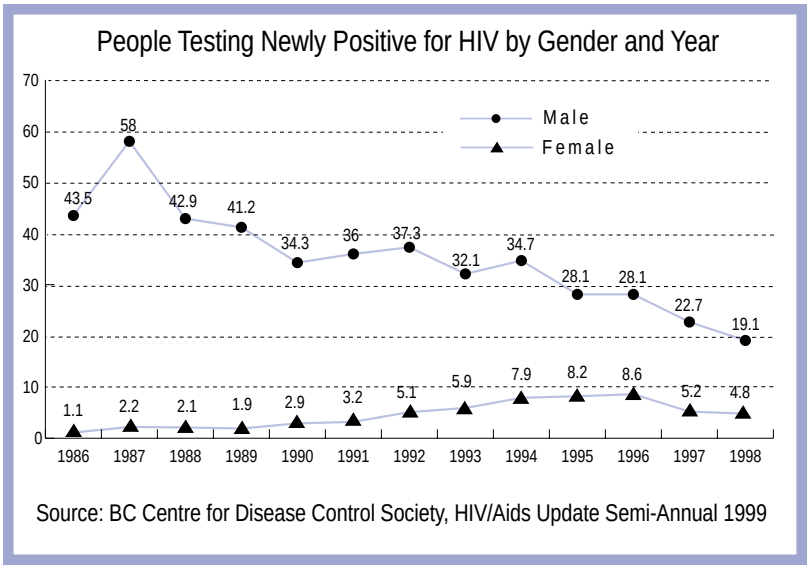
WOMEN AND HIV/AIDS ACCESS TO CARE

This summary focuses on women with HIV/AIDS and their access to appropriate antiretroviral treatment and physician care in British Columbia (BC). The main concerns that are unique to women with HIV/AIDS in regards to health care include:

- of those who test newly positive for HIV, women as a percentage are among the fastest growing population both in BC and internationally;
- women access antiretroviral therapy at lower rates than men;
- women are at increased risk for poverty and violence, which increases the exposure risk to the virus and results in fewer care-seeking behaviours;
- adolescent females may be at increased physiological risk for HIV/AIDS;
- marginalized women, such as Aboriginal women and women with at-risk behaviours, face greater barriers to antiretroviral treatment; and,
- women develop certain unique manifestations of the HIV infection, such as gynecologic infections and cervical cancer, and may be more likely to experience anemia; however, it is important to note that in general, most manifestations of AIDS and HIV-related illnesses in women are similar to those in men.

Epidemiology of women with HIV/AIDS

Since 1994, there have been over 1,100 women who tested newly positive for HIV in BC. Between January 1 and June 30, 1999, there were 56 women who were tested newly positive for HIV in BC. Overall, the rate of HIV infection for women has decreased for the past 2.5 years after increasing since 1986, and peaking in 1996 at 8.57 per 100,000 population (Graph 1). However, it is not known how many women and men are HIV positive and have not yet been tested for the infection.

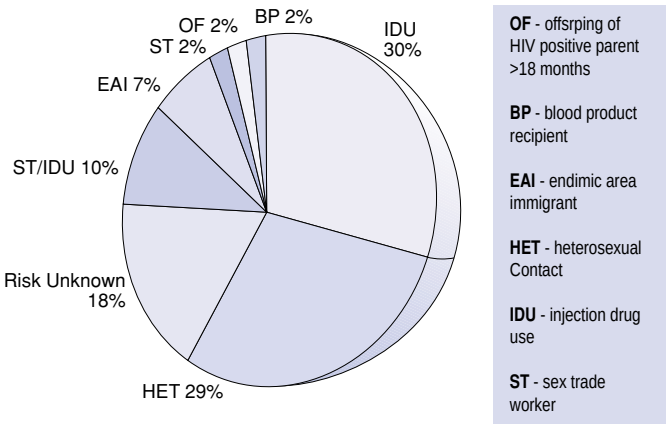


From January to June 1999, the majority of women who are newly testing positive for HIV in BC were caucasian (39%), followed closely by Aboriginal women (30%). HIV affects the Aboriginal population in disproportionate numbers, as they make up only 4% to 5%[1] of the entire population of British Columbia.

Almost two-thirds of women contracted the virus though Injection Drug Use (IDU) (30%) and heterosexual contact (29%) (Graph 2). It is clear that heterosexual contact is becoming a more significant mode of HIV transmission to women.

In terms of the social context, sexual abuse and sexual assault are strongly associated with testing positive for HIV. A study that profiled 110 HIV-infected women found that of the 81 women who responded to the question regarding prior sexual assault or abuse, 53% reported being sexually assaulted as an adult; 43% reported being sexually abused as a child; and 27% reported being sexually abused or assaulted both as a child and as an adult. Women who were sexually abused as a child were more likely to have injection drug use as a risk factor than those who were not abused as a child (54% versus 7.5%).[2] Education and income were also significant factors since one-third of the women surveyed did not complete high school, and one-half had an annual household income of less than $20,000.

Females Testing Positive for HIV in BC by Risk Factor.
January 1 - June 30, 1999



Source: BC Centre for Disease Control Society, Unpublished Tables

Women's Access to Antiretroviral Treatment

HIV positive women in British Columbia are less likely to access antiretroviral therapy than other groups, such as homosexual men with HIV/AIDS. There are many reasons why women are accessing antiretroviral therapy at lower rates despite the universal access policy adopted by the BC Ministry of Health. Women may perceive the therapy to be ineffective and fear the side effects associated with the treatment, there may be a lack of treatment advice and support from the medical system, and there may be a lack of a peer support system which facilitates access to information regarding antiretroviral therapy. This is supported by the profile[3] of HIV-infected women in British Columbia which found that of those women surveyed, a total of 27.5% had decided they did not want to try antiretroviral therapy, and 31.1% had decided to stop antiretroviral therapy after starting it. The most frequent concerns about this therapy were a perceived lack of effectiveness and fear of side effects.

Another issue in the study examines the use of health care services and satisfaction with the HIV-infected women's medical care. Most of the women, 84%, were seeing a family doctor for their general medical care, and 59% were seeing a family doctor for care of their HIV or AIDS infection. Of these women, 45% reported that they did not receive medical care for HIV in their own community, and 23% stated they had to travel more than 50 km to receive their care. Of the women who had a family doctor around the time they received a positive test result, only 28% felt that their doctor was up-to-date with medical knowledge about HIV and AIDS.

In addition:

- 66% of these women felt that their doctor was compassionate and respectful;
- 63% felt that their doctor was willing to treat HIV-positive patients;
- 17% of the women had a doctor refuse to see them (a doctor's refusal to see the woman was more common among women with a positive test result in 1991 or earlier than among those with a positive test result after 1991); and,
- 47% were satisfied with their doctor's care[4].

Another issue unique to women with HIV/AIDS is the decision about whether or not to have a child. The women who participated in the study reported that their doctor had discussed issues related to pregnancy with them, and in almost all of the cases, the doctor recommended against pregnancy. However, since this study was conducted, there have been advances in antiretroviral treatment. Currently, there is less than a 3% rate of transmission between a woman who is HIV positive and her fetus.

Another study[5] which focused on the barriers to use of free antiretroviral therapy in injection drug users reported that female IDUs received anti-retroviral therapy half as often as males after adjusting for baseline characteristics.

This study also reported that physicians with the least antiretroviral therapy experience were more than five times less likely to prescribe the therapy for IDUs, relative to most experienced physicians. In addition, physician HIV/AIDS experience was substantially associated with patient survival in previous studies.[6] Similarly, a study[6] that examined adherence and acceptance to antiretroviral therapy among HIV-infected women in a correctional facility found that acceptance and adherence with antiretroviral agents appear to be significantly associated with "trust in medications", "trust in the health care system", and "interpersonal relationships with physicians and peers".

HIV Myths and Realities

Stereotypical beliefs and perceptions of HIV positive women by society influence the care and treatment of women with HIV. Examples of myths, which are pervasive in the diagnosis and subsequent treatment of women with HIV, include:

Myth:

Heterosexual women are not at risk for HIV

Reality: Almost one third of newly tested women who tested HIV positive contracted it through heterosexual contact. Although women may be at significant risk for the HIV infection, they are frequently not diagnosed. Traditionally, the medical community has focused treatment and prevention of HIV/AIDS on persons with high-risk behaviours such as bisexual and homosexual men. As heterosexual women are not recognized as being a high risk for HIV, they are often diagnosed in the later stages of their infection. Early diagnosis of HIV infection in women requires that physicians are informed and play an active role in recognizing infection, instituting care, and referring women to support services.

Myth:

Only promiscuous women get HIV

Reality: In women who have acquired this disease by heterosexual contact, the median number of sexual partners since 1970 is 3.[8] Perceptions that heterosexual intercourse is not a significant risk factor complicate the problem of detecting HIV transmission in women.

Currently, it is believed that many women who have HIV are not aware that they are infected.[9] As HIV spreads beyond the stereotypical risk behaviours and urban areas, it is important for health care professionals across the province to supportively communicate to all women the importance of HIV testing. In addition, any indication or measure of sexually transmitted diseases should lead to an HIV test. Pregnancy is also a particularly important time for physicians to offer testing to women, as women can begin taking drug regimes to greatly reduce the transmission of the virus to their fetus. It is important though that physicians offer women a choice regarding testing, respecting the client's decision if she should decide against it. An integral component of the HIV screening and testing process is pre-and post-test counseling. Pre-test counseling should include an explanation of how the tests are done, and the meaning of a positive or negative test result. It is also important to the physician to discuss the issues of confidentiality and voluntary disclosure with the client.

Although all women are at risk for HIV infection, there are certain marginalized populations that are at increased risk for contracting the virus. The effective management of HIV infection in women requires recognition by the physician and the patient of risk behaviours. In order for health care providers to make an early diagnosis of HIV, it is imperative that they inquire about the drug use and sexual behaviours of both their patients and their patients' partners. However, it is important to be aware of the sensitive nature of these questions. The majority of these women have experienced horrific physical and sexual past and present abuse. It is important for health care providers to be aware of the issues impacting these women's lives.

Positive relationships with physicians and peers are important for improving adherence to antiretroviral therapy, especially for populations that have historically been marginalized by mainstream medical system. It is essential for physicians to be aware of the current treatment practices and guidelines for women with HIV/AIDS in order to ensure the best possible health care for their clients. It is vital for physicians to redirect their attention beyond the stereotypical high-risk behaviours and strongly consider all women to be at risk for HIV. Through heightened awareness and detailed interviewing and screening techniques, physicians can learn to identify women at significant risk and offer counseling and testing to make an early diagnosis, and can connect these women to treatment options and support networks. The volume and speed of change regarding prevention strategies, therapies and guidelines necessitates expert assistance for physicians in managing the complex issues surrounding this virus.

Physician Resources

1-800-665-7677 – 24-hour hotline – information and guidance for treating clients with HIV

(604) 875-2212 – Oak Tree Clinic – for specific questions regarding HIV in women

Two web sites provide more information: http://www.hivatis.org and http://www.cdcnpin.org.

Patient Support

1-800-661-4337 Toll-free HIV/AIDS Hotline – a confidential number for patient support

[1] Includes Status and Non-Status First Nations, Metis and Inuit, living on and off reserve; [2] Kirkham and Lobb. p. 320; [3] Kirkham and Lobb; [4] Kirkham and Lobb; [5]Kirkham and Lobb; Strathdee et al, p. 548-549; [6]Markson et al; and Kitahata et al; [7]Mostashari et al, p. 341; [8]National Institute of Allergy and Infectious Diseases and the Centers for Disease Control, p. 2; [9]Ibid, p. 322.

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