

HIV's Unsolicited Flirtation with the African Woman: A Review of the Present Status

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Received Date: 12 Jan 2016

Accepted Date: 22 Jan 2016

Published Date: 26 Jan 2016

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Citation: Mabayoje VO. (2016). HIV's Unsolicited Flirtation with the African Woman: A Review of the Present Status. M J HIV. 1(1): 002.

ABSTRACT

Introduction: Human immune deficiency virus (HIV) is a virus that has plagued both men and women since the onset of the pandemic in the early eighties. However over time it as became evident that the virus through various means has a predilection for the female sex.

Aim: The aim of this paper is to highlight this problem, consider the various causes and offer suggestions as to how the problems may be overcome.

Materials and Methods: Review of existing literature, personal and similar published work emphasizing and supporting the subject. Dext top referencing.

Results and Conclusion: Various studies have repeatedly confirmed that the female sex is significantly more vulnerable without a doubt to HIV infection than the male sex. There has to be a more active and aggressive approach designed towards reducing the higher incidence of HIV among the female sex. This may include increased societal awareness and education and reduction in cultural practices that predispose them to HIV

KEYWORDS: HIV; AIDS; Female Condoms; Culture Education

INTRODUCTION

The human immune deficiency virus (HIV) first reared its head in the early eighties when young homosexual men (MSM) curiously began presenting with features suggestive of Pneumocystis carinii Pneumonia (PCP) now jirovechi (PJP) and Kaposi sarcoma. These presentations were occurring mostly in healthcare centers located in the USA especially in New York and California. It was in 1982 the first cases were scientifically described. Later the virus was isolated from one of these patients with lymphadenopathy and identified in the laboratory by Gallo and colleagues [1]. This eventually identified the HIV as the cause of AIDs. However it might be mentioned for historical purposes that as far back as the early 1900s the Simian immunodeficiency (SIV) virus the 'relative' of HIV that resides harmlessly in monkeys and Apes were first transmitted to the human race where they evolved into pathological species and eventually renamed HIV [2]. In 1980 a male from San Fransisco the first case of AIDS recognized at the time was reported to the center for Disease control (CDC).

Later that same year this first case, 'patient zero' was identified as Gaetan Dugas a Kaposi sarcoma patient that was

HIV positive, a flight attendant known to frequent many bath houses and was subsequently linked to many of the cases at the time [3]. Gaetan Dugas is thought to have introduced HIV from Canada in to the United States (transcontinental transmission) and has often been compared to Typhoid Mary (Mary Mallon) responsible for the typhoid epidemic of the early 1990s in New York City [4]. Presently the number of those living with HIV world wide is 36.9 million, however 70% of them reside in Sub-Saharan Africa [5, 6]. Of this 70% the majority are females.

HIV not only affects the health of individuals, it impacts households, communities, and the development and economic growth of nations. Many of the countries hardest hit by HIV also suffer from other infectious diseases, food insecurity, and other serious problems. In most studies carried out on the prevalence and incidence of HIV it has been found consistently that females are more frequently infected than males. This cannot be over emphasized. Studies carried out in our institution correspond with studies carried out elsewhere in Africa in this respect. For example in studies carried out in our center based in sub-saharan Africa and published

recently it was noted that females were much more infected than males. One such study revealed that 68.92% of the total infected study population were females and this was found to be statistically significantly higher than males ($p=0<0.005$). Another study showed that 73.8% of the study population were females [7, 8].

African females could also be two to six times more infected with HIV than men. Even though the vast majority of new HIV infections in sub-Saharan Africa occur in adults over the age of 25, HIV disproportionately affects young women. More than 4 in 10 new infections among women are in young women aged 15-24. 15-19 year olds are particularly at risk equating to higher HIV prevalence rates when they are older. For example, in Mozambique, HIV prevalence is 7% among 15-19 year olds but rises to 15% for 25 years olds. Likewise, in Lesotho, HIV prevalence rises from 4% among 15-19 year olds to 24% among 20-24 year olds. A review of 45 studies across sub-Saharan Africa found that relationships between young women and older men are common and associated with unsafe sexual behaviour and low condom use, which heightens their risk of HIV infection. This has been established in similar environs to ours repeatedly as mentioned earlier, since the introduction of highly active antiretroviral drugs in 1996 there has been a dramatic increase in the quality and length of life of infected individuals [9-12]. However it is unfortunate that females that contribute significantly to the development of nations through the nurturing of both men and women from birth do not appear to be receiving the optimal benefits from HAART due to their increased susceptibility to HIV infection. Several reasons have been proposed for this disparity in HIV infection among males and females. This becomes ironical when in the same breath it is said men have more 'risky' sexual habits than women yet women are more infected.

Reasons for this disparity include (biological) cyclical hormonal (oestrogen and progesterone) changes in females which make the wall of the vagina thinner and easier for the virus to penetrate during sexual activity. This factor operates both during adolescence and towards menarche. Immaturity of the female reproductive system also contributes as they are more prone to damage during sexual activity. Early marriage is encouraged in many African countries making these females fall victim to HIV. Gender inequalities also often compounds an existing hapless situation. This is often expressed by cultural, legal and political factors that impede a woman's ability to protect herself from HIV.

Due to these disparities, many women and girls are often powerless to abstain from sex, or to persuade their husbands or partners to use condoms. Neither option is realistic for women who are at risk of sexual violence or who would like to have children.

Marriage is often no protection. Many new HIV infections occur in women who are married or in long-term relationships with one partner. In Kenya, many more married and widowed women are HIV-positive than those who have never been

married. In Zambia, married or cohabiting people are estimated to account for as much as 60 percent of new HIV infections [13-15].

There are important socio-economic reason at play within the African concept. Women are expected to and do bear pain and discomfort as part of their 'duties'. Women are not empowered enough to be able to negotiate for safer sex. Lack of sufficient exposure in terms of education makes it more difficult for women to attain decision making positions in emerging African societies, decisions that would enable protection of fellow women. Due to this lack of education more women take up prostitution as a means of living at a point in their lives making them more susceptible to HIV infection. Homes headed by women who make provision for the clothing, feeding, education etc. of the child and or children are more at risk for HIV infection than homes headed by men [16].

More emphasis should be placed on education of the female child and even imposing sanctions on parents who fail to ensure the education of their female offspring to prescribed acceptable levels. Women should insist on the use of condoms for every sexual encounter. The use of female condoms should be made more popular and the female condoms made more widely available enabling women feel and realize they too can have more powers to exert when the issue of condom use arises during sexual activity.

There is need for drastic change and indeed if necessary a paradigm shift as regards the role of women in the African society. Early marriage, male inheritance of wives of deceased relatives and other similar sexual practices should be abolished for the sake of the survival of the woman into old age rather than early onset of death brought on by HIV especially when it can be avoidable. There is need to stem the increasing feminization of HIV and AIDS. It has been said that AIDS is the leading cause of death among women of reproductive age [17].

Rather unfortunately, all this is occurring in the background of a world consumed to near paranoia levels with concerns of other competing interests such as mass migration from expansive warring regions of the world and global terrorism which have apparently pushed such vital issues into the back burner making the situation more precarious and uncertain. Apart from increasing emphasis on education and exposure, more should be done to narrow or if possible totally obliterate the gender inequality gap fuelling this disparity. Our women are the mothers of the nation and should be treated as such. More research should also be focused into tackling the biological causes. It has also been shown that pre-exposure prophylaxis in females has the effect of significantly reducing the lifetime HIV risk in women. In a study it was noted the risk was reduced from 40% to 27% and at the same time life expectancy was increased¹⁸. . If more attention is focused into all these complex and multifactorial intrinsic problems it would move us nearer to the predicted world wide AIDS free society by 2030.

CONCLUSION

There has to be a more active and aggressive approach designed towards reducing the higher incidence of HIV among the female sex. This may include increased societal awareness and education and reduction in cultural practices that predispose them to HIV.

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