

# Women and HIV

## The Feminisation of HIV/AIDS: Global and Irish Perspectives

A seminar organised by Cairde and the National Women's Council of Ireland

**2<sup>nd</sup> June 2004**

*"The face of AIDS is increasingly  
a young female face."*

Carol Bellamy, UNICEF, February 2004.



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Women's Health Action Project, Cairde and the In from the Margin, National Women's Council of Ireland are hosting a discussion about ....

**Women and HIV**  
***The Feminisation of HIV/AIDS:***  
***Global and Irish Perspectives***

**Wednesday June 2<sup>nd</sup> 2004**  
**10.30 – 1.00 pm**

**Whitefriar Community Centre, Aungier Street, Dublin**

<b>10.30am</b>	<b>Registration &amp; Coffee</b>
<b>10.45am</b>	<b>Introduction</b> <ul style="list-style-type: none"><li>• <b>Anne Brennan - In from the Margin, National Women's Council of Ireland</b></li><li>• <b>Stephanie Whyte – Women's Health Action, Cairde</b></li></ul>
<b>10.55am</b>	<b>Women and HIV/AIDS: the Global Picture</b> <ul style="list-style-type: none"><li>• <b>Breda Gahan – Concern</b></li></ul>
<b>11.10am</b>	<b>The Irish Experience</b> <ul style="list-style-type: none"><li>• <b>Patricia Mendes – Cairde</b></li><li>• <b>Ann Nolan – Dublin AIDS Alliance</b></li></ul>
<b>11.40am</b>	<b>Q&amp;A and Discussion</b>
<b>12.10</b>	<b>Coffee</b>
<b>12.20</b>	<b>Responses: A Role for Microbicides?</b> <ul style="list-style-type: none"><li>• <b>Rebekah Webb – Global Campaign for Microbicides (Europe)</b></li></ul>
<b>12.40</b>	<b>Q&amp;A and Discussion</b>
<b>1pm</b>	<b>Close</b>

**Women and HIV  
Introduction  
Wednesday 2<sup>nd</sup> June 2004**

According to UNAIDS, gender roles and relations have a significant influence on the course and impact of the HIV/AIDS epidemic in every region of the world. Understanding the influence of gender roles and relations on individuals' and communities' ability to protect themselves from HIV and effectively cope with the impact of AIDS is crucial for expanding the response to the epidemic.

Research has shown that being a girl or boy, a woman or a man influences how a person experiences and responds to the HIV/AIDS epidemic.

A gender based approach to understanding HIV/AIDS examines the ways in which gender influences:

- Individual risk and vulnerability to HIV;
- The experience of living with HIV/AIDS;
- The impact of an individual's HIV-related illness and death within a family or community and
- Responses to the epidemic at the individual, community and national level.

\*\*\*\*\*

Women are disproportionately vulnerable to HIV, and account for half of the 40 million people living with HIV around the world.

This vulnerability is primarily due to....

- Inadequate knowledge about HIV and AIDS;
- Poverty and poor access to education;
- Insufficient access to HIV prevention services;
- Inability to negotiate safer sex due to inequality;
- Increased use of sexual violence as a tool of conflict;
- Lack of female controlled HIV prevention methods;
- Biological vulnerability to infection – male-to-female transmission is estimated to be twice as likely as than female to male.

## **The Feminisation of HIV/AIDS – A Global Perspective**

### **Breda Gahan - Concern**

#### **Overview**

Around half of all people LIVING WITH HIV in the world are female (20 million - WAC 2004).

Up to 100,000,000 females are AFFECTED by HIV/AIDS globally (girls, female orphans, sisters, mothers, carers, grandmothers, home-care volunteers, female health workers).

Sub-Saharan Africa remains by far the region worst-affected by the HIV/AIDS epidemic.

African women are much more likely to be infected with HIV than men.

In Sub-Saharan Africa, 58 percent of those living with HIV were women as of end 2003 and young women aged 15 to 24 were 2.5 times more likely to be infected than young men according to six recent national surveys (UNAIDS Dec. 2003).

#### **Vulnerability of young women**

The main drivers of the global HIV/AIDS pandemic continue to be poverty, inequality (esp. gender), injustice and stigma. Women are disproportionately affected by all these factors.

HIV and other sexually transmitted infections also show "biological sexism": women's bodies are more susceptible to the viral and bacterial agents that cause them. Men transmit infections more efficiently to women than vice versa. In fact, women are physically, biologically, economically, socially and culturally more vulnerable to HIV infection.

Sexual activity tends to start earlier for women, and young women tend to have sex with much older partners.

Gender inequality means that many women and girls cannot say 'no' to unwanted and unprotected sex without fear of reprisal. Across the world, between one fifth and a half of all girls and young women report that their first sexual encounter was forced.

Harmful traditional and customary practices, including sexual abuse and rape, female genital mutilation, battering and trafficking of women and girls fuels the spread of HIV/AIDS.

Vulnerability is also due to inadequate knowledge about AIDS, insufficient access to HIV prevention services, inability to negotiate safer sex, and a lack of female-controlled HIV prevention methods, such as microbicides and female condoms. In some of the regions worst-affected by AIDS, more than half of girls aged 15 to 19 have either never heard about AIDS or have at least one major misconception about how HIV is transmitted.

#### **Women and girls are at higher risk than men and boys (UNFPA Fact Sheet)**

Studies in several countries have found that some rural widows resorted to commercial sex to survive, because they had no legal right of inheritance to their husbands' property.

Women may be blamed for bringing AIDS into the house. Those known or thought to have HIV may be evicted, ostracized, dismissed from work, or even beaten or killed. In December 1998 Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on World AIDS Day about her HIV status.

AIDS risk increases from some traditional practices, such as female genital mutilation (circumcision), early and forced marriage, or the "inheritance" of widows among brothers.

Domestic violence, rape and other forms of sexual abuse are not only violations of human rights; they are closely linked to the spread of HIV/AIDS.

Emergency and conflict situations increase rape and sexual violence rates, spreading HIV infection.

### **Impact on families and communities**

Poor women are becoming even less economically secure as a result of AIDS, often deprived of rights to housing, property or inheritance or even adequate health services.

In rural areas, AIDS has caused the collapse of coping systems that for centuries have helped women to feed their families during times of drought and famine, leading in turn to family break-ups, migration, and yet greater risk of HIV infection.

#### **Possible impacts on agricultural dependent households -**

- Father becomes sick with HIV/AIDS
- He reduces work on farm
- Increase in healthcare expenses for him
- Household reduces food consumption
- Father stops work altogether
- Children drop out of school
- Father dies
- Mother becomes sick and eventually dies
- Orphans are taken care of by grandmother

HIV/AIDS is threatening recent positive gains in basic education and disproportionately affecting girls' primary school enrolments. In high prevalence countries, girls' enrolment in school has decreased in the past decade. As AIDS forces girls to drop out of school, whether they are forced to take care of a sick relative, run the household, or help support the family, they fall deeper into poverty. Their children in turn are less likely to attend school and more likely to become infected. Thus, society pays many times over the deadly price of the impact on women of AIDS.

HIV and AIDS have significantly increased the burden of care for many women. Poverty and poor public services have also combined with AIDS to turn the care burden for women into a crisis with far-reaching social, health and economic consequences.

AIDS intensifies the feminization of poverty, particularly in hard-hit countries, and dis-empowers women. Entire families are also affected as vulnerability increases when women's time caring for the sick is taken away from other productive tasks within the household.

### **Prevention, protection and treatment issues**

Women are twice as likely as men to contract HIV from a single act of unprotected sex, but they remain dependent on male cooperation to protect themselves from infection.

Going to school is protective. Education is important for everyone, but it is especially significant for girls. Girls who have been educated are likely to marry later, for example, to have smaller and healthier families. Educated women can recognize the importance of health care and know how to seek it for themselves and their children. Education helps girls and women to know their rights and to gain confidence to claim them (UNFPA Executive Director Thoraya A. Obaid).

Many mainstream prevention strategies are untenable, for example those based exclusively on the 'ABC' approach -- "abstain, be faithful, use a condom". It is men who need to change. Men initiate sex, men control it and men pay for it with their greater wealth. Empowering women through legal, educational and economic measures is the way to change men (Jeremy Laurant UK Independent May 2004).

### **Changing Ideas about Masculinity**

Sensitizing boys and men to share responsibility for safe and healthy reproductive and sexual behaviour, and to respect girls and women as equals, is a fundamental tenet of many UNFPA-supported programmes.

### **Treatment access - Zambia Case Study**

The Zambian National AIDS Council report in 2003 shows that of the 870,000 HIV positive Zambians, 70 percent are women.

That gender ratio is not reflected in the statistics of those receiving ARVs however. Instead, the majority enrolled in the ARV treatment programme appear to be men.

In Petauke a small rural town in eastern Zambia where 40 people are receiving ARVs only 3 are women. Dr Muchango Siwale, who works at the local hospital, says that women traditionally try and ignore their health needs. "Women do not know their own value. They are real beasts of burden. They get sick but, as long as they are able to pick up a hoe and till the land, they carry on till they drop dead."

Banda, a midwife, said in her 10 years at the hospital she had seen women bringing their husbands on wheelbarrows, bicycles and even on their backs, like babies. But she has yet to see a man even offer the support of his arm and bring his wife for treatment.

Harriet Munjira and her husband, Benson, are both HIV-positive. But as they can only afford treatment for one person, naturally, Benson is receiving the ARVs.

### **Experiences of women living with and affected HIV/AIDS (photographs)**

1. Katongole and Nabuma his carer in Uganda  
Katongole still has some strength, but he is too sick to work. Nabuma a home-care volunteer from NAWA visits him regularly, gives traditional medicine and provides emotional support.
2. Nyinakulama (Katongole's wife) in Uganda  
Nyinakulama now lives in Mpigi sub-county. She and her husband come from Rwanda. Nyinakulama has been sick form one year and bedridden for 3 months. Her carer Felista who works with Nabuma is providing palliative home care. Katongole and Nyinakulama have 4 children, aged 10, 7, 6 and 3.
3. Edisa a grandmother in Uganda  
Edisa is 67 years old. She has lost her husband and all 9 adult children to "slim disease". I met her on the day after she had buried her last surviving daughter. She now cares for 14 grandchildren. She is making a mat for the children to sleep on.
4. Sebina and her mother in Uganda  
Sebina has recently returned to her parent's home in Mamba village with her 3 children. She was working in a restaurant in Kampala. Her husband left her when she got sick and he suspected that she had HIV infection. She was also dismissed from her job. Now she has no income. Her mother says that they will try to sell some of their agricultural produce.
5. Nafka a grandmother in Uganda cares for 16 orphans  
Nafka does not know her age. 8 of her 10 adult children have died of AIDS. The last two are also sick. Nafks and her husband now look after 16 orphans. Two of the boys attend school. None of her

granddaughters now attend school due to the cost of clothes and books. Also they are occupied with the task of planting and harvesting for their “new extended family”.

6. Lucia, Nafka's granddaughter in Uganda

Lucia is 7 years old. She has witnessed both her parents succumb to the pain and eventual death from HIV/AIDS. She is one of the many orphans affected. Her own risk and vulnerability to HIV infection has increased with the loss of her parents. Will Lucia be able to refuse sex until she is ready or insist on condom use later? Can we support to keep Lucia HIV free?

7. Netshiet with Tefere in Ethiopia

Netshiet was forced into marriage at 15 years. She became ill after that and found out that she was HIV+. Her husband left her when he found out she was infected. Her family would not take her back. She had nowhere to go. She was planning suicide. Then she heard about a local NGO Mekdim in Addis Ababa (supported by Concern). Here she met Terefe. They are working with other PLWHA and educating young people on prevention and care.

8. Female health workers in D. R. Congo

Female health workers campaigning for fidelity, and HIV/AIDS prevention on World AIDS Day 2003 in Kinshasa, DRC. Conflict and violence in this country has increased the spread of HIV.

## Global initiatives/international campaigns

The **World AIDS Campaign 2004: Women, Girls and HIV and AIDS** seeks to raise awareness and help address the issues affecting women and girls around HIV and AIDS.

### Objectives

- Promote the role of women and girls in tackling the epidemic.
- Encourage women and girls living with HIV to tell their story.
- Highlight the impact HIV and AIDS has on women and girls globally, regionally and nationally.
- Challenge gender differences that make women and girls more vulnerable to HIV.
- Ensure national policies and responses focus on the impact of AIDS on women and girls.
- Increase the self-esteem of women, especially those vulnerable to/or infected with HIV.
- Build awareness, credibility and legitimacy of the targets in the UNGASS Declaration of Commitment relating to women and girls.

See more at <http://www.unaids.org/en/events/campaigns/world+aids+campaign+2004.asp>

An emerging **Global Coalition on Women and AIDS**, launched by UNAIDS in February 2004, is also seeking to bring local and global activity together, identify gaps and reinforce the work that is already underway.

### The Coalition's Focus

- **preventing** HIV infection among girls and young women
- **reducing** violence against women
- **protecting** the property and inheritance rights of women and girls
- **ensuring** equal access by women and girls to care and treatment
- **supporting** improved community-based care
- **promoting** access to new prevention options for women, including microbicides
- **supporting** on-going efforts towards universal education for girls

See more at [http://www.unaids.org/en/events/coalition\\_women\\_and\\_aids.asp](http://www.unaids.org/en/events/coalition_women_and_aids.asp)



**Amnesty International** has launched a global CAMPAIGN TO STOP VIOLENCE AGAINST WOMEN - "It's in our hands". 1 IN 3 WOMEN in the world will suffer serious violence in their lifetime. See at <http://web.amnesty.org/mav/index/engact770212004>

**The International Community of Women Living with HIV/AIDS** (ICW) is an international network which strives to share with the global community the experiences, views and contributions of 19 million incredible women worldwide, who are also HIV positive. See more at [http://www.icw.org/tiki-view\\_articles.php](http://www.icw.org/tiki-view_articles.php)

## **Conclusion**

***"the face of AIDS is increasingly a young female face"***

Carol Bellamy Executive Director of UNICEF at the Feb. 2004 Dublin AIDS Conference

***"there is a direct correlation between women's status, the violation of their human rights, and HIV transmission"***

Noeleen Heyzer, Executive Director of the UN Development Fund for Women (UNIFEM)

***"women's further empowerment is key to a global HIV/AIDS response"***

UN Secretary-General Kofi Annan on International Women's Day 2004

**Breda Gahan, Global HIV/AIDS Programme Advisor, Concern**  
**June 2<sup>nd</sup> 2004**

**The Issues Emerging for Minority Ethnic Women  
living with HIV in Ireland.  
Patricia Mendes – Cairde  
June 2<sup>nd</sup> 2004**

**This input will focus on two main areas....**

- 1) Key Issues Affecting Minority Ethnic Women living with HIV in Ireland and**
- 2) Key Issues in HIV Prevention for Minority Ethnic Women in Ireland**

**Key Issues Affecting Minority Ethnic Women living with HIV in Ireland**

**POVERTY & UNEMPLOYMENT**

- **Direct provision and dispersal - €19.10 per week**
- **Lone parents**
- **Not entitled to work**
- **Qualifications not recognised**
- **Lack of affordable childcare**
- **Periodic illness**

**ACCOMMODATION**

- **Positive asylum seeking women who are in direct provision in hostels have no control over their diets.**
- **Asylum seeking women living in communal hostels do not have privacy with their medication and their status.**
- **Women who are entitled to private accommodation have problems in getting houses or apartments because of racism and because few landlords want to accept any rent allowance from the social welfare.**

## **ASYLUM PROCESS & IMMIGRATION**

- **Many positive asylum seeking women are not aware of support organisations and helpful information available to them about how to address HIV in their asylum applications. Many are totally reliant on the Refugee Legal Service, as they cannot afford private lawyers.**
- **Women living in rural areas do not have the same access to information as those in urban areas because of lack of facilities and services.**
- **Many positive women have fears that their asylum applications will be rejected or their work permits not renewed, if their status is discovered.**
- **Many positive women fears about their future access to treatment if their asylum applications prove unsuccessful and they are deported.**

## **HEALTH**

- **Most women have been infected with a long term partner, and are coming to terms with this within a relationship, often without support.**
- **Many experience ongoing health problems.**
- **Lack of information - health information, entitlements, how the system works. Positive women lack information on health issues other than their treatment.**
- **Ethnic Minority Women in general are not aware of free medical examination.**
- **Women do not know where to go to access information and often this information isn't given by the GPs.**
- **Minority ethnic women have real problems being accepted on a GP list.**

- **Women have very little understanding of the health system; they can not differentiate between social workers in hospitals, social welfare officers, community welfare officers and Health Departments.**

## **RACISM**

- **A significant amount of racist comments are made within the context of public service provision e.g. in the Bus, the GP's Clinics, Social Welfare Offices (by staff and customers/clients alike).**
- **Some women have been physically attacked in the city centre and in the residential areas, e.g. throwing eggs to them.**

**There are other issues regarding:**

**RELATIONSHIPS**

**SOCIAL LIFE**

**CHILDCARE**

**EDUCATION & TRAINING**

## **Key Issues in HIV Prevention for Minority Ethnic Women in Ireland**

- **Lack of information about HIV, little understanding of the illness, how it can be treated.**
- **Stigma**
- **Lack of information about treatment available in Ireland, and their entitlement to it.**
- **Lack of understanding of the benefits of early diagnosis etc.**
- **Fears about HIV affecting asylum applications and work permits are a major barrier.**

- **Little or no access to condoms – very expensive, particularly for asylum seekers whose disposable income is only €19.10 per week.**
- **Many women in long term relationships cannot introduce condoms into the relationship, particularly without support.**
- **Many partners not willing to use condoms.**

#### **Recent HIV Statistics for Ireland**

Year	Male	Female	Total
1999 Jan – Sept	82 54%	62 41%	151 (7 sex unknown)
2000	174 60%	116 40%	290
2001	163 55%	134 45%	297
2002	165 46%	198 54%	364
2003 Jan-June	100 48%	106 51%	207 (1 sex unknown)

#### **AIDS Cases and Deaths up to end 1999**

	Male	Female	Total
AIDS Cases	558 81%	133 19%	691
AIDS Deaths	285 82%	64 18%	349

[www.ndsc.ie](http://www.ndsc.ie)

## Women & HIV

### The Feminisation of HIV/AIDS

#### Global and Irish Perspectives

Ann Nolan – Director, Dublin AIDS Alliance

My presentation is a very brief summary of a dissertation I completed a few years ago, which focused on the factors placing women at risk for HIV in Ireland. My information is drawn largely from an analysis of existing documentation and my own experience of working in the sector.

#### 1. Heterosexual Discourse

Heterosexual discourse privatises individual experience within a perceived “natural” and “normative” framework. Consequently, women’s sexuality is largely silent and negated within the public domain of health care debate, and the latter is biologically reductionist to the extent that it locates sexuality within the strict confines of ‘normal’ and ‘abnormal’ function – which is one of the concerns I’ve voiced to the ERHA’s Sexual Health Strategy Committee, as it is largely comprised of medical personnel. Sexual health remains largely a taboo subject within the public domain and there is an unwillingness to challenge the safety issues surrounding the heterosexual paradigm of male penetration and female reception.

Women will seek advice from their GP’s around reproductive health, contraception, etc. but I would question the extent to which these consultations are sufficiently frank and open. Anecdotally it would appear that GP’s are complicit in the silence, and oftentimes fail to ask the right questions. Example: “He doesn’t like using condoms” – “Not to worry there are other forms of contraception” – but of course none of those will protect you from HIV or other STI’s.

WSW are frequently assumed to be heterosexual, so whatever chance heterosexual women have of acquiring safer sex information from GP's, WSW have even fewer.

## 2. Misinformation & Misrepresentation of HIV/AIDS

A high level of complacency exists among many young women because they've grown up post the high velocity media coverage that characterised HIV/AIDS in the eighties and early nineties. While we now know that some of the media messages at that time were incorrect, surprisingly they continue to inform people's perception of HIV/AIDS. Misinformation has continued to mislead – the most common one we experience is that you'd know if someone is HIV+ by looking at them. I am forever surprised by the prevalence of this belief.

Moreover, Gay men and IDU's constituted the groups most at risk for HIV/AIDS in Ireland up to the last few years, and the public perception still tends to subscribe to this view. If there is a change at all, it tends to suggest that HIV is now something that occurs to Africans but not to people like us.

Examples: Alliance Sexual Health Centre, What on Earth are They Doing? (1998) – a) 65% of 15 – 17 year olds believed that the pill is an important part of HIV prevention, b) 30% believed they were not at risk because they are not involved in injecting drug use, c) overall the assumption prevailed that HIV is associated with casual sex and/or multiple partners. An analysis of European KAB studies (1998) demonstrated that throughout Europe knowledge of HIV/AIDS is insufficient and in many cases incorrect. Kissing, drinking from someone else's glass, and sitting on a toilet seat were considered high risk activities by 16%, 9% and 13% of Europe's population. A significant proportion of the population further believed that coitus interruptus, washing after sex and taking the pill were effective in protecting against HIV. A smaller, but not insignificant number equated treatment with cure, believing that there is a vaccine or cure for HIV/AIDS

### 3. Magical Thinking

Probably one of the factors least identified, but will remain the core reason why even with information and education, women will continue to take risks and HIV will continue to be transmitted – as human beings we tend to operate on the premise that ‘it won’t happen to me’ – like every smoker in the room, like every fast driver, at some level there is a tendency for all of us to believe that we are invincible!

Again the analysis of European KABs demonstrated that in particular women tend to ignore the possibility that a steady partner and/or husband may have other sexual partners. Similarly in the budding phase of a new relationship, women may not want to worry about the others sexual partners and the risk they represent. The European analysis found that a ‘large’ number of respondents thought they knew with certainty that their partners were faithful when in fact the contrary was true. In my experience, the shift from condom use to the pill tends to mark a phase of commitment and growing intimacy. Our cultural construction of love or growing intimacy precludes our ability to perceive the lover as a possible health threat.

I have met a number of women who have subsequently tested HIV+ and love was the reason they chose to shift from condom use to the pill. I experienced shock from my GP when I said that I didn’t wish to explore any other means of contraception until my partner and I had had a sexual health screening; a friend informed me that she moved from condoms to the pill at a point at which she felt confidence in the relationship. Asked if her GP had sought to engage in discussion she said that he would just know that she was serious about the relationship! In the Cork study many stated that characteristics of their relationship promised protection from HIV. Example: a) “I have a steady relationship with a girl who has had limited sexual experience”, b) “I am faithful in a sexual relationship with somebody I trust”. A study



conducted in the UK found that many women felt that planning contraception is 'cold and clinical' and prefer spontaneity and risk-taking, which is deemed more romantic. Cultural constructions of love and desire don't help here.

Many modern relationships are characterised by serial monogamy, and each love/loving and/or intimate experience lends itself to a degree of magical thinking.

#### 4. Unequal Power Relationships

Safer sex messages assume far too much about male/female equality and the power dynamic between men and women represents an important but neglected aspect of HIV prevention for women. It is frequently forgotten that male consent is required for condom use.

(The Womens Aid report " Teenage Tolerance" (1999)). The most common reason cited for engaging in sexual intercourse at a party, was pressure. None of the young men gave this as a reason. Both young men and young women agreed that sex was expected after a certain length of time, and all agreed that continuing to refuse sex would result in the termination of the relationship. Overwhelmingly it was felt by the women involved in the study that sexual pleasure and sexual needs was something experienced by men which women "...had to comply with or resist". Some men cited excessive drinking as a reason to continue sex even after their partner had clearly said 'no', and also stated that it was a form of 'pay-back' after a night out. Men admitted to using a wide range of forms of pressure, including the threat of leaving a relationship, refusing to accept 'no' and trying to 'talk her around'. While not exclusively, some of the men in the study failed to even recognise that their approach was coercive. Equally worrying, young women in some instances posited coercion within the context of 'normality'.

Studies in the UK and Ireland have identified promiscuity labelling of women who carry condoms.

In the US, the CDC found that following training women were frequently willing to use condoms but more often than not their male counterparts were unwilling.

ECOSEP which operated under the NOW project focused on capacity building for women around sexual health, and the NICDTF are now funding a similar initiative. But we're taking a new approach now. Many of those programmes failed to recognise that men need to be educated around safer sex, and safer sexual negotiation. For many men, they don't see their resistance to condoms as anything other than perfectly reasonable. In order to challenge that, men need to be involved in workshops that empower both sexes to alter patterns of sexual behaviour.

## 5. Identity Labelling

The analysis of European KABS cited earlier found that in no country is homosexuality a legitimate, well-accepted and integrated form of sexual expression, valued in the same way as heterosexuality. However, from Kinsey to more contemporary KABS, it has been shown that approximately 40% will have engaged in sexual intercourse with another male, but the minority – approximately 10% - will remain exclusively homosexual/gay.

The dichotomisation of heterosexuality and homosexuality obscures the diversity human sexual desire and expression. This is again an overlooked factor in HIV prevention. Both in the U.S. and Vital Statistics Ireland 2000, demonstrates that msm but who did not identify as Gay or Bisexual had a lower perception of HIV risk than men who did. Furthermore, those who did not identify but had engaged in anal intercourse with another man in the previous year had tended more often than not to have engaged in unprotected anal intercourse.

What has been called the 'balkanisation of sexual desire' affects women to the extent that cultural 'norms' prevent a realisation that a male sexual partner may have previously engaged in unprotected receptive or penetrative sex with a same sex partner. The prejudice that surrounds gay sexual practises may also suggest that male partners may be unwilling to disclose such information for fear of rejection. Unprotected anal intercourse is a particularly high-risk activity that easily facilitates the transmission of HIV.

While WSW have been identified as the group least at risk for HIV transmission, low risk is not synonymous with no risk. A small number of cases have been reported in both the US and UK, and all but one remains unverified. The relative silence and stigma that surrounds WSW, will preclude Lesbian access to safer sexual information and education as the Sigma 2002 report demonstrated.

#### 6. Information Deficit

Silence of the media and sexual health promotion is poor.

## **Topical Microbicides:**

### **New Hope for Non-Condom Prevention of HIV and other STIs**

**Rebekah Webb -  
European Coordinator  
Global Campaign for Microbicides  
rwebb@global-campaign.org**

## **The Need**

- AIDS kills more people than any other infectious disease
  - in Sub-Saharan Africa, 67% of the almost 9 million HIV+ youth (15-25 years) are female
- HIV is rapidly becoming a “women’s epidemic”
  - of every 10 people newly infected with HIV, 6 are women
  - increasing rates of new infections among women in Eastern Europe (1 in 3)
- ABC is gender-blind (violence, economic dependency)

## **What is a microbicide?**

*Microbicides* are substances that can reduce the transmission of HIV and other STI pathogens when applied vaginally and, possibly, rectally.

*Currently*, they are topical products formulated as gels or creams applied with an applicator.

*Future formulations* could include sponges, time-released vaginal rings or gels combined with barrier devices such as diaphragms or cervical caps.

### **What will they change?**

- Will be more acceptable to both partners
- Will not require active male cooperation
- Will be appropriate within marriage
- Allow skin-to-skin intimacy
- Allow conception
- Prevent serious STIs
- Expand the range of options available to women

### **Other advantages...**

- Will be available over the counter
  - could be distributed like condoms in stores, at agencies or by outreach workers
- Are likely to be inexpensive
- Some will help boost the vagina's natural defences

### **How would we use a microbicide?**

- Along with condoms for extra protection
- As primary protection for individuals and/or couples unable or unwilling to use condoms consistently
- As a mouth rinse for protection during oral sex.
- As a potentially low-cost way of reducing perinatal transmission via vaginal washing prior to delivery

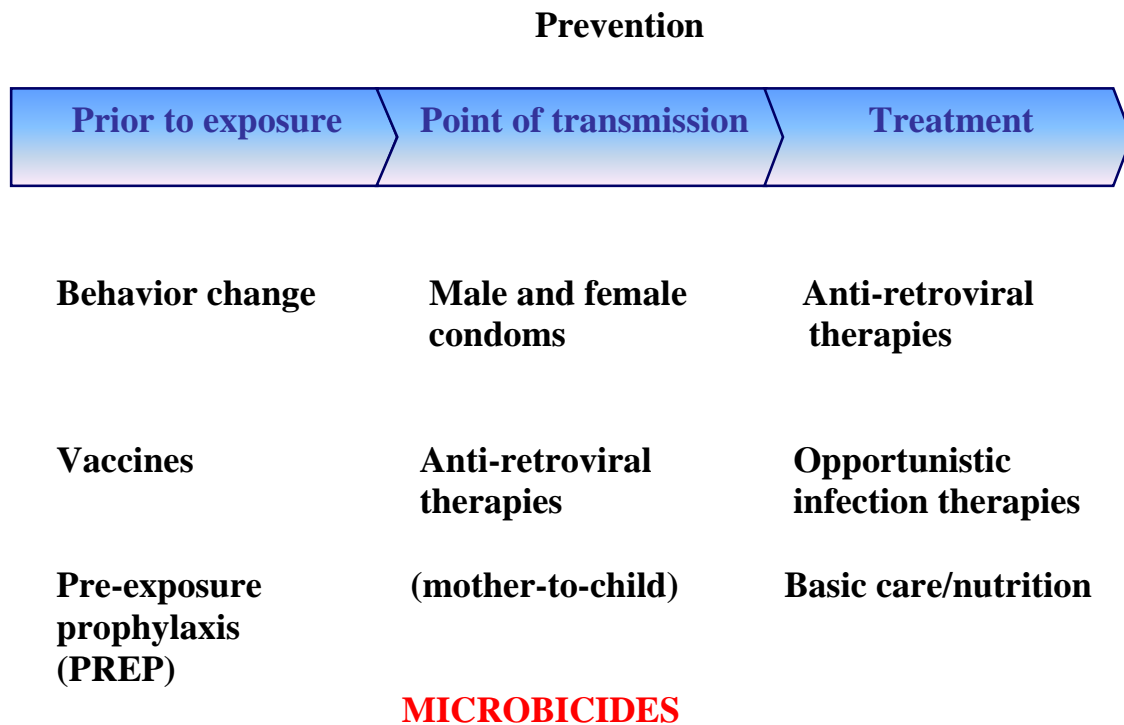
### How would they benefit HIV+ women?

- Reduce risk of re-infection with other HIV strains
- Help protect their partners – a bi-directional effect
- Reduce risk of other STIs, yeast and bladder infections
- Increase chances of getting pregnant safely and having HIV negative babies

### How effective will they be?

- **First** microbicides will be **40-60%** protective
- **Second** generation products will be **60-80%**
- should be promoted as an addition or “back-up” to condoms, not as a replacement
- use with harm reduction messages, such as:
  - *Use a male or female condom every time you have sex; if you absolutely can't use a condom, use a microbicide*
  - *Use a microbicide with your condom for added pleasure and protection*

## Positioning microbicides in the prevention spectrum



**Microbicides offer a woman-controlled method to reduce transmission.**

### How will they work?

- Four different mechanisms of action:
  - Boost natural defenses
  - Coat membranes in gel
  - Kill HIV/bacteria
  - Prevent HIV from attaching
  - Combine all four

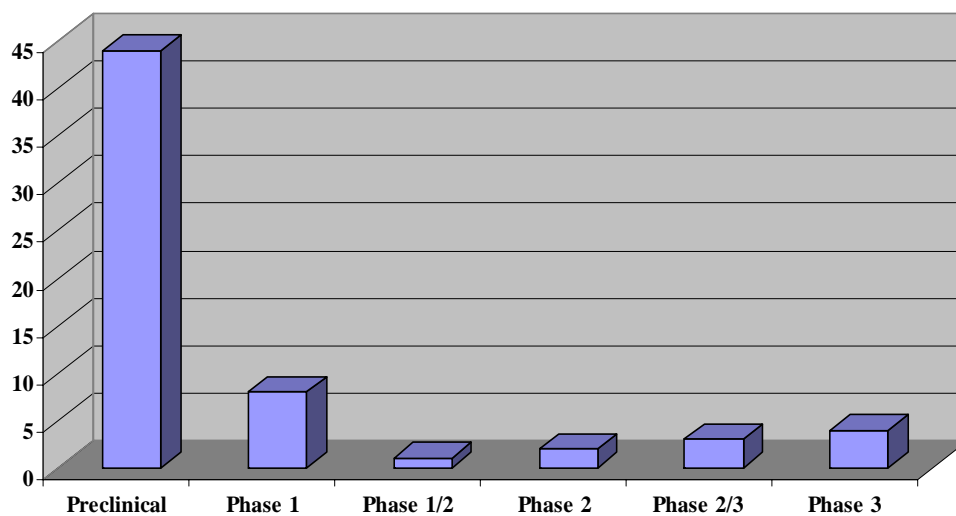
## Why don't they exist yet?

- Women's needs are not recognised
- Research is expensive
- No large pharmaceutical company is interested:
  - perceived low profitability
  - liability concerns
  - lack of in-house expertise
  - uncertain regulatory environment

## Current Product Status

■ Total pre-clinical	44
■ Total clinical	18
■ Phase I	8
■ Phase I/II	1
■ Phase II	2
■ Phase II/III	3
■ Phase III	4

## Where are we now?



Source: Alliance for Microbicide Development



## **Funding realities and needs**

### **Pharmaco-Economic Analysis showed:**

- Discovery through Phase II costs about \$10 million
- Phase III trials can cost an additional \$46-50 million
- If existing portfolio were owned by a single Pharmaco, it would need to invest roughly **\$775 million** over the next five years to ensure success
- BUT, at 2002 levels, only \$230 million available from governmental and philanthropic grants

**Therefore, \$500 million shortfall at least !**

### **Potential public health impact**

If a .....60% effective product

Offered to.....73 lower income countries

Is used by.... 20% people reached by health care

during..... ...50% of unprotected sex acts

**= 2.5 million HIV infections averted  
over 3 years**

(including women, men and children)

## **The advocacy agenda**

- The EU member states need to play a larger role in making microbicides a reality
- European government's investments in microbicide research and development should be:
  - substantially increased in the coming year, and
  - raised annually until first products reach the market.
- Without this investment, we may not see user-controlled HIV prevention tools available within this decade.

## **Global Campaign for Microbicides**

- Unifying umbrella for NGO activism and interaction with scientific community
- 25 active partner organisations; 200 endorsing groups worldwide
- GOALS:
  - Raise awareness and mobilize political support for increased funding for **microbicide research, female condom and cervical barrier methods;**
  - Create a supportive policy environment for their timely development, introduction and use;
  - Ensure that as science proceeds, the public interest is protected and the rights and interests of trial participants, users, and communities are fully represented and respected.

## **Awareness-raising and resource mobilization**

- Strategies differ between global North and South
- North- increase public investment in research and development
- South- demonstrate demand and confront myths that act as barriers

## **Supportive policy environment**

- Anticipating and answering policy questions
- Building knowledge, capacity of policy-makers
- Building networks to tackle policy issues
- Providing evidence of impact of new prevention technologies
- Support research that addresses policy questions

## **Protecting public interest**

- Global Campaign's "constituency" is the eventual users of microbicides
- GCM advocates WITHIN the microbicides field on issues that affect our constituency
- Ethics consultations
- Community involvement in research
- Trade-offs between speed, certainty, and expense

## **Conclusions**

- Women-initiated tools could potentially fill an important gap in protection
- Could be used as a fall-back when condom use is not possible
- Important to ensure that trials adequately funded
- Plan ahead to ensure that microbicides will:
  - meet women's needs (e.g. conceive/not conceive)
  - are acceptable, affordable and accessible
  - not seen as a barrier to intimacy
- Continued research required into vaccines and other potential new technologies for HIV prevention
- Continue to promote condoms

**For more information...**  
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**List of Participants**  
**June 2<sup>nd</sup> 2004**

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## Useful websites:

**Cairde** a non government organisation working with ethnic minorities to challenge health inequalities. [www.cairde.ie](http://www.cairde.ie)

The **National Women's Council of Ireland** [www.nwci.ie](http://www.nwci.ie)

The **Global Campaign for Microbicides** [www.global-campaign.org](http://www.global-campaign.org)

**Concern** [www.concern.ie](http://www.concern.ie)

The **World AIDS Campaign 2004: Women, Girls and HIV and AIDS** seeks to raise awareness and help address the issues affecting women and girls around HIV and AIDS. <http://www.unaids.org/en/events/campaigns/world+aids+campaign+2004.asp>

An emerging **Global Coalition on Women and AIDS**, launched by UNAIDS in February 2004, is also seeking to bring local and global activity together, identify gaps and reinforce the work that is already underway. [http://www.unaids.org/en/events/coalition\\_women\\_and\\_aids.asp](http://www.unaids.org/en/events/coalition_women_and_aids.asp)

**Amnesty International** has launched a global CAMPAIGN TO STOP VIOLENCE AGAINST WOMEN - "It's in our hands". 1 IN 3 WOMEN in the world will suffer serious violence in their lifetime. See at <http://web.amnesty.org/mav/index/engact770212004>

**The International Community of Women Living with HIV/AIDS (ICW)** [http://www.icw.org/tiki-view\\_articles.php](http://www.icw.org/tiki-view_articles.php)