatment and prevention of opportunistic infections as well as the timing and dosages of anti-retroviral therapies.

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¹ Viral load refers to the amount of HIV present in the blood. Anti-viral treatments can bring the viral load down from tens of thousands to almost undetectable levels.

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